Chapter Nine

Health

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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 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 Health, Housing and Community Services. The Minister for Health, Housing and Community Services exercises overall responsibility over the Commonwealth Department of Health, Housing and Community Services, represents the portfolio in Cabinet and has particular responsibility for Budget matters and major policy decisions. The Minister for Aged, Family and Health Services has responsibility for the development and administration of particular health matters, including the Pharmaceutical Benefits Scheme and Therapeutic Goods. 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 his/her 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.

THE HEALTH OF AUSTRALIANS

The following information from various sources provides a profile of the health of the Australian population.

National Health Survey, 1989–90

During 1989–90 the ABS interviewed approximately 57,000 persons in the first of a new series of five yearly National Health Surveys. The survey focused on the health status of Australians, their use of health facilities and services and lifestyle factors affecting the health of the nation. The following statistics represent just a selection of those available.

Health status

As shown in the following table, of the population aged 18 years and over, 79.2 per cent reported that their health was good or excellent, while 16.3 per cent reported their health was fair and only 4.5 per cent reported they were in poor health.

PERSONS AGED 18 AND OVER: SELF ASSESSED HEALTH STATUS(a), 1989–90
(per cent)

	Self assessed health status				
Whether experienced illness condition	*Excellent*	*Good*	*Fair*	*Poor*	*Total*
No recent or long-term conditions	47.6	48.0	4.2	*0.2	100.0
Recent conditions only	38.8	51.6	8.6	1.0	100.0
Long-term conditions only	40.4	50.6	8.5	*0.5	100.0
Both recent and long-term conditions	21.7	49.9	21.5	6.9	100.0
Total					
Per cent	**29.2**	**50.0**	**16.3**	**4.5**	**100.0**
Number ('000)	**3,633.3**	**6,221.2**	**2,023.7**	**566.0**	**12,444.2**

(a) As reported by respondents.
* Relative standard error between 25 per cent and 50 per cent.
Source: National Health Survey: Summary of Results, 1989–90 (4364.0).

Some 72.9 per cent of the population reported experiencing one or more illnesses/injuries during the two weeks prior to interview. This compared to 62.3 per cent of persons who reported a recent illness in the Australian Health Survey of 1983. Of these recent conditions, headaches (due to unspecified or trivial cause) were the most frequently reported single condition affecting 12.2 per cent of the population.

Of the total Australian population, 66.2 per cent reported having one or more long-term conditions (conditions which had lasted or were expected to last for a period of six months or more), with more females reporting such a condition than males (68.4% and 64.0% respectively).

Eyesight disorders of refraction and accommodation (including long and short sight) were the most frequently reported long-term conditions affecting 31.5 per cent of the population, or approximately 5.4 million persons. Other frequently reported conditions included arthritis, which was reported as a long-term condition by 1.8 million persons or 10.6 per cent of the population, hay fever (9.8%), unspecified back trouble (8.1%), asthma (8.0%) and hypertension (7.1%).

PERSONS WHO EXPERIENCED LONG-TERM CONDITIONS: TYPE OF CONDITION(a) BY AGE AND SEX, 1989–90
(rate(b))

	Age group (years)									
Type of condition	*<5*	*5–14*	*15–24*	*25–44*	*45–64*	*65–74*	*>74*	*Males*	*Females*	*Persons*
Neoplasms	*1.5	*1.6	*1.7	10.1	30.4	58.8	56.9	16.0	16.2	16.1
Endocrine, nutritional and metabolic disorders	4.0	5.0	10.2	39.8	126.9	161.6	115.7	52.6	58.8	55.7
Mental disorders	*4.2	17.5	15.1	21.1	30.3	36.0	36.1	20.8	22.7	21.8
Nervous system and sense organ diseases	35.9	119.5	221.4	317.6	721.8	787.8	790.0	349.8	414.6	382.3
Circulatory system diseases	10.0	10.2	20.8	84.7	252.6	432.8	482.7	106.1	155.8	131.0
Respiratory system diseases	134.4	240.6	246.6	227.3	210.6	218.9	177.6	212.0	227.5	219.8
Digestive system diseases	11.9	10.8	16.5	44.0	95.6	135.8	142.3	52.0	53.5	52.7
Genitourinary system diseases	4.7	10.3	14.9	27.2	45.5	44.2	53.7	13.5	40.1	26.8
Diseases of the skin and subcutaneous tissue	61.1	46.8	59.4	64.1	47.4	55.3	58.8	49.7	63.3	56.5
Diseases of the musculoskeletal system and connective tissue	9.5	33.1	153.9	269.6	430.2	526.5	560.4	246.1	269.9	258.0

For footnotes *see* end of table.

