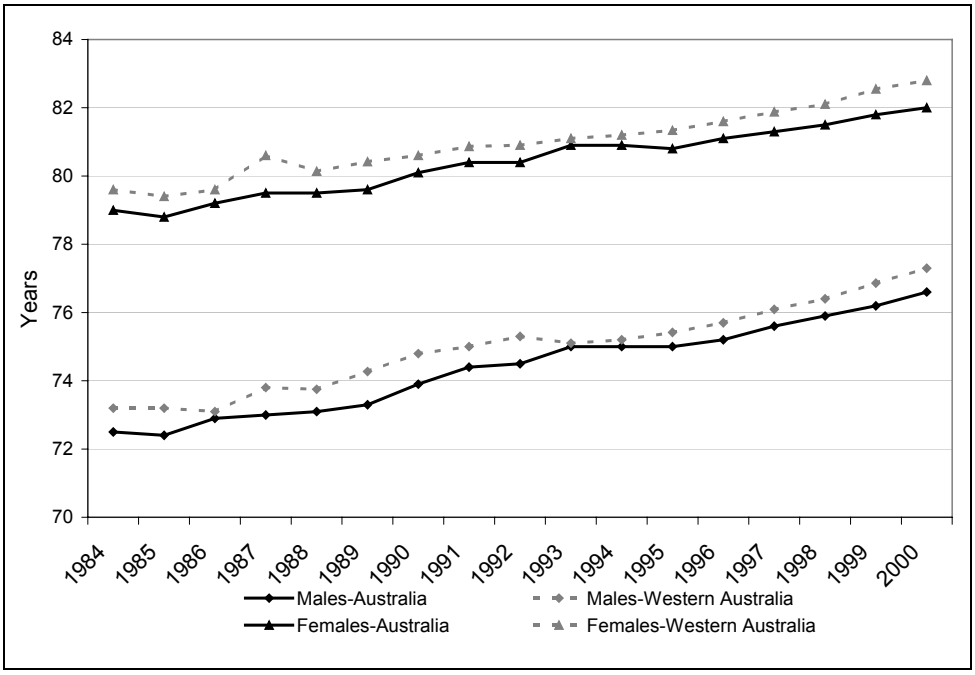
LIFE EXPECTANCY OF WESTERN AUSTRALIANS

Rationale

Life expectancy is the average number of years of life a person can be expected to live, if current age-specific mortality rates do not change throughout the person's lifetime. However, as mortality rates change, so does life expectancy. In the earlier part of the twentieth century, reductions in infant and child mortality - particularly through the diminished impact of infectious diseases in childhood and early adulthood - were largely accountable for increased life expectancy. Since the latter half of the twentieth century, significant gains occurred through reductions in mortality rates for diseases of the circulatory system and cancer[1].

Although life expectancy does not provide an indication of disease severity or quality of life, it does provide insight into the effects changes in social, economic and environmental circumstances and health care provision have had over time.

Figure 5: Life expectancy at birth for Western Australia and Australia by sex



Trends

There have been significant increases in male and female life expectancy at birth for both Australians and Western Australians between 1984-2000. WA male life expectancy at birth increased by 4.1 years from 73.2 to 77.3, and for females by 3.2 years from 79.6 to 82.8. Australian male life expectancy at birth increased by 4.1 years from 72.5 to 76.6 and for females by 3.0 years from 79.0 to 82.0. These increases reflect the ageing population, as well as an increase in the survival of males and females over the period.

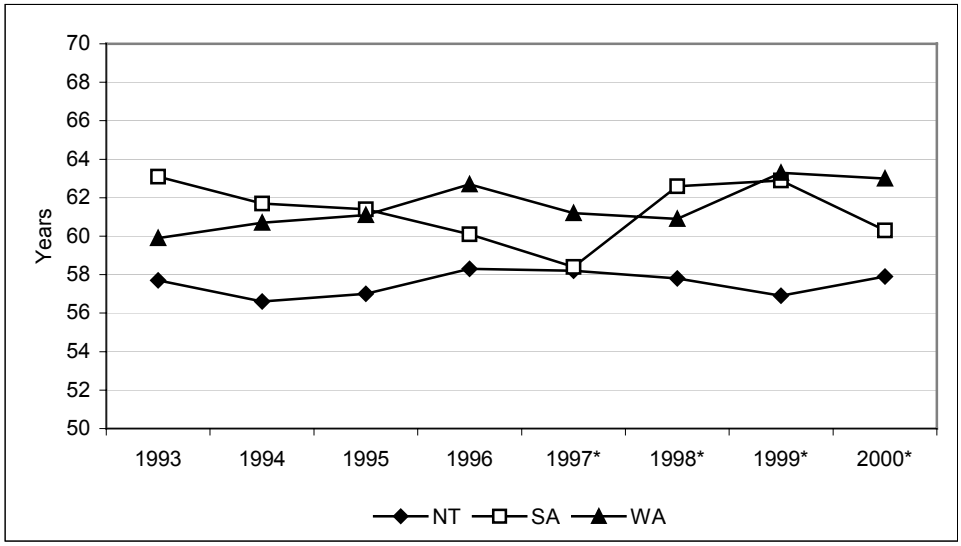
[1] Australian Institute of Health and Welfare 2002. Australia's health 2002. Canberra: AIHW.

Comparisons
In 2000[2], Western Australians had a slightly better life expectancy at birth compared with Australians in general. Females could expect to live 82.8 years (82 years nationally), and males 77.3 years (76.6 years nationally).

Life expectancy of Western Australian Aboriginal people compared with those of the Northern Territory and South Australia for 1992-2000

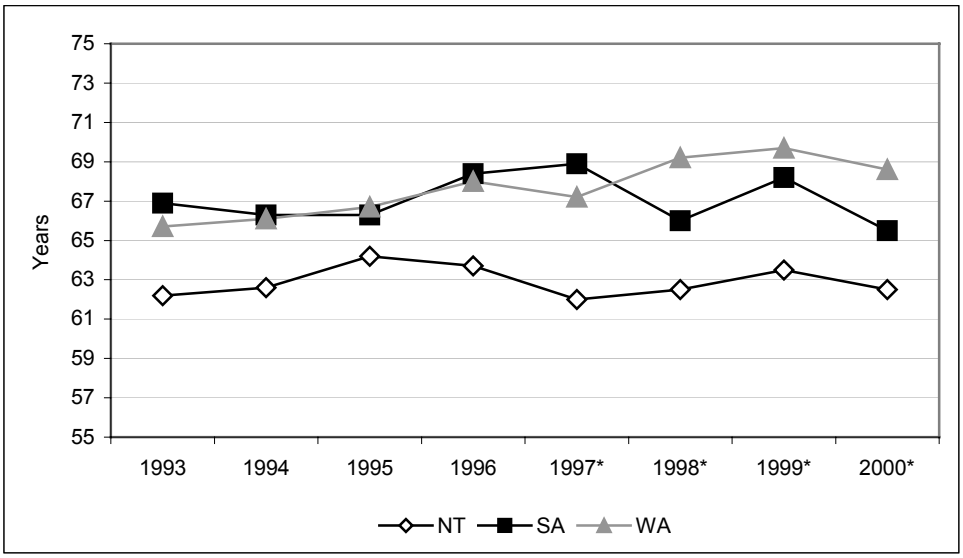
Rationale
In general, Aboriginal people have poorer health and higher mortality rates than non-Aboriginal people. Life expectancy among Aboriginal people is significantly lower than that for the rest of the population. As the quality of Indigenous identification varies across Australia, comparison of Aboriginal statistics has been limited to those States and Territories acknowledged by the ABS to have good quality data.

Figure 6: Life expectancy at birth for WA, NT, and SA Aboriginal males



[2] Results based on a three-year moving average when the year 2000 represents deaths between 1999 and 2001.

Figure 7: Life expectancy at birth for WA, NT, and SA Aboriginal females



Comparisons

In 2000, the WA Aboriginal life expectancy at birth was 63 years among males (NT: 57.9; SA: 60.3) and 68.6 years among females (NT: 62.5; SA: 65.5). This was 14.3 years less than that for all WA males (77.3) and 14.2 years less than all WA females (82.8).

Trends

During the period 1992-2000, there were significant increases in WA Aboriginal life expectancy from 59.9 years to 63.0 years for males and from 65.7 years to 68.6 years for females. The changes for SA and NT Aboriginal males and females were not significant.

Method

Aboriginal five-year age and sex-specific mortality data were used to estimate life expectancy at birth for WA, NT and SA. The number of deaths is based on year of death for 1991-2001. As NT and SA Aboriginal population figures were not available for 1997-2001 they were extrapolated from the 1991-1996 ABS estimates by linear regression using the Rates Calculator. The Australian and WA life expectancy figures for 1992 to 1999 are derived by averaging three-year population and death data for each year (1991, 1992, 1993 = 1992; 1999, 2000, 2001 = 2000). This change, introduced by the ABS, is to reduce the impact of year-to-year statistical variations.

Explanatory notes

a. Changes affecting Australian and WA results from 1994 include:
   - The population and deaths data are based on Australian residents physically present in Australia over the three year period (ie those temporarily overseas are excluded); and
   - They have been actuarially graduated on the same principles as those used for the quinquennial Australian life tables prepared by the AGA. State life tables are produced along the same principles.

b. Aboriginal life expectancy at birth must be interpreted with caution. Accurate age-specific mortality rates depend not only on the adequate identification of Aboriginal deaths but also on accurate Aboriginal population figures. Between the 1991 and 1996 census there was a large increase in the number of Aboriginal people counted – more than could be explained by natural increase. The accuracy of the population estimates may vary over time and therefore make the monitoring of trends less meaningful.

c. Five to six per cent of deaths for the most recent year of available data (2001) are not recorded as occurring in that year until data from the following year are available. This results in the lowering of 2000 life expectancy at birth when reported in the subsequent year. For Aboriginal deaths in WA and SA this can be as high as 10 to 20 per cent, and even higher within the NT.[3]

d. WA, NT and SA Aboriginal life expectancy at birth is reported as per the Australian and WA life expectancy and is based on three years of averaged population and death data for each year.

e. To achieve consistency with results routinely reported during the year for WA Aboriginals, Rates Calculator WA Aboriginal population data has been used to calculate life expectancy at birth as opposed to the ABS Experimental Estimates for WA. Results differ from those reported in previous annual reports, but provide a consistent population denominator for WA and reduce the impact of year-to-year statistical variations. Results will differ as the WA Aboriginal population figures used in the Rates Calculator have been updated, and only Aboriginal deaths of usual residents of WA have been included.

f. The 1984-2000 life expectancy at birth for Australia and WA is as reported by the ABS. Annual life tables were calculated by the Australian Statistician until 1994. From 1995, the life tables have been produced as a joint venture between the ABS and the Australian Government Actuary.

Data sources:

Mortality database, Health Information Centre, DOH.
Abraham B, d'Espaignet and Stevenson C (1995). Australian health trends 1995. Canberra: AIHW.
ABS (1994, 1996-01). Demography Western Australia 1994-00. Catalogue No. 3311.5. Canberra: ABS.
ABS (1997-2001). Death Australia 1996-2000. Catalogue No. 3302.0. Canberra: ABS.
ABS (1998). Experimental Estimates of the Aboriginal and Torres Strait Islander Population, 1991 to 1996. Catalogue No. 3230.0.

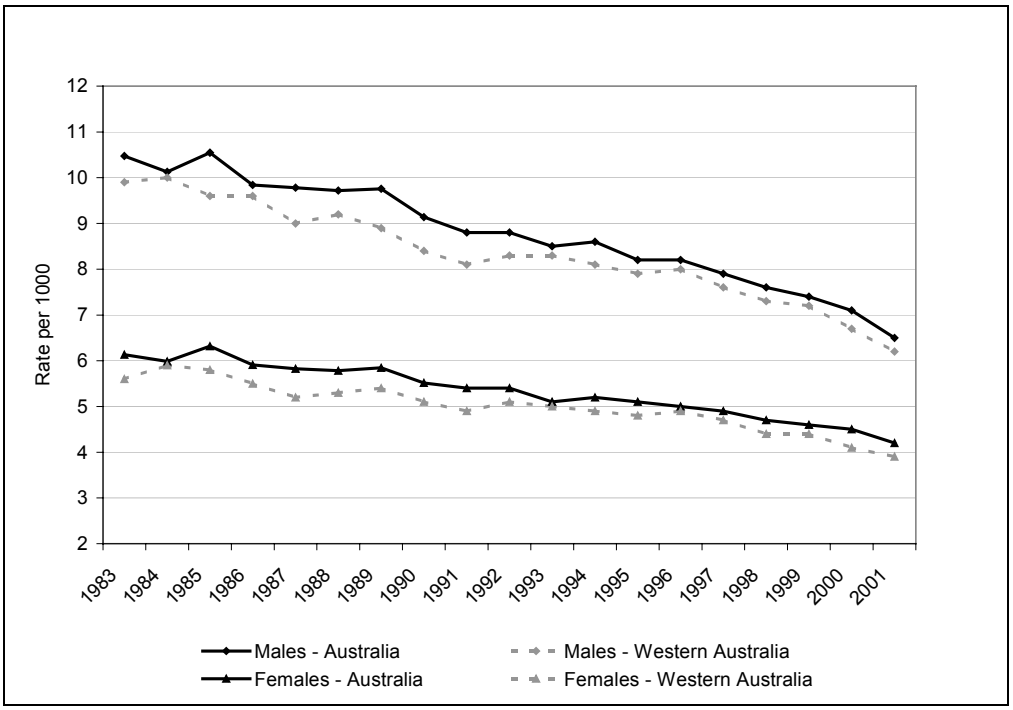
[3] ABS (1996). Occasional paper: Mortality of Indigenous Australians. Catalogue No. 3315, Canberra: ABS.

CHANGES IN ALL-CAUSES MORTALITY IN WESTERN AUSTRALIA

Rationale

Mortality is one of the most widely available measures of ill health. The mortality rate expresses the incidence of death in a particular population over a period of time. While health related behaviours (such as smoking, nutritional adequacy, and alcohol or other drug abuse) are important factors affecting mortality, the scope of factors affecting the likelihood of death also includes demographic and socio-economic variables (age, sex, marital status, income and education). To ensure meaningful comparison of the mortality rate between populations, the mortality rate is standardised to account for differences in the age profile of the populations being compared. This indicator measures the age-standardised mortality rate per 1,000 population from all-causes for each sex.

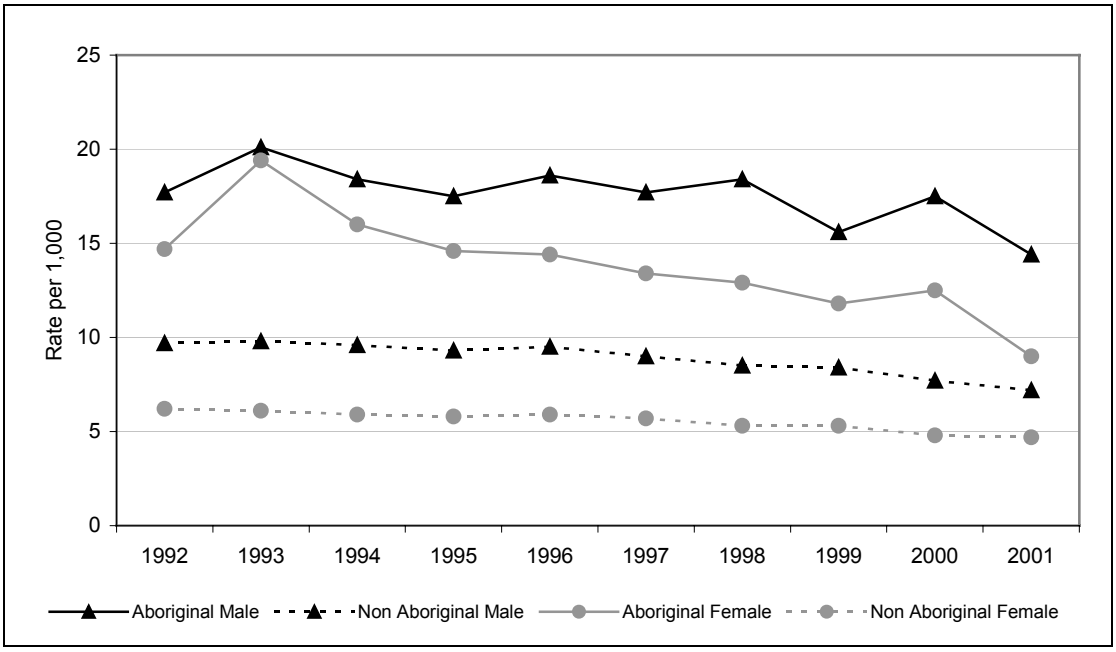
Figure 8: Age-standardised mortality rate for Western Australia and Australia by sex



Trends
During the period 1983 to 2001, there was a significant decrease in the Australian and WA age-standardised mortality rates, with male rates having declined more rapidly than female rates. A major contributor to this has been the dramatic decrease in cardiovascular deaths among males. More modest decreases in mortality due to injury and, since the late 1980s, a decrease in lung cancer deaths among males relative to increasing female lung cancer deaths also contributed to the relatively larger fall in the male mortality rate.[4]

Comparisons
In 2001 the WA age-standardised mortality rates (males 6.2 per 1,000; females 3.9 per 1,000) were similar to, but less than, the equivalent Australian mortality rates (males 6.5 per 1,000; females 4.2 per 1,000).

Figure 9: Age-standardised mortality rate for Western Australia by sex and Aboriginality



Trends
While the mortality rates significantly declined for male and female Aboriginals and non-Aboriginals over 1992 to 2001, the mortality rate for Aboriginal females declined most rapidly.

Comparisons
In 2001 the mortality rate for Aboriginal males (14.4 per 1,000) was twice that of non-Aboriginal males (7.2 per 1,000), and the mortality rate for Aboriginal females (9.0 per 1,000) was almost twice that of non-Aboriginal females (4.7 per 1,000).

[4] Taylor R, Lewis M, and Powles J (1998). The Australian mortality decline: cause-specific mortality 1907-90. Australian and New Zealand Journal of Public Health. 22 (1): 37-44.

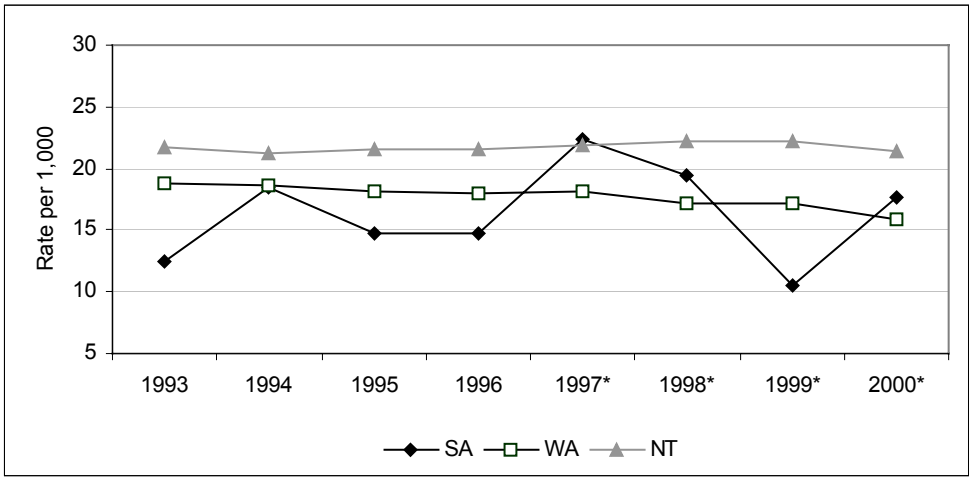
Circulatory system diseases, accidents, self harm, assault, cancers, respiratory diseases, and endocrine/metabolic diseases accounted for the greatest number of deaths among both Aboriginals and non-Aboriginals, although Aboriginals were more likely to die from these causes at younger ages than the non-Aboriginal population[5].

Changes in WA Aboriginal mortality rates

Rationale

In general, Aboriginal people have poorer health and therefore higher mortality rates than non-Aboriginal people. The most accurate recording of Aboriginality in the mortality registers, and the smallest discrepancies between the 1991-based population projections and the 1996-based population estimates were for WA, NT and SA. Therefore, trends in Aboriginal mortality rates in NT and SA were compared to those in WA using data from 1992-2001.

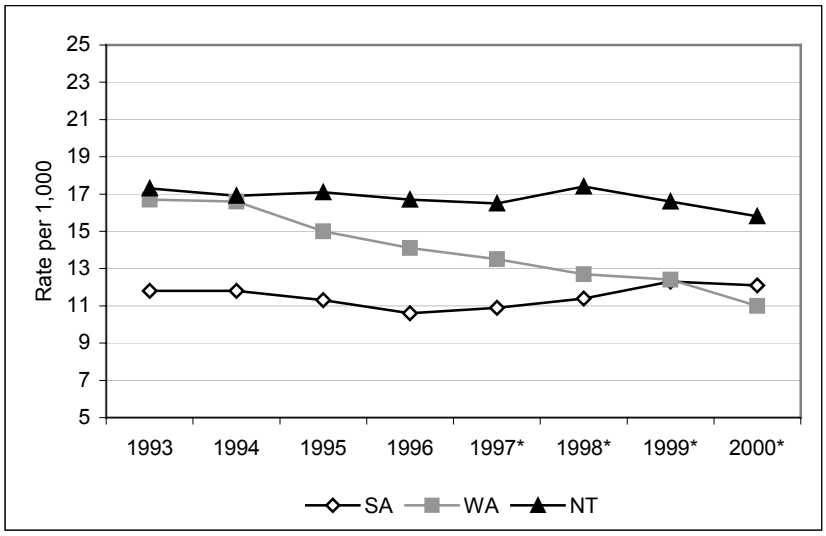
Figure 10: Aboriginal male mortality rates for WA, NT, and SA



* NT and SA Aboriginal population figures were not available for 1997 to 2000; they were extrapolated from the 1991-1996 ABS estimates by linear regression.

[5] Australian Institute of Health and Welfare 2002. Australia's health 2002. Canberra: AIHW.

Figure 11: Aboriginal female mortality rates for WA, NT, and SA



Note: *NT and SA Aboriginal population figures were not available for 1997 to 2000; they were extrapolated from the 1991-1996 ABS estimates by linear regression.

Trends

There was a significant reduction in all-causes mortality for both Aboriginal males and females in WA. These trends were not observed in either SA or NT.

Comparisons

The 2000 Western Australian Aboriginal age-standardised mortality rates of 15.8 per 1,000 among males (NT: 21.4; SA: 17.6) and 11.0 per 1,000 among females (NT: 15.8; SA: 12.1) were almost three times the overall Western Australian mortality rates (males: 6.2; females: 3.9). Aboriginal females in all three States had lower mortality rates than Aboriginal males.

