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Health

Health

Introduction

This chapter provides information on various aspects of the health of the Australian population and the activities of the Commonwealth relating to health. There is, however, government responsibility for health at the State/Territory and local levels. There are constitutional limits on the Commonwealth Government's role in the health care field, and the primary responsibility for planning and provision of health services is with the State and Territory Governments.

At the national level, health services in Australia are administered by the Commonwealth Government. The Government appoints two Ministers to the Portfolio of Human Services and Health (and a Parliamentary Secretary to the Minister for Human Services and Health). The Minister for Human Services and Health exercises overall responsibility over the Commonwealth Department of Human Services and Health, represents the portfolio in Cabinet and has particular responsibility for Budget matters and major policy decisions. The other Minister primarily has responsibility for Family Services. The Commonwealth Government is primarily concerned with the formation of broad national policies, and influences policy making in health services through its financial arrangements with the State and Territory Governments, through the provision of benefits and grants to organisations and individuals, and through the regulation of health insurance.

The direct provision of health services, broadly speaking, is the responsibility of the State and Territory Governments. Each has a Minister who is responsible to the Government of the particular State or Territory for the administration of its health authorities. In some, the responsibility for health services is shared by several authorities whilst in others, one authority is responsible for all these functions.

Health care is also delivered by local government, semi-voluntary agencies, and profit making non-governmental organisations. Information on the activities of government and other bodies on health-related matters is provided later in this chapter.

This chapter uses data from the most up-to-date sources available at the time of writing. For data from the 1989–90 National Health Survey, please refer to the Health Chapter of *Year Book Australia 1995*. Data from the 1995 National Health Survey will be available late in 1996.

Health status

Healthy lifestyles and risk factors

Overweight and obesity

Overweight and obesity are risk factors for many health conditions, including coronary heart disease, stroke, cancer, high blood pressure, diabetes and respiratory and musculoskeletal problems.

8.1 Persons aged 18 years and over who were overweight or obese
(%)

	1989–90	1994–95
Sex		
Males	44.4	49.7
Females	30.9	33.5
Age		
18–34 years	27.1	32.1
35–54 years	43.9	46.9
55 years & over	45.0	49.2

Source: AIHW Australian Health Indicators No.4, June 1995.

Physical activity

Regular physical activity is important in the prevention of many health conditions, including coronary heart disease, hypertension, diabetes, osteoporosis and obesity. It also provides health benefits associated with improved self esteem.

In 1994–95, 64% of Australians aged 18 years and over reported that they exercised

regularly. An estimated 36% or 4.5 million people reported that they did not currently exercise for sport or recreation. Among men, participation was fairly constant at 60% across all age groups. However, the proportion of women who exercised decreased with age from 71% of under-35-year-olds to 57% of those aged 55 years and over.

Over the last five years, there has been a statistically significant increase in the percentage of adult Australians who walk for exercise. In 1989–90, 41.1% of men and 49.2% of women walked for exercise. By 1994–95, 52.0% of men and 57.7% of women walked for exercise.

8.2 Percentage of adults who engage in any exercise for sport or recreation

	1989–90	1994–95
Sex		
Males	64.5	63.2
Females	64.0	65.9
Age		
18–34 years	70.9	67.7
35–54 years	60.9	65.4
55 years & over	59.1	58.9

Source: AIHW Australian Health Indicators No.4, June 1995.

Use of tobacco and alcohol

Tobacco smoking is a risk factor for heart disease, stroke, lung cancer and chronic lung disease.

In 1994–95, approximately 3.2 million adult Australians were smokers, compared with 3.5 million in 1989–90. In 1994–95, a higher proportion of men (27.3%) were smokers than women (22.7%). Young adults (aged 18–34 years) (31.2%) were twice as likely to be smokers as were adults aged 55 years and over (15.5%).

8.3 Percentage of adults who currently smoke

	1989–90	1994–95
Sex		
Males	31.6	27.3
Females	25.1	22.7
Age		
18–34 years	35.3	31.2
35–54 years	28.9	25.4
55 years & over	17.9	15.5

Source: AIHW Australian Health Indicators No.4, June 1995.

High levels of alcohol consumption have been linked to an increased risk of heart disease, stroke, brain and liver damage, and some cancers. Alcohol intoxication is also a leading cause of road traffic accidents.

In 1994–95, 8% of adult Australians drank alcohol at levels considered by the National Health and Medical Research Council to be dangerous to their health. This percentage has decreased since 1989–90, when 11% of adults drank at dangerous levels. In 1994–95, men were nearly twice as likely to drink alcohol at risk levels (9.7%) as women (5.5%). The age group most likely to drink at risk levels was the 18–34 years age group (8.9%).

8.4 Percentage of adults who drink at risk levels

	1989–90	1994–95
Sex		
Males	14.6	9.7
Females	7.5	5.5
Age		
18–34 years	13.0	8.9
35–54 years	11.7	7.9
55 years & over	7.7	5.3

Source: AIHW Australian Health Indicators No.4, June 1995.

Use of illicit drugs

The 1993 National Drug Strategy Household Survey found that, of persons aged 14 years and over, respondents were most likely to have ever tried marijuana/hash (34%) and tranquillisers (34%). Thirteen per cent of respondents had used marijuana/hash in the twelve months prior to the Survey, and 11% had used tranquillisers. In the twelve months before the Survey, 2% of respondents had used amphetamines, and each of the following drugs had been used by 1% of respondents: cocaine/crack, hallucinogens, inhalants, ecstasy/designer drugs and injected drugs.

The 1993 National Drug Strategy Household Survey asked respondents what drugs they thought of when people spoke about a drug problem. Heroin and marijuana were each mentioned by 30% of respondents. Fifteen per cent mentioned alcohol, 10% mentioned cocaine and 3% mentioned tobacco.

Use of medication

The Drug Utilization Sub-Committee (DUSC), which maintains a database that estimates community prescription drug use in Australia, reports that 163 million prescriptions were dispensed in 1994. Of the ten most commonly used prescription drugs in the community, three were antibiotics and two were pain relievers. Other commonly prescribed types of medication were for the treatment of asthma, hypertension (high blood pressure) and insomnia.

8.5 Most commonly used drugs, 1994

Drug	Description	No. of prescriptions
Amoxycillin	Antibiotic	5 864 731
Salbutamol	Used in treatment of asthma	4 397 913
Paracetamol(a)	Pain relief	4 136 079
Codeine with paracetamol(a)	Pain relief	3 654 776
Amoxycillin with clavulanic acid	Antibiotic	3 415 962
Enalapril	Used in treatment of hypertension (high blood pressure)	3 126 504
Temazepam	Sedative commonly used in treatment of insomnia	3 031 695
Ranitidine	Used in treatment of duodenal & gastric ulcers	2 968 141
Betamethasone	Corticosteroid used for its anti-inflammatory, anti-rheumatic & anti-allergenic effects	2 790 929
Doxycycline	Antibiotic	2 755 977

(a) This drug is available without a prescription, therefore the number of prescriptions for this drug understates actual community use.

Source: Department of Human Services and Health, Drug Utilization Sub-Committee database, 1994.

Dental health

According to the 1994 National Dental Telephone Interview Survey, an estimated 9.3 million people aged 5 years and over had a dental consultation in the twelve months prior to survey interview. The most common types of treatment or service received were teeth cleaned and scaled (64.6%) and teeth filled (40.6%).

Males (42.7%) were more likely to have had teeth filled than females (38.6%). The type of treatment or service provided varied with age. Those aged 5 to 24 years were less likely to have teeth filled than older age groups (table 8.6).

8.6 Persons aged 5 years and over who had a dental consultation(a), 1994
(%)

	Age group (years)						Males	Females	Persons	
Treatment/service	5–14	15–24	25–44	45–64	65–74	>74			%	'000
Tooth/teeth extracted	11.1	14.5	12.5	12.4	10.9	9.5	12.9	11.8	12.3	1 142.1
Tooth/teeth filled	30.3	26.0	50.6	48.3	46.2	37.8	42.7	38.6	40.6	3 770.0
Teeth cleaned & scaled	47.2	68.7	73.0	68.5	65.3	53.9	64.8	64.5	64.6	5 998.5
Other treatment	20.7	24.3	23.3	28.7	25.3	27.8	22.4	25.8	24.2	2 247.1
Total who had a dental consultation(b)	**79.2**	**58.8**	**51.7**	**52.1**	**46.4**	**35.8**	**54.1**	**58.1**	**56.1**	**9 285.6**

(a) In the two weeks prior to interview. (b) Each person may have reported more than one type of treatment or service and therefore components do not add to totals.

Source: 1994 National Dental Telephone Interview Survey, Australian Institute of Health and Welfare, Dental Statistics and Research Unit.

The prevalence of edentulism (no natural teeth) is presented in table 8.7. There was a high rate of edentulism among adults and older adults. However, edentulism has decreased markedly in all age cohorts, particularly among middle-aged adults. For example, for those aged 55–64 years, the prevalence of edentulism has decreased from 40.2% in 1979 to 20.6% in 1994.

8.7 Prevalence of tooth loss
(%)

	Age group (years)						
Year	15–24	25–34	35–44	45–54	55–64	65–74	>74
Edentulous (%)(a)							
1979	1.3	5.4	14.0	26.5	40.2	60.7	78.6
1989–90	0.6	1.4	5.7	14.9	28.9	43.2	63.4
1994	0.1	0.5	4.0	10.9	20.6	32.5	52.2
Mean number of missing teeth(b)							
1995	1.8	2.6	4.3	7.1	9.7	12.5	15.4

(a) Percentage of persons edentulous (i.e. having no natural teeth). (b) Mean number of missing teeth in dentate persons.
Source: 1979 Special Supplementary Survey; 1989–90 National Health Survey, Health Related Actions, Australia (4375.0); Australian Institute of Health and Welfare, Dental Statistics and Research Unit; 1992–93 Telephone Interview Survey, Australian Institute of Health and Welfare, Dental Statistics and Research Unit.