Method

Since the risk of death varies greatly with age and sex, for the purposes of comparison between geographic areas over time, and between population subgroups, the sex-specific age-standardised mortality rates were used. This allows populations with different age distributions - either populations at the same time, or the same population at different times – to be compared. The sex-specific age-standardised mortality rates were calculated for the total population and Aboriginal people based on year of death. While results differ to those reported in previous annual reports, the revised methodology provides a consistent population denominator for WA and reduces the impact of year-to-year statistical variations. Aboriginal age-standardised mortality rates are derived by averaging three year population and death data for each year (1992, 1993, 1994=1993; 1999, 2000, 2001=2000).

Explanatory notes

a. Mortality rates are restricted in their ability to reflect differentials in other important dimensions of health status, such as disease incidence and severity, and to issues pertinent to the quality of life before death (disability and handicap).

b. Information on trends in Aboriginal mortality rates must be interpreted with caution as accurate rates not only depend on the adequate identification of Aboriginal deaths, but also on accurate Aboriginal population figures. Between the 1991 and 1996 census there was a large increase in the number of Aboriginal people counted – more than could be explained by natural increase. The accuracy of the population estimates may vary over time and therefore make the monitoring of trends less meaningful.

c. Mortality rates reported for the most recent year will differ from those subsequently reported for that year, as some deaths occurring in the most recent year will not be registered until the following year. For the total population five to six per cent of deaths occurring in Australia for the most recently available year are not registered until the following year. For deaths of Aboriginal people this can be as high as 10 to 20 per cent and even higher for the NT.[6]

d. The 1983-2001 WA and 1992-2001 Australian sex-specific age-standardised mortality rates were calculated using the Rates Calculator. Sex-specific Australian age-standardised mortality rates for 1983-1990 have been provided by the ABS.

e. The 1992-2000 WA, NT and SA Aboriginal sex-specific age-standardised mortality rates were calculated using the Rates Calculator. The 1992-2001 WA Aboriginal population data are those derived for routine use within the Rates Calculator, whereas the NT and SA data are those of the 1991-1996 ABS Experimental Estimates of Aboriginal and Torres Strait Islander Population.

Data sources:
Mortality Database, Health Information Centre, DOH.
ABS (1998). Experimental Estimates of the Aboriginal and Torres Strait Islander Population, 1991 to 1996. Catalogue No. 3230.0.
ABS (1998). Australian mortality data 1983-90. Unpublished data.

[6] ABS (1996). Occasional paper: Mortality of Indigenous Australians. Catalogue No. 3315, Canberra: ABS.

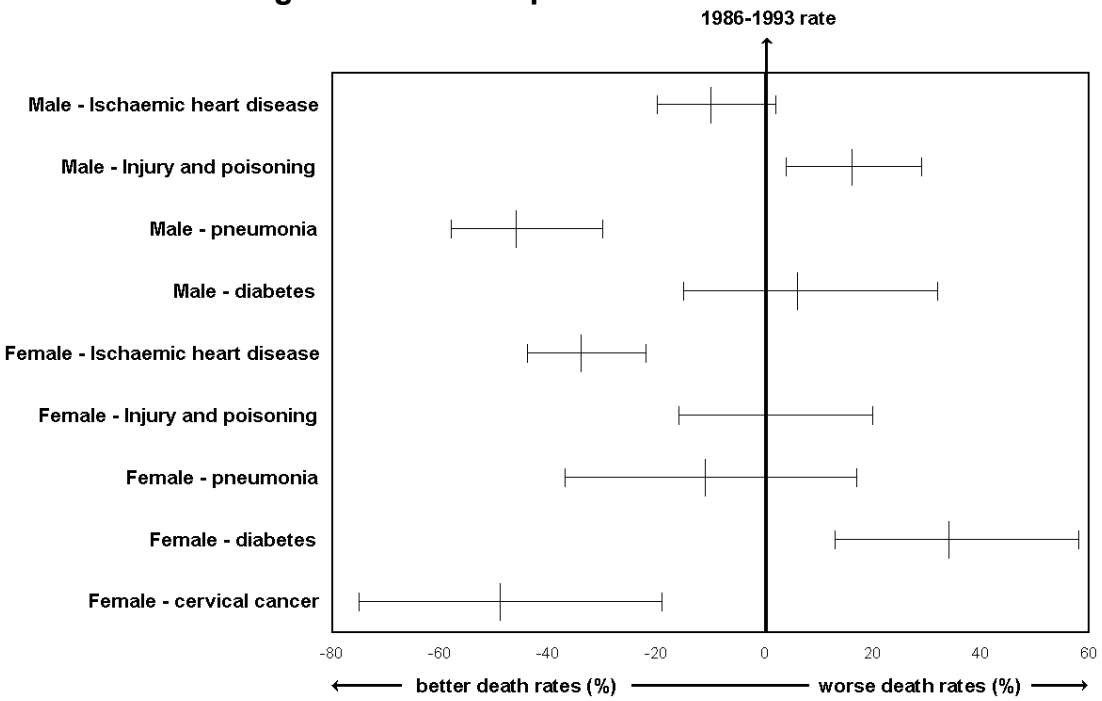
CHANGES IN SPECIFIC CAUSES OF ABORIGINAL MORTALITY

Rationale

National Performance Health Indicators for Indigenous people include ischaemic heart disease (IHD), injury and poisoning, pneumonia, diabetes and cervical cancer as these conditions are major causes of ill-health and death in the Australian Indigenous population. There is also a large relative differential in mortality for these conditions between the Indigenous population and total population. Lifestyle behaviours such as smoking, nutritional intake, alcohol and drug abuse, hygiene and living conditions increase the risk of death from these major causes. Intervention strategies targeted at changing lifestyle behaviour can potentially prevent many of these deaths.

Mortality is one of the most widely available measures of ill health. The standardised mortality ratio (SMR) compares the death rate in a standard population to that of the population of interest over a period of time. The SMR provides an estimate of the number of deaths expected, compared with those observed, after making adjustment for variations in the population's age and sex distribution.

Figure 12: Percentage improvement for selected conditions in Aboriginals during 1994-2001 compared to 1986-1993



Trends

The above figure shows the percentage improvement of 1994-2001 WA Indigenous death rates over 1986-1993 death rates for WA Indigenous people. While death rates from injury and poisoning in WA Indigenous males significantly increased between 1986-1993 and 1994-2001, the decline in mortality from pneumonia was significant. The WA Indigenous male mortality rate from IHD and diabetes remained similar over this time.

The WA Indigenous female death rate for diabetes increased significantly between 1986-1993 and 1994-2001, while the rates for injury and poisoning, and pneumonia remained similar. Significant decreases in death rates were seen for IHD and cervical cancer.

Figure 13: Percentage improvement for selected conditions in SA and NT Aboriginal males compared to WA Aboriginal males during 1994-2001

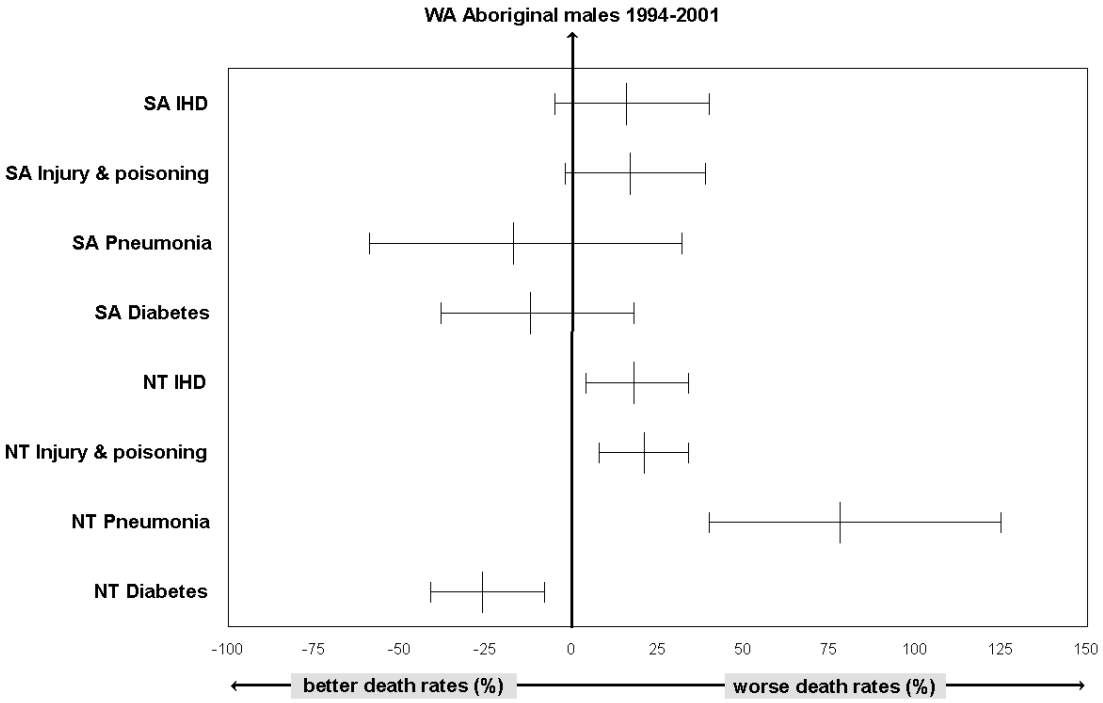
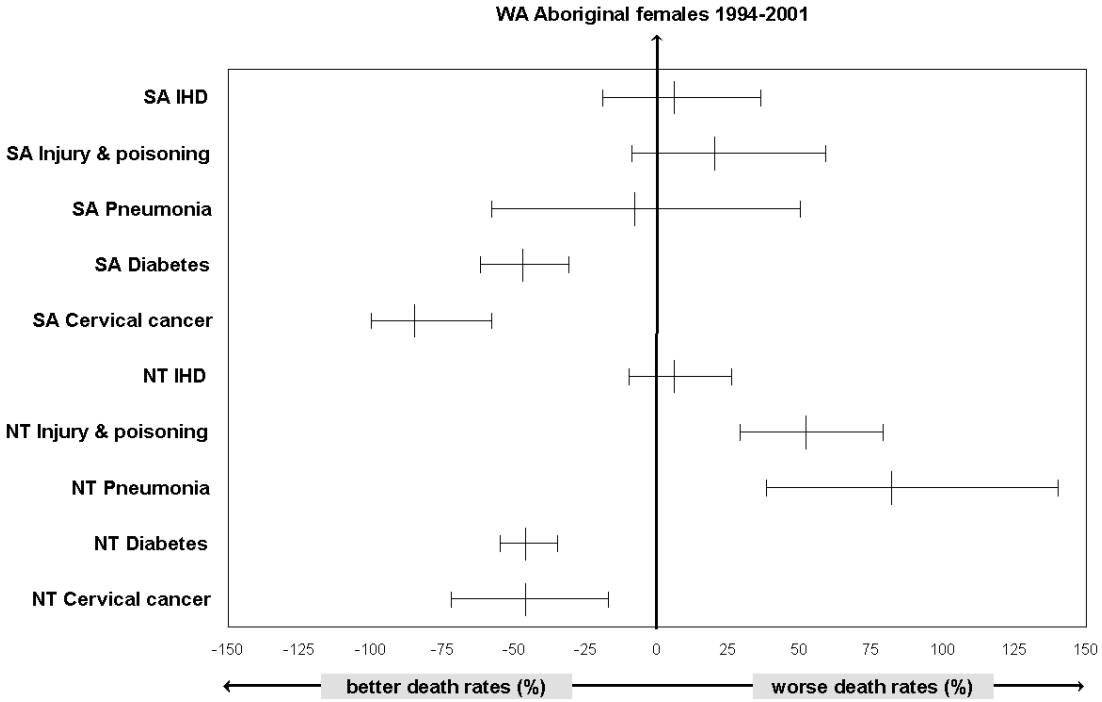


Figure 14: Percentage improvement for selected conditions in SA and NT Aboriginal females compared to WA Aboriginal females during 1994-2001



Comparisons

The above figures show 1994-2001 death rates for WA Indigenous females have been set at 0, and each horizontal bar represents the 95% confidence interval of the 1994-2001 SA or NT Indigenous death rate. If a 95% confidence interval includes 0, the SA or NT death rate is not statistically different to that of its WA gender counterpart. If the 95% confidence interval in its entirety is below 0, then the SA or NT death rate for that condition is statistically significantly better than its WA gender counterpart, and if it is entirely greater than 0 the death rate is statistically significantly worse. The vertical line on each horizontal bar indicates the percentage improvement.

Based on mortality data from 1994-2001, SA Indigenous male death rates from IHD, injury and poisoning, pneumonia and diabetes were similar to WA Indigenous males over the same period. In contrast, NT Indigenous male mortality rates significantly increased for IHD, injury and poisoning, and pneumonia; and significantly decreased for diabetes compared to their WA counterparts in the earlier time period.

Between 1994-2001, SA Indigenous females had significantly decreased mortality rates for diabetes and cervical cancer in comparison to WA Indigenous females. Their rates of death from IHD, injury and poisoning, and pneumonia were similar, however. While the rate of death from IHD remained similar for NT Indigenous females' mortality rates from injury and poisoning, and pneumonia increased significantly. The decreased death rates from diabetes and cervical cancer were also significant.

Method

The SMR compares the actual number of deaths in the population under study to the expected number of deaths which would have occurred if that population had experienced the age-specific death rates of the standard population. The indirect method of standardisation is useful when the number of events is small. Data was aggregated over the 1986-93 and 1994-2001 periods.

For the trend in WA Aboriginal mortality for specific conditions, the WA Aboriginal 1986-1993 sex and age-specific mortality rates were used as the standard and applied to the 1994-2001 WA Aboriginal population for males and females so as to determine the expected numbers of cases for the conditions examined.

For comparisons with SA and the NT, the WA Aboriginal 1994-2001 sex and age-specific mortality rates were used as the standard and applied to the 1994-2001 SA and NT Aboriginal population for males and females in order to determine the expected number of cases for the conditions examined.

The actual number of deaths for the 1994-2001 WA, SA and NT Aboriginals and 1986-1993 WA Aboriginals are based on year of death.

Explanatory notes

a. Mortality data is limited in the ability to reflect differentials in other important dimensions of health status such as disease incidence and severity or to issues pertinent to the quality of life before death (disability and handicap). Accurate age-specific mortality rates depend not only on the adequate identification of Aboriginal deaths but also on accurate Aboriginal population figures. Between the 1991 and 1996 census there was a large increase in the number of Aboriginal people counted – more than could be explained by natural increase. The accuracy of the population estimates may vary over time and therefore make the monitoring of trends less meaningful.

b. For the total Australian population, registration of five to six per cent of deaths occurs in the following year. For deaths of Aboriginal people this can be as high as 10 to 20 per cent and even higher for the NT.[7] Therefore, Aboriginal mortality rates for the period 1994-2001 are underestimated, particularly for the NT, because of the incomplete registration of deaths occurring in 2001.

c. WA Aboriginal population figures are those of the Health Information Centre Rates Calculator and the SA and NT population data are that of the ABS Experimental Estimates for 1991-96. The 1997, 1998, 1999, 2000 and 2001 SA and NT data are extrapolations based on linear regression. All calculations for the SMR were undertaken with the Health Information Centre Rates Calculator.

Data sources:
Mortality Database, Health Information Centre, DOH.
ABS (1998). Experimental Estimates of the Aboriginal and Torres Strait Islander Population, 1991 to 1996. Catalogue No. 3230.0.
ABS (2001). Australian Mortality Database 1991-2000.

[7] ABS (1996). Occasional paper: Mortality of Indigenous Australians. Catalogue No. 3315, Canberra: ABS.

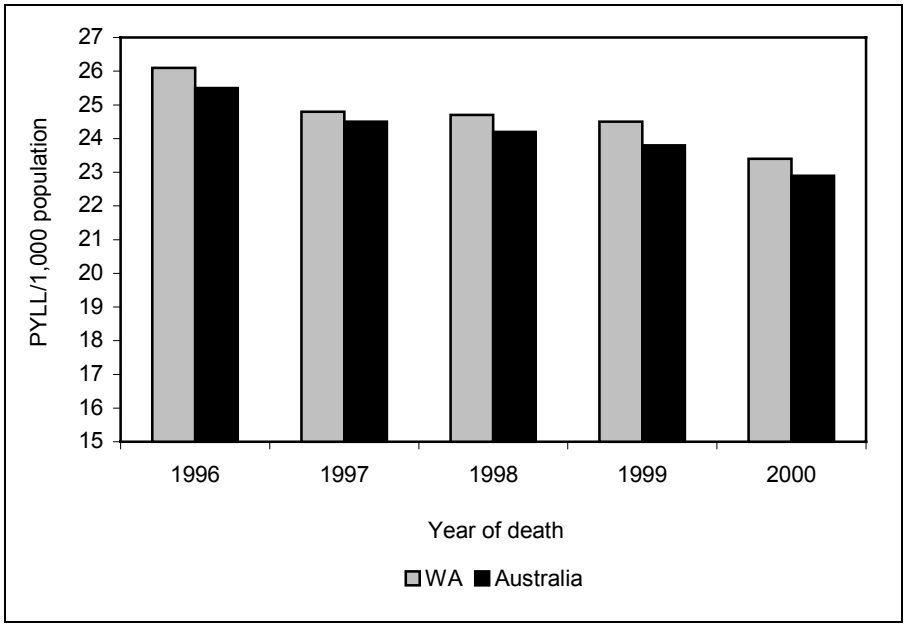
Loss of life from premature death due to preventable diseases or injury

This indicator measures the Person Years of Life Lost (PYLL) from premature death due to preventable diseases or injury.

Rationale
Person Years of Life Lost (PYLL) takes into account the loss of normal life span years when measuring the impact of individual causes of death, the younger the person the higher the value of Person Years of Life Lost (PYLL).

The Department of Health undertakes a number of programs and activities specifically designed to reduce incidence of preventable health conditions. Declining PYLL relative to population is consistent with positive outcomes from these programs. The programs are aimed at the early detection and prevention of cancer, heart disease, diabetes and injury.

Figure 15: Person years of life lost per 1,000 population due to preventable disease or injury, WA and Australia



Data source:
Mortality Database, Health Information Centre, DOH.

The information for this performance indicator has been obtained by examining cause of death information shown on death certificates in respect to preventable and partly preventable health conditions.

Trends
Loss of life from premature deaths due to preventable disease or injury among both the WA and Australian population has decreased over the five-year period.

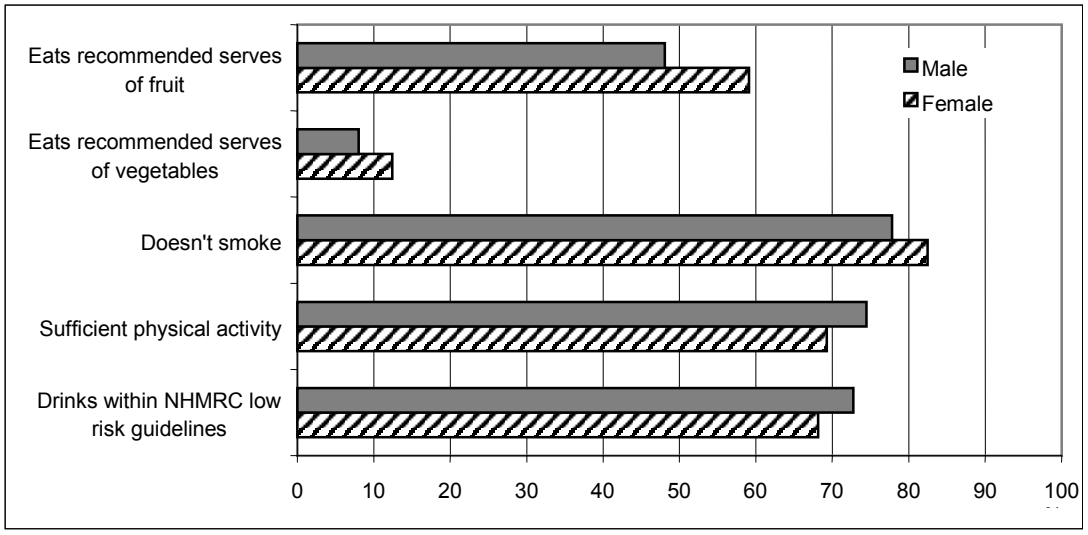
RISK FACTORS FOR DISEASE

Rationale

The Department of Health's Health and Wellbeing Surveillance System tracks the health status of Western Australians. People are asked questions about their lifestyle because how people behave can affect their health. The main lifestyle risk factors are smoking, excessive alcohol consumption, poor nutrition and too little physical activity. These behavioural risk factors also contribute to physiological risk factors such as high blood pressure, high cholesterol and obesity.

Information from the surveillance system can tell us whether or not there are changes taking place in peoples' lifestyle choices that are consistent with the Department's health promotion campaigns.

Figure 16: Proportion of people who choose lifestyle habits that promote good health by sex– March 2002 to June 2003



Trends

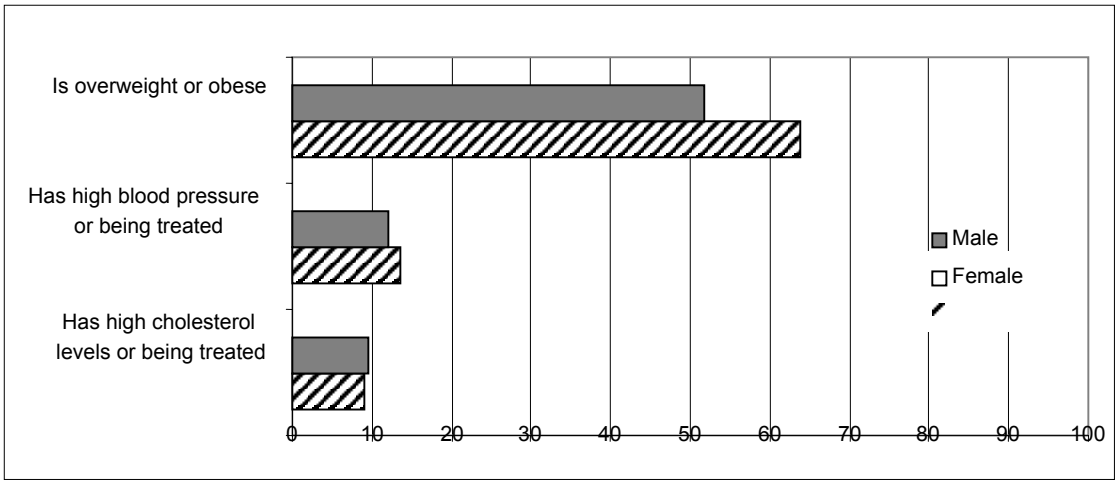
The 2000 Collaborative Health and Wellbeing Survey surveyed 10,000 people using the same questions currently used to establish lifestyle habits. In comparing 2000 with 2003, results from only those aged 18 and over were used. In 2003 the main differences are:

- More people in Metro and Peel, and Country services areas drink outside recommended guidelines;
- More people in Metro and Peel do sufficient physical activity;
- More people in Metro and Peel don't smoke;
- More people in WA are within normal weight limits; and
- Blood pressure and cholesterol levels are higher across the State.