In 1994, approximately 3.9 million people (29.7%) aged 18 years and over had dentures or false teeth. Some 10.7% had full sets in both jaws.

Females (33.1%) were more likely than males (26.1%) to report having dentures or false teeth and the likelihood of having dentures or false teeth increased markedly with age, with 84.9% of those aged 75 years and over having false teeth (table 8.8).

8.8 Persons aged 15 years and over who had dentures or false teeth, 1994
(%)

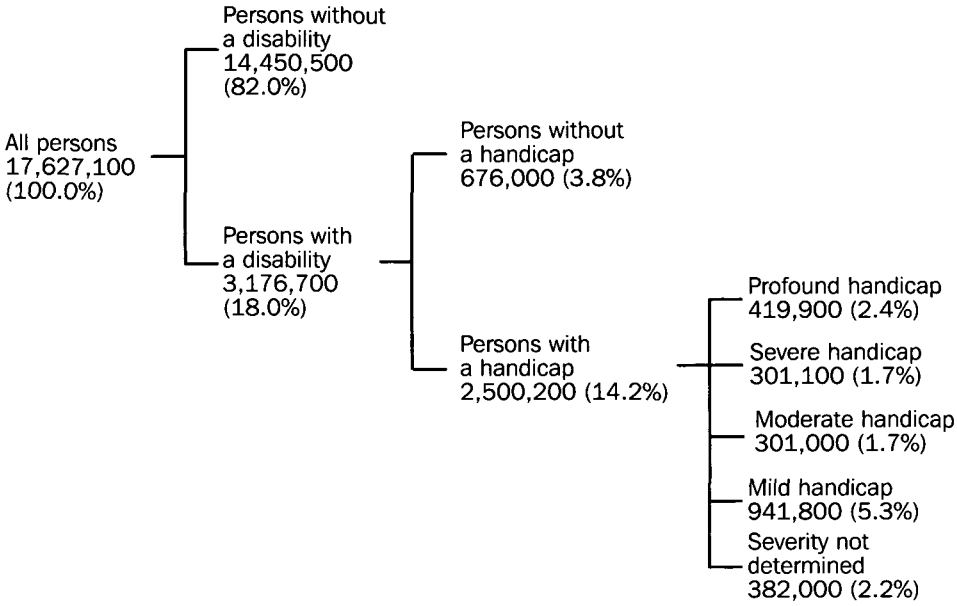
	Age group (years)									Persons	
	18–24	25–34	35–44	45–54	55–64	65–74	>74	Males	Females	%	'000
Has dentures or false teeth											
Full sets in both jaws	—	0.2	3.9	10.9	20.4	30.5	51.4	7.5	13.7	10.7	1 417.2
Other(a)	1.2	4.6	14.9	29.5	37.4	41.9	33.5	18.6	19.4	19.0	2 516.6
Total with dentures or false teeth	1.2	4.8	18.8	40.4	57.8	72.4	84.9	26.1	33.1	29.7	3 933.8
Does not have dentures or false teeth	98.8	95.2	81.2	59.6	42.2	27.6	15.1	73.9	66.9	70.3	9 311.3
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**13 245.1**

(a) Includes those who have a full set in upper or lower jaw, and those who have partial sets in either or both jaws.
Source: 1994 National Dental Telephone Interview Survey, Australian Institute of Health and Welfare, Dental Statistics and Research Unit.

Disability

Based on the results of the Survey of Disability, Ageing and Carers conducted by the ABS in 1993, there were an estimated 3,176,700 persons, or 18.0% of the Australian population who had a disability and, of these, 2,500,200 or 78.7% were also classified as having a handicap. The distribution of the population according to disability, handicap and severity of handicap is illustrated in the diagram 8.9.

8.9 Number of persons with a disability and/or handicap, 1993



It was estimated that 44.2% of the 2,762,900 persons aged 60 years and over had a disability, showing the high correlation of age to disability.

The survey also found that there were 577,500 persons aged 15 years and over (4.2% of the Australian population aged 15 years and over) who were principal carers.

Congenital malformations

Major congenital malformations include defects arising during embryonic development, such as spina bifida, congenital heart defects, cleft lip and palate, and also chromosomal abnormalities such as Down's syndrome.

Among all births in Australia in 1991 and 1992, there were 4,588 (1.8%) and 4,500 (1.7%) infants, respectively, born with major congenital malformations detected at, or soon after, birth.

The most frequently notified groups of malformations were the musculoskeletal system, congenital heart defects, genital malformations and chromosomal abnormalities (table 8.10). The most common specific malformations were congenital dislocation of the hip, ventricular septal defect, hypospadias, Down's syndrome, and cleft lip and palate.

8.10 Major congenital malformations by anatomical system(a)

	No.		Rate per 10 000 births	
Anatomical system	1991	1992	1991	1992
Nervous system	403	384	15.6	14.5
Eye	104	79	4.0	3.0
Ear, face & neck	49	40	1.9	1.5
Heart	808	894	31.2	33.7
Circulatory system	367	377	14.2	14.2
Respiratory system	156	115	6.0	4.3

For footnotes see end of table. ...continued

8.10 Major congenital malformations by anatomical system(a) — *continued*

	No.		Rate per 10 000 births	
Anatomical system	1991	1992	1991	1992
Cleft palate/lip	367	389	14.2	14.6
Digestive system	330	332	12.8	12.5
Genital organ	764	727	29.5	27.4
Urinary system	472	431	18.2	16.2
Limbs	429	408	16.6	15.4
Other musculoskeletal	1 166	1 006	45.1	37.9
Integument	33	29	1.3	1.1
Chromosomal	584	548	22.6	20.6
Other & unspecified	120	117	4.6	4.4
All foetuses & infants	4 588	4 500	177.3	169.4

(a) Infants may be included in more than one anatomical system category.
Source: Australian Institute of Health and Welfare, National Perinatal Statistics Unit.

Communicable diseases

Under the National Notifiable Diseases Surveillance System, State and Territory health authorities submit reports of communicable disease notifications for compilation by the Commonwealth Department of Human Services and Health. Case definitions for the diseases have varied from State to State and with time, as have the diseases included in the system. Since 1991, 44 diseases have been included, as recommended by the National Health and Medical Research Council.

Campylobacteriosis, a bacterial disease transmitted by contaminated food or water, has been the most commonly reported disease in recent years (table 8.11).

8.11 Notifiable diseases, cases notified

Disease	1989	1990	1991	1992	1993
Arbovirus infection					
Arbovirus infection n.e.c.	2 809	2 008	199	303	578
Dengue(b)	(c)	(c)	46	366	690
Ross River infection(b)	(c)	(c)	3 532	5 630	5 425
Botulism	(c)	(c)	(c)	—	—
Brucellosis	20	46	28	29	20
Campylobacteriosis	4 279	5 683	8 672	9 135	8 102
Chancroid	3	13	—	5	1
Cholera	—	1	—	3	6
Chlamydial infection(a)	504	5	4 044	6 293	6 493
Diphtheria	1	7	8	14	1
Donovanosis	99	91	72	78	67
Gonococcal infection	3 153	1 919	2 530	2 908	2 805
Haemophilus influenzae type b infection	(c)	(c)	549	501	397
Hepatitis A	460	530	2 195	2 109	2 002
Hepatitis B	3 017	2 970	3 652	5 219	2 254
Hepatitis C	(c)	(c)	4 116	8 812	7 573
Hepatitis(a)	43	707	338	70	72
HIV infection(d)	(c)	(c)	53	n.a.	470
Hydatid infection	15	16	44	38	32
Legionnellosis	104	90	110	185	178
Leprosy	34	31	13	16	15
Leptospirosis	99	121	169	159	178
Listeriosis	(c)	(c)	44	38	53

For footnotes see end of table. ...continued

8.11 Notifiable diseases, cases notified — *continued*

Disease	1989	1990	1991	1992	1993
Lymphogranuloma venereum	—	—	—	3	1
Malaria	770	882	790	712	684
Measles	169	880	1 380	1 425	4 536
Meningococcal infections	204	295	285	292	378
Mumps	(c)	(c)	(c)	23	28
Ornithosis	25	23	136	94	98
Pertussis	614	862	337	739	3 990
Poliomyelitis	—	—	—	—	—
Q fever	353	431	595	543	889
Rabies	—	—	—	—	—
Rubella(e)	—	2	620	3 810	3 812
Salmonellosis(a)	4 492	4 564	5 440	4 614	4 727
Shigellosis	779	610	902	694	706
Syphilis	2 099	1 643	2 053	2 695	2 293
Tetanus	11	6	7	14	10
Tuberculosis	1 351	684	590	970	1 073
Typhoid	57	70	88	50	72
Viral haemorrhagic fever	—	—	—	—	—
Yellow fever	—	—	—	—	—
Yersiniosis(a)	241	433	515	567	459

(a) Not elsewhere classified. (b) Dengue and Ross River virus infection were included in 'Arbovirus infection' from 1988–90. (c) Not notifiable. (d) Data on diagnosis of HIV infections are included in tables 8.12 and 8.13. (e) Notified only as Congenital Rubella Syndrome from 1988–90.

Source: National Notifiable Diseases Surveillance System of the Communicable Diseases Network of Australia and New Zealand.

HIV and AIDS

HIV and AIDS surveillance is conducted by the National Centre in HIV Epidemiology and Clinical Research in collaboration with the State and Territory health authorities and the Commonwealth of Australia.

A total of 18,769 HIV diagnoses had been reported to 31 December 1994. Of these, 5,732 cases had been diagnosed as having AIDS and 4,040 of those had died (table 8.12). Of all persons who were diagnosed as having HIV, 12,055 reported the source of exposure to the virus. Of these, 80.8% reported male homosexual/bisexual contact as the exposure category (table 8.13). In the 12-month period from January to December 1994, there were 973 reports of HIV diagnosis, 784 reports of AIDS and 646 deaths from AIDS.

8.12 Diagnoses of HIV infection and AIDS, and deaths from AIDS to 31 December 1994

	NSW	Vic.	Qld	SA	WA	Tas.	NT	ACT	**Aust.**
HIV diagnoses									
Males	9 621	3 173	1 463	528	696	69	78	152	**15 780**
Females	520	154	85	43	58	4	4	13	**881**
Sex not reported	2 045	43	—	—	—	—	—	—	**2 088**
Persons(a)	12 194	3 377	1 552	571	755	73	82	165	**18 769**
AIDS diagnoses									
Males	3 254	1 155	520	235	228	31	23	64	**5 510**
Females	113	37	23	14	12	2	—	3	**204**
Persons(a)	3 377	1 198	545	249	240	33	23	67	**5 732**

For footnotes see end of table. ...continued

8.12 Diagnoses of HIV infection and AIDS, and deaths from AIDS to 31 December 1994 — *continued*

	NSW	Vic.	Qld	SA	WA	Tas.	NT	ACT	**Aust.**
AIDS deaths									
Males	2 263	879	357	148	164	21	17	46	**3 895**
Females	74	19	17	10	7	2	—	2	**131**
Persons(a)	2 343	904	376	158	171	23	17	48	**4 040**

(a) Includes persons whose sex was reported as transsexual.
Source: Communicable Diseases Intelligence, Department of Human Services and Health.

8.13 Diagnoses of HIV infection to 31 December 1994

	Males	Females	**Persons(a)**	%
Male homosexual/bisexual contact	9 741	n.a.	**9 741**	80.8
Male homosexual/bisexual contact & ID use	357	n.a.	**357**	3.0
ID use				
Heterosexual	108	53	**164**	1.4
Not further specified	340	95	**454**	3.8
Total	*448*	*148*	***618***	*5.1*
Heterosexual contact				
Sex with ID user	13	23	**36**	0.3
Sex with bisexual male	n.a.	21	**21**	0.2
From specified country	36	20	**56**	0.5
Sex with person from specified country	44	24	**68**	0.6
Sex with person with medically acquired HIV	4	5	**9**	0.1
Sex with HIV-infected person, exposure not specified	25	21	**46**	0.4
Not further specified	405	219	**627**	5.2
Total	*527*	*333*	***863***	*7.1*
Haemophilia/coagulation disorder	191	2	**193**	1.6
Receipt of blood transfusion, blood components or tissue	104	65	**169**	1.4
Health care setting(b)	1	8	**9**	0.1
Total adults/adolescents(a)	*11 369*	556	***11 950***	*99.1*
Children under 13 years at diagnosis of HIV				
Mother with/at risk for HIV infection	20	16	**36**	0.3
Haemophilia/coagulation disorder	51	—	**51**	0.4
Receipt of blood transfusion, blood components or tissue	12	5	**18**	0.2
Total children(a)	*83*	*21*	***105***	*0.9*
Total(a)	**11 452**	**577**	**12 055**	**100.0**
Other/undetermined(c)	4 338	306	**6 727**	—

(a) Total column includes cases for which sex was not reported. (b) The category 'Health care setting' includes 4 cases of occupationally acquired HIV infection and 4 cases of transmission in surgical rooms. (c) The 'Other/undetermined' category includes 6 710 adults/adolescents and 26 children. Twenty people whose sex was reported as transsexual are included in the 'Other/undetermined' category. The 'Other/undetermined' category was excluded from the calculation of the percentage of cases attributed to each exposure category.
Source: Communicable Diseases Intelligence, Department of Human Services and Health.

Causes of death

Information relating to crude death rates and life expectancy is contained in *Chapter 5, Demography*.

Causes of death in Australia are classified according to the ninth revision of the International Classification of Diseases (ICD) produced by the World Health Organisation.

The major causes of the 126,683 deaths in the community in 1994 remained diseases of the circulatory system (accounting for 43.3%), neoplasms (27.0%), diseases of the respiratory system (7.9%) and accidents, poisonings and violence (5.7%). In 1994, less than 1% of all deaths were due to infectious and parasitic diseases (table 8.14).

8.14 Causes of death, 1994

Cause of death	Age group (years) <1	1–14	15–24	25–34	35–44	45–54	55–64	65–74	75–84	>84	Total(a)
					No.						
Infectious & parasitic diseases	17	20	20	63	72	62	75	177	339	197	**1 042**
Neoplasms	15	164	134	339	1 125	2 731	5 738	10 785	9 409	3 762	**34 203**
Endocrine, nutritional & metabolic diseases & immunity disorders	22	32	28	180	268	293	436	942	1 171	739	**4 111**
Diseases of the nervous system & sense organs	35	87	59	71	104	118	176	515	1 014	765	**2 944**
Diseases of the circulatory system	12	33	61	186	554	1 567	3 873	11 412	20 294	16 891	**54 886**
Diseases of the respiratory system	25	32	37	65	77	223	832	2 677	3 498	2 491	**9 958**
Diseases of the digestive system	3	4	7	34	145	301	487	800	1 140	937	**3 858**
Congenital anomalies	454	82	37	33	28	22	30	40	16	12	**754**
All other diseases(b)	687	24	108	200	178	134	280	878	2 195	2 508	**7 193**
Signs, symptoms & ill-defined conditions	213	22	13	23	23	19	22	28	66	117	**547**
Accidents, poisonings & violence	29	305	1 312	1 233	1 088	816	550	614	683	554	**7 187**
All causes	**1 512**	**805**	**1 816**	**2 427**	**3 662**	**6 286**	**12 499**	**28 868**	**39 825**	**28 973**	**126 683**
					Rate(c)						
Infectious & parasitic diseases	7	1	1	2	3	3	5	14	51	110	**6**
Neoplasms	6	5	5	12	42	127	386	850	1 428	2 091	**192**
Endocrine, nutritional & metabolic diseases & immunity disorders	9	1	1	6	10	14	29	74	178	411	**23**
Diseases of the nervous system & sense organs	14	2	2	3	4	6	12	41	154	425	**17**
Diseases of the circulatory system	5	1	2	7	21	73	260	899	3 081	9 389	**308**
Diseases of the respiratory system	10	1	1	2	3	10	56	211	531	1 385	**56**
Diseases of the digestive system	1	—	—	1	5	14	33	63	173	521	**22**
Congenital anomalies	176	2	1	1	1	1	2	3	2	7	**4**
All other diseases(b)	266	1	4	7	7	6	19	69	333	1 394	**40**
Signs, symptoms & ill-defined conditions	83	1	—	1	1	1	1	2	10	65	**3**
Accidents, poisonings & violence	11	9	48	44	40	38	37	48	104	308	**40**
All causes	**586**	**22**	**66**	**86**	**136**	**293**	**840**	**2 275**	**6 046**	**16 106**	**710**

For footnotes see end of table.

...continued

8.14 Causes of death, 1994 — *continued*

Cause of death	Age group (years)										
	<1	1–14	15–24	25–34	35–44	45–54	55–64	65–74	75–84	>84	**Total(a)**
	%(d)										
Infectious & parasitic diseases	1.1	2.5	1.1	2.6	2.0	1.0	0.6	0.6	0.9	0.7	**0.8**
Neoplasms	1.0	20.4	7.4	14.0	30.7	43.4	45.9	37.4	23.6	13.0	**27.0**
Endocrine, nutritional & metabolic diseases & immunity disorders	1.5	4.0	1.5	7.4	7.3	4.7	3.5	3.3	2.9	2.6	**3.2**
Diseases of the nervous system & sense organs	2.3	10.8	3.2	2.9	2.8	1.9	1.4	1.8	2.5	2.6	**2.3**
Diseases of the circulatory system	0.8	4.1	3.4	7.7	15.1	24.9	31.0	39.5	51.0	58.3	**43.3**
Diseases of the respiratory system	1.7	4.0	2.0	2.7	2.1	3.5	6.7	9.3	8.8	8.6	**7.9**
Diseases of the digestive system	0.2	0.5	0.4	1.4	4.0	4.8	3.9	2.8	2.9	3.2	**3.0**
Congenital anomalies	30.0	10.2	2.0	1.4	0.8	0.3	0.2	0.1	—	—	**0.6**
All other diseases(b)	45.4	3.0	5.9	8.2	4.9	2.1	2.2	3.0	5.5	8.7	**5.7**
Signs, symptoms & ill-defined conditions	14.1	2.7	0.7	0.9	0.6	0.3	0.2	0.1	0.2	0.4	**0.4**
Accidents, poisonings & violence	1.9	37.9	72.2	50.8	29.7	13.0	4.4	2.1	1.7	1.9	**5.7**
All causes	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

(a) Total includes 10 deaths where age is not known. (b) Includes 695 deaths from conditions originating in the perinatal period, 2 111 deaths from diseases of the genitourinary system, and 2 985 deaths due to mental disorders. (c) Rates are per 100 000 of population at risk, except for children under one year of age which are per 100 000 live births registered. (d) Percentage of all deaths within each age group.

Source: Unpublished ABS Causes of Death data, 1994.

The relative importance of groups of causes of death varies with age. The majority of infant deaths (66.7% in 1994) occur within less than 28 days of birth. Most of these neonatal deaths are due to conditions present from birth. For those aged from 1 to 34 years external causes (accidents, poisonings and violence) predominate. In the 35 to 44 year old age group, neoplasms (30.7%) join external causes (29.7%) as a major cause of death. From 45 onwards neoplasms and diseases of the circulatory system are the two major causes of death, with the latter the major cause after the age of 65.