Comparisons

The figure on the previous page compares the proportion of men and women who choose lifestyle habits that promote good health. While our food habits, particularly those meeting the recommended five serves of vegetables a day need some improvement, the majority of WA people are making healthy lifestyle choices. However, as the below figure shows, there are many people with physiological risk factors of high BMI (which is an indicator of obesity), high blood pressure and high cholesterol levels.

Figure 17: Proportion of people who have physiological risk factors by sex – March 2002 to June 2003



More women than men have high blood pressure/are taking medication for high blood pressure, and are overweight or obese. There are no differences in high cholesterol levels.

Table 12: Risk factors by locality – March 2002 to June 2003

Lifestyle choices	% Metro and Peel	% South West	% Country services
Drinks within NHMRC low risk guidelines*	71.2	70.6	68.1
Sufficient physical activity+	73.4	70.4	68.8
Doesn't smoke*	82.0	80.2	76.4
Eats recommended serves of vegetables	10.2	10.2	10.2
Eats recommended serves of fruit	53.8	57.0	51.8
Physiological Risk Factors			
Has high cholesterol levels or being treated *	9.8	10.3	7.9
Has high blood pressure or being treated *	12.6	15.9	12.3
Is overweight or obese	65.7	58.3	59.7

Note: * asked of people aged 16 and over
+ asked of people aged 16 to 64 years using the Active Australia questions

Compared with the rest of the State

- A higher proportion of South West residents eat the recommended serves of fruit;
- A significantly lower proportion of Country services residents drink within recommended guidelines;
- A higher proportion of Country services residents smoke;
- More Metro and Peel residents are overweight or obese; and
- A higher proportion of Country services residents have high blood pressure and high cholesterol levels.

Explanatory notes

a. The data have been age and sex adjusted to the estimated 2002-2003 Estimated Resident Population for WA.
b. Significant differences for long-term conditions were determined using Chi-Square analysis and comparison of confidence intervals.
c. Data for Peel and Metro were combined due to the low numbers in the Peel region.

Data sources
WA Health and Wellbeing Surveillance System, Health Information Centre, DOH
2000 Collaborative Health and Wellbeing Survey, Health Information Centre, DOH

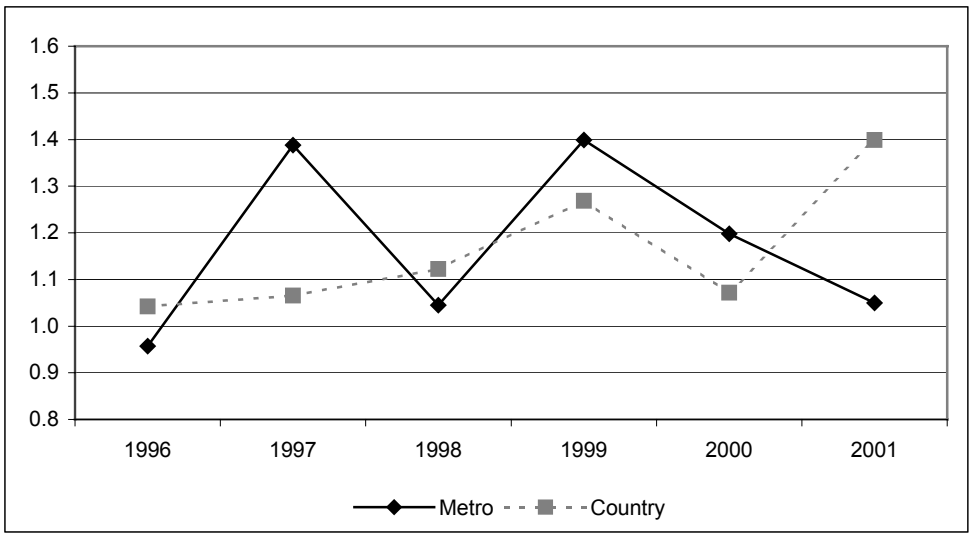
ACCESSIBILITY OF SERVICES – ACCESSIBILITY INDEX VARIATIONS

Rationale

Equity of access to health care across populations is a major component of public health policy. If the needs across populations were uniform, equity could simply be defined according to equal measures of access. Such measurement is insufficient, however, when there are different health requirements across populations, and defining access *according to need* becomes more appropriate. The importance of measuring access conditionally is highlighted when considering the great disparity in health status between Aboriginals and non-Aboriginals in Australia. [8]

Hospital care reduces morbidity and mortality in a population. The more a population accesses hospital care according to its needs, the access-to-need ratio approaches one. Thus service accessibility can be evaluated across populations by comparing their access-to-need ratios and calculating an index of access. The ultimate goal of WA public health policy is to attain an index of access approaching statistical unity with equitable access of services for Aboriginal people and irrespective of area of residence.

Figure 18: Accessibility index variations by Aboriginality and area of residence



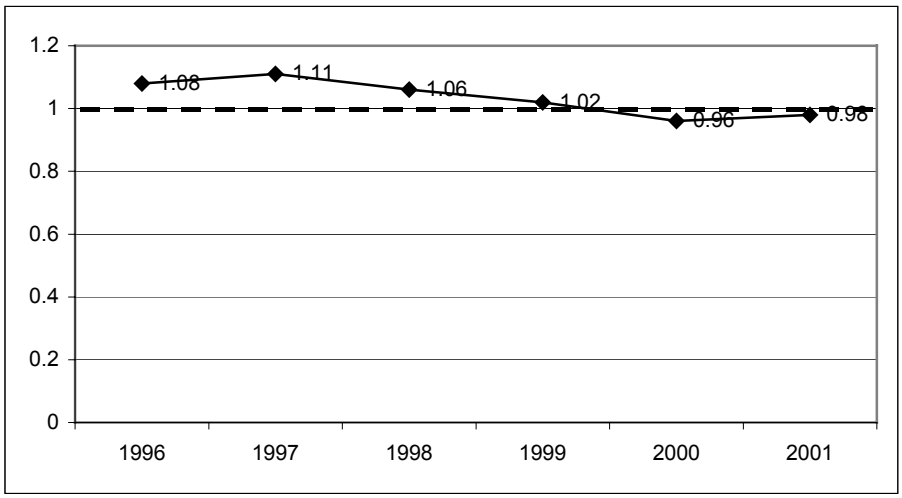
Comparisons

During 1996 to 2001, Aboriginal level of access was similar to or better than that of non-Aboriginals based on their health needs in both metropolitan and country areas. Aboriginal access levels in the country appear to be increasing relative to non-Aboriginals, possibly attributable to Aboriginal country hospitalisation rates having significantly increased in absolute terms as well as in comparison to the

[8] RA McDermott, AJ Plant and G Mooney. Has access to hospital improved for Aborigines in the Northern Territory? Aust NZ J Public Health 1996; 20:589-593.

non-Aboriginal population. Based on this measure of accessibility it seems that Aboriginal people are gaining access to hospital services relative to patterns of access observed in the non-Aboriginal population.

Figure 19: Accessibility index variations for all persons by area of residence



While previously country residents accessed health services more than metropolitan residents, there has been a decline in country health service access relative to the metropolitan area. In 2000 and 2001 metropolitan access levels exceeded those of the country based on need.

It must be noted that this measure does not allow for other social variables such as distance or time costs borne by remote populations. The observed trends could also be impacted upon by an increase in the number of doctors working in remote areas over time, or patient subsidies to relieve costs of travel and hospital care.

Method

The measure of service provision is the age-standardised rate for hospital admissions while the indicator of need is the age-standardised mortality rate. Measures of equity of access for Aboriginal and Non-Aboriginal people living in the country and metropolitan areas are obtained when the ratio for Aboriginals is divided by the ratio for Non-Aboriginals living in those respective areas. Comparison of country to metropolitan residents is for all persons regardless of race or sex.

Explanatory notes

The calculated ratios may differ slightly from previously reported data due to changes in both the mortality and hospital morbidity databases. These changes reflect the addition of new data, correction of existing data and removal of duplicate records.

Data sources:
WA Hospital Morbidity Data System, Health Information Centre, DOH.
Mortality Database, Health Information Centre, DOH.

PATIENT EVALUATION OF HOSPITAL SERVICES – ALL HOSPITALS

Rationale
Ratings of patient satisfaction with hospital services give an indication of the perceived quality of service provision. Research has shown that satisfaction is related to better health outcomes.[9]

Trends
A survey to measure patient satisfaction with hospitals in WA was conducted among patients during 2002-2003. The overall response rate among admitted patients was 47%. The State outcome score for all admitted patients in 2002-2003 was 83 out of 100. The score indicates that WA hospital patients generally perceived their hospital stay as beneficial and that hospitals were succeeding in their objective to restore the health of their patients.

Table 13: 2002-2003 mean scale scores for patient groups with outcome score and overall indicator of satisfaction

	Overnight adult	Overnight child	Maternity
Access to hospital	70.9	62.9	N/A
Availability of people caring for you	89.3	86.5	87.6
Meeting personal as well as clinical needs	90.3	87.9	89.8
Continuity of care	78.2	76.8	82.6
Information & communication between hospital staff and you	83.4	83.7	84.0
Right to be involved in decisions about your care and treatment	68.5	68.8	74.8
The residential aspects of the hospital	66.3	63.4	67.5
Overall indicator of satisfaction	79.7	77.7	80.6
Patient rated outcome of hospital stay	82.9	85.4	80.3

The table above presents the seven major scales with the overall indicator of satisfaction and patient rated outcome of hospital stay by three of the patient types for 2002-2003. Overall, the results indicate a high level of satisfaction with the availability of hospital staff, the meeting of personal needs and information and communication with hospital staff. However, for involvement in decisions about care and treatment, and residential aspects of the hospital, the scores are below 80 across all patient groups, and continuity of care and access to hospital also score below 80 among overnight patients, suggesting these are areas that require improvement.

Comparisons
The ratings among overnight child respondents are significantly lower than overnight adult patients for access to hospital and availability of staff, and significantly lower than maternity patients for continuity of care, residential aspects and the overall indicator of satisfaction. Maternity patients rate continuity of care

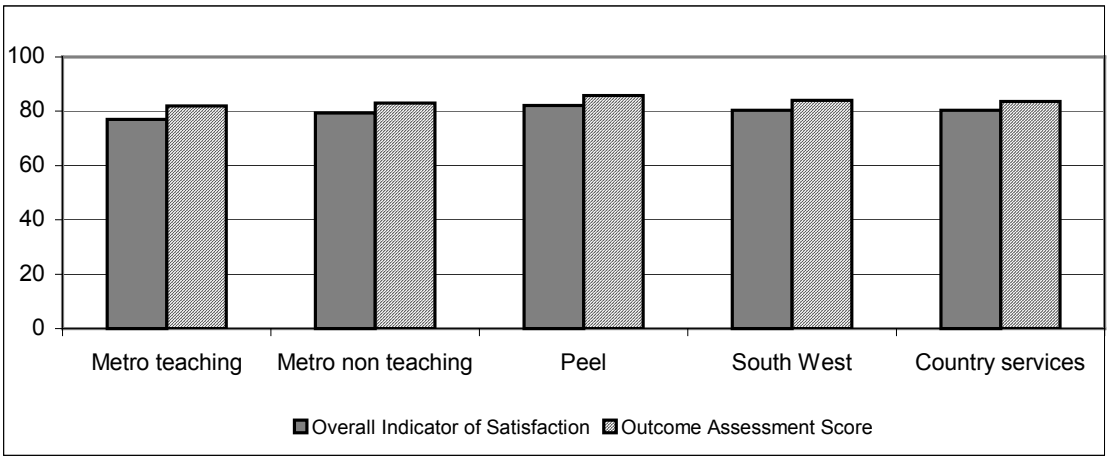
[9] Kreulen, Stommel et al. 2002; Lewin, Skea et al. 2002; Mills 2002; Ostir, Simonsick et al. 2002

and involvement in decisions significantly higher than the other patient groups. Overnight child respondents rate significantly higher for the patient rated outcome of the hospital stay, and maternity patients higher.

The patient rated outcome score measures patients' perceptions of the benefit of their hospital stay. The overall indicator of satisfaction measures the patients' reported satisfaction with the services received while in hospital. The figure below presents the outcome score and the overall indicator of satisfaction for adult and child overnight patients by hospital locality.

In general, overall patient satisfaction is significantly lower for Metropolitan Teaching Hospitals but similar across all other hospital localities. Metropolitan Teaching Hospitals also score significantly lower than Peel, South West and Country Services hospitals on patient ratings of outcomes, but are similar to Metropolitan Non-Teaching hospitals.

Figure 20: Comparison of overnight satisfaction and outcome scores by locality



AUDITOR GENERAL

INDEPENDENT AUDIT OPINION

To the Parliament of Western Australia

DEPARTMENT OF HEALTH
PERFORMANCE INDICATORS FOR THE YEAR ENDED JUNE 30, 2003

Qualifications

Key Effectiveness Indicators

The key effectiveness indicators reported for Outcome 3 are not key measures of the Department's achievement of the outcome *"Improvement in the quality of life of people with chronic illness and disability"*.

Key Efficiency Indicators

The Department has not reported key efficiency indicators for approximately $185 million of their total expenditure of $563 million for the year. In addition, the key efficiency indicators reported for the Department's three outputs were unable to be verified due to inadequate supporting documentation.

Qualified Audit Opinion

In my opinion, the Department of Health's key effectiveness performance indicators reported for Outcome 1 and Outcome 2 are relevant and appropriate and fairly represent indicated performance. However, as a result of the matters raised above, no opinion is provided on the Department's key effectiveness indicators for Outcome 3, or for the Department's key efficiency indicators for Outputs 1, 2 and 3.

Scope

The Director General's Role

The Director General is responsible for developing and maintaining proper records and systems for preparing performance indicators.

The performance indicators consist of key indicators of efficiency and effectiveness.

Summary of my Role

As required by the Financial Administration and Audit Act 1985, I have independently audited the performance indicators to express an opinion on them. This was done by looking at a sample of the evidence.

An audit does not guarantee that every amount and disclosure in the performance indicators is error free, nor does it examine all evidence and every transaction. However, my audit procedures should identify errors or omissions significant enough to adversely affect the decisions of users of the performance indicators.

D D R PEARSON
AUDITOR GENERAL
October 10, 2003

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

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

R101 Loss of life from premature death due to preventable diseases or injury
R102 Suicide rate per 100,000 population
R103 Notification rates per 100,000 for enteric diseases
R104 Percentage of target population who had a pap smear in the past two years
R105A Percentage of target population screened for breast cancer
R105B BreastScreen small invasive cancer detection rate for women screened

Output 1 Prevention and promotion

R106 Average cost per woman screened at BreastScreen WA
R107 Average cost per vaccine distributed
R108 Average cost per microbiology/chemical sample
R109 Average cost per monitoring inspection
R110 Average cost per Aboriginal Health priority program
R111 Average cost per priority health promotion program
R112 Genomics education investment per head of population
R113 Average cost per Child Health and Community Health priority area
R114 Average cost per cervical screening test monitored

Outcome 2 Restoration to health of people with acute illness

R201 Proportion of privately managed public patients discharged to home
R202 Proportion of patients admitted from the oral waiting list who had completed treatment during the year
R203 Unplanned readmission rate for the same or related condition of privately managed public patient
R204 Rate of post-operative embolism for privately managed public patients
R205 Survival rates for sentinel conditions of privately managed public patients
R206 Response times for St John Ambulance priority 1 calls

Output 2 Diagnosis and treatment

R207 Average cost per call of Health Call Centre and Health Direct Telephone Triage service
R208 Average cost of admitted patient episodes for privately managed public patient services
R209 Average cost for renal dialysis treatment at privately managed facilities
R210 Average cost of non-admitted patient attendances for privately managed public hospital services

R211 Average cost per admission of cases facilitated by the Central Wait List Bureau (CWLB)
R212 Average cost per blood donation
R213 Average cost of patient transfers by Royal Flying Doctor Service Western Operations
R214 Average cost of patient transfers by St John Ambulance service
R215 Average cost of support per organ donation
R216 Average cost per dental treatment

Outcome 3 Improvement in the quality of life of people with chronic illness and disability

R301 Number of persons with acquired brain injury resident in rehabilitative care accommodation and the proportion of persons discharged to home or community care
R302 Rate per 1,000 population who receive HACC services (less than 70 years and 70 years and over)
R303 Rate of return to acute in-patient care of patients receiving rehabilitative care
R304 Proportion of cancer related deaths for patients accessing admitted palliative care services
R305 Percentages of population targeted by special support services provided by non-government organisations to assist people with a chronic health condition and their families or young people at risk

Output 3 Continuing care

R306 Average cost of HACC services per person with long term disability
R307 Average cost of providing oxygen to metropolitan patients in their own homes
R308 Average cost per client for community based palliative care
R309 Yearly service cost per client receiving specific support services from non-government organisations providing services for chronic health conditions
R310 Average cost for an admitted palliative care day in a privately managed facility
R311 Average subsidy per episode of care and bedday to support people living in metropolitan licensed psychiatric hostels

INTRODUCTION

The Department of Health (DOH) is required under the Financial Administration and Audit Act (1985) (FAAA) and the supporting Treasurer's Instruction TI 904, to present annual indicators of effectiveness and efficiency to Parliament. The effectiveness indicators report appropriateness, quality, access and equity of the services provided while efficiency indicators show accountability for funds spent in delivery of the services.

The performance indicators in this report provide the Parliament and public of Western Australia with information on the performance in the delivery of services, the management or funding of which is provided directly from Royal Street. This includes programs managed by branches of Royal Street and Non Government Organisation contracts, for example the Royal Flying Doctor Service contract and privately managed public patient contracts.

Health services provided and managed through the Department of Health separate legal reporting entities, according to Section 15 of the Hospital and Health Services Act 1927, are reported in separate reports. In 2002/2003 these reports are for the Metropolitan Health Service, the Peel Health Service, the WA Country Health Service and the South West Health Service.

The performance indicators reported in the Royal Street Annual Report together with the four health services annual reports listed above form an important part of the DOH's accountability framework and demonstrate the ongoing commitment of the DOH to promoting, protecting and restoring the health of the people of Western Australia.

A key aim in presenting this information, and that reported by the separate legal reporting entities, is to assist the public to understand the complex and diverse nature of the services and activities of the health system and how these contribute to its performance.

The performance indicators reported in the following pages address the extent to which the strategies and activities of the Royal Street Divisions and those contracted to provide services have contributed to the DOH's required health outcomes and outputs, viz.,

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

OUTCOME 2
Restoration to health of people with acute illness.
(Output 2 - Diagnosis and Treatment)

OUTCOME 3
Improvement in the quality of life of people with chronic illness and disability.
(Output 3 - Continuing Care)

In the unified DOH structure the performance indicators listed in this report as well as those in the Health Services reports indicate the funding and activity covered by the performance indicators in the 2002/2003 Annual Reports.

While some of the indicators reported are similar to those in previous Royal Street Divisions Annual Reports, many are new indicators reported for the first time. Where possible comparisons with previous years' data have been provided.

CPI INFLATOR SERIES (CPI)

The index figures are derived from the CPI all groups, weighted average of the 8 capital cities index numbers. For the financial year series the index is the average of the December and March quarter and is rebased to reflect a mid year point of the 5 year series that appears in the annual reports. The average of the December and March quarter is used, because the full year index series is not available in time for the annual reporting cycle. The calendar year series uses a similar methodology but is based on the average of the June and September quarter.

The financial year costs for the annual report can be adjusted by applying the following formula, the results will be all financial data will be converted to 00/01 dollars:

Cost_n x (100/Index_n) where n is the financial year or calendar year where appropriate

The index figures for the financial years and calendar years to be applied are provided below:

Calendar year	1998	1999	2000	2001	2002
Index (base 2000)	94.24	95.57	100.00	104.24	107.39
Financial year	1998/99	1999/00	2000/01	2001/02	2002/03
Index (base 2000/01)	92.31	94.43	100.00	103.03	106.36

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

The services (outputs) which enable the DOH to meet this outcome are provided by a range of health professionals in Health Services as well those involved with planning, monitoring, evaluation and budget allocation activities in the Royal Street Divisions of the DOH. Some of the interventions undertaken include regulatory and control functions performed centrally for the whole health system. Other functions include monitoring the health status of the population to ensure that prevention and promotion programs are successfully meeting their objectives.

Indicators developed to measure performance of the Royal Street Division in Outcome 1 link to the areas indicated in the framework table below. While the whole of DOH activities are directed to the achievements of the outcomes listed in the above outcome statement, these health outcomes are influenced also by socioeconomic, lifestyle and personal choice factors.

Indicators measuring the extent and impact of drug abuse are not reported. They are reported in the Drug and Alcohol Authority Annual Report.

Table 14: List of Effectiveness (Outcome 1) and Efficiency (Output 1) Indicators

PI	Performance Indicators	Community Health Services	Monitoring of Diseases	Communicable Disease Management	Health Regulation & Control
	Effectiveness Indicators (OUTCOME Indicators)				
R101	Loss of Life from Premature Death due to Preventable Disease or Injury		✔		
R102	Suicide rate per 100,000 population	✔	✔		
R103	Notification Rates per 100,000 for Enteric Diseases				✔
R104	Percentage of Target Population who had a Pap Smear in the Past Two Years		✔		
R105A	Percentage of Target Population Screened for Breast Cancer	✔	✔		
R105B	BreastScreen Small Invasive Cancer Detection Rate for Women Screened	✔	✔		

Table 14: List of Effectiveness (Outcome 1) and Efficiency (Output 1) Indicators cont.

PI	Performance Indicators	Community Health Services	Monitoring of Diseases	Communicable Disease Management	Health Regulation & Control
	Efficiency Indicators (OUTPUT Indicators)				
R106	Average Cost per Woman Screened at BreastScreen WA		✔		
R107	Average Cost Per Vaccine Distributed	✔		✔	
R108	Average Cost per Microbiology/Chemical Sample				✔
R109	Average Cost Per Monitoring Inspection				✔
R110	Average Cost per Aboriginal Health Priority Program		✔		
R111	Average Cost Per Priority Health Promotion Program	✔			
R112	Genomics Education Investment Per Head of Population	✔			
R113	Average Cost Per Child and Community Health Priority Area	✔			
R114	Average Cost Per Cervical Screening Test Monitored		✔		

R101: Loss of life from premature death due to major identifiable causes of preventable diseases or injury

This indicator provides a measure of the impact of several major programs directed at minimising the number of deaths due to a range of preventable diseases and injury. This represents a subset of those conditions described in the Overview Section *"Loss of life from premature death due to preventable disease or injury".* Specifically this indicator covers programs addressing suicide, heart disease, melanoma, breast, cervical and lung cancers and falls.