In 1994 the perinatal death rate for Australia was 8.0 per 1,000 total births, a slight decrease from the rate of 8.2 in 1993. The three main causes of death in the foetus or infant were hypoxia, birth asphyxia and other respiratory conditions (33.2%), other conditions originating in the perinatal period (28.8%), and congenital anomalies (22.9%). In 39.7% of all perinatal deaths no contributing maternal condition was reported. The most common contributing maternal condition was complications of the placenta, cord and membranes, which was reported for 33.1% of all perinatal deaths.

8.15 Causes of perinatal deaths, 1994

Cause of death	Number of deaths			Rate		
	Foetal	Neonatal	Perinatal	Foetal(a)	Neonatal(b)	Perinatal(a)
Conditions in foetus/infant						
Slow foetal growth, foetal malnutrition & immaturity	113.0	104.0	217.0	0.4	0.4	0.8
Birth trauma	1.0	55.0	56.0	—	0.2	0.2
Hypoxia, birth asphyxia & other respiratory conditions	433.0	223.0	656.0	1.7	0.9	2.5
Foetal and neonatal haemorrhage	28.0	39.0	67.0	0.1	0.2	0.3
Haemolytic disease of foetus or newborn	7.0	1.0	8.0	—	—	—
Other conditions originating in the perinatal period	474.0	96.0	570.0	1.8	0.4	2.2
Congenital anomalies	142.0	310.0	452.0	0.6	1.2	1.7
All other causes	9.0	41.0	50.0	—	0.2	0.2
Conditions in mother						
Maternal conditions which may be unrelated to present pregnancy	145.0	74.0	219.0	0.6	0.3	0.9
Maternal complications of pregnancy	108.0	248.0	356.0	0.4	1.0	1.4
Complications of placenta, cord & membranes	516.0	138.0	654.0	2.0	0.6	2.5
Other complications of labour & delivery	38.0	25.0	63.0	0.2	0.1	0.2
No maternal condition reported	400.0	384.0	784.0	1.5	1.5	3.0
All causes						
1994	1 207.0	869.0	2 076.0	4.7	3.4	8.0
1993	1 245.0	886.0	2 131.0	4.8	3.4	8.2
1992	1 493.0	1 015.0	2 508.0	5.6	3.8	9.4
1991	1 478.0	1 012.0	2 490.0	5.7	3.9	9.6
1990	1 590.0	1 122.0	2 712.0	6.0	4.3	10.3
1989	1 451.0	1 058.0	2 509.0	5.8	4.2	10.0

(a) Per 1 000 births registered (live births and stillbirths) weighing 500 grams or more at birth. (b) Per 1 000 live births registered weighing 500 grams or more at birth.
Source: Unpublished ABS Causes of Death data, 1994.

Injury

At 7,187, the number of external causes of deaths registered in 1994 was 4% lower than the number in 1992 and approximately 20% lower than the highest number on record (8,942 in 1971). Injury deaths accounted for 5.7% of all deaths, and occurred at a crude rate of 40.3 deaths per 100,000 mid-year population, the lowest on record. Allowing for changes in the age and sex distribution of the Australian population, the rate for 1994 was 37.2 deaths per 100,000 mid-year population.

The major external causes of death for males and females are shown in table 8.16. Suicides and motor vehicle traffic accidents were the leading external causes, accounting for 31% and 27%, respectively of all deaths due to external causes. Despite a slight decline in the number of deaths registrations attributed to suicide in 1994, the proportion of all injury deaths due to suicide remained at about 31%. For the third year in succession, the number of registered deaths due to motor vehicle traffic accidents (1,959) was lower than the number of suicides (2,258). There are notable differences in the burden of injury deaths between the sexes. The overall crude death rate for males (57.3 per 100,000) is more than double the female rate (23.5 per 100,000). Suicide deaths account for a significantly greater proportion of all injury deaths in males and occur at a rate that is four times the rate for females (table 8.17). In contrast, while accidental fall deaths occur at about similar rates in both sexes; they are the second leading external cause of death in females (26% of deaths) but only account for 9% of injury deaths in males.

8.16 External causes of death, 1994

Cause of death	No.	%	Crude death rate(a)
Males			
Suicide	1 830	36.0	20.6
Motor vehicle traffic accidents	1 369	26.9	15.4
Accidental falls	458	9.0	5.2
Homicide	211	4.1	2.4
Drowning & submersion	208	4.1	2.3
Poisoning by drugs/medications	183	3.6	2.1
Other	828	16.3	9.3
All external causes	5 087	100.0	57.3
Females			
Suicide	428	20.4	4.8
Motor vehicle traffic accidents	590	28.1	6.6
Accidental falls	545	26.0	6.1
Homicide	121	5.8	1.4
Drowning & submersion	41	2.0	0.5
Poisoning by drugs/medications	102	4.9	1.1
Other	273	13.0	3.0
All external causes	2 100	100.0	23.5
Persons			
Suicide	2 258	31.4	12.7
Motor vehicle traffic accidents	1 959	27.3	11.0
Accidental falls	1 003	14.0	5.6
Homicide	332	4.6	1.9
Drowning & submersion	249	3.5	1.4
Poisoning by drugs/medications	285	4.0	1.6
Other	1 101	15.3	6.2
All external causes	7 187	100.0	40.3

(a) Deaths per 100 000 mid-year population.
Source: Derived from ABS Causes of Death data 1994.

Suicide

Between 1982 and 1994, there were 26,711 deaths from suicide in Australia. Since 1991, the number of persons dying from suicide has been greater than those killed in motor vehicle traffic accidents. This is due more to the rapid decline in the number of persons dying in motor vehicle accidents than to an increase in the number of suicides. The standardised suicide rate has increased slightly since 1982 from 12.2 deaths per 100,000 of the mid-year population to 12.6 deaths per 100,000 of the mid-year population in 1994. During the thirteen year period, there was some fluctuation in the standardised death rate for suicide, but the peak occurred in 1987 when there were 13.9 deaths per 100,000 of the mid-year population. In 1994, the standardised death rate from suicide for males was 20.5 deaths per 100,000 of the male mid-year population, while for females the standardise rate was 4.7 suicide deaths per 100,000 of the female mid-year population.

The age-specific death rate is the number of deaths per 100,000 of mid-year population for particular age groups. The highest age-specific death rates for suicide have traditionally been in the 75 years and over age group. However, one factor causing concern among social researchers has been the increase in the rate of suicides among persons in the 15–24 years age group. The age-specific death rate for this age group has increased from 11.4 suicide deaths per 100,000 of the mid-year population in 1982 to 15.8 deaths per 100,000 of the mid-year population in 1994. The age-specific death rate for males aged 15 to 24 years old has increased by almost 39% between 1982 and 1994, from 19.3 to 26.8 suicides per 100,000 of the mid-year population respectively.

8.17 Age-specific suicide death rates(a), 1994

	Age group (years)									
	10–14	15–24	25–34	35–44	45–54	55–64	65–74	75–84	>85	**Total**
Males	0.5	26.8	29.3	26.3	24.7	23.1	23.6	29.7	41.4	**20.6**
Females	0.5	4.3	6.0	7.3	6.5	6.4	4.8	7.1	7.1	**4.8**
Total	**0.5**	**15.8**	**17.7**	**16.8**	**15.8**	**14.8**	**13.6**	**16.1**	**17.2**	**12.7**

(a) Suicide deaths per 100 000 mid-year population of same age and sex.
Source: Unpublished ABS Causes of Death data, 1994.

The predominance of males amongst suicides as a cause of death is indicated by the fact that in 1994 there were 428 male suicides to every 100 female suicides. This continues the upward trend in the disparity in the sex ratio of male to female suicides. The most notable difference in this ratio again occurred in the 15–24 years age group where there were 610 male suicide deaths for every 100 female deaths from this cause.

Since 1982, Queensland and Tasmania have consistently recorded standardised suicide rates higher than the national rate. This trend continued in 1994 when these two States recorded standardised suicide rates of 14.2 and 15.0 suicide deaths per 100,000 of mid-year population respectively.

Marital status also appears to have an impact on the rate of suicide, with persons who have been widowed having a higher rate of suicide than any of the other marital status categories. This is followed by persons who are divorced, then never married. Married persons have the lowest rate of suicide of the four marital status categories.

Health care delivery

Medicare

The Health Insurance Act provides for a Medicare Benefits Schedule which lists a schedule fee applicable to each medical service. The Schedule covers services attracting Medicare benefits rendered by legally qualified medical practitioners, certain prescribed services rendered by approved dentists and optometrical consultations by optometrists. Medical services in Australia are generally delivered by either private medical practitioners on a fee-for-service basis, or medical practitioners employed in hospitals and community health centres. The Schedule is constantly reviewed through ongoing consultations with the medical profession and it is updated twice yearly to reflect current medical practice.

Medicare benefits are payable at the rate of 85% of the schedule fee for services. For private in-patients in hospitals, 75% of the schedule fee for services is payable.

Public hospitals

In 1991–92 there were 713 public acute care and Department of Veterans Affairs hospitals, 45 public psychiatric hospitals, 1,444 nursing homes, and 1,198 hostels in Australia. A more important indicator of the supply of health care facilities is the number of beds per 1,000 population. Excluding beds in public psychiatric hospitals, there were 3.3 hospital beds available for acute care per 1,000 population in Australia in 1991–92. This followed a steady decline from 1985–86 to 1991–92, when the ratio of available beds fell by 4% a year, from 4.1 to 3.3 beds per 1,000 population.

The number of beds available in public psychiatric hospitals in Australia decreased from 2.3 per 1,000 population in 1970 to 0.4 in 1991–92. During the 1970s and early 1980s, the supply contracted by 6% per year. Between 1985–86 and 1987–88, the annual rate of decrease was almost 20%. This rapid reduction in beds resulted from moves to deinstitutionalise patients requiring acute or long-term psychiatric care. Since 1987–88, the reduction in bed supply has continued at 2% per year.

Use of hospitals

Rates of admission to acute hospitals have fluctuated over the last two decades. An increase during the 1970s was followed by a slight decline in the early 1980s. From 1982–83 to 1988–89, admissions per 1,000 persons fluctuated around 215, then increased substantially to 245 in 1991–92.

By international standards, Australia's rate of admission to acute care hospitals is high, but its comparatively short average length of stay, 4.8 days for 1991–92, is the lowest among the OECD countries.

The sustained reductions in length of hospital stay are reflected in falls in the number of bed-days used by patients in acute hospitals. Between 1982–83 and 1991–92, the number of bed-days per 1,000 population fell by 2.5% per year, from 1,490 to 1,218.

Same-day surgery

In recent years, the increasing use of same-day treatments has accelerated the decline in length of stay. The proportion of same-day patients in public acute hospitals increased from 20% in 1987–88 to 28% in 1991–92. In 1991–92, 43% of admissions to private hospitals were same-day patients.

Private hospitals

Information on facilities, patients, staffing and finances was collected from the 329 private acute and psychiatric hospitals and 111 free-standing day hospital facilities which were in operation throughout Australia during 1993–94. Some of the findings were as follows:

- The average number of beds available for in-patient overnight accommodation increased by 2.4%, to 21,521, between 1991–92 and 1993–94.
- There were 1,432,900 in-patient separations from private hospitals during 1993–94, of which 87.3% were from private acute and psychiatric hospitals and 12.7% from free-standing day hospital facilities.
- Occupied-bed days for private acute and psychiatric hospitals totalled 5.2 million. The average length of stay per in-patient separation was 4.1 days.
- The number of full-time equivalent staff engaged at all private hospitals was 34,411 of whom 59.3% were nursing staff.
- Total operating expenditure for private acute and psychiatric hospitals during 1993–94 amounted to $2,226 million of which 60.3% was expended on salaries and wages (including on-costs). Revenue received during the year was $2,492 million, nearly all (95.1%) of which was received as payments from or in respect of patients.
- Total operating expenditure for free-standing day hospital facilities during 1993–94 amounted to $61.1 million and revenue received during the year was $76.5 million.

Comparison of public and private hospitals

There were 1,079 acute hospitals and free-standing day hospital facilities with 76,976 available beds in Australia in 1991–92. Almost 75% of the beds were in public hospitals.

Total throughput in acute hospitals in 1991–92 was 4.27 million separations, or 20.8 million bed days. The public sector accounted for 71% of the separations and 78% of the bed days.

8.18 Public and private acute hospitals and free-standing day hospital facilities, 1991–92

	Public	Private(a)	**Total**
Bed supply			
Number of facilities	713	366	**1 079**
Number of beds/chairs	57 053	19 923	**76 976**
Activity			
Total separations	3 024 870	1 244 590	**4 269 460**
Total occupied bed days	16 121 711	4 670 725	**20 792 436**
Average length of stay (days)	5.3	3.8	**4.9**
Average length of stay (days) excluding free-standing day hospital facilities	5.3	4.1	**5.0**
Average length of stay (days) excluding all same-day separations	7.0	5.4	**6.6**
Average occupancy rate (%)	77.2	64.1	**73.8**
Average occupancy rate (%) excluding free-standing day hospital facilities	77.2	64.2	**73.9**
Total non-inpatient services	**30 676 201**	**802 618**	**31 478 819**

(a) Includes free-standing day hospital facilities.
Source: Hospitals, Australia, 1991–92 (4391.0).

Health work force

According to labour force estimates, in 1994–95 there were approximately 255,400 people employed in health occupations in Australia, comprising just over 3% of the total number of employed people. The largest component of the medical workforce was registered nurses (152,900 people), of which 92.7% were women.

There were approximately 29,700 general medical practitioners in 1994–95 and 13,500 specialist medical practitioners. 70.9% of general medical practitioners and 75.5% of specialist medical practitioners were male.

8.19 Persons employed in health occupations(a), 1994–95

	Males	Females	**Persons**
General medical practitioners	21 100	8 600	**29 700**
Specialist medical practitioners	10 200	3 300	**13 500**
Dental practitioners	8 000	*1 600	**9 600**
Pharmacists	7 700	5 300	**12 900**
Occupational therapists	*500	5 600	**6 100**
Optometrists	*1 200	*600	***1 800**
Physiotherapists	*1 400	6 400	**7 800**
Speech pathologists	*200	*2 300	***2 500**
Chiropractors & osteopaths	2 400	*200	***2 700**
Podiatrists	*500	*1 100	***1 500**
Radiographers	*1700	4 200	**6 000**
Other health diagnosis & treatment practitioners	2 500	6 000	**8 600**
Registered nurses	11 200	141 700	**152 900**
Total employed in health occupations	**68 600**	**186 900**	**255 400**
Total employed	4 612 400	3 445 500	**8 057 900**

(a) Figures are averages of estimates over four quarters rounded to the nearest hundred.
Source: Labour Force Estimates, August 1994 to May 1995.

Health Programs

National Health Advancement Program

The National Health Advancement Program (NHAP) replaces the National Health Promotion and the National Better Health Programs following completion of their terms of agreement and subsequent evaluation.

The NHAP aims to improve the health of all Australians, with specific emphasis on reducing the health status inequalities of the lower socio-economic groups, through the commitment of $22.1 million in four target areas: a national health promotion infrastructure strategy; a national strategy to protect the health of all Australians from environmental impacts on their health and well-being; implementation of the national food and nutrition policy to improve accessibility to affordable nutritious food, and programs for disadvantaged groups; and further development, refinement and application of national health goals and targets, including planning and development of a coordinated national injury control strategy.

The continuing development and evaluation of national health goals and targets is part of a larger review of the health system, which aims to assist in setting directions for the organisation and funding of health services and for improving health in Australia. The current set of goals and targets identifies areas for improvement in preventable mortality and morbidity, healthy lifestyles and risk factors, health literacy and health skills, environmental health and the administration of the health care system. Areas chosen for initial focus are cardiovascular disease, cancer, injury and mental health.

Aboriginal health

A National Survey of Aboriginal and Torres Strait Islander people was conducted by the ABS in 1994. Results from the Survey, including health-related subjects, are presented in the special article *Profile of Australia's Indigenous People* in *Chapter 5, Demography*.

Programs for the aged and people with disabilities

Details on these programs are contained in *Chapter 7, Social Security and Welfare*.

Homeless youth

The Innovative Health Services for Homeless Youth Program was established in 1989 as part of the $100 million strategy, 'Towards Social Justice for Young Australians'. The Program develops and implements innovative primary health care services for homeless youth and a further $8.8 million over the period 1993–94 to 1996–97 was allocated in the 1993 Budget ($17.6 million when cost shared with States and Territories). Emphasis is being placed on community involvement in service delivery. The ultimate objective of the Program is to encourage a more positive attitude among homeless young people towards their personal health care.

Mental health

The emphasis has shifted from institutions for care of people with mental illness to mental health services provided in the general health sector, such as psychiatric units in general hospitals, and a range of community-based services across the health, housing and community service sectors.

Commonwealth funding of $269 million over six years to 30 June 1998 is being provided to assist in implementing the National Mental Health Strategy to accelerate the process of reform in the mental health sector. Of this, approximately $189 million is available directly to the States and Territories. About $68 million will be allocated to national initiatives and $5 million will be used to support mental health medical research.

The main objectives of the reform process include: expanding community-based mental health services; improving consumer rights; reforming mental health legislation; restructuring the mental health work force; and promoting mental health and community awareness of mental health problems and mental disorders.

Diet and nutrition

The Food and Nutrition Program aims to further the goal of the National Food and Nutrition Policy 'to improve health and reduce the burden of diet-related early death, illness and disability among Australians'.

Key issues are social justice, the quality and sustainability of the food supply, and intersector involvement including governments, industry and the community. The Program aims at improving the knowledge and skills that enable Australians to choose a healthy diet, incorporating food and nutrition into the food system, improving the diet of people with special needs and establishing ongoing monitoring and surveillance.

Projects are being undertaken to: develop nutrition curriculum material for all primary and secondary schools, supported by professional development for teachers; develop point-of-sale material to assist consumers to make healthy food choices in the retail environment; improve the nutritional quality of hotel meals; demonstrate the feasibility of reducing the level of fat from meat in the food supply; develop a video to assist older people to consume a healthy diet; to encourage local government to integrate food and nutrition issues into local planning and to improve the access and availability of nutritious food; develop resources to assist Aboriginal and Torres Strait Islander communities to address food and nutrition concerns; develop a new national food selection guide; develop an ethnic aged nutrition resource for nursing homes and hostels; develop a 'choose your meal' exhibit at the National Science and Technology Centre; and develop a national monitoring and surveillance strategy.

The need for national information about diet and nutrition has been recognised in many forums. This need is being addressed through the National Nutrition Survey, which is a joint project between the ABS and the Department of Human Services and Health, in association with other health agencies. The survey results will contribute to the development and monitoring of health goals and targets for nutrition and diet-related disease, as well as assist with the development of food policy and regulations associated with food safety and composition.

Drugs

The National Drug Strategy is a major national effort to minimise the harmful effects of drug use on Australian society and has been in operation since 1985.

The broad range of strategies implemented under the National Drug Strategy (formerly the National Campaign Against Drug Abuse) has resulted in a number of significant achievements, particularly in relation to tobacco and alcohol, where between 1985 and 1992, the death rates per 100,000 population attributable to tobacco and alcohol continued to decline.

Dental health

The 1993–94 Federal Budget included funding for the creation of a Commonwealth Dental Health Program. The aims of the Program are to reduce barriers, including economic, geographical and attitudinal barriers, to dental care for eligible persons; to ensure equitable access of eligible persons to appropriate dental services; to improve the availability of effective and efficient dental interventions with an emphasis on prevention and early management of dental problems; and to achieve high standards of program management, service delivery, monitoring and evaluation, and accountability.