Cancer, heart disease, mental health and injury represent four of the six national health priority areas. The importance of focusing on these conditions is underscored by death from these causes accounting for over 40% of years of life lost from all preventable deaths that occurred prior to the age of 69 years.

PYLL are used to reflect the impact of premature deaths. Deaths occurring in WA and Australia over the period 1997 to 2001, from any of the four major categories of disease and injury known to be largely preventable, were extracted from the State and national mortality databases, by year of death. The total number of preventable deaths by year and age group were obtained and the PYLL (from 0 to 69 years) calculated. The number of PYLL from each of these causes was expressed per 1,000 population.

Table 15: Person-years of life lost due to preventable diseases and injury

	Western Australia						Australia					
	1996	1997	1998	1999	2000	2001	1996	1997	1998	1999	2000	2001
Suicide	4.0	4.3	5.0	4.0	4.4	4.2	4.0	4.4	4.4	3.9	3.6	3.4
IHD	3.4	2.9	2.9	2.8	2.4	2.7	3.5	3.5	3.3	3.2	3.0	2.7
Breast ca	2.5	2.9	2.4	2.6	2.0	1.8	2.6	2.8	2.5	2.5	2.3	2.2
Lung ca	1.3	1.4	1.4	1.5	1.5	1.2	1.6	1.6	1.5	1.5	1.5	1.4
Cervix ca	0.4	0.4	0.4	0.3	0.3	0.3	0.4	0.3	0.3	0.3	0.3	0.3
Falls	0.2	0.2	0.1	0.2	0.2	0.2	0.3	0.2	0.2	0.2	0.3	0.2

Data source:
Mortality Database, Health Information Centre, DOH.

The PYLL per 1,000 population in Western Australia and Australian populations were similar for each condition.

There has been no change in the annual PYLL per 1,000 population for both the WA and Australian population during the last 5 years. The increase in PYLL per 1,000 for ischaemic heart disease during 2001 for WA was the exception to the other conditions which either decreased or remained unchanged during 2001.[b]

R101: Loss of life from premature death due to major identifiable causes of preventable diseases or injury cont.

Programs conducted by the Department of Health that aim to minimise death due to preventable diseases or injury include programs promoting healthier lifestyles. These programs include breast and cervical screening, tobacco control, nutrition, physical activity and injury prevention and programs are delivered across the State.

Notes

Cases with the following ICD-10 codes as cause of death were considered to belong to the four major categories of disease and injury that are known to be largely preventable.

Suicides	X60 - X84
Falls	W00 - W19.9
Ischaemic heart disease	I20 - I25.9
Breast cancer	C50 - C50.9
Cervix cancer	C53 - C53.9
Melanoma	C43 - C43.9
Lung cancer	C33 - C34.9

Although not all cases of these conditions will be avoidable, it is very difficult to assess what proportion are avoidable without extensive meta-analysis of the literature. The cancers identified above are those for which the Department of Health has screening or health promotion programs; premature deaths from these should be largely preventable. Changes in the various risk factors would only vary slightly over the five-year period, so this method still provides a reasonable estimate of changing trends and national comparisons. Due to some cases still being before the Coroner's office, 2001 mortality data are preliminary. Non-WA residents who died in WA were included.

Additional deaths registered in years following the year of occurrence may result in slight changes in some data shown in this report compared with previous years. In addition some deaths occurring in 2001 were not registered by the ABS until 2002 and were not included in this analysis. The preliminary nature of the 2001 death data is likely to effect the calculation of PYLLs for conditions which contribute to the greatest proportion of deaths. Consequently no trend analysis was applied to these data.

R102: Suicide rate per 100,000 population

This indicator measures the suicide rate per 100,000 population.

Rationale

Suicide is a significant cause of premature preventable death in Western Australia. Dealing with the causes of suicide is complex, not only because of its tragic nature and impact on all those associated with the person who dies, but also because of the psycho/social variables involved in its causation. Groups at higher risk have been identified including young males, in particular young indigenous males, individuals who have depression or other mental health problems, individuals who have previously attempted suicide and youth in remote or rural areas.

Table 16: Suicide rate per 100,000 population, WA and Australia

Age adjusted rate		1997	1998	1999	2000	2001	1997-2001
All persons 65 years and older	Australia	15.4	13.8	13.1	13.5	11.8	13.5*
	WA	13.6	17.3	14.6	7.3	12.5	13.0
All persons 35-64 years	Australia	16.9	16.9	16.3	15.7	15.1	16.2*
	WA	15.6	16.0	13.4	16.8	15.8	15.5
All persons 20-34 years	Australia	22.9	23.0	20.8	18.5	17.8	20.6*
	WA	24.7	30.6	23.6	22.1	22.9	24.8
All persons 0-19 years	Australia	3.3	3.0	2.6	2.7	2.2	2.8*
	WA	3.3	3.3	3.4	3.9	2.7	3.3
Age standardised rate		**1997**	**1998**	**1999**	**2000**	**2001**	**1997-2001**
All males	Australia	22.9	22.7	21.5	19.9	18.7	21.1*
	WA	22.5	26.6	21.5	20.4	21.3	22.4
All females	Australia	6.0	5.5	5.1	5.2	4.9	5.4*
	WA	5.8	5.4	4.9	6.0	5.5	5.5
All people	Australia	14.3	14.0	13.1	12.4	11.7	13.1*
	WA	13.9	15.8	13	13.2	13.3	13.8

Data source:
Mortality Database, Health Information Centre, DOH.

Note: * indicates significant decrease in rates from 1997 to 2001.

Trends and comparisons

In Western Australia the suicide rate between 1997 and 2001 was highest for persons aged 20 to 34 years. WA had a significantly higher rate than the National rate for this age group. The suicide rate for males was four times higher than that among females.

Between 1997 and 2001, Australian suicide rates (for each age group and for the total population) declined significantly. However, this was not apparent in WA, partly because of the abnormally high rate in 1998. WA's smaller population can result in higher yearly variability in suicide death rates.

R102: Suicide rate per 100,000 population cont.

For Aboriginal people the suicide rate was higher than for non-Aboriginal people. The Aboriginal trend figures should be interpreted with caution due to the low numbers of suicides and uncertainty about the accuracy of Aboriginal population estimates.

Table 17: Suicide rate per 100,000 population by Aboriginality

Population	1996	1997	1998	1999	2000
Non Aboriginal	12.6	13.3	13.2	12.5	12.0
Aboriginal	16.7	19.0	22.3	27.0	23.5

Data source:
Mortality Database, Health Information Centre, DOH.

In order to reduce the number of deaths due to suicide, to reduce injury and self-harm resulting from suicide attempts and to reduce the prevalence of suicidal thinking and behaviours a whole of population approach is required including services for high risk populations and individuals. Therefore, in Western Australia a State coordinated response to suicide prevention is occurring. The Department of Health through the Office of Mental Health specifically supports suicide prevention initiatives and public mental health services to provide intervention for people who are at risk of suicide.

Specific initiatives include the Ministerial Council for Suicide Prevention (MCSP) that consists of a range of government Departments and non-government agencies, and special interest groups all of whom work collaboratively in the areas of research, public education, education and training, consumer consultation and Aboriginal suicide issues. There is also the Youth Counsellor Program that provides counselling for young people experiencing emotional problems in order to reduce the risk of youth suicide. The Youth Counsellor Program has established a network of counsellors across the state. Most positions are located in regional areas and half the positions are for Aboriginal youth. Deliberate self-harm social work positions within the emergency departments of Royal Perth, Fremantle and Sir Charles Gairdner Hospitals are also supported. The purpose of these positions is to ensure that people treated for deliberate self-harm are referred to ongoing mental health care. The Samaritans Youth Liaison Program is also supported to provide support to rural youth at risk of suicide and their families through a 24 hour 1800 Youthline.

Public mental health services provide intensive support through assessment, treatment and follow up of people of all ages at risk of suicide or who have engaged in self-harm or attempted suicide.

R102: Suicide rate per 100,000 population cont.

The notes below refer to table 16.

Note 1:
Rates are age adjusted.

Note 2:
The previous years aboriginal suicide rate are not the same as those reported in previous annual reports for these years. This is due to the following:

(a) The Aboriginal population denominators used to calculate the rates have been updated since last year. Information from the 2001 ABS Census was used to determine the 2001 population figures for years previous to that were adjusted based on the data from previous census. This is the method used to determine Aboriginal population figures after each census year and occurs every 5 years.

(b) A new standard population was used in the calculation of age-standardised rates this year. It is convention (ABS, AIHW) to update the Australian standard population used in rates calculations every decade.

(c) The Aboriginal suicide rates are calculated using a 3-year rolling average method. This means updates to any suicides deaths for years already reported will have an effect upon the other years using those updates in the 3-year rolling average method.

(d) Using 2001 ABS Census data has allowed the estimation of the Aboriginal population in five year age-groups up to 85 years and older, whereas previously the population figures were only estimated up to 75 years and older.

R103: Notification rates per 100,000 for enteric diseases

This indicator provides a measure of the Environmental Health and Communicable Disease Control components of Public Health activity directed at preventing enteric infections.

Rationale

Incidence rates for enteric diseases are influenced by a wide range of factors, including personal hygiene, food safety and water quality. Ongoing surveillance of notifiable disease data is a crucial element in identifying and preventing outbreaks of food/or water-borne enteric infections.

Trends

Both the overall notification rates for enteric infections and the rates for individual diseases have fluctuated over the past five years. Notification rates since 2000 are not directly comparable to rates for previous years, as data from 2000 onwards include notifications received from either medical practitioners or directly from pathology laboratories, whereas in earlier years only notifications from medical practitioners were available. While this improves overall ascertainment of enteric disease in Western Australia, it makes interpretation of trends problematic.

Table 18: Crude notification rates (per 100,000 population) of enteric infectious diseases in Western Australia

Enteric Diseases	1998	1999	2000	2001	2002
Amoebiasis	0.4	0.4	0.7	0.7	0.6
Botulism	NN*	NN*	NN*	0.0	0.0
Campylobacteriosis	92.3	76.4	105.0	136.2	112.4
Cholera	0.0	0.0	0.0	0.0	0.0
Cryptosporidiosis	NN*	NN*	NN*	8.7	11.4
Giardiasis	55.7	43.4	49.5	51.0	49.9
Hepatitis A	7.7	15.9	10.1	1.9	1.6
Hepatitis E	NN*	NN*	NN*	0.1	0.0
Listeriosis	0.2	0.6	0.6	0.6	0.6
Paratyphoid fever	0.1	0.1	0.1	0.3	0.3
Salmonellosis	36.6	37.7	49.8	45.1	37.7
Shiga toxin (Verotoxin) producing *E.coli* (STEC/VTEC) infection	NN*	NN*	NN*	0.2	0.2
Shigellosis	8.4	6.0	5.9	4.1	6.6
Typhoid	0.7	0.5	0.4	0.7	0.3
Vibrio parahaemolyticus	0.1	0.1	0.1	0.1	0.3
Yersiniosis	0.1	0.3	0.1	0.2	0.2
Total	**202.2**	**181.6**	**222.1**	**249.9**	**221.9**

Data source:
Western Australian Notifiable Infectious Diseases Database (WANIDD), Communicable Disease Control Branch, DOH.

Note: * indicates Not Notifiable

R103: Notification rates per 100,000 for enteric diseases cont.

The rate of Campylobacteriosis notification in 2002 decreased by 17.5% compared to that of 2001, but was still higher than the rate in 2000, the first year in which laboratory-only notifications were included.

Similarly, there was a 16.4% decline in notifications of Salmonellosis in 2002 compared to 2001, sustaining the decline observed from the previous year. When the added ascertainment due to laboratory-only notifications is discounted, the notification rate for Salmonellosis in 2002 was significantly lower than rates recorded in 1998 and 1999.

Notifications for Shigellosis, which come predominantly from remote areas of the state, increased in 2002, after several years of decline. The few cases of typhoid and paratyphoid fever notified in 2002 were introduced from overseas countries, and there was no local transmission. The rate of Hepatitis A notification fell to historically low levels in 2002, continuing a steep decline from the peak observed in 1999.

Notifications for Cryptosporidiosis increased in 2002, although the significance of this is unknown, given there are only two years of data available.

Notes

(a) The risk of infection with the range of micro-organisms which cause gastrointestinal illness is influenced by a variety of factors, including personal hygiene, contact with pets and other animals, food safety practice both in households and at commercial premises, water supply issues, climatic conditions, and international travel. In addition, notification rates amongst individuals with enteric infections are influenced by other factors, including: whether those afflicted seek medical attention; whether a faecal sample is submitted for examination; and whether the case is notified to the Department of Health if an organism is identified. Therefore, notification rates for enteric infections are influenced by many factors outside the control of the providers of public health services, and variation between years is at best a crude indicator of the effectiveness of public health programs such as those aimed at ensuring food and water safety, and the investigation and control of outbreaks.

(b) In 2002, State government Public Health providers in both metropolitan and rural areas collaborated closely with local government environmental health officers, laboratories and medical practitioners in the investigation of potentially food- or water-borne enteric infections and the control of a number of identified outbreaks.

(c) Data from 1998 to 2001 have been up-dated and may differ slightly from figures reported in previous Annual Reports. This is due to the late receipt of some notifications, changes in population estimates used to calculate rates, and deletion of occasional duplicate records.

(d) Because of the wide variability in rates between years, statistical tests of linear trend were not indicated. Age-standardisation has not been performed because the population age distribution has varied relatively little over the 5 year period 1998-2002, and because of the very small number of cases in some age-strata for several of the diseases.

(e) Notification rates shown for 2000 and subsequent years are not directly comparable to rates for previous years. Prior to 2000, data include only notifications received from medical practitioners. However, since January 2000 most pathology laboratories in the state have also provided notifications to the Department of Health, and inclusion of these cases improved ascertainment considerably: 26.1% of all enteric disease notifications in 2000 were notified only by laboratories.

R104: Percentage of target population who had a Pap smear in the past two years

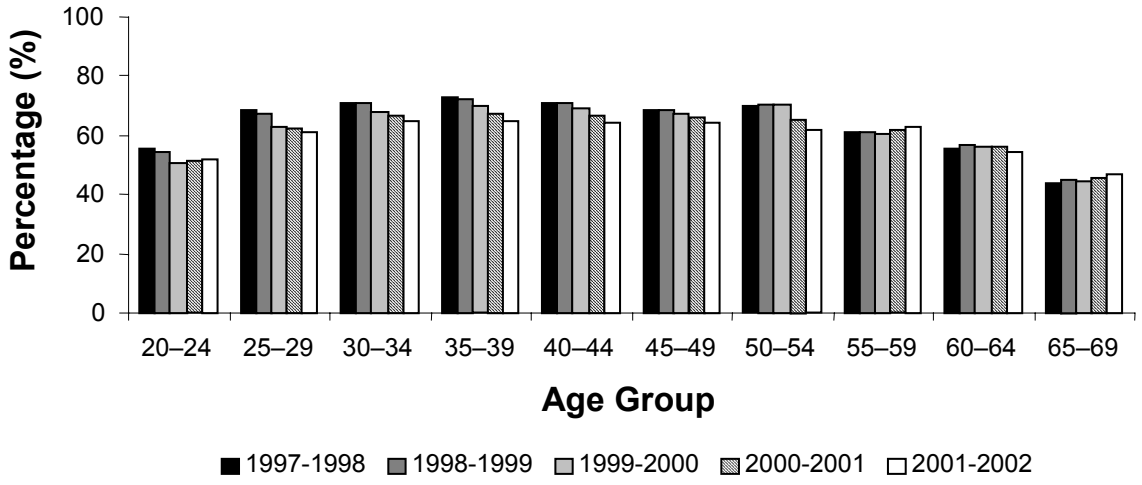
This indicator reports the percentage of population who had a Pap smear in the past two years.

Rationale

Each year in Western Australia approximately 90 new cases of cervical cancer are diagnosed and 30 women die from the disease. Cervical cancer has a long pre-invasive phase and it is estimated that up to 90 per cent of the most common form of cancer of the cervix (squamous) can be prevented by women aged 20 to 69 years having regular, two-yearly Pap smears. The Western Australian Cervical Cancer Prevention Program (WACCPP) promotes cervical cancer awareness to increase the proportion of women who regularly undergo screening, in accordance with the *National Policy for Screening for the Prevention of Cervical Cancer.* The Program maintains the State Cervical Cytology Registry database, contributes to policy development and coordinates education and training for health professionals.

The WACCPP does not provide clinical services. Cervical screening tests are performed by medical professionals, including GPs, Specialist Obstetricians/ Gynaecologists and credentialled Nurse Pap Smear Providers.

Figure 22: Percentage of target population who had a Pap smear in a two-year period, by five-year age groups



Note: Includes all women aged between 20 and 69 years, with an address in WA at the time of the Pap smear. Excludes women's records after the date of hysterectomy or from the initial vault smear i.e. post hysterectomy.

R104: Percentage of target population who had a Pap smear in the past two years cont.

The total screening coverage among women aged 20-69 years during the 2001-2002 period was 60.9%. The 1997-98 period denoted a peak in the percentage (66.0%) of WA women screened in the target age group (20-69 years), coinciding with the 1998 National Media Campaign. Since this time, there has been a 5.1% decline in the screening rates in WA. This corresponds with the gradual cessation of the National Media Campaign, and is in keeping with the national trend.

Closer examination of specific age groups reveals a declining trend in screening rates among younger women, and an increasing trend among older women. Declining rates among young women has given rise to an identified priority group for the Program. The largest increase in screening coverage over the entire comparison period was among women aged 65-69 years, with an increase of 3.1% over five years. This trend is encouraging given the strategic focus on women aged 50 years and over, however it should be noted this group still retains the lowest screening rate overall.

In accordance with the *National Policy for Screening for the Prevention of Cervical Cancer*, the WACCPP has implemented strategies to maximise the participation by eligible women in routine two-yearly screening. The Program is designing new initiatives to target unscreened and under-screened women in WA, as women within these categories are recognised to be at greater risk of developing cervical cancer.

The Policy states:

> *All women who have ever been sexually active should commence having Pap smears between the ages of 18 to 20 years, or one or two years after first sexual intercourse, whichever is later. In some cases, it may be appropriate to start screening before 18 years of age.*
>
> *Pap smears may cease at the age of 70 years for women who have had two normal Pap smears within the last five years. Women over 70 years who have never had a Pap smear, or who request a Pap smear, should be screened.*

This Policy applies only to women with no symptoms or history suggestive of cervical pathology. Women with a past history of high-grade cervical lesions, or who are being followed-up for a previous abnormal smear should be managed in accordance with the National Health and Medical Research Council guidelines.

R104: Percentage of target population who had a Pap smear in the past two years cont.

Explanatory notes:

- The percentage of all women in the Western Australian target population who have been screened at least once over a two-year period gives an indication of the impact of the WACCPP. Women were counted only once in the two-year period, even if they had multiple tests over that time.
- The incidence of cervical cancer increases with age. Studies have indicated three out of every four women who develop cervical cancer have either never had a Pap smear or have not had one within the last five years.
- The WACCPP conducted a statewide recruitment campaign entitled the *Primary Recruitment Strategy* aimed at increasing the proportion of women screened. *Phase I* was implemented from 1999-2001 and *Phase II* was implemented from 2001-2003. *Phase III* of this Strategic Plan will be implemented from 2003-2005.
- Data may differ slightly from that reported in previous years due to additions and amendments to both the Cervical Cytology Register and population databases used to calculate screening percentages.

Data Sources:
Cervical Cytology Registry of Western Australia, Cancer Prevention and Detection Directorate, DOH.
Target Population figures derived from 1997 through to 2000 ABS Estimated Resident Female Population for Western Australia by five-year age groups, adjusted for hysterectomy (1995 National Health Survey).
Target Population figures derived from 2001 to 2002 ABS Estimated Resident Female Population for Western Australia by five-year age groups, adjusted for hysterectomy (2001 National Health Survey). Figures provided by AIHW.
***Screening for the Prevention of Cervical Cancer*, 1998, Commonwealth Department of Health and Family Services, Canberra.**

R105A: Percentage of target population screened for breast cancer

This indicator measures the uptake of screening in the target population.

Rationale

Breast cancer affects 1 in 11 women in their lifetime in Australia. Breast cancer is the most common cause of death from cancer in Australian women.[1] There is still no evident cause for breast cancer and no means for preventing the disease. The best strategy for reducing the mortality of breast cancer is through early detection within a coordinated population screening program providing high quality screening and assessment services.

Mammography screening for women in the target age group of 50-69 years leads to a reduction in morbidity and mortality through the early detection of breast cancer. Breast cancer treatment is known to be most effective in early stage disease. A series of international randomised trials have observed substantial reductions for breast cancer mortality of 25-35 per cent for women aged 50-69 years offered breast cancer screening. It is estimated that a participation rate of 70 per cent or more is required to obtain the most effective breast cancer mortality reduction[2].

Table 19: Participation rate in the target age group of women aged 50-69 years

WA : 24 month screening period ending 30 June				
1999	2000	2001	2002	2003
54%	53%	58%	59%	57%

Data Source:
Mammography Screening Registry, BreastScreen WA, DOH.

Results

The WA participation rate for the 24 months to June 2003 was 57 per cent compared with 59 per cent for the 24 months to June 2002. While the total number of women aged 50-69 screened at least once in the 24-months to June 2003 increased by 2%, the total estimated population in that age group increased by 6%, resulting in a fall in the overall participation rate.

Note

Recruitment to the breast screening program relies significantly on the encouragement of patients by General Practitioners.

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1 Commonwealth Department of Health and Family Services and AIHW (1998). National Health Priority Areas Report on Cancer Control 1997. AIHW Cat. No. PHE 4.

2 Commonwealth Department of Human Services and Health (1994), National Program for the Early Detection of Breast Cancer – National Accreditation Requirements.

R105B: BreastScreen small invasive cancer detection rate for women screened

This indicator reports the small invasive cancer detection rate for women undergoing breast screening

Rationale
Early detection of breast cancer means detecting cancers while they are small and impalpable. The smaller the size of the cancer at diagnosis the better the chance of effective treatment. The mortality reduction that can be achieved from population screening is determined by the rate of small pre-metastic cancers detected. Women with small-localised invasive cancers have a 5-year survival rate of more than 90 per cent.[10]

Table 20: BreastScreen WA small invasive cancer detection rate

	2001	2002
Detection Rate of small invasive cancer per 10,000 women screened by BreastScreen WA	28	30

Data Source:
Mammography Screening Registry, BreastScreen WA, DOH.

Note: The numbers in this table are not strictly comparable as the definition of small invasive cancer was revised in July 2001.

BreastScreen WA detected 247 invasive breast cancers for the calendar year 2002 in women aged 50-69 years. Of these, 160 (65%) were invasive breast cancers less than or equal to 15mm in diameter. There were 54,085 women aged 50-69 years screened in that 12-month period.