The amount to be provided over the four years 1993–94 to 1996–97 will total $278 million. Additional funds are provided for administration. Total funds are paid to the States in the form of grants. Allocation of Commonwealth funds between States is linked to the numbers of Health Card holders.

In the first full year (calendar year 1994) of the Program an additional 300,000 eligible people received dental care.

In the first four years of the Program it is expected that in excess of 1.5 million people will access dental treatment due to Commonwealth funding.

$670,000 of national funding was allocated to set up five trial projects to test new ways of improving access to dental care in remote Australia, particularly to Aboriginal and Torres Strait Islander communities. Mobile dental teams will be set up in some States to reduce excessive waiting for rural communities.

A Charter of Clients' Rights and Responsibilities under the Program has been developed for distribution by public dental clinics and was launched on 8 August 1995.

Organ and tissue donation

Australia operates under an 'opting in' system for organ and tissue donation. In addition to the efforts of non-government organisations to increase the rate of donation, the Commonwealth and the States share the cost of the Australian Bone Marrow Donor Registry for recruiting and matching unrelated bone marrow donors, and the Australian Co-ordinating Committee on Organ Registries and Donation (ACCORD), a committee established by the Australian Health Ministers' Advisory Council to develop and implement strategies to overcome the low donation rates in Australia — currently about 10 donations per million of population.

ACCORD has facilitated public and professional research surveys to identify reasons for the low donor rate in Australia. From the results of these surveys, strategies to increase the organ donor rate have been developed. It aims to lift the Australian rate of organ donation to between 14 and 15 donors per million population through concerted public and professional education and information programs.

Family planning

Commonwealth funding is provided to approved non-government organisations to assist them to provide clinical and non-clinical services associated with family planning. Eligible activities may include medical practitioner and nursing services; training of health professionals in family planning techniques; counselling services for clients; preparation and dissemination of information and publicity; workshops; and research. The Commonwealth allocation for Family Planning in 1994–95 was $14.3 million.

Survivors of torture and trauma

The Program of Assistance for the Survivors of Torture and Trauma is designed to help people who have been subject to the kinds of debilitating trauma that can arise from living with war, terrorism, political and civil unrest, famine, widespread disease and economic collapse. Some of these people will have survived systematic torture, both mental and physical. The vast majority of these survivors will be from a non-English speaking background.

From 1994–95 to 1997–98, the Commonwealth Government will spend $5.2 million under this new program to help refugees and migrants who have survived torture and trauma before coming to Australia. The Program is funding a service in each State and Territory except the Northern Territory, where a service is expected to begin in 1995–96. The funds will be used to provide free initial counselling and advocacy to survivors and help in accessing mainstream health and health-related services.

Women's health

National Women's Health Program

This Program, which commenced in 1989–90, aims to improve the health and well-being of all women in Australia with a focus on those most at risk, and to encourage the health system to be more responsive to the health needs of women. A new four-year phase of the Program with funding of $30 million was announced in the 1993 Budget. The Program is cost-shared with the States and Territories on a dollar-for-dollar basis. The Program provides funding for improvements in general health services for women and for the establishment of primary health care services specifically for women.

Cancer screening programs

In 1990, the Commonwealth Government announced the establishment of the National Program for the Early Detection of Breast Cancer to reduce mortality and morbidity from breast cancer. A network of dedicated and accredited screening and assessment services has been established across the country to provide access to the target group of women aged between 50 and 69 years. All States and Territories are participating in the Program.

Commonwealth expenditure from 1990–1994 was $53.7 million, and funding for 1994–95 is $43.6 million. Cost-sharing agreements for the new five-year period from 1994–95 have been accepted by all States, during which time $236.5 million in Commonwealth funds have been committed.

In 1995, the Commonwealth Government committed $42 million over four years to the National Cervical Screening Program. This builds on the Organised Approach to Preventing Cancer of the Cervix begun in 1992.

The Program aims to further reduce morbidity and mortality from cervical cancer by encouraging women to have regular biennial Pap smears and by improving the reliability and accessibility of screening services. More than half the women at risk are now being screened regularly but 340 still die each year from cervical cancer.

All States and Territories are contributing to the Program to support continuation and strengthening of reform measures. Six State-based cytology registries have now been established to remind women when their Pap smears are due and provide a safety net for follow-up of women with abnormal Pap smears.

Alternative Birthing Services Program

In recognition of increased community desire for greater choice in birthing services, the Commonwealth introduced a $6.4 million four-year incentive package in 1989–90 to assist States and Territories to provide a range of alternative birthing services. A further $8.9 million over four years was allocated in the 1993 Budget.

Health care financing

Total health expenditure

Total health expenditure (both public and private sectors) in 1993–94 was $36,400 million or $2,049 per person. Health expenditure per person increased at an average annual rate of 2.8% in real terms between 1982–83 and 1993–94. Health expenditure as a proportion of gross domestic product (GDP) was estimated to be 8.5% in 1993–94.

The average annual growth rate in real health expenditure for the period after the introduction of Medicare from 1984–85 to 1993–94 was 4.0%.

Health expenditure by Australian Governments in 1993–94 was $24,800 million or $1,398 per person.

8.20 Total health expenditure(a) and rate of growth

	Expenditure ($m)		Rate of growth (%)	
Year	Current prices	Constant 1989–90 prices(a)	Current prices	Constant 1989–90 prices(a)
1982–83	13 239	20 673	..	..
1983–84	14 958	21 960	13.0	6.2
1984–85	16 546	22 862	10.6	4.1
1985–86	18 586	24 180	12.3	5.8
1986–87	21 115	25 341	13.6	4.8
1987–88	23 328	26 287	10.5	3.7
1988–89	26 127	27 719	12.0	5.4
1989–90	28 795	28 795	10.2	3.9
1990–91	31 224	29 435	8.4	2.2
1991–92	33 172	30 340	6.2	3.1
1992–93	34 848	31 461	5.1	3.7
1993–94(b)	36 369	32 573	4.4	3.5

(a) Health expenditure for 1982–83 to 1993–94 is deflated to constant prices using specific health deflators. (b) Based on preliminary AIHW and ABS estimates.
Source: Australian Institute of Health and Welfare, Health Expenditure Data Base.

Medicare financing

Details of the health financing arrangements under the Medicare program introduced by the Commonwealth Government in February 1984 are available in *Year Book Australia 1984*.

The Medicare levy was increased from 1% to 1.25% of taxable income on 1 December 1986, increased to 1.4% on 1 July 1993 and again increased to 1.5% on 1 July 1995.

From 1 July 1994 no levy was payable by single people earning less than $12,689 per annum or by sole parents and married couples with combined incomes of less than $22,975 per annum with a further $2,258 per annum allowed for each dependent child.

Commonwealth Government funding of hospitals

In 1993–94, hospital funding grants by the Commonwealth Government to the States and Territories totalled $5,246 million. Other expenditure included $33 million for the expansion of post-acute and palliative care, $13 million for the expansion of day-only treatment, $52 million for the treatment of AIDS patients in public hospitals and $7.5 million for the continued development of cost-based case-mix systems.

Household expenditure on medical care and health

The 1993–94 Household Expenditure Survey provides estimates of expenditure on medical care and health by households across Australia. Expenditure is net of any refunds and rebates received from Medicare, private health insurance companies, and employers.

Household expenditure on medical care and health expenses varies according to the life cycle stage of a household (table 8.21). These changes are associated with changes in household size, the amount of income earned and the age of household members. For the first group, which consists of lone persons under 35 years, for whom household size and income is relatively low, expenditure is the lowest ($10.58 per week). As the cycle progresses and household size and income peak at the stage when the household consists of a couple with dependent and non-dependent children, health expenditure is also high ($42.92 per week). By the time a household comprises of one person only, aged 65 and over, expenditure has decreased to $12.80 per week.

Pharmaceutical Benefits Scheme

The Scheme was established under the provisions of the *National Health Act 1953*. It provides to the Australian community a large range of necessary medicines prescribed by medical and dental practitioners. The medicines can be dispensed by an approved pharmacist upon presentation of a prescription.

Depending on the circumstances, the patient may pay as little as $2.60 and need pay no more than $16.80 for any prescription listed on the Pharmaceutical Benefits Schedule (PBS).

There is a safety net whereby high users of medicines receive financial protection.

The expenditure threshold for the safety net varies according to the patient's circumstances, but for most families it is $600 each calendar year. (This figure is adjusted for inflation at the beginning of each calendar year.) Once the patient or his/her immediate family has spent $600 on PBS medicines in a year, they need only pay $2.60 for additional PBS items for the rest of the calendar year.

If the patient holds a special concession card, the safety net limit is $135.20 per calendar year (similarly adjusted for inflation). When the patient has spent $135.20 on PBS medicines for his/her self and/or his/her dependants they can get further PBS medicines free for the rest of the year.

In 1994–95 the total cost of the Scheme was $2,342 million. This includes $444.9 million from the patient contribution of prescriptions processed for payment. This figure does not include the cost of drugs supplied through special arrangements, such as the Royal Flying Doctor Services, methadone maintenance programs and hormone treatment.

Retirees who do not get a Social Security or Veterans' Affairs pension, but whose income is below the pension cut-off point, qualify for cheaper prescription medicines if they are eligible to hold a Commonwealth Seniors Health Card.

8.21 Household expenditure on medical care and health expenses, 1993–94

	Single person only, aged <35	Married couple only, reference person aged <35	Married couple with dependent children only: Eldest child aged <5	Eldest child aged 5–14	Eldest child aged 15–20	Married couple with: Dependent & nondependent children only	Nondependent children only	Married couple only, reference person aged 55–64	Married couple only, reference person aged >65	Single person only, aged >65
Average weekly household income ($)	439.8	854.3	647.9	764.4	874.5	1 100.1	1 004.8	533.8	356.9	171.7
Average number of persons in household	1.0	2.0	3.5	4.3	4.3	4.7	3.4	2.0	2.0	1.0
Average weekly household expenditure(a)(b) ($)										
Accident & health insurance										
Hospital, medical & dental insurance	3.1	8.8	10.4	10.9	13.1	14.1	14.7	11.5	7.9	3.1
Ambulance insurance (separate insurance)	0.1	0.2	0.2	0.2	0.2	0.3	0.3	0.3	0.2	0.1
Sickness & personal accident insurance(c)	0.9	1.3	0.9	1.1	0.9	1.0	1.0	0.6	0.1	0.0
Total	4.1	10.3	11.5	12.2	14.2	15.3	16.1	12.3	8.1	3.3
Practitioners fees										
General practitioner doctor's fees(c)	0.4	0.8	1.4	1.1	1.3	1.3	0.9	0.8	0.5	0.1
Specialist doctor's fees(c)	0.5	2.0	1.8	1.7	1.9	1.9	1.9	1.2	1.4	0.6
Dental charges(c)	0.8	2.2	2.4	4.6	5.4	4.7	4.0	2.3	1.4	0.8
Optician's fees (including spectacles)(c)	0.3	0.7	0.6	0.8	1.7	2.6	2.0	2.0	1.7	0.7
Practitioner's fees, n.e.c.(c)	0.4	0.7	0.9	0.9	1.1	1.0	1.1	0.5	0.5	0.6
Total	2.4	6.4	7.1	9.0	11.3	11.4	9.8	6.8	5.5	2.7
Medicines, pharmaceutical products, therapeutic appliances & equipment	1.7	3.1	5.8	4.6	5.9	6.2	5.9	5.0	4.5	4.2
Other health charges(d)	n.p.	0.6	0.8	0.5	1.4	0.9	0.7	0.4	0.6	1.6
Total medical care & health expenses	**9.3**	**20.4**	**25.0**	**26.3**	**32.9**	**33.8**	**32.4**	**24.5**	**18.6**	**11.7**

(a) The average obtained when the total estimated expenditure for a particular expenditure item is divided by the estimated number of households within the scope of the survey in the relevant category of household type. (b) Net of refunds and rebates. (c) At least one of the estimates in this row has a relative standard error greater than 25%. (d) All of the estimates in this row have a relative standard error greater than 25%.

Source: Unpublished data from the 1993–94 Household Expenditure Survey.

The steady decline in the proportion of the population covered by private health insurance for hospital cover has continued from 44.5% in June 1990 to 35.0% in June 1995 (see table 8.22).

In response to this decline, the Commonwealth Government introduced reforms to the health insurance system in order to enable the industry to provide products offering better value for money. The reforms, which came into effect on 29 May 1995, will provide health funds the opportunity, through contracting arrangements with doctors and hospitals, to offer insurance products that eliminate or make known out-of-pocket costs and therefore provide members with financial certainty.

Health funds also offer ancillary cover which provides benefits towards the cost of a range of services not covered under Medicare. This may include ancillary private dental services, optical, chiropractic, podiatry, home nursing and other services. In June 1995, nearly 6 million people had ancillary cover.

8.22 Persons with private insurance for hospital cover
(%)

	June 1990	June 1992	June 1994	June 1995
With private insurance for hospital cover	44.5	41.0	37.2	35.0
Without private insurance for hospital cover	55.5	59.0	62.8	65.0
Total	**100.0**	**100.0**	**100.0**	**100.0**

Source: Private Health Insurance Administration Council, Coverage of Basic Hospital tables, June 1995.

Health-related organisations

International

World Health Organization

The World Health Organization (WHO) is a specialised agency of the United Nations having as its objective the attainment by all peoples of the highest level of health. Australia is assigned to the Western Pacific Region, the headquarters of which is at Manila, and is represented annually at both the World Health Assembly in Geneva and the Regional Committee Meeting in Manila. Australia's assessed contribution to WHO's core budget for 1995 was $7.8 million.

The International Agency for Research on Cancer

The International Agency for Research on Cancer (IARC) was established in 1965 within the framework of the WHO. The headquarters of the agency are located in Lyons, France. The objectives and functions of the agency are to provide for planning, promoting and developing research in all phases of the causation, treatment and prevention of cancer. Australia's contribution to the IARC for 1994 was $1.1 million.

Australian Government

Health and Community Services Ministerial Council

The Health and Community Services Ministerial Council incorporates the Australian Health Ministers' Conference (AHMC), Australian Health Ministers' Advisory Council (AHMAC), Community Services Ministers' Conference (CSMC) and the Standing Committee of the Community Services and Income Security Administrators (SCCSISA).

The Health and Community Services Ministerial Council was formed in 1993 by a decision of the Council of Australian Governments (COAG), thus bringing together the Australian Health Ministers' Conference and the Community Services Ministers' Conference.

The Australian Health Ministers' Conference and its advisory body, the Australian Health Ministers' Advisory Council (AHMAC), provide a mechanism through which the Commonwealth, State and Territory and New Zealand Governments can discuss matters of mutual interest concerning health policy, services and programs. The AHMC comprises the Commonwealth, State, Territory and New

Zealand Ministers responsible for Health. Neither the Conference nor the Council has statutory powers and decisions are reached by consensus.

In 1995, Health Ministers considered a wide range of issues including Aboriginal health, the health workforce, hospital and health funding, national health goals and targets, organ donation and transplantation, health policy for young people, mental health, HIV/AIDS and Hepatitis C.

Similarly, the Community Services Ministers' Conference (CSMC) and its advisory body, the Standing Committee of Community Services and Income Security Administrators (SCCSISA) provide a mechanism through which the Commonwealth, State and Territory, New Zealand and Papua New Guinea Governments can discuss matters of mutual interest concerning community services and welfare policy and programs. The CSMC comprises the Commonwealth, State, Territory, New Zealand and Papua New Guinea Ministers responsible for community services and welfare. Neither the Conference nor the Council has statutory powers and decisions are reached by consensus.

In 1995, Community Services Ministers discussed a wide range of issues including child care, education and training, homeless youth protocols, crisis accommodation, child protection and mutual recognition.

Meeting jointly as the Health and Community Services Ministerial Council, Ministers considered disability services, home and community care, mental health, acquired brain injury, Aboriginal deaths in custody, industry training, aged care and female genital mutilation.

Department of Human Services and Health

The Department of Human Services and Health is concerned with the planning and development of a range of health and welfare policies, including the national health insurance system, Medicare.

The Department is responsible for:

- the promotion of good health and reduction of illness through regulatory, promotional and funding programs;
- the provision of care and services appropriate to their needs for aged people and people with disabilities;
- ensuring that all Australians have access to necessary health services at reasonable cost through financial arrangements with the States and Territories, the direct provision of some health services and through appropriate health insurance;
- improving the health of Aboriginal and Torres Strait Islander people by improving access to culturally appropriate, needs-based and cost-effective health care; and
- improving the quality of life and the choices available for families and children at home, at work and in the general community.

Australian Institute of Health and Welfare

The Australian Institute of Health and Welfare (AIHW), is a statutory authority within the Commonwealth Human Services and Health portfolio. The Institute's mission is to inform community discussion and to support public policy-making on health and welfare issues by coordinating, developing, analysing and disseminating national information on the health status of Australians, health and welfare services and housing assistance, and by undertaking and supporting related research and analysis.

The AIHW works closely with other agencies which collect data, produce statistics and undertake research and analysis in the health, welfare and housing assistance fields.

The AIHW also provides support to the States and Territories in the health and welfare areas, primarily through the Australian Health Ministers' Advisory Council, the Standing Committee of Community Services and Income Security Administrators and State and Territory housing authorities.

The Institute's major divisions are located in Canberra and its National Injury Surveillance Unit is located in Adelaide. The Institute also supports three external units: the AIHW National Perinatal Statistics Unit (Sydney); the AIHW Dental Statistics and Research Unit (Adelaide); and the AIHW National Reference

Centre for Classification in Health (Brisbane). In addition, the AIHW jointly funds with the ABS the Aboriginal and Torres Strait Islander Health and Welfare Information Unit within the ABS National Centre for Aboriginal and Torres Strait Islander Statistics, Darwin.

National Health and Medical Research Council

The National Health and Medical Research Council (NHMRC) is a statutory authority, within the Commonwealth Human Services and Health portfolio, which provides advice to the Commonwealth, State and Territory governments and the community on matters relating to individual and public health and health ethics issues. It also advises the Minister for Human Services and Health on funding for medical and public health research.

The NHMRC statement of strategic intent is that the NHMRC will work with others for the health of all Australians, by promoting informed debate on ethics and policy, providing knowledge-based advice, fostering a high-quality and internationally recognised research base, and applying research rigour to health issues.

The Council members are drawn from State and Territory health departments, professional and scientific organisations, unions, universities, business, consumer groups and the Aboriginal and Torres Strait Islander Commission. It operates via a comprehensive network of expert committees and working parties, thus drawing on a broad spectrum of expertise from the health area and the community.

The Private Health Insurance Administration Council

The Private Health Insurance Administration Council (PHIAC) is a statutory authority that was established in June 1989. The main powers and functions of the Council, which are set out in section 82G of the National Health Act, are as follows:

- to monitor the financial performance of health funds to ensure that the statutory reserve requirements are being met;
- to administer the reinsurance account arrangements;
- to collect and disseminate financial and statistical data, including tabling of an annual report to Parliament on the operations of health funds;
- to establish uniform reporting standards for funds;
- to impose levies to cover the operating costs of the Council and any unpaid claims of a collapsed fund;
- to receive applications for the review of acute care certificates and application fees, and administer the funding arrangements for the operation of the Acute Care Advisory Committees;
- to obtain from registered organisations, for the purposes of modelling, evaluation and research, information referred to in the Hospital Casemix Protocol; and
- to collect and disseminate information about private health insurance, for the purpose of enabling people to make informed choices about private health insurance.