The rate of small invasive cancers detected exceeds the ≥25 per 10,000 women screened recommended in the Performance Objective in the BreastScreen Australia National Accreditation Standards (2001). The rate standard was chosen on the basis of crude data for all screens in 1997 from all States/Territories and is comparable to rates achieved in a number of international breast screening programs.

The average crude small cancer detection rate for 2000 for women aged 50-69 years for BreastScreen Australia nationally was 29.5 per 10,000 women screened.

[10] NHS Breast Screening Programme. NHS Screening Program Review 1999 – Meeting New Challenges: Sheffield. NHS Breast Screening Programme 1999.

R106: Average cost per woman screened at BreastScreen WA

This indicator reports the average cost of each breast screening episode.

Table 21: Cost per woman screened for provision of breast screening services

	1998/1999	1999/2000	2000/2001	2001/2002	2002/2003
Actual costs	$99.20	$127.30	$115.20	$116.87	$119.48
Adjusted costs*	$107.46	$134.81	$115.20	$113.43	$112.34

Data Sources:
Population Health Division, DOH.
Financial System, DOH.
Mammography Screening Registry, BreastScreen WA, DOH.

Trends

BreastScreen WA screened 70,798 women in 2002/2003 – a 0.8% decrease from 71,404 in 2001/2002. The adjusted average cost per woman screened at BreastScreen WA has decreased over time.

R107: Average cost per vaccine distributed

This indicator measures the average cost of scheduled vaccines purchased and distributed by the Department of Health.

Rationale
Immunisation significantly reduces the incidence of diseases in the community and is an essential element in the control of communicable diseases, particularly for reducing illness in childhood and influenza related illness and mortality in older populations.

Vaccines are essential to the prevention and control of numerous communicable diseases, particularly for childhood infections such as diptheria, polio, tetanus, whooping cough, *Haemophilus influenzae* type b, measles, mumps, rubella, meningococcal C, and pneumococcal; and for influenza in older persons.

Table 22: Average cost per vaccine distributed – WA (childhood immunisation and adult influenza vaccination)

	1999/2000	2000/01	2001/02	2002/03
Actual Costs	$14.39	$14.31	$15.87	$23.41
Adjusted Costs *	$15.24	$14.31	$15.40	$22.01

Data Sources:
Public Health Division databases and records, DOH.
Financial System, DOH.

Trends
The average cost of the vaccines distributed has risen with the introduction of new and more expensive vaccines to the routine immunisation schedule following additions to the list of diseases for which prevention by immunisation is now recommended and included in government supported immunisation programs.

R108: Average cost per microbiology/chemical sample

This performance indicator measures the average cost of public health micro biological and chemical sample testing.

Rationale
Microbiological and chemical sampling is an important tool for the prevention of illness and maintenance of quality community facilities. Regular testing for microbiological contamination ensures the quality of products for human consumption. Other testing is for purposes of early detection of mosquito-borne diseases such as Ross River Virus and Australian Encephalitis.

Table 23: Average cost per public health microbiological and chemical sample testing

	1999/2000	2000/2001	2001/2002	2002/2003
Actual costs	$48.17	$48.99	$50.70	$40.91
Adjusted costs*	$51.01	$48.99	$49.21	$38.46

Data sources:
Public Health Division, DOH.
Financial System, DOH.

Trends
More samples were processed in 2002/03 compared with the previous two years in response to specific environmental situations which arose during the year. The resultant economy of scale meant that the average cost of processing was lower in 2002/03 than the two previous years.

R109: Average cost per monitoring inspection

The performance indicator measures the average cost per inspection of commercial food preparation and processing environments.

Rationale
Monitoring of food preparation and processing environments reinforces good hygiene practice by industry and facilitates pre-emptive action by the DOH.

Table 24: Average cost per inspection of commercial food preparation and processing environments

	2000/2001	2001/2002	2002/2003
Actual costs	$727.71	$760.31	$396.00
Adjusted costs*	$727.71	$737.95	$372.32

Data Sources:
Public Health Division databases and records, DOH.
Financial System, DOH.

Trends
The *estimated* average cost per monitoring inspection in 2002/2003 is significantly lower than the 2001/2002 average cost. In 2002/2003, the estimated average cost was significantly down due to the fact that the monitoring of food premises is a two-year program and in 2002/2003 only the metropolitan and Wheatbelt areas were inspected.

R110: Average cost per Aboriginal Health priority program

This indicator measures the average cost per Aboriginal Health Priority Program.

Rationale
It is recognised that the health status of the Aboriginal population is often measurably lower than that of the general population. The DOH dedicates resources to develop and support special programs that respond to identified health needs and which work towards correcting the imbalance.

The major health problems among Aboriginal people are diabetes, heart disease, respiratory and other infections, nutritional disorders, injuries and violence and maternal and child health disorders. Underlying the range of diseases that affect Aboriginal people are poor nutrition, alcohol and substance abuse, low levels of physical activity, sub-standard living conditions, high levels of psycho-social stress, violence and under utilisation of health services. At a deeper level, the cause of these problems and their reflection in ill health is poverty which includes low income and unemployment, limited education, dispossession and lack of empowerment.

Aboriginal health priority programs
Sixteen different Aboriginal programs are funded to promote good health in areas such as environmental health, primary and mental health and work towards the prevention of lifestyle health problems. The programs focus across a wide range of health issues. The programs are delivered across the State in rural, remote and metropolitan areas.

The Office of Aboriginal Health assists in the development of innovative programs and support programs, however the bulk of funding is allocated to supporting health care services provided by Aboriginal community controlled organisations, in partnership with the Commonwealth. This orientation involves a community development approach as well as contract management.

Table 25: Average cost per Aboriginal Health priority program

	2002/2003
Total costs all Programs	$22,785,195
Average cost per Program	$1,424,075
CPI adjusted cost per Program	$1,388,920

Data Source:
Public Health Division Databases and Records, DOH.

Note: This is the first year that this indicator has been reported, therefore previous years comparison are not available.

R111: Average cost per priority health promotion program

This indicator reports the average cost per priority health promotion program.

Rationale
The leading causes of death and disability in Western Australia include cardiovascular disease, cancers, diabetes, osteoporosis, stroke, mental health, injuries and falls in older people. The health, economic and social burden of these health problems to the health system and the community which is very large is a compelling reason to invest in primary prevention.

Much of the death, disability and illness caused by these health problems are preventable. Smoking, eating a poor diet, being physically inactive and overweight are all preventable risk factors for cardiovascular disease, diabetes and some cancers.

Health Promotion Programs
Four priority health promotion programs are funded to promote healthier lifestyles. These are tobacco control, nutrition, physical activity and injury prevention. These programs are delivered across the State.

A range of strategies that are consistent with international evidence are used to target statewide and specific population groups and sub-groups. The strategies include healthy public policy, legislation, structural change, mass media campaigns, public and school education promotion, sponsorship, research and evaluation, capacity building and intersectoral collaboration with key stakeholders.

Some projects have been reoriented to ensure the quality of the programs was maintained and to better meet the needs of the population.

Table 26: Average cost per priority health promotion program

	2002/2003
Actual	$1.75 million
CPI Adjusted	$1.65 million

Data Sources:
Public Health Division Databases and Records, DOH.
Financial Systems, DOH.

Note: This is the first year that this indicator has been reported, therefore previous years comparison are not available.

R112: Genomics education investment per head of population

This performance indicator measures the investment into genomics education and health policy analysis per head of population.

Rationale
At present there are more than 8,000 known genetic conditions and it is estimated that up to 65% of the population will suffer a medical condition which is either wholly genetic or has a strong genetic component.

Community knowledge about the link between genetics and disease provides choices for individuals and families at risk for hereditary disease such as cancer, cystic fibrosis, thalassaemia and spina bifida, allowing early prevention or intervention measures to be implemented.

The average investment per head of population for Genomics education was 0.54 cents in 2002/2003.

Data Source:
Public Health Division Databases and Records, DOH.

R113: Average cost per Child Health and Community Health priority area

This indicator reports on the cost per Child Health and Community Health priority area.

Rationale
Community Health aims to reduce mortality and morbidity by targeting the determinants of health and associated risk and protective factors using a broad range of strategies including prevention, early detection, diagnosis and treatment and therapy services.

Strategies, which support primary care providers to action the wider prevention agenda of population health and effectively support chronic disease management, aim to reduce hospital demand and effectively deliver health services to the consumers in an integrated and coordinated system.

Child and community health priority areas
Five priority areas were funded in 2002/03. These priorities include Child Health, School and Youth Health, Adult and Ageing, Gender Health and Primary Health Care partnerships.

Table 27: Average cost per Child Health and Community Health priority area

	2002/2003
Actual	$1.7m
CPI Adjusted	$1.6m

Data Source:
Public Health Division Databases and Records, DOH.

Note: This is the first year that this indicator has been reported, therefore previous years comparison are not available.

R114: Average cost per cervical screening test monitored

This indicator reports the average cost per cervical screening test monitored.

Rationale
The WA Cervical Cancer Prevention Program (WACCPP) coordinates recruitment programs to increase the proportion of women who regularly undergo cervical screening, and maintains a record of their Pap smear and other cervical test results within the State Cervical Cytology Registry (CCR) database. The CCR also acts as a 'safety net' to women by providing a reminder should their cervical investigations become overdue.

This performance indicator does not take into account the cost of physically screening a woman, as the WACCPP does not provide clinical services. Cervical screening tests are performed by medical practitioners, including GPs, Specialist Obstetricians/Gynaecologists and credentialled Nurse Pap Smear Providers.

Table 28: Average cost per cervical screening test monitored

	1997/1998	1998/1999	1999/2000	2000/2001	2001/2002
Actual costs	$4.04	$3.07	$4.39	$5.70	$6.16
Adjusted costs*	$4.44	$3.32	$4.64	$5.70	$5.98

Data Sources:
Cervical Cytology Registry of Western Australia, Cancer Prevention and Detection Directorate, DOH.
Financial System, DOH

RESTORATION TO HEALTH OF PEOPLE WITH ACUTE ILLNESS

The achievement of this component of the health objective involves activities which:

- Ensure that people have access to acute care services when they need them so that intervention occurs as soon as possible. Timely and appropriate access ensures that acute illnesses do not progress.
- Provide quality diagnostic and treatment services to ensure the maximum restoration to health after an acute injury or illness.
- Provide appropriate after-care and rehabilitation to ensure physical and social functioning is restored.
- Provide appropriate obstetric care during pregnancy and the birth episode to both mother and child.

Over the whole of the DOH services the activities required to meet this outcome are mostly provided in hospitals wholly managed by the DOH. These Health Services report separately on the services they provide. The Royal Street Division mainly provides a policy, planning and support role to health services.

The Royal Street Division contracts with the private sector to provide services for public patients. This section of the annual report contains indicators reporting on those services.

The Royal Street Division is also responsible for the state wide services contracts, for example patient transport service provided by St John Ambulance and the Royal Flying Doctor Service and the provision of blood products provided by the Australian Blood Transfusion. The private provider elective surgery contracts are also reported here.

While other sections of DOH, for example hospitals, play a more major role in the restoration of people to health the following table lists the indicators which show the performance of the Royal Street Division in relation to Outcome 2 - restoration to health of people with acute illness.

Table 29: List of Effectiveness (Outcome 2) and Efficiency (Output 2) Indicators

PI	PERFORMANCE INDICATORS	Expedite Admitted care	Diagnosis & Treatment
	Effectiveness Indicators (Outcome 2)		
R201	Proportion of Privately Managed Public Patients Discharged to Home		✔
R202	Proportion of Patients Admitted from the Oral Waiting List Who had Completed Treatment during the year		✔
R203	Unplanned Readmission Rate for the Same or Related Condition of Privately Managed Public Patients		✔
R204	Rate of Post Operative Embolism for Privately Managed Public Patients		✔
R205	Survival Rates for Sentinel Conditions of Privately Managed Public Patients		✔
R206	Response Times for St John Ambulance Priority 1Calls	✔	
	Efficiency Indicators (Output 2 Indicators)		
R207	Average Cost per Call of Health Call Centre and Telephone Triage Service	✔	
R208	Average Cost of Admitted Patient Episodes for Privately Managed Public Patient Services		✔
R209	Average Cost for Renal Dialysis Treatment at Privately Managed Facilities		✔
R210	Average Cost of Non-admitted Patient Attendances for Privately Managed Public Hospital Services		✔
R211	Average Cost per Admission of Cases Facilitated by the Central Wait List Bureau (CWLB)	✔	
R212	Average Cost per Blood Donation		✔
R213	Average Cost of Patient Transfers by Royal Flying Doctor Service Western Operations	✔	
R214	Average Cost of Patient Transfers by St John Ambulance Service	✔	
R215	Average Cost of Support per Organ Donation		✔
R216	Average Cost Per Dental Treatment		✔

R201: Proportion of privately managed public patients discharged home

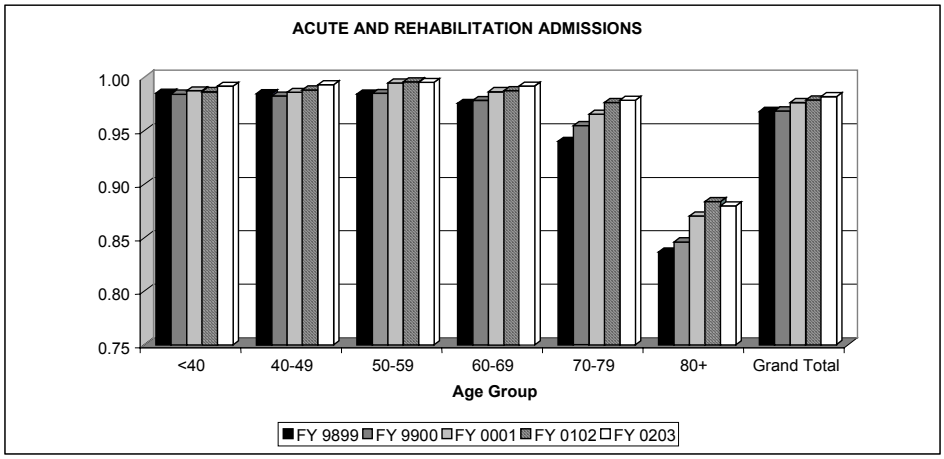
This indicator reports the proportion of privately managed public patients discharged to home.

Rationale

A direct measure of the extent to which people have been restored to health after an acute illness is that they are well enough to be discharged home after hospitalisation for an acute illness. The percentage of people discharge home over time provides an indication of how effective the public system is in restoring people to health.

The performance indicator shows the percentage of all separations for patients admitted to hospitals (excluding inter-hospital transfers) directly funded under a contractual arrangement from Royal Street appropriation that are discharged home. The contracts which are in scope for this performance indicator include approximately ten private providers with whom the Department of Health has arrangements for the care of public patients and the Department of Veterans Affairs patients.

Figure 23: Proportion of hospital separations discharged to home



Data Source: Hospital Morbidity Data System, 1998 to 2003, DOH.

Note: Data from previous years has been updated so is not comparable with previous annual reports.

Over the last five years, there has been a steady or increasing proportion of discharges to home, among patients who receive public patient care in privately managed facilities. The data contribute to the body of evidence that the probability of being restored to health, as demonstrated by being able to go home after hospitalisation, is more likely for patients in younger age groups. Overall, in 2002/2003, 98 out of every 100 patients admitted as public patients into privately managed hospitals have been discharged to their place of residence.

Note

The data include only patients admitted for acute or rehabilitative conditions. Same day psychiatric episodes are specifically excluded.

R202: Proportion of patients admitted from the oral waiting list who had completed treatment during the year

This indicator measures the rate of access to general and specialist oral health services at the Oral Health Centre of Western Australia (OHCWA).

Rationale
The OHCWA provides general and specialist oral health care to those eligible for state government subsidised dental care.

Table 30: Patients on OHCWA waiting list on 1 July 2002 and the percentage removed from the list during the year

Type of service	Total patients on waitlist as at 1 July 2002	Patients remaining on waitlist as at 30 June 2003 (from 1 July 2002)	% removed from waitlist	Total patients on waitlist as at 30 June 2003
General Practice	3,896	36	99.1	546
Orthodontics	2,329	807	64.4	1970
Oral Surgery	871	9	99.0	429
Periodontics	610	88	85.6	321
Paedodontics	436	65	85.1	426
Other*	149	6	96.0	214

Data Source:
Oral Health Centre of WA database.

Note 1: *Other refers to other specialties of endodontics, oral medicine/pathology and tempero-mandibular joint clinic/special restorative.

Note 2: The majority of the patients on the Waitlist as at 1 July 2002 were transferred to OHCWA from the Perth Dental Hospital which ceased operations on 31 December 2001.

The specialties of general practice, oral surgery, periodontics, and paedodontics treated during the year over 85% of all the patients on the waiting list at 1 July 2002. Close to 100% of general practice and oral surgery patients on the waiting list received services in the period.

Waiting list numbers as at 30 June 2003 show that in almost all categories there have been substantial reductions in waiting lists compared to 1 July 2002.

2002/03 is the first full year of operation of OHCWA. Future annual reports will show performance over time.

R203: Unplanned readmission rate for the same or related condition of privately managed public patients

This indicator reports the unplanned readmission rate for the same or related condition for privately managed public patients.

Rationale
Good medical and/or surgical care intervention with appropriate discharge planning decreases the likelihood of unplanned hospital readmissions. Unplanned readmissions necessitate patients spending additional time in hospital as well as utilising additional hospital resources.

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

Table 31: Unplanned readmission rate for the same or related condition of privately managed public patients

	2000/2001	2001/2002	2002/2003
Readmission Rate	2.6%	2.6%	2.9%

Data Source:
Hospital Morbidity Data System, DOH.

The table shows the rate of unplanned readmissions within 28 days to the same hospital for the same or similar condition or a complication of the condition. The indicator reports readmission rates for public patients in a privately managed hospital.

The results show stable rates of readmission over the three-year reporting period and are similar to rates for the public hospitals.

R204: Rate of post operative embolism for privately managed public patients

This indicator measures the percentage of public patients in privately managed facilities who underwent surgery and subsequently developed a pulmonary embolism.

Rationale
Patients post operatively can develop a blood clot in the deep veins of the leg. This can travel to the lungs and cause circulatory problems. This is known as a pulmonary embolism and is one of the main preventable causes of death in fit people undergoing elective surgery.

Hospital staff can take special precautions to decrease the risk of this happening. A very low percentage of cases developing a pulmonary embolism post operatively indicates that the appropriate precautions have been taken.

By monitoring the incidence of post-operative pulmonary embolism which occur, a hospital can ensure clinical protocols which minimise such risks are in place and are working. The monitoring of post-operative complications is important in ensuring the optimum recovery rate for people with acute illness.

Cases are selected for reporting using the criteria as defined by the Australian Council on Health Care Standards (ACHS). The ACHS standard for good practice is a rate less than 0.8%. Cases are reported for pulmonary embolisms if the post-operative length of stay is greater than or equal to 7 days.

Table 32: Rate of post operative embolism for privately managed public patients

2000	2001	2002
Nil	0.19%	0.17%

Data Source:
Hospital Morbidity Data System, DOH.

The rate of public patients who suffered post operative pulmonary emboli and who were treated in privately managed facilities in 2002 was below the threshold set by ACHS. The result is similar to the previous year.

R205: Survival rates for sentinel conditions of privately managed public patients

This indicator reports survival rates for stroke, heart attack and treatment for fractured neck of femur (FNOF) for public patients in privately managed hospitals.

Rationale

The survival rate of patients in hospital can be affected by many factors which include the diagnosis, the treatment given or procedure performed, age, co-morbidities at the time of the admission and complications which may have developed while in hospital. Comparisons of 'whole of hospital' survival rates are not appropriate due to differences in mortality associated with different diagnoses.

Three sentinel conditions, stroke, AMI (heart attack) and hip fractures (FNOF) are reported. There is evidence that early intervention and appropriate care results in higher recovery rates.

Table 33: The survival rates for sentinel conditions of privately managed public patients

	2000			2001			2002		
	Discharged			Discharged			Discharged		
Condition	Alive	Total	% Alive	Alive	Total	% Alive	Alive	Total	% Alive
Stroke	124	156	79.49%	123	159	77.36%	112	143	78.32%
AMI	158	174	90.80%	156	170	91.76%	155	165	93.93%
FNOF	69	69	100.0%	55	60	91.67%	59	63	93.65%

Data Source:
Hospital Morbidity Data System, DOH.

These rates are comparable with the Metropolitan Teaching Hospital survival rates for these conditions.

R206: Response times for St John Ambulance Priority 1 calls

This indicator reports the average waiting times for Priority 1 calls.

Rationale
Timely access to appropriate health services can be critical to the outcome of treatment of acute illness and injury.

To facilitate timely response and transport of patients to the appropriate facilities, the DOH contracts with St John Ambulance Australia – WA Ambulance Service.

The St John Ambulance contract requires rapid ambulance response to emergencies in the metropolitan area and major regional centres. The service is staffed by salaried paramedics.

Priority 1 calls are those where the ambulance aims to be in attendance within ten minutes of the call being made.

Table 34: Response times for St John Ambulance Priority 1 calls

	2000/2001	2001/2002	2002/2003
Waiting Time (minutes)	9.3	9.7	10.0

Data Source:
DOH, Unpublished.

There was a 6.5% increase in Priority 1 calls in the period 1 July 2002 to 30 June 2003.

R207: Average cost per call of Health Call Centre and Health Direct Telephone Triage Service

This indicator reports the average cost per call of Health Call Centre and the Health Direct telephone triage service.

Rationale
The Health Call Centre and Health Direct telephone triage service were developed to provide a single contact point for the West Australian public to have immediate access to information and advice about worrying or urgent health problems.

The Centre improves access to the available services and promotes early treatment, thereby assisting those with injury or acute illness to be restored to health. This service also provides reassurance for those with chronic illness who are living in the community.

The Health Call Centre and Health Direct program:

- Operates 24 hours a day, seven days a week and is available statewide at no cost to users
- The service provides a comprehensive telephone assessment and triage by registered nurses, including:
  - detailed assessment of relevant medical history;
  - explanation of appropriate type of health care needed, and the level of urgency;
  - provision of details and location of appropriate and available health services if needed; and
  - explanation of relevant self-care/home-care as appropriate.

Although some calls can last as long as 20-30 minutes the average call length is around nine minutes.

The Call Centre also maintains an extensive health information and health provider database.

Approximately 70% of calls to Health Direct are received outside normal hours when reduced health services are available.

Table 35: Call volumes and average cost per call

	1999/2000	2000/2002	2001/2002	2002/2003
Health Direct Calls	144,050	196,802	217,603	213,921
Average Cost per Call	$28.17	$24.90	$25.01	$25.98
CPI Adjusted Cost	$29.83	$24.90	$24.27	$24.43

Data Source:
DOH, Unpublished.

R208: Average cost of admitted patient episodes for privately managed public patient services

The indicator measures the average cost of admitted patient episodes for privately managed public patient services. It excludes the cost of public patients who attend privately managed renal dialysis units. (The information for renal dialysis is reported separately in PI R209).