PHIAC disseminates statistics through an annual report and through quarterly reports that are made available to health funds, the Federal Government and State Governments and other users with an interest in health insurance. The statistics are compiled from registered health benefits organisations' quarterly returns and provide data on membership and coverage, bed days, and benefit paid.

As at 30 June 1995, 35.0% of the Australian population held private health insurance hospital cover.

Australian Quarantine and Inspection Service (AQIS)

AQIS carries significant health-related responsibilities in export inspection, quarantine administration and imported food.

Export inspection activities are derived from the *Export Control Act 1982*, which is the principal legislation for export activities, and subordinate legislation comprising regulations enabled under this Act and Ministerial Orders made under these regulations.

Inspection covers meat, fish, dairy products, processed foods and vegetables, dried fruit, fresh fruit and vegetables, grains, horticultural and plant products, live animals, and some animal products. The aims of the inspectorate are to assist the export of Australian agricultural, forestry and fishery products by providing information, services and facilities that enable exporters to comply with the animal and plant health requirements of importing countries. It also aims to provide effective inspection services for food and other products under AQIS control to ensure they are safe and wholesome, are informatively described, meet international requirements and facilitate trade.

In 1994–95, AQIS provided inspection for over $3,000 million worth of export meat to over eighty destinations. Inspection services are also provided by AQIS on behalf of Governments in New South Wales, the Northern Territory and the Australian Capital Territory for meat produced for domestic consumption.

A range of non-prescribed goods is also inspected and certified on an ad hoc basis where overseas governments require this as a condition of entry of Australian goods.

AQIS quarantine activities derive from the *Quarantine Act 1908* and the *Biological Control Act 1984*. Programs are designed to address the risk of introduction of diseases and pests while enabling the importation of cleared agricultural products. Animal and plant health requirements are negotiated with exporting countries involving the latest technology for assurance of quarantine safety.

Quarantine activities in some States are contracted to State Departments of Agriculture on the Commonwealth's behalf, and include both monitoring and surveillance elements. In 1994–95, inspections based on risk management principles were undertaken of 6,000 ships, 31,000 aircraft, 6.3 million crew and passengers, one million cargo containers and 1.8 million airfreight consignments.

Quarantine responsibilities include the administration of animal quarantine stations at Sydney, Melbourne, Adelaide and Perth and a high security quarantine station on the Cocos (Keeling) Islands, and the supervision of a range of plant quarantine stations and private facilities for both animal and plant quarantine.

Consignments of high- and medium-risk imported foods are also subject to food inspection under the provisions of the *Imported Foods Act 1993*. In 1994–95, a total of 35,078 shipments were subject to AQIS clearance, of which 13,296 were released after initial inspection. A closer inspection was conducted on 21,782 shipments, of which 707 failed to meet relevant standards. Where an overseas government's inspections system can be shown to provide equivalent safety assurances to Australia's food inspection system, food accompanied by that agency's certification is allowed entry without additional routine testing on arrival.

AQIS has significant international involvement in the development of international food safety standards and related aspects of hygiene and manufacturing practice.

National Food Authority

The National Food Authority is a statutory authority established by the *National Food Authority Act 1991*. Its primary function is to develop, vary and review standards for food available in Australia.

The objectives of the Authority in relation to food standards are:

- to protect public health and safety;
- to provide consumers with information;
- to promote trade and commerce; and
- to promote the alignment of Australian food standards with international food standards.

The Authority is currently reviewing food standards to ensure consistency between the Food Standards Code and the standards-setting objectives of the Authority. The review will seek to ensure flexibility in the Code and to accommodate innovation. It also provides a mechanism for the proposed development of joint food standards with New Zealand.

The Authority runs the Imported Food Inspection Program jointly with AQIS and provides national coordination of food recalls. It also publishes the biennial Australian Market Basket Survey.

National Occupational Health and Safety Commission

The National Occupational Health and Safety Commission (Worksafe Australia) is a tripartite body comprising representatives of the peak employee and employer bodies — the Australian Council of Trade Unions and the Australian Chambers of Commerce and Industry — as well as the Commonwealth, State and Territory Governments. The mission of the National Commission is to lead national efforts to provide healthy and safe working environments, and to reduce the incidence and severity of occupational injury and disease.

Worksafe Australia has primary Commonwealth responsibility for occupational health and safety statistics.

A report relating to workers' compensation cases reported in 1992–93 involving a fatality, a permanent disability or a temporary disability resulting in five days or more off work, based on information supplied by Commonwealth, State and Territory agencies which administer workers' compensation systems, contained the following main findings:

- Of all the cases included on the database, 76% involved males and 24% females.
- The incidence rate for males for all industries was 35 cases per 1,000 wage and salary earners; for females, 14 per 1,000 wage and salary earners; and for persons, 25 per 1,000 wage and salary earners.
- The frequency rate for males for all industries was 21 cases per million hours worked; for females, 11 per million hours worked; and for persons, 17 per million hours worked.
- Around one in 39 workers sustained a work-related injury or disease in 1992–93, compared with one in 40 in 1991–92.
- The average duration was nearly 10 weeks per injury or disease case.
- In 1992–93 the total estimated cost of workers' compensation claims for all of Australia was $4.8 billion. This direct cost alone represented 1.2% of non-farm GDP, and 2.4% of non-farm wages, salaries and supplements.

Therapeutic Goods Administration

The Therapeutic Goods Administration (TGA) is an organisation within the Department of Human Services and Health. Its role is to undertake activities with the goal of ensuring that therapeutic goods available in Australia are safe, effective and of high quality. Therapeutic goods include prescription drugs, non-prescription medicines, traditional remedies and all types of medical equipment (therapeutic devices).

TGA monitors the quality of therapeutic goods available in Australia by sampling products for testing and investigating problems and deficiencies. The various laboratories analyse therapeutic goods for acceptable quality and carry out developmental research associated with new or improved testing methods and development of standards.

In 1994–95, tests were performed on 1,309 selected products for human use to check compliance with official standards. A total of 211 of these products failed to comply. Investigations were also conducted on reported drug (121) and device (477) problems. These investigations resulted in the recall of 6 drug products and 22 device products. A total of 32 drug recalls and 108 device recalls in 1994–95 included voluntary recalls by suppliers.

Australian Radiation Laboratory

The Australian Radiation Laboratory develops national policy relating to radiation health and:

- formulates policy by developing codes of practice and by undertaking other regulatory, compliance, surveillance and advisory responsibilities at the national level with respect to public and occupational health aspects of radiation;
- maintains national standards of radiation exposure and working standard of absorbed dose;
- provides advice in relation to the quality and use of radio-pharmaceutical substances; and
- in support of the above activities, undertakes research and development in the fields of ionizing and non-ionizing radiations which have implications for public and occupational health.

Cancer registries

Cancer is a major cause of morbidity and mortality. Each year in Australia about 60,000 new cases of cancer are diagnosed and 30,000 people die from cancer. This equates to an average risk of 1 in 3 men and 1 in 4 women being directly affected by cancer in their lifetime.

Cancer is a notifiable disease in all States and Territories and is the only major disease category for which an almost complete coverage of incidence data is available. It is also the only major cause of death in Australia that is continuing to increase. If this situation is to be changed, good information on the occurrence of different types of cancer, on characteristics of patients, and on survival and mortality is essential to provide a sound basis for epidemiological studies and the initiation of new prevention and treatment programs.

The only effective method of obtaining cancer incidence data is through universal registration of cancer cases. Cancer incidence data are available from cancer registries which operate in each State and Territory. These registries are supported by a mix of State and Territory government and anti-cancer council funding.

The National Cancer Statistics Clearing House operated jointly by the Australian Institute of Health and Welfare and the Australasian Association of Cancer Registries compiles data produced by State and Territory registries on an ongoing basis and produces national statistics on the incidence of cancer.

Communicable Diseases Network — Australia New Zealand

The Communicable Diseases Network — Australia New Zealand was established in 1990 to enhance national capacity for communicable disease surveillance and control. The Network operates on a cooperative basis with the involvement of health authorities from the Commonwealth, States, Territories and New Zealand, and representatives from other government agencies including the Australian Defence Forces and the Department of Primary Industries and Energy, and non-government organisations which contribute to communicable disease control in Australia. The Network coordinates national surveillance of communicable diseases through the National Notifiable Diseases Surveillance System, the National Mycobacterial Surveillance System, the Hib Case Reporting Scheme, the Serious Adverse Events Following Immunisation Surveillance Scheme and the National Acute Hepatitis C Surveillance System. It also facilitates and coordinates communicable disease control activities where a national response is required.

Australian non-government

National Heart Foundation of Australia

The National Heart Foundation of Australia is a voluntary organisation, supported almost entirely by public donations, established with the objective of reducing the toll of heart disease in Australia. It does this by programs sponsoring research in cardiovascular disease, community and professional education directed to prevention, treatment and rehabilitation of heart disease and community service programs including rehabilitation of heart patients, risk assessment clinics and surveys, and documentation of various aspects of heart disease and treatment of heart disease in Australia.

The Foundation's income in 1994 was $24.3 million of which $17.5 million was from public donations and bequests. Since the inception of the Foundation, research has been a major function. With increasing opportunities for prevention and control of heart disease, the Foundation's education and community service activities are increasing significantly. In 1994, expenditure on research, education and community service totalled $15.0 million.

Australian Red Cross

The Australian Red Cross runs the Blood Transfusion Service in Australia, based on donations from voluntary non-remunerated donors. The service is funded by the Commonwealth Government and State Governments (approximately 98%) and Red Cross (approximately 2%). The cost of providing the service in 1993–94 was $93.1 million.

Plasma products are manufactured by the Commonwealth Serum Laboratories from plasma from Red Cross blood donors, and distributed by Red Cross.

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