Rationale

The government health system in Western Australia has entered into contractual arrangements with private sector health service providers in the State to deliver free hospital Medicare Scheme entitlements to the community. The admitted patient services provided under private management arrangements are equivalent to those provided to public patients in public hospitals.

Table 36: Average cost of admitted patient episodes for privately managed public patient services

Year	Total Dollars	Average Cost of Admitted care	CPI Adjusted
2002/03	$93,573,163	$2,427	$2,282
2001/02	$75,810,986	$2,228	$2,162
2000/01	$73,381,173	$2,328	$2,328

Data Source:
DOH, Unpublished.

The annual average cost of admitted patient care is affected by variations in the mix, complexity and demand for admitted patient type services from year to year.

R209: Average cost for renal dialysis treatment at privately managed facilities

The indicator reports the average cost of admitted patient episodes for privately managed renal dialysis.

Rationale

The government health system in Western Australia has entered into contractual arrangements with Non Government health service providers to deliver public patient renal dialysis services to the community.

These services are provided through arrangements that are similar to those available to public patients who attend public hospitals.

Table 37: Average cost for renal dialysis treatment at privately managed facilities

Year	Total Dollars	Average Cost per Dialysis Treatment	CPI Adjusted
2002/03	$3,326,310	$372	$349
2001/02	$1,686,221	$263	$255
2000/01	$1,936,318	$217	$217

Data Source:
DOH, Unpublished

The increase in average cost per dialysis in a privately managed dedicated facility can be attributed to the higher cost of provision of dialysis service at a rural and remote site which was commenced in late 2002.

R210: Average cost of non-admitted patient attendances for privately managed public hospital services

This indicator reports average cost of non-admitted patient attendances for privately managed public hospital services.

Rationale

The government health system in Western Australia has entered into contractual arrangements with private sector health service providers in the State to deliver hospital services to the community.

The indicator measures the average cost of non-admitted patient attendances for privately managed public hospital services.

Table 38: Average cost of non-admitted patient attendances for privately managed public hospital services

Year	Total Dollars	Average Cost of Non-Admitted Attendance	CPI Adjusted
2002/03	$21,280,511	$243	$228
2001/02	$13,947,086	$165	$160
2000/01	$12,573,996	$146	$146

Data Source:
DOH, Unpublished

Review of benchmarking of non admitted services to reflect the required level of care led to an increase in the price of some components of non admitted care services.

R211: Average cost per admission of cases facilitated by the Central Wait List Bureau (CWLB)

This indicator reports the average cost of the CWLB service per waiting list admission assisted by CWLB.

Rationale
For health services to be effective access to non emergency surgery needs to be provided on the basis of clinical need. If patients requiring treatment in hospital are waiting for excessively long periods there is the potential for them to experience an increased degree of pain, dysfunction and disability possibly leading to deterioration in their condition.

The Central Wait List Bureau facilitates access to required treatment of persons who are waiting for non emergency surgery.

In addition to directly targeting individual patients the CWLB undertakes routine audits of wait lists to assist it to target those cases most at risk or those where waiting time is over clinically desirable boundaries.

Table 39: Average cost per admission of cases facilitated by Central Wait List Bureau (CWLB)

	2001/2002	2002/2003
Actual Cost	$4,419.44	$4,014.20
CPI Adjusted	$4,289.47	$3,774.16

Data Source:
DOH, Unpublished.

The reduction in the average cost per case can vary significantly from year to year depending on the mix of cases. In 2002/2003 more low cost endoscopy procedures were performed than in the previous year.

R212: Average cost per blood donation

This indicator reports the average cost per donation of blood under the contract between the Australian Red Cross Blood Service and the Department of Health.

Rationale
Blood transfusions are often an essential requirement in the treatment of people with severe injuries, for people undergoing many different types of surgery, for extremely premature infants and for the treatment of a range of medical and haematological disorders.

Australia's blood product supply depends on people making donations voluntarily and regularly. Without regular donation of blood from the public, blood stocks would not be able to be maintained at a level which ensures that needed blood products are available when required.

Costs include blood collection, processing and distribution.

Table 40: Average cost per blood donation

	2000/2001	2001/2002	2002/2003
Cost per blood donation	$251	$267	$271
CPI adjusted cost	$251	$259	$255

Data Source:
DOH, Unpublished

The range of blood products produced from blood donations in 2002/2003 was consistent with that of 2001/02. Also, there were no significant changes to donor selection, testing or manufacturing processes during the period. An additional 9,000 donations were collected in 2002/03. The cost per collection cost rose by less than 2%.

R213: Average cost of patient transfers by Royal Flying Doctor Service Western Operations

The indicator reports the average cost per patient for an interhospital aeromedical transport.

Rationale
Many West Australians residing in remote and rural areas of the State depend on aeromedical transfers to get access to tertiary and secondary hospitals. Rapid aerial transport to hospital by the Royal Flying Doctor Service Western Operations (RFDSWO) can be critical to the outcome of an illness or accident.

The DOH contracts with the RFDSWO to provide aeromedical transport from small, remote and rural hospitals to regional hospitals and from remote and rural areas to metropolitan secondary and tertiary hospitals for patients for whom transfer to required medical care by commercial aircraft or road transport would be medically unsafe.

The service provides medical and nursing care to patients in its care.

Table 41: Average cost of patient transfers by Royal Flying Doctor Service Western Operations

	2002/2003
Average Cost per transfer	$2,771
CPI Adjusted cost	$2,605

Data Source:
DOH, Unpublished.

Note: This is the first year that this indicator has been reported, therefore previous years comparison are not available.

Four thousand patients were transported in 2002/03, a 2.5% increase over the number transported in 2001/02.

R214: Average cost of patient transfers by St John Ambulance Service

This indicator reports the average cost to the Department of Health for a Priority 1 call in the metropolitan area.

Rationale
Timely access to appropriate Health Services can be critical to the outcome of illness and in the treatment of patients after accidents.

To facilitate timely response and transport of patients to the appropriate facilities, the DOH contracts with St John Ambulance Australia – WA Ambulance Service.

The St John Ambulance contract aims to ensure a rapid ambulance response to emergencies in the metropolitan area and major regional centres. The service is staffed by salaried paramedics.

Priority 1 calls are those where the ambulance aims to be in attendance within ten minutes of the call requesting the ambulance being made.

Table 42: Average payment for Priority 1 Call

	2000/2001	2001/2002	2002/2003
Average Payment per Priority 1 Call	$419	$426	$399
Average CPI Adjusted Payment per call	$419	$413	$375

Data Source:
DOH, Unpublished

R215: Average cost of support per organ donation

This indicator reports the average cost of support per organ donation.

Rationale
DonateWest aims to maximise the rates of organ and tissue donation in Western Australia and facilitate the most positive outcome and support for donor families.

Access to donated organs is an important part of assisting the restoration to health of people who suffer certain types of organ failure. The organ donor program promoted by DonateWest facilitates organ and tissue donation across Western Australia. DonateWest works with all hospitals within WA and liaises with hospitals and agencies interstate.

Table 43: Average cost of support per organ donation

	2000/2001	2001/2002	2002/2003
Cost per Organ Donation	$35,719	$60,732	$33,400
CPI Adjusted per Organ Donation	$35,719	$58,946	$31,403

Data Source:
DOH, Unpublished.

The cost per organ donation in 2002/03 was 55% of the cost in the previous year as the number people receiving organ donations almost doubled.

R216: Average cost per dental treatment

This indicator reports the average cost per dental treatment.

Rationale
The Oral Health Centre of Western Australia (OHCWA) provides general and specialist oral health care to those eligible for State Government subsidised care. This indicator measures the cost per treatment provided by OHCWA.

Table 44: Cost per type of dental treatment provided by OHCWA

Discipline	Total Cost (2002/2003)	Number of Patients	Actual Cost/Patient
Emergency Services	$58,967	837	$70.45
General Practice	$466,290	2,510	$185.77
Undergraduate	$2,002,214	4,299	$465.74
Orthodontics	$2,848,608	3,408	$835.86
Paedodontics	$185,315	566	$327.41
Periodontics	$43,258	821	$52.69
Oral Surgery	$880,110	2,020	$435.70
Other*	$169,089	935	$180.84

Data Source:
Oral Health Centre of WA database.

Note: *Other refers to other specialties of endodontics, oral medicine/pathology and tempero-mandibular joint clinic/special restorative.

OHCWA opened on 1 January 2002. Future annual reports will provide annual comparative figures.

Notes

- The Undergraduate discipline refers to general practice work undertaken by undergraduate dental students at OHCWA.
- The Emergency Services discipline refers to emergency general practice work undertaken at weekend and public holiday clinics.
- There may be some discrepancies in patient numbers for General Practice, Oral Surgery and Periodontics.

Improvement in the quality of life for people with chronic illness and disability

The achievement of this component of the health objective involves provision of services and programs that improve and maintain an optimal quality of life for people with chronic illness, disability or terminal disease.

To enable people with chronic illness or disability to maintain as much independence in their everyday life as their illness permits, services are provided in clients' homes to enable normal patterns of living that are valued in the general community. Sometimes services are provided in residential facilities when the care needs of the clients exceed what can be provided in a normal home environment.

Indicators developed to measure performance of the Royal Street Division in Outcome 3 link to the areas indicated in the framework table below.

Table 45: List of Effectiveness (Outcome 3) and Efficiency (Output 3) Indicators

PI	Performance Indicators	Home Care	Residential Care	Ambulatory care	Admitted Care
	Effectiveness Indicators (Outcome 3 Indicators)				
R301	Number of Persons with Acquired Brain Injury Resident in Rehabilitative Care Accommodation and the Proportion of Persons Discharged to Home or Community Care				✔
R302	Rate per 1,000 Population who Receive HACC Services (less than 70 Years and 70 Years and Over)	✔	✔		
R303	Rate of Return to Acute In-Patient Care of Patients Receiving Rehabilitative Care				✔
R304	Proportion of Cancer-related Deaths for Patients Accessing Admitted Palliative Care Services				✔
R305	Percentage of Population Targeted by Special Support Services Provided by Non-Government Organisations to Assist People with a Chronic Health Condition and their Families or Young People at Risk	✔		✔	
	Efficiency Indicators **(Output Indicators)**				
R306	Average Cost of HACC Services per Person with Long Term Disability	✔			
R307	Average Cost of Providing Oxygen to Metropolitan Patients in their Own Homes	✔			
R308	Average Cost Per Client for Community Based Palliative Care	✔			
R309	Yearly Service Cost per Client Receiving Specific Support Services from Non-Government Organisations Providing Services for Chronic Health Conditions	✔			
R310	Average Cost for an Admitted Palliative Care Day in a Privately Managed Facility				✔
R311	Average Subsidy per Episode of Care and Bedday to Support People Living in Metropolitan Licensed Psychiatric Hostels		✔		

R301:	Number of persons with acquired brain injury resident in rehabilitative care accommodation and the proportion of persons discharged to home or community care

This indicator reports the number of persons with acquired brain injury resident in rehabilitative care accommodation and the proportion of persons discharged to home or community care.

Rationale
The quality of life for people with acquired brain injury who suffer from some forms of chronic disability is often improved if they receive rehabilitation therapy services in a dedicated rehabilitative accommodation facility.

Rehabilitation therapy for people with acquired brain injury can take up to eighteen months or more before improvement in functional ability is sufficient to allow discharge to a more independent living environment.

Monitoring discharge destinations is a useful measure of the effectiveness of the rehabilitation services that are provided in a rehabilitative residential care environment.

Definition of Terms

Acquired brain injury
Acquired Brain Injury can be the result of trauma, hypoxia, infection, stroke or neoplasm that has resulted in an impairment in cognitive, physical emotional and/or independent functioning. Impairments may be either temporary or permanent and vary in severity from mild to profound.

Rehabilitation
Rehabilitation is that part of the continuum of health care that is concerned with the restoration of an individual's optimal functional ability after an acute illness or injury.

The person with the disability participates in a multidisciplinary program aimed at improvement in functional capacity, retraining in lost skills and/or change in psychosocial adaptation usually following an acute medical or chronic disease process.

R301: Number of persons with acquired brain injury resident in rehabilitative care accommodation and the proportion of persons discharged to home or community care cont.

Table 46: Number of persons with acquired brain injury resident in rehabilitative care accommodation and the proportion of persons discharged to home or community care

Year	Total number of clients	Number discharged	Discharge destination		% of persons discharged from the transitional rehabilitation program to a setting in which they are considered able to live more independently
			Home/Oats Street	Permanent care	
2000/2001	13	3	3	-	23%
2001/2002	17	8	6	2	47%
2002/2003	14	4	3	1	28%

Data Source:
DOH, Unpublished.

Note

1. The "Oats Street" facility is designed to provide a supportive and restorative living environment for persons who require further time to adjust to returning to independent supported living in the community.

2. For some people the severity of long term disability as a result of acquired brain injury may require discharge to a residential care facility.

3. The number of discharges each year depends on the severity of disability and the time involved in the rehabilitation process. For people with severe brain injury the achievement of maximum restoration of independent living skills can require more than twelve months of rehabilitative care.

R302: Rate per 1,000 population who receive HACC services (less than 70 years and 70 years and over)

This indicator reports the rate per 1,000 population who receive HACC services (less than 70 years and 70 years and over).

Rationale

The quality of life of persons with chronic disease or a disability can be significantly improved through access to HACC program services. Domestic assistance, nursing care, home maintenance and transport are provided by the HACC program.

The performance indicator is split into two components.

1. Rate per 1,000 of people aged 70 years or over who receive HACC services
2. Rate per 1,000 of people aged less than 70 years who receive HACC services

Table 47 Rate per 1,000 population who receive HACC services (less than 70 years and 70 years and over)

Rate per 1,000 population	2001/2002	2002/2003
Persons aged 70 years or over	238	270
Persons aged less than 70 years	8	9

Data Source:
HACC Minimum Data Set Database.

Results

1. There was an increase of 13.4% in the rate of services to persons aged 70 years or over.

2. There was an increase of 12.5% in the rate of services to persons aged less than 70 years.

Note

The increase in the rate of services to the population in 2002/2003 is partly the result of improvement in the quality of activity statistics reported by individual HACC service providers.

R303: Rate of return to acute in-patient care of patients receiving rehabilitative care

This indicator reports the rate of return to acute in-patient care of patients who receive rehabilitative care.

Rationale
The DOH (Royal St) contracts a private hospital to provide rehabilitation to persons who have had an acute illness and who need rehabilitative care. The care may be provided by a range of health professionals including medical practitioners, physiotherapists or speech therapists whose work is directed to restoring the patients' functional ability and to enable an acceptable quality of life when they are discharged home.

An indication of the effectiveness of the program is the rate of return to acute in-patient care.

Definition of Rehabilitation
Rehabilitation is that part of the continuum of health care that is concerned with the restoration of an individual's optimal functional ability after an acute illness or injury.

The person with the disability participates in a multidisciplinary program aimed at improvement in functional capacity, retraining in lost skills and/or change in psychosocial adaptation usually following an acute medical or chronic disease process.

Table 48: Rate of return to acute in-patient care of patients receiving rehabilitative care

Measure	2000/01	2001/02	2002/03
Rate of Return	2.0%	2.0%	2.3%

Data Source:
DOH, Unpublished.

Note

The data represents those cases where a patient has been readmitted into the same Restorative Care Unit (RCU) within 28 days of discharge for the same or related condition. The data shows a low rate of return to restorative care after discharge.

R304: Proportion of cancer related deaths for patients accessing admitted palliative care services

This indicator reports the rate of access to the admitted palliative care program in the metropolitan area per cancer-related death.

Rationale

Palliative care provides for the well being of a patient with terminal illness, working to ensure dignity, peace and comfort for the person over the duration of the illness. During the illness care may be provided in hospital or at home.

Palliative care is also concerned with the family and carers of the person with the illness, supporting them in their role of caring for the ill person and also dealing with their grief during the illness and after. The service deals directly with quality of life issues.

This indicator is a measure of how readily the admitted palliative care services can be accessed by those who may have a requirement to use them.

Table 49: Rate of patient access to admitted care relative to cancer related deaths

Calender Year	1999	2000	2001	2002
Individuals with a palliation episode(s)	507	1,089	1,482	1,628
Cancer Deaths	2,548	2,490	2,407	N/A
Proportion of patients using palliative care services	19.9%	43.7%	61.6%	N/A

Data Source:
DOH, Unpublished

Note: Not available

Presentation and Interpretation of Results

The table shows that the percentage of patients with terminal disease who use a palliative care service in the metropolitan area has risen from 19.9% in 1999 to 61.6% in 2001. Note the mortality figures for 2002 were not available at the time of publication.

While a proportion of people may choose not to use admitted palliative care services and prefer to remain in their own home attended by family members, the figures above show that a greater percentage are using admitted palliative care services each year. The increased proportion of those with cancer who use these services is an indication of the ease of access to and the effectiveness of the service.

Notes

- The number of cancer-related deaths is a nationally accepted proxy for the need for palliative care. Around 90% of patients referred to palliative care services have cancer.
- Admitted palliative care includes admission for symptom management, respite care and for terminal care.

R305: Percentages of population targeted by special support services provided by non-government organisations to assist people with a chronic health condition and their families or young people at risk

This indicator supports efficiency indicator R309 that relates only to funding provided to non-government organisations from the DOH (Royal Street) budget allocation.

Rationale

The Department of Health has identified people with specific chronic health conditions and special needs groups in the population, who require targeted health services.

Chronic health conditions include multiple sclerosis, asthma, cystic fibrosis, diabetes and arthritis. Targeted populations include homeless and youth-at–risk. Services are provided to ensure persons with chronic health conditions and their families and those in targeted populations are supported to deal with the different phases of their health condition and the family and community pressures that may accompany them.

This indicator shows the proportion of the Western Australian population that report having specific chronic health conditions or represent a target population of significance or have been recognised as being homeless or youth-at-risk.

Table 50 Percentage of population targeted by special support services

Chronic Condition or Health Issue	% Female Population	% Male Population
Heart	4.1	5.7
Stroke*	1.3	1.9
Diabetes	3.9	3.5
Cancer	4.9	4.4
Mental Health Condition	8.1	5.8
Injury serious enough to require treatment within last 12 months	17.5	25.8
Asthma	10.7	9.1
Other respiratory condition	2.7	3.2
Arthritis*	23.8	18.6
Osteoporosis*	8.9	2.2

Data Sources:
2002-2003 WA Health and Wellbeing Surveillance System, Health Information Centre, DOH.
Neurological Council of Western Australia and the Neuro-Science Unit SCGH.
The State Homelessness Taskforce Report 2002.

Note: *only asked of people aged 16 years and over

R306: Average cost of HACC services per person with long term disability

This indicator reports the average cost of home and community care (HACC) services provided to person with a long term disability.

Rationale

It is important to maintain a good quality of life for people living in their own homes when they have a long-term disability or a chronic illness. Access to the appropriate services is most important.

Table 51: Average cost of HACC services per person with long term disability

Costs	1998/99	1999/00	2000/01	2001/02	2002/03
Actual	$1,751	$1,902	$1,707	$2,050	$1,862
CPI Adjusted	$1,897	$2,014	$1,707	$1,989	$1,751

Data Sources:
HACC Minimum Data Set Database
HACC Program Plan Documents

Note

The clients of the HACC Program have the right to 'opt out' of being included in the Minimum Data Set collection. The figures used here therefore relate only to those clients who agree to be part of the reporting process.

R307: Average cost of providing oxygen to metropolitan patients in their own homes

This indicator reports the average cost of providing oxygen to metropolitan patients in their own homes.

Rationale
An objective of the health system is to assist people with chronic illness to maintain a high as possible quality of life to enable them to continue to live in the community.

Home oxygen is prescribed to eligible patients who meet certain clinical criteria and who would be unable to reside in their own home without this service.

Table 52: Average cost of providing oxygen to metropolitan patients in their own homes

Year	Contracted Price for Provision of Equipment and Gas	Average Number of Clients	Average Cost per Client	CPI Adjusted Cost per Client
2002/2003	$1,369,029	729	$1,877	$1,765

Data Source:
DOH, Unpublished.

Note
This is the first year that this indicator has been reported, therefore previous years' comparisons are not available.

R308: Average cost per client for community based palliative care

This indicator reports on the average cost per client for community based palliative care.

Rationale
Palliative care provides for the wellbeing of a person with terminal illness, working to ensure dignity, peace and comfort for the person over the duration of their illness.

Palliative care is also concerned with the family and carer of the person with terminal illness, supporting them in the role of caring for the ill person and also dealing with their grief during the illness and after. The service deals directly with quality of life issues and is provided in metropolitan and rural areas.

Community based palliative care is provided by visiting palliative care workers to the person's home.

Table 53: Average cost per client for community based palliative care

	2002/2003
Actual Cost per client for community based palliative care	$3,065.65
CPI Adjusted Cost Per Patient	$2,882.33

Data Source:
DOH, Unpublished.

Note
This is the first year that this indicator has been reported, therefore previous years' comparisons are not available.

R309: Yearly service cost per client receiving specific support services from non-government organisations providing services for chronic health conditions

This indicator reports the yearly service cost per client receiving specific support services from non-government organisations providing services for chronic health conditions.

Rationale
Non-government organisations provide client based services to a number of people suffering from a chronic health condition or who are members of a targeted population (e.g. homeless youth).

This indicator measures the service cost per client per annum across these provider organisations.

Table 54: Yearly service cost per client receiving specific support services from non-government organisations providing services for chronic health conditions

	2002/2003
Actual Costs	$94.25
CPI Adjusted	$88.61

Data Source:
DOH, Unpublished.

Note 1
This is the first year that this indicator has been reported, therefore previous years' comparisons are not available.

Note 2
Only those organisations who provided services in relation to the Effectiveness criteria (Performance Indicator R305) and who reported client based outputs have been included. A small number of providers in this group did not provide services across all three reported years or reported occasions of service rather than number of clients.

R310: Average cost for an admitted palliative care day in a privately managed facility

This indicator reports the average cost for an admitted palliative care day in a privately managed facility.

Rationale
Palliative care provides for the wellbeing of a person with terminal illness, working to ensure dignity, peace and comfort for the person over the duration of the illness.

This indicator measures the price per admitted palliative care day for privately managed facilities and includes some administrative costs.

Method
The price paid is based on a price determined in an independent costing study conducted at the Cottage Hospice in 1998, with their cooperation. Since then this price has been indexed regularly, as recommended.

Table 55: Average cost for an admitted palliative care day in a privately managed facility

Year	2001/2002	2002/2003
Actual Average Price	$424	$405
CPI Adjusted	$412	$381

Data Source:
DOH, Unpublished.

R311: Average subsidy per episode of care and bedday to support people living in metropolitan licensed psychiatric hostels

This indicator reports the average subsidy per episode of care and bedday to support people living in metropolitan Department of Health licensed psychiatric hostels.

Rationale
Licensed psychiatric hostels provide Personal Care Support services to residents with mental health disabilities to assist them to develop and maintain their current skills, autonomy and self-management in the area of personal care in order to improve their overall quality of life.

In 2000/2001, the Office of Mental Health in collaboration with psychiatric hostels examined the Private Psychiatric Hostels industry in Western Australia. As a result of this review the subsidies to psychiatric hostels were significantly increased to enable the hostel to provide the required standard of care of a residential facility.

Trends
In 2002/2003, 587 persons resided within psychiatric hostels, a 9% increase from 1998/1999. There has been a rise in costs associated with the provision of Personal Care Support services.

Table 56: Average subsidy per episode of care and per bedday for people living in psychiatric hostels between 1998/1999 to 2002/2003

	1999/98	1999/00	2000/01	2001/02	2002/03
Average subsidy per episode					
Actual	$1,639	$1,712	$1,794	$2,207	$2,431
Adjusted	$1,776	$1,813	$1,794	$2,142	$2,286
Average subsidy per bedday					
Actual	$6	$6	$7	$9	$9
Adjusted	$6	$7	$7	$8	$9

Data Sources:
Office of Mental, DOH.
Mental Health Information System, Health Information Centre, DOH.
Resource Management, DOH.

AUDITOR GENERAL

INDEPENDENT AUDIT OPINION

To the Parliament of Western Australia

DEPARTMENT OF HEALTH
FINANCIAL STATEMENTS FOR THE YEAR ENDED JUNE 30, 2003

Audit Opinion
In my opinion,

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

(ii) the financial statements are based on proper accounts and present fairly in accordance with applicable Accounting Standards and other mandatory professional reporting requirements in Australia and the Treasurer's Instructions, the financial position of the Department at June 30, 2003 and its financial performance and cash flows for the year ended on that date.

Scope
The Director General's Role
The Director General is responsible for keeping proper accounts and maintaining adequate systems of internal control, preparing the financial statements, and complying with the Financial Administration and Audit Act 1985 (the Act) and other relevant written law.

The financial statements consist of the Statement of Financial Performance, Statement of Financial Position, Statement of Cash Flows, Output Schedule of Expenses and Revenues, Summary of Consolidated Fund Appropriations and Revenue Estimates, and the Notes to the Financial Statements.

Summary of my Role
As required by the Act, I have independently audited the accounts and financial statements to express an opinion on the controls and financial statements. This was done by looking at a sample of the evidence.

An audit does not guarantee that every amount and disclosure in the financial statements is error free. The term "reasonable assurance" recognises that an audit does not examine all evidence and every transaction. However, my audit procedures should identify errors or omissions significant enough to adversely affect the decisions of users of the financial statements.

D D R PEARSON
AUDITOR GENERAL
October 10, 2003

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

Statement of Financial Performance
For the year ended 30 June 2003

	Note	2003 $000	2002 $000
COST OF SERVICES			
Expenses from ordinary activities			
Employee expenses	4	59,859	67,173
Grants and subsidies	5	270,199	266,604
Supplies and services	6	174,858	148,387
Repair and maintenance		2,754	2,200
Depreciation expenses	7	6,101	6,123
Borrowing costs expense	8	9,178	9,650
Capital user charge	9	6,288	7,439
Asset revaluation decrement	25	17,434	-
Other expenses from ordinary activities	10	16,798	14,349
Total cost of services		563,469	521,925
Revenues from ordinary activities			
Revenue from operating activities			
User charges and fees		6,052	5,409
Commonwealth grants and contributions	11	102,548	99,176
Revenue from non-operating activities			
Proceeds from disposal of non-current assets		1,374	61
Other revenues from ordinary activities		9,803	11,023
Total revenues from ordinary activities		119,777	115,669
NET COST OF SERVICES	26	443,692	406,256
REVENUES FROM STATE GOVERNMENT			
Output appropriations	12	402,679	400,848
Liabilities assumed by the Treasurer	12	198	138
Resources received free of charge	12	1,900	1,474
Assets assumed/(transferred)	12	26	-
Total revenues from State Government		404,803	402,460
Change in net assets before restructuring		(38,889)	(3,796)
Net revenues/(expenses) from restructuring	13	-	4,552
CHANGE IN NET ASSETS AFTER RESTRUCTURING		(38,889)	756
Net increase/(decrease) in asset revaluation reserve	25	4,389	549
Net initial adjustments on adoption of AASB 1028 "Employee Benefits"		(173)	-
Total revenues, expenses and valuation adjustments recognised directly in equity		4,216	549
Total changes in equity other than those resulting from transactions with WA State Government as owners		(34,673)	1,305

The Statement of Financial Performance should be read in conjunction with the accompanying notes.

Statement of Financial Position
As at 30 June 2003

	Note	2003 $000	2002 $000
CURRENT ASSETS			
Cash assets	14	43	3,490
Restricted cash assets	15	2,966	2,875
Inventories	16	6,758	802
Receivables	17	7,702	9,595
Amounts receivable for outputs	18	5,472	-
Prepayments		1,025	2,357
Total Current Assets		23,966	19,119
NON - CURRENT ASSETS			
Restricted cash assets	15	2,622	2,622
Amounts receivable for outputs	18	8,984	8,845
Land and buildings	19	145,411	161,505
Plant and equipment	20	7,257	8,438
Total Non - Current Assets		164,274	181,410
TOTAL ASSETS		188,240	200,529
CURRENT LIABILITIES			
Payables	21	21,252	2,710
Accrued salaries		1,516	4,412
Provisions	22	9,564	9,251
Interest-bearing liabilities	23	2,984	2,720
Other liabilities	24	561	545
Total Current Liabilities		35,877	19,638
NON - CURRENT LIABILITIES			
Provisions	22	2,419	3,060
Interest-bearing liabilities	23	91,723	94,707
Other liabilities	24	9,716	9,990
Total Non - Current Liabilities		103,858	107,757
Total Liabilities		139,735	127,395
EQUITY			
Contributed equity	25	16,865	6,821
Accumulated surplus/(deficiency)	25	(137,131)	(98,069)
Asset revaluation reserve	25	168,771	164,382
Total Equity		48,505	73,134
TOTAL LIABILITIES AND EQUITY		188,240	200,529

The Statement of Financial Position should be read in conjunction with the accompanying notes.

Statement of Cash Flow
For the year ended 30 June 2003

	Note	2003 $000 Inflows (Outflows)	2002 $000 Inflows (Outflows)
CASH FLOWS FROM GOVERNMENT			
Output appropriations		396,822	391,994
Capital appropriations		11,350	6,821
Holding account drawdowns		237	-
Net cash provided by Government		408,409	398,815
Utilised as follows:			
CASH FLOWS FROM OPERATING ACTIVITIES			
Payments			
Employee costs		(55,390)	(58,481)
Superannuation		(4,446)	(4,400)
Supplies and services		(186,664)	(159,675)
Grants and subsidies		(262,737)	(267,200)
Borrowing costs		(9,371)	(9,652)
Capital user charge		(6,288)	(7,439)
GST payments on purchases		(46,242)	(43,223)
Receipts			
User charges and fees		5,931	4,905
Commonwealth grants and contributions	11	102,548	99,176
Interest received		72	130
GST receipts on sales		1,181	1,660
GST receipts from taxation authority		48,562	39,450
Other receipts		9,059	20,407
Net cash used in operating activities	26c	(403,785)	(384,342)
CASH FLOWS FROM INVESTING ACTIVITIES			
Payments for purchase of non-current assets		(2,238)	(9,008)
Receipts from the sale of non-current assets		23	61
Net cash used in investing activities		(2,215)	(8,947)
CASH FLOWS FROM FINANCING ACTIVITIES			
Repayment of borrowings		(212)	(202)
Repayment of lease liabilities		(2,508)	(2,281)
Net cash used in financing activities		(2,720)	(2,483)
Net increase/(decrease) in cash held		(311)	3,043
Cash assets at the beginning of the financial year		8,987	2,859
Cash assets transferred from/(to) other government agencies		(3,045)	3,085
CASH ASSETS AT THE END OF THE FINANCIAL YEAR	26a	5,631	8,987

The Statement of Cash Flows should be read in conjuction with the accompanying notes.

Output Schedule of Expenses and Revenue

For the year ended 30 June 2003

	PREVENTION AND PROMOTION		DIAGNOSIS AND TREATMENT		CONTINUING CARE		TOTAL	
	2003 $000	2002 $000	2003 $000	2002 $000	2003 $000	2002 $000	2003 $000	2002 $000
COST OF SERVICES								
Expenses from ordinary activities								
Employee expenses	27,577	29,530	25,575	28,871	6,707	8,772	59,859	67,173
Grants and subsidies	44,207	55,933	91,717	81,990	134,275	128,681	270,199	266,604
Supplies and services	27,123	24,713	143,633	118,624	4,102	5,050	174,858	148,387
Repair and maintenance	997	923	1,352	981	405	296	2,754	2,200
Depreciation expenses	1,067	1,194	4,761	4,606	273	323	6,101	6,123
Borrowing costs expense	1,437	1,860	5,961	5,731	1,780	2,059	9,178	9,650
Capital user charge	1,036	1,516	3,968	4,245	1,284	1,678	6,288	7,439
Asset revaluation decrement	-	-	17,434	-	-	-	17,434	-
Other expenses from ordinary activities	6,584	7,000	8,207	6,072	2,007	1,277	16,798	14,349
Total cost of services	110,028	122,669	302,608	251,120	150,833	148,136	563,469	521,925
Revenues from ordinary activities								
User charges and fees	1,902	2,430	3,889	2,621	261	358	6,052	5,409
Commonwealth grants and contributions	33,734	30,331	5,282	11,251	63,532	57,594	102,548	99,176
Proceeds from disposal of non-current assets	4	44	1,365	16	5	1	1,374	61
Other revenues from ordinary activities	4,065	4,290	5,714	6,605	24	128	9,803	11,023
Total revenues from ordinary activities	39,705	37,095	16,250	20,493	63,822	58,081	119,777	115,669
NET COST OF SERVICES	70,323	85,574	286,358	230,627	87,011	90,055	443,692	406,256
REVENUES FROM STATE GOVERNMENT								
Output appropriations	66,375	82,475	254,087	228,511	82,217	89,862	402,679	400,848
Liabilities assumed by the Treasurer	44	50	121	72	33	16	198	138
Resources received free of charge	363	324	1,161	824	376	326	1,900	1,474
Assets assumed/(transferred)	4	-	17	-	5	-	26	-
Total revenues from State Government	66,786	82,849	255,386	229,407	82,631	90,204	404,803	402,460
Net revenues/(expenses) from restructuring	-	4,377	-	175	-	-	-	4,552
CHANGE IN NET ASSETS AFTER RESTRUCTURING	(3,537)	1,652	(30,972)	(1,045)	(4,380)	149	(38,889)	756

The Output Schedule of Expenses and Revenues should be read in conjunction with the accompanying notes.

Summary of Consolidated Fund Appropriations and Revenue Estimates
For the year ended 30 June 2003

	NOTE	2003 ESTIMATE $000	2003 ACTUAL $000	VARIANCE $000	2003 ACTUAL $000	2002 ACTUAL $000	VARIANCE $000
PURCHASE OF OUTPUTS	30 (a), (b)						
Item 113 Net amount appropriated to purchase output		281,737	287,428	5,691	287,428	264,690	22,738
Item 114 Contribution to Hospital Fund		2,027,197	2,059,410	32,213	2,059,410	1,953,096	106,314
Amount Authorised by Other Statutes							
- Salaries and Allowances Act 1975		630	630	-	630	630	-
- Lotteries Commission Act 1990		71,810	75,000	3,190	75,000	72,000	3,000
Total appropriations provided to purchase outputs		2,381,374	2,422,468	41,094	2,422,468	2,290,416	132,052
CAPITAL	30 (c), (d)						
Item 179 Capital Contribution		38,389	38,389	-	38,389	89,112	(50,723)
ADMINISTERED	30 (e)						
Item 115 Office of Health Review		1,009	1,009	-	1,009	983	26
Amount Authorised by Other Statutes							
- Tobacco Control Act 1990		16,517	16,517	-	16,517	16,114	403
Total administered appropriations		17,526	17,526	-	17,526	17,097	429
Grand Total of Appropriations		2,437,289	2,478,383	41,094	2,478,383	2,396,625	81,758
Details of Expenditure by Outputs	30 (a), (b)						
Prevention and Promotion Output		263,726	283,781	20,055	283,781	234,930	48,851
Diagnosis and Treatment Output		2,275,878	2,410,718	134,840	2,410,718	2,261,064	149,654
Continuing Care Output		209,022	218,250	9,228	218,250	210,571	7,679
Total Cost of Outputs		2,748,626	2,912,749	164,123	2,912,749	2,706,565	206,184
Total operating revenues		(367,252)	(457,499)	(90,247)	(457,499)	(397,532)	(59,967)
Net Cost of Outputs		2,381,374	2,455,250	73,876	2,455,250	2,309,033	146,217
Adjustment for movement in cash balances and other accrual items		-	(32,782)	(32,782)	(32,782)	(18,617)	(14,165)
Total appropriations provided to purchase outputs		2,381,374	2,422,468	41,094	2,422,468	2,290,416	132,052
Capital Expenditure							
Purchase of non-current physical assets		108,738	94,694	(14,044)	94,694	95,336	(642)
Repayment of borrowings		8,942	10,868	1,926	10,868	9,987	881
Adjustments for other funding sources		(79,291)	(67,173)	12,118	(67,173)	(16,211)	(50,962)
Capital Contribution (appropriation)		38,389	38,389	-	38,389	89,112	(50,723)
DETAILS OF REVENUE ESTIMATES							
Revenue disclosed as Administered Revenues		688,993	717,889	28,896	717,889	660,759	57,130

The Summary of Consolidated Fund Appropriations and Revenue Estimates should be read in conjunction with the accompanying notes. This Summary provides the basis for the Explanatory Statement information requirements of TI 945, set out in Note 30.

1. Departmental mission and funding

The Department's mission as the principal health authority is to ensure the best achievable health status for all of the West Australian community.

The Department is predominantly funded by Parliamentary appropriations. The financial statements encompass all funds through which the Department controls resources to carry on its functions.

In the process of reporting on the Department as a single entity, all intra-entity transactions and balances have been eliminated.

2. Significant accounting policies

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

General Statement

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

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

Basis of accounting

The financial statements have been prepared in accordance with Australian Accounting Standard AAS 29 "Financial Reporting by Government Departments".

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

Administered assets, liabilities, expenses and revenues are not integral to the Department in carrying out its functions and are disclosed in the notes to the financial statements, forming part of the general purpose financial report of the Department (refer note 36). The administered items are disclosed on the same basis as is described above for the financial statements of the Department. The administered assets, liabilities, expenses and revenues are those which the Government requires the Department to administer on its behalf. The assets do not render any service potential or future economic benefits to the Department, the liabilities do not require the future sacrifice of service potential or future economic benefits of the Department, and the expenses and revenues are not attributable to the Department.

2. Significant accounting policies (continued)

As the administered assets, liabilities, expenses and revenues are not recognised in the principal financial statements of the Department, the disclosure requirements of Australian Accounting Standard AAS 33 "Presentation and Disclosure of Financial Instruments", are not applied to administered transactions.

(a) Output appropriations

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

(b) Contributed equity

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

(c) Net appropriation determination

Pursuant to section 23A of the Financial Administration and Audit Act, the net appropriation determination by the Treasurer provides for retention of the following moneys received by the Department:

- Proceeds from services provided by Health Statistics Branch;
- Proceeds from services provided by Environmental Health Services;
- Proceeds from services provided by Community Support Services;
- Proceeds from services provided by Health Promotion Services;
- Proceeds from services provided by Miscellaneous Services;
- Proceeds for services provided by the Drug and Alcohol Office;
- GST input credits;
- GST receipts on sales; and
- Commonwealth Specific Purpose Programs.

There are also some items of revenues that are subsumed under the Hospital Fund.

Retained revenues may only be applied to the outputs specified in the 2002/2003 Budget Statements.

2. Significant accounting policies (continued)

(d) Grants and other contributions revenue

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

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

(e) Revenue recognition

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

(f) Acquisitions of assets

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

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

(g) Depreciation of non-current assets

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

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

Buildings	50 years
Computer equipment	5 years
Furniture and fittings	10 to 15 years
Other plant and equipment	10 to 15 years

(h) Revaluation of land and buildings

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

The valuations of land have been undertaken by the Valuer General’s Office in Western Australia, on the current existing use valuation basis for primarily all Crown Land and current market valuation basis for freehold title land.

2. Significant accounting policies (continued)

The valuations of buildings have been carried out by the Department of Health in conjunction with the Department of Housing and Works using "as constructed" drawings. The buildings are valued at "Replacement Capital Value", which is defined as the estimated written down replacement cost of the most appropriate modern equivalent replacement facility having a similar service potential to the existing asset. All building costs are Perth based and include elements of electrical, mechanical and plumbing services. Loose and freestanding furniture and equipment together with specialised medical equipment are excluded from this valuation.

(i) Leases

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 incidental 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 leased buildings, and are depreciated to the Statement of Financial Performance over the period which the Department is expected to benefit from 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.

Finance lease liabilities are allocated between current and non-current components. The principal component of lease payments due on or before the end of the succeeding year is disclosed as a current liability, and the remainder of the lease liability is disclosed as a non-current liability.

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

(j) Cash

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

(k) Accrued salaries

The accrued salaries suspense account (refer note 15) consists of amounts paid annually into a suspense account over a period of 10 financial years to largely meet the additional cash outflow in each eleventh year when 27 pay days occur in that year instead of the normal 26. No interest is received on this account.

Accrued salaries represent the amount due to staff but unpaid at the end of the financial year, as the end of the last pay period for that financial year does not coincide with the end of the financial year. Accrued salaries are settled within a few days of the financial year end. The Department considers the carrying amount of accrued salaries to be equivalent to the net fair value.

2. Significant accounting policies (continued)

(l) Inventories

Inventories are valued at the lower of cost and net realisable values. Costs are assigned on the weighted average basis.

(m) Receivables

Receivables are recognised immediately when invoices are delivered to debtors, as they are due for settlement no more than 14 days from the date of recognition.

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

(n) Payables

Payables, including accruals not yet billed, are recognised when the Department becomes obliged to make payments in the future for goods and services received. Payables are generally settled within 30 days.

(o) Interest-bearing liabilities

As a consequence of the closure of several public hospitals in recent years, the Department has taken up Treasury Loans as detailed in note 23. The Department is funded for the debt servicing arrangements. The related borrowing costs expense is recognised on an accrual basis.

(p) Employee benefits

Annual leave

This benefit is recognised at the reporting date in respect to employees' services up to that date and is measured at the nominal amounts expected to be paid when the liabilities are settled.

Long service leave

The liability for long service leave expected to be settled within 12 months of the reporting date is recognised in the provisions for employee benefits and is measured at the nominal amounts expected to be paid when the liability is settled. The liability for long service leave expected to be settled more than 12 months from the reporting date is recognised in the provisions for employee benefits and is measured at the present value of expected future payments to be made in respect of services provided by employees up to the reporting date. Consideration is given, when assessing expected future payments, to expected future wage and salary levels including relevant on costs, experience of employee departures and periods of service. Expected future payments are discounted using market yields at the reporting date on national government bonds with terms to maturity and currency that match, as closely as possible, the estimated future cash outflows.

This method of measurement of the liability is consistent with the requirements of Australian Accounting Standard AASB 1028 "Employee Benefits".

2. Significant accounting policies (continued)

Superannuation

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

The superannuation expense comprises the following elements:

(i) change in the unfunded employer's liability in respect of current employees who are members of the Pension Scheme and current employees who accrued a benefit on transfer from that Scheme to the Gold State Superannuation Scheme; and

(ii) employer contributions paid to the Gold State Superannuation Scheme and the West State Superannuation Scheme.

The superannuation expense does not include payment of pensions to retirees, as this does not constitute part of the cost of services provided by the Department in the current year.

A revenue "Liabilities assumed by the Treasurer" equivalent to (i) is recognised under Revenues from Government in the Statement of Financial Performance as the unfunded liability is assumed by the Treasurer. The GESB makes the benefit payments and is recouped by the Treasurer.

The Department is funded for employer contributions in respect of the Gold State Superannuation Scheme and the West State Superannuation Scheme. These contributions were paid to the GESB during the year. The GESB subsequently paid the employer contributions in respect of the Gold State Superannuation Scheme to the Consolidated Fund.

Employee benefit on-costs

Employee benefit on-costs, are recognised and included in employee benefit liabilities and costs when the employee benefits to which they relate are recognised as liabilities and expenses. (See notes 4 and 22).

(q) Resources received free of charge or for nominal value

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

(r) Comparative figures

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

(s) Rounding of amounts

Amounts in the financial statements have been rounded to the nearest thousand dollars, or in certain cases, to the nearest dollar.

3. Outputs of the Department

Information about the Department's outputs and, the expenses and revenues which are reliably attributable to those outputs is set out in the Output Schedule. Information about expenses, revenues, assets and liabilities administered by the Department are given in the schedule of Administered Expenses and Revenues and the schedule of Administered Assets and Liabilities (note 36).

The three key outputs of the Department:

Prevention and Promotion
Services aim to improve the health of Western Australians by reducing the incidence of preventable disease, injury, disability and premature death.

Diagnosis and Treatment
Services provided to improve the health of Western Australians by restoring the health of people with acute illness. The services provided to diagnose and treat patients include emergency services, ambulatory care (or outpatient services including primary care services), services for those people who are admitted to hospitals, oral health services, and other supporting services such as patient transport and the supply of highly specialised drugs.

Continuing Care
Services provided to people and their carers who require support with moderate to severe functional disabilities and/or terminal illness to assist in the maintenance or improvement of their quality of life.

	2003 $000	2002 $000
4. Employee expenses		
Salaries and wages	46,650	54,873
Superannuation	4,860	4,665
Annual leave	3,731	3,117
Long service leave	869	846
Other staff costs	3,749	3,672
Total	**59,859**	**67,173**

These employee expenses include superannuation WorkCover premiums and other employment on-costs associated with the recognition of annual and long service leave liability. The related on-costs liability is included in employee entitlement liabilities at Note 22.

5. Grants and subsidies		
Payments to other affiliated health organisations	262,805	254,716
Payments to government organisations	4,745	9,367
Spectacle subsidy scheme	2,561	2,520
Other	88	1
Total	**270,199**	**266,604**
6. Supplies and services		
Contracts for services	149,107	126,896
Medical supplies	15,590	11,851
Other consumables	4,423	4,311
Operating lease rentals	4,995	4,528
Other	743	801
Total	**174,858**	**148,387**

		2003 $000	2002 $000
7.	**Depreciation expenses**		
	Buildings	872	752
	Leased buildings	2,729	2,814
	Computer equipment	1,722	1,820
	Plant and equipment	760	716
	Furniture and fittings	18	21
	Total	**6,101**	**6,123**
8.	**Borrowing costs expense**		
	Finance lease finance charges	8,720	9,127
	Interest on Treasury loans	458	523
	Total	**9,178**	**9,650**
9.	**Capital User Charge**		
	Capital user charge	**6,288**	**7,439**

A capital user charge rate of 8% has been set by the Government and represents the opportunity cost of capital invested in the net assets of the Department used in the provision of outputs. The charge is calculated on the net assets adjusted to take account of exempt assets. Payments are made to the Department of Treasury and Finance on a quarterly basis.

10.	**Other expenses from ordinary activities**		
	Promotional expenses	3,784	2,356
	Advertising	702	723
	Communication	1,803	2,474
	Computer related expenses	3,006	2,588
	Travel related expenses	1,159	1,162
	Legal expense	235	318
	External auditor remuneration (Note 12)	220	178
	Scholarships	1,727	698
	Insurance	301	250
	Doubtful debts expense	13	2
	Carrying amount of non-current assets disposed of	1,489	162
	Other	2,359	3,438
	Total	**16,798**	**14,349**
11.	**Commonwealth grants and contributions**		
	Controlled revenues	102,548	99,176
	Administered revenues (Note 36)	145,683	103,835
	Total	**248,231**	**203,011**

12. Revenues from State Government

	2003 Controlled $000	2003 Administered $000 (note 36)	2003 Total $000	2002 Total $000
Output appropriations (I)				
Amount appropriated to purchase outputs	257,502	29,926	287,428	264,690
Contribution to Hospital Fund	144,547	1,914,863	2,059,410	1,953,096
Amount authorised by other statutes				
- Lotteries Commission Act 1990	-	75,000	75,000	72,000
- Salaries and Allowances Act 1975	630	-	630	630
- Tobacco Control Act 1990	-	16,517	16,517	16,114
Office of Health Review	-	1,009	1,009	983
	402,679	2,037,315	2,439,994	2,307,513
Capital appropriations	11,350	27,039	38,389	89,112
Total	**414,029**	**2,064,354**	**2,478,383**	**2,396,625**

	2003 $000	2002 $000
Liabilities assumed by the Treasurer		
- Superannuation (II)	**198**	**138**
Assets assumed/(transferred) (III)		
- Transfer to WA Country Health Service	**26**	**-**
Resources received free of charge (IV)		
Education Department - accommodation	1,225	1,208
Office of the Auditor General - external audit services	220	178
Valuer General's Office - valuation of assets	77	31
Department of Land Administration - land services	319	27
Other	59	30
Total	**1,900**	**1,474**

(i) Output appropriations are accrual amounts reflecting the full cost of outputs delivered. The appropriation revenue comprises a cash component and a receivable (asset). The receivable (holding account) comprises the depreciation expense for the year and any agreed increase in leave liability during the year.

(ii) The assumption of the superannuation liability by the Treasurer is only a notional revenue to offset the notional superannuation expense reported in respect of current employees who are members of the pension scheme and current employees who have a transfer benefit entitlement under the Gold State scheme.

(iii) Where the non-reciprocal transfer of assets/liabilities is not a consequence of the restructuring of administrative arrangements, the transfer is disclosed here.

(iv) Where assets or services have been received free of charge or for nominal consideration, the Department recognises revenues (except where the contributions of assets or services are in the nature of contributions by owners in which case the Department shall make a direct adjustment to equity) equivalent to the fair value of the assets and/or the fair value of those services that can be reliably determined and which would have been purchased if not donated, and those fair values shall be recognised as assets or expenses, as applicable.

	2003 $000	2002 $000
13. Net revenues /(expenses) from restructuring		
Assets		
Cash	-	3,085
Prepayments	-	65
Receivables	-	86
Land and buildings	-	1,475
Plant and equipment	-	67
Liabilities		
Employee entitlements	-	(226)
Net revenues/(expenses) from restructuring	**-**	**4,552**
14. Cash assets		
Operating bank account	42	3,488
Cash on hand	1	2
	43	**3,490**
15. Restricted cash assets		
Current		
Commonwealth Trust Accounts (i)	2,966	2,875
Non-current		
Accrued Salaries Suspense Account (ii)	2,622	2,622
	5,588	**5,497**

(i) Cash held in the account is to be used only for the specific purposes stipulated by Commonwealth Government.
(ii) Amount held in suspense account at the Department of Treasury and Finance is only to be used for the purpose of meeting the 27th pay in a financial year that occurs every 11 years.

16. Inventories		
Engineering supplies (at cost)	152	167
Other supplies (at cost)	6,606	635
	6,758	**802**
17. Receivables		
Debtors	3,014	1,317
Provision for doubtful debts	(32)	(19)
GST receivable	4,720	8,297
	7,702	**9,595**

	2003 $000	2002 $000
18. Amounts receivable for outputs		
Current	5,472	-
Non-current	8,984	8,845
	14,456	**8,845**

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

19. Land and buildings

Land		
At fair value	22,089	1,209
At cost	-	312
At valuation June 1996	2	7
At valuation June 1997	2,375	2,375
At valuation June 1998	7,023	12,795
At valuation June 1999	3,561	11,138
At valuation June 2000	9,742	11,092
	44,792	38,928
Buildings		
At fair value	28,480	5,126
Accumulated depreciation	(16,247)	(2,672)
	12,233	2,454
At cost	10,894	13,380
Accumulated depreciation	(435)	(200)
	10,459	13,180
At valuation June 1998	5,375	24,093
Accumulated depreciation	(759)	(10,990)
	4,616	13,103
At valuation June 1999	3,390	3,390
Accumulated depreciation	(1,964)	(1,920)
	1,426	1,470
At valuation June 2000	244	3,554
Accumulated depreciation	(53)	(2,182)
	191	1,372
	28,925	31,579
Building under construction		
Construction costs	888	29
Leased buildings		
At fair value	89,672	-
At cost	-	55,920
At valuation June 1999	-	52,099
Accumulated depreciation	(18,866)	(17,050)
	70,806	90,969
Total	**145,411**	**161,505**

19. Land and buildings (continued)

Land and buildings are carried at a mixture of cost and valuation. Recent valuations are equivalent to fair value. The revaluation of land was performed in accordance with an independent valuation by the Valuer General's Office, on the current existing use valuation basis for primarily all Crown Land and current market valuation basis for freehold title land. The clinical buildings were valued at "Replacement Capital Value" by the Department of Health in conjunction with the Department of Housing and Works.

Reconciliations

Reconciliations of the carrying amounts of land and buildings at the beginning and end of the current financial year are set out below.

	Land $000	Buildings $000	Building under construction $000	Leased buildings $000	**2003 Total $000**
Carrying amount at the start of year	38,928	31,579	29	90,969	161,505
Additions	5,500	-	888	-	6,388
Disposals	(4,215)	(1,592)	(29)	-	(5,836)
Revaluation increments/(decrements)	4,579	(190)	-	(17,434)	(13,045)
Depreciation	-	(872)	-	(2,729)	(3,601)
Carrying amount at the end of year	44,792	28,925	888	70,806	**145,411**

20. Plant and equipment

	2003 $000	**2002 $000**
Computer equipment		
At cost	10,545	11,222
Accumulated depreciation	(6,797)	(6,552)
	3,748	4,670
Furniture and fittings		
At cost	393	433
Accumulated depreciation	(157)	(164)
	236	269
Other plant and equipment		
At cost	7,502	7,125
Accumulated depreciation	(4,229)	(3,626)
	3,273	3,499
Total	**7,257**	**8,438**

20. Plant and equipment (continued)

Reconciliations

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

	Computer equipment $000	Furniture & fittings $000	Other plant & equipment $000	**2003 Total $000**
Carrying amount at the start of year	4,670	269	3,499	8,438
Additions	1,087	13	655	1,755
Disposals	(281)	(28)	(121)	(430)
Depreciation	(1,722)	(18)	(760)	(2,500)
Write-off	(6)	-	-	(6)
Carrying amount at the end of year	3,748	236	3,273	**7,257**

	2003 $000	**2002 $000**
21. Payables		
Current Liabilities		
Creditors	21,215	2,666
Interest	37	44
	21,252	**2,710**
22. Provisions		
Current		
Annual leave	5,028	4,806
Long service leave	4,315	4,240
Superannuation	221	205
	9,564	9,251
Non-current		
Long service leave	2,411	3,060
Deferred salary scheme	8	-
	2,419	3,060
Total	**11,983**	**12,311**

The settlement of annual and long service leave liabilities gives rise to the payment of employment on-costs including superannuation and WorkCover premiums. The liability for such on-costs is included here. The associated expense is included under Other staff costs (under Employee expenses) at Note 4.

The Department considers the carrying amount of employee benefits to approximate the net fair value.

	2003 $000	2002 $000

22. Provisions (continued)

Employee Benefit Liabilities

The aggregate employee entitlement liability recognised and included in the financial statements is as follows:
Provision for employee benefits:

Current	9,564	9,251
Non-current	2,419	3,060
	11,983	**12,311**

23. Interest-bearing liabilities

Current		
Treasury loans	222	212
Finance lease liabilities (secured)	2,762	2,508
	2,984	**2,720**
Non-current		
Treasury loans	5,547	5,769
Finance lease liabilities (secured)	86,176	88,938
	91,723	**94,707**

Lease liabilities are effectively secured as the rights to the leased assets revert to the lessor in the event of default.

The carrying amounts of non current assets pledged as security are:

Buildings under finance lease	70,806	90,969

24. Other liabilities

Income received in advance		
Current	561	545
Non-current	9,716	9,990
	10,277	**10,535**

25. Equity

Equity represents the residual interest in the net assets of the Department. The Government holds the equity interest in the Department on behalf of the community. The asset revaluation reserve represents that portion of equity resulting from the revaluation of non-current assets.

Contributed equity

Balance at the beginning of the year	6,821	-
Capital contributions (I)	11,350	6,821
Contributions by owners (II)	5,500	-
Distribution to Owner (III)	(6,806)	-
Balance at the end of the year	**16,865**	**6,821**

(I) Capital Contributions have been designated as contributions by owners and are credited directly to equity in the Statement of Financial Position.
(II) Non-reciprocal transfer of Perth Dental Hospital property.
(III) Distribution to Owner is the non-reciprocal transfer of assets on 1 July 2002 to WA Alcohol and Drug Authority and also net assets to WA Country Health Services. In addition, during the financial year land valuing $2.6 Million was transferred for sale.

	2003 $000	2002 $000

25. Equity (continued)

Asset revaluation reserve

Balance at the beginning of the year	164,382	163,833
Net revaluation increments/(decrements)		
- Land	4,579	63
- Buildings	(190)	486
Balance at the end of the year	**168,771**	**164,382**
Asset revaluation decrements recognised as an expense:		
- Leased Buildings	**17,434**	**-**

The asset revaluation reserve is used to record increments and decrements on the revaluation of non-current assets, as described in accounting policy note 2(h).

Accumulated surplus/(deficiency)

Balance at the beginning of the year	(98,069)	(98,825)
Change in net assets after restructuring	(38,889)	756
Net initial adjustments on adoption of AASB 1028 "Employee Benefits"	(173)	-
Balance at the end of the year	**(137,131)**	**(98,069)**

26. Notes to the Statement of Cash Flows

(a) Reconciliation of cash

For the purpose of the Statement of Cash Flows, cash includes cash assets and restricted cash assets. Cash at the end of the financial year as shown in the Statement of Cash Flows is reconciled to the related items in the Statement of Financial Position as follows:

Cash assets	43	3,490
Restricted cash assets	5,588	5,497
	5,631	**8,987**

(b) Non-cash financing and investing activities

During the financial year, there were no assets/liabilities transferred/assumed from other government agencies not reflected in the Statement of Cash Flows.

(c) Reconciliation of net cost of services to net cash flows used in operating activities

Net Cost of Services (Statement of Financial Performance)	**(443,692)**	**(406,256)**
Non-cash items:		
Depreciation expenses	6,101	6,123
Superannuation liability assumed by Treasurer	198	138
Resources received free of charge	1,900	1,474
Net (gain)/loss on disposal of non-current assets	115	101
Asset revaluation decrement	17,434	-
Other	1,830	157

	2003 $000	2002 $000
26. Notes to the Statement of Cash Flows (continued)		
(Increase)/decrease in assets:		
Inventories	(5,956)	669
Receivables	1,893	(2,042)
Prepayments	1,332	1,450
Increase/(decrease) in liabilities:		
Payables	18,542	1,952
Accrued salaries	(2,896)	3,160
Provisions	(328)	360
Other liabilities	(258)	8,372
Net Cash Used in Operating Activities	**(403,785)**	**(384,342)**

(d) Financing facilities

At the reporting date, the Department had fully drawn on all financing facilities, details of which are disclosed in the financial statements.

27. Commitments for expenditure

(a) Finance lease commitments

Payable within 1 year	11,407	11,407
Payable later than 1 year and not later than 5 years	45,629	45,629
Payable later than 5 years	110,685	122,092
Minimum finance lease payments	167,721	179,128
Less: Future finance charges	78,784	87,682
Finance lease liabilities	**88,937**	**91,446**
Included in the financial statements as:		
Current (Note 23)	2,762	2,508
Non-current (Note 23)	86,175	88,938
	88,937	**91,446**

(b) Operating lease commitments

Commitments in relation to non-cancellable operating leases contracted for at reporting date but not recognised as liabilities:

Payable within 1 year	2,970	2,710
Payable later than 1 year and not later than 5 years	10,527	3,659
Payable later than 5 years	4,989	582
	18,486	**6,951**

	2003 $000	2002 $000

27. Commitments for expenditure (continued)

(c) Private sector contracts for the provision of health services

Expenditure commitments in relation to health services contracted for at reporting date with private sector organisations, but not recognised as liabilities:

Payable within 1 year	285,974	293,593
Payable later than 1 year and not later than 5 years	612,446	647,191
Payable later than 5 years and not later than ten years	636,439	523,126
Payable later than ten years	635,444	607,162
	2,170,303	**2,071,072**

(d) Capital expenditure commitments

The Department has no major capital commitments as at 30 June 2003.

(e) Other expenditure commitments

Other expenditure contracted for at reporting date but not recognised as liabilities:

Payable within 1 year	**8,253**	**4,789**

28. Contingent liabilities

In addition to the liabilities incorporated in the financial statements, the Department has the following contingent liabilities:

Pending potential litigation that may affect the Financial position (not recoverable from RiskCover)	**1,020**

The Department does not have any contingent assets.

29. Events occurring after reporting date

The Department is not aware of any material events occurring after reporting date.

30. Explanatory Statement: CONSOLIDATED FUND - APPROPRIATIONS

The Summary of Consolidated Fund Appropriations and Revenue Estimates discloses appropriations and other statutes expenditure estimates, the actual expenditures made and revenue estimates and payments into the Consolidated Fund. Appropriations are now on an accrual basis.

The following explanations are provided in accordance with Treasurer's Instruction 945. Significant variations are considered to be those greater than 5%.

30. Explanatory Statement: CONSOLIDATED FUND - APPROPRIATIONS (continued)

(a) Significant variances between estimate and actual – Total appropriation to purchase outputs:
Although there was no significant variation in the total appropriation, there were significant offsetting variances in the following output expenditures:

	2003 Estimate $000	2003 Actual $000	Variance $000
Prevention and Promotion Output	263,726	283,781	20,055

Increased demand for services and cost pressures funded by operating revenue, supplementary funding from Government and internal funding sources.

Diagnosis and Treatment Output	2,275,878	2,410,718	134,840

Increased demand for services and cost pressures funded by operating revenue, supplementary funding from Government and internal funding sources.

(b) Significant variances between actual and prior year actual – Total appropriation to purchase outputs:

	2002 Actual $000	2003 Actual $000	Variance $000
Net amount of appropriation provided to purchase outputs for the year	2,309,033	2,455,250	146,217
Total operating revenue	397,532	457,499	(59,967)

Net amount of appropriation provided to purchase outputs for the year
The variance is due additional funding provided to Health to meet increased costs of service delivery.

Total operating revenue
The variance arises from increased revenue from the Commonwealth and other funding sources.

Output Expenditure

	2002 Actual $000	2003 Actual $000	Variance $000
Prevention and Promotion Output	234,930	283,781	48,851

Variation is a result of increased demand for services and cost pressures funded by operating revenue, supplementary funding from Government and internal funding sources.

Diagnosis and Treatment Output	2,261,064	2,410,718	149,654

Variation is a result of increased demand for services and cost pressures funded by operating revenue, supplementary funding from Government and internal funding sources.

30. Explanatory Statement: CONSOLIDATED FUND - APPROPRIATIONS (continued)

(c) Significant variances between estimate and actual - Capital contribution: No significant variances.

(d) Significant variances between actual and prior year actual - Capital contribution:

	2002 Actual $000	2003 Actual $000	Variance $000
Capital Contribution	89,112	38,389	(50,723)

The variance represents a change in funding sources from capital contribution to a withdrawal of "Amounts Receivable for Outputs".

(e) Significant variances between estimate and actual, and actual and prior year actual – Total administered appropriations: No significant variances.

31. Financial instruments

(a) Interest rate risk exposure

The Department's exposure to interest rate risks and the effective interest rates of financial assets and liabilities as at the reporting date are as follows:

	Weighted average effective interest rate %	Floating interest rate $000	Fixed interest rate maturities 1 year or less $000	1 to 5 years $000	Over 5 years $000	Non interest bearing $000	**2003 TOTAL $000**	**2002 TOTAL $000**
30 June 2003								
Financial Assets								
Cash assets	-	-	-	-	-	43	43	3,490
Restricted cash assets	-	-	-	-	-	5,588	5,588	5,497
Receivables	-	-	-	-	-	7,702	7,702	9,595
		-	-	-	-	13,333	13,333	18,582
Financial Liabilities								
Payables	-	-	-	-	-	21,252	21,252	2,710
Lease liabilities	9.9	-	2,762	14,142	72,034	-	88,938	91,446
Treasury loans	7.8	-	222	1,061	4,486	-	5,769	5,981
		-	2,984	15,203	76,520	21,252	115,959	100,137
		-	**(2,984)**	**(15,203)**	**(76,520)**	**(7,919)**	**(102,626)**	**(81,555)**

31. Financial instruments (continued)

(b) Credit risk exposure

The Department's maximum exposure to credit risk without taking into account of the value of any collateral or other security obtained is as follows:

	2003 $000	2002 $000
Financial Assets		
Receivables	**132**	**610**

(c) Net fair values

The carrying amount of financial assets and financial liabilities recorded in the financial statements are not materially different from their net fair values, determined in accordance with the accounting policies disclosed in note 2 to the financial statements.

32. Remuneration and retirement benefits of senior officers

Remuneration
The number of senior officers, whose total of fees, salaries, superannuation and other benefits for the financial year, fall within the following bands are:

	2003	2002
$60,000 - $70,000	-	1
$70,001 - $80,000	-	2
$90,001 - $100,000	-	1
$100,001 - $110,000	-	2
$110,001 - $120,000	-	4
$130,001 - $140,000	-	2
$150,001 - $160,000	1	1
$160,001 - $170,000	1	-
$170,001 - $180,000	-	1
$180,001 - $190,000	1	-
$200,001 - $210,000	1	-
$260,001 - $270,000	1	-

	$000	$000
The total remuneration of senior officers is:	**986**	**1,789**

The superannuation included here represents the superannuation expense incurred by the Department in respect of senior officers.

	2003 $000	2002 $000

33. Supplementary Financial Information

Write off's

Revenue, debt, public and other property written off under the authority of:

The Accountable Officer	-	3
The Minister for Health	9	9
	9	**12**

34. Other Statement of Receipts and Payments

Commonwealth Grant – Christmas and Cocos Island

Balance as at July 1	**-**	**138**
Receipts		
Commonwealth Disbursements	**420**	**475**
Payments		
Retainer Fee	30	30
Service Delivery Agreement Development Project	-	50
Purchase of WA Health Services	488	395
Less Adjustment for Previous year	(98)	
Indian Oceans Territories Health Services Development Project	-	126
Adjustment for GST	-	12
	420	**613**
Balance as at June 30	**-**	**-**

35. Affiliated Bodies

The nature of assistance provided in the form of grants and subsidies to all non-government agencies (whether affiliated or not) during the year are outlined below:

Aboriginal health	21,524	16,583
Acute patient care	54,091	45,697
Aged and continuing care	131,690	127,347
Dental services	8,286	3,396
Drug abuse strategy	-	13,239
Mental health	18,364	19,926
Public health	21,942	18,174
Research and development	6,908	10,354
	262,805	**254,716**

36. Schedule of Administered Items

DETAILS	NOTE	PREVENTION AND PROMOTION		DIAGNOSIS AND TREATMENT		CONTINUING CARE		TOTAL	
		2003 $000	2002 $000	2003 $000	2002 $000	2003 $000	2002 $000	2003 $000	2002 $000
ADMINISTERED EXPENSES AND REVENUES	**(a)**								
EXPENSES									
Appropriations transferred		111,158	118,003	2,034,117	1,847,023	73,439	65,623	2,218,714	2,030,649
Other expenses		-	-	3	31	-	-	3	31
Total administered expenses		111,158	118,003	2,034,120	1,847,054	73,439	65,623	2,218,717	2,030,680
REVENUES									
Appropriations from Government for transfer	**12**	104,434	120,488	1,910,655	1,818,723	49,266	49,745	2,064,355	1,988,956
Commonwealth grants and contributions	**11**	6,285	406	115,441	85,324	23,957	18,105	145,683	103,835
Total administered revenues		110,719	120,894	2,026,096	1,904,047	73,223	67,850	2,210,038	2,092,791
ADMINISTERED ASSETS AND LIABILITIES	**(a)**								
Current Assets									
Cash assets		973	1,222	17,809	22,362	643	807	19,425	24,391
Total administered current assets		973	1,222	17,809	22,362	643	807	19,425	24,391
Current Liabilities									
Payables		76	86	1,388	1,578	50	57	1,514	1,721
Total administered current liabilities		76	86	1,388	1,578	50	57	1,514	1,721

NOTE

(a) Health services are statutory authorities in their own right and are controlled by their respective Boards. Accordingly, the Department only administers funds appropriated to health services and once allocated, it is the respective Boards who control these funds, assets and liabilities.

37. Commonwealth Trust Accounts

These funds are incorporated into the controlled and administered transactions of the Department's financial statements.

a) Statement of Receipts and Payments

	2002/2003				2001/2002			
Trust Account	Opening balance $000	Receipts $000	Payments $000	Closing balance $000	Opening balance $000	Receipts $000	Payments $000	Closing balance $000
Commonwealth Grants and Advances Account	19,687	248,317	256,892	11,112	18,237	204,499	203,049	19,687

b) Purpose of Commonwealth Trust Accounts

Commonwealth Grants and Advances Account
To hold funds received from the Commonwealth for the purposes stated in the Register of Commonwealth Programs which is maintained by the Department of Health.