PERSONS WHO EXPERIENCED LONG-TERM CONDITIONS: TYPE OF CONDITION(a) BY AGE AND SEX, 1989–90 — *continued*
(rate(b))

	Age group (years)									
Type of condition	*<5*	*5–14*	*15–24*	*25–44*	*45–64*	*65–74*	*>74*	*Males*	*Females*	*Persons*
Symptoms, signs and ill defined conditions	30.1	41.0	41.4	42.6	42.0	55.3	54.7	35.9	49.1	42.5
Injury and poisoning	*1.7	5.9	19.4	16.6	13.6	14.8	19.2	16.7	10.9	13.8
Other(c)	10.1	8.0	22.2	26.1	25.3	31.4	47.1	21.1	27.0	24.2
Total persons(d)										
Rate(b)	**258.4**	**421.4**	**554.5**	**674.4**	**896.4**	**949.0**	**958.3**	**639.6**	**682.3**	**661.0**
Number ('000)	**321.2**	**1,045.3**	**1,529.4**	**3,615.3**	**2,912.0**	**1,147.4**	**659.4**	**5,421.0**	**5,808.9**	**11,229.9**

(a) Condition groups based on chapter headings of the International Classification of Diseases, Ninth Revision (ICD9). (b) Rate per 1,000 population of same age and sex. (c) Includes infectious and parasitic diseases, diseases of the blood and blood forming organs, complications of pregnancy, childbirth and the puerperium, congenital anomalies, disability n.e.c. and unspecified illness. (d) Each person may have reported more than one type of illness and therefore components do not add to totals.
Source: National Health Survey: Summary of Results, 1989–90 (4364.0).

Health related actions

Over three-quarters of the population surveyed (75.5%), reported taking a health-related action during the two weeks prior to interview, ranging from using medications or taking vitamins/minerals (the most frequent) to having been a hospital in-patient.

During the two weeks prior to interview, 20.0 per cent of respondents (an estimated 3.4 million persons) had consulted a doctor. The table below shows the strong association between doctor consultations and age once beyond preschool years.

PERSONS WHO TOOK HEALTH RELATED ACTION DURING THE TWO WEEKS PRIOR TO INTERVIEW: TYPE OF ACTION BY AGE, 1989–90
(rate(a))

	Age group (years)								*Number of persons ('000)*
Type of action	*<5*	*5–14*	*15–24*	*25–44*	*45–64*	*65–74*	*>74*	*Total*	
Hospital in-patient episode	7.5	5.3	8.7	8.5	11.2	10.9	21.6	9.2	156.7
Visit to casualty/ outpatients	34.0	17.0	25.8	21.9	24.9	38.8	36.4	25.1	425.7
Doctor consultation	237.8	141.0	165.0	172.6	224.7	322.1	370.9	200.1	3,400.2
Dental consultation(b)	21.9	91.2	47.9	50.7	49.4	45.6	20.0	53.1	876.0
Consultation with other health professional	151.6	58.7	82.5	93.5	97.1	109.6	134.0	94.4	1,603.3
Taken vitamins/minerals	147.5	180.7	223.5	261.8	261.1	251.0	227.4	233.1	3,960.0
Used other medications	609.5	476.8	576.7	624.6	730.9	853.5	891.7	641.6	10,899.8
Days away from work/ school	. .	136.1	113.2	67.8	47.9	. .	. .	68.8	1,168.8
Other days of reduced activity(b)	113.4	91.0	83.0	89.3	107.5	139.7	157.5	99.7	1,644.8
Total persons(c)									
Rate	**715.5**	**636.0**	**699.2**	**752.4**	**819.4**	**906.0**	**931.1**	**755.0**	
Number ('000)	**889.5**	**1,577.7**	**1,928.4**	**4,033.8**	**2,662.0**	**1,095.3**	**640.7**		**12,827.2**

(a) Rate per 1,000 population of same age. (b) Persons aged 2 years and over. (c) Each person may have taken more than one type of action during the two weeks prior to interview and therefore components do not add to totals.
Source: National Health Survey: Summary of Results, 1989–90 (4364.0).

Use of medications (including vitamin and mineral supplements) was the most frequently reported health-related action taken. Some 70.4 per cent of the population (about 11.9 million people) reported using medications in the two weeks prior to interview. The proportion of persons using medications was higher for females (76.2%) than males (64.5%).

PERSONS WHO USED MEDICATION DURING THE TWO WEEKS PRIOR TO INTERVIEW: TYPE OF MEDICATION BY AGE AND SEX, 1989–90 (rate(a))

	Age group (years)									
Type of medication	*<5*	*5–14*	*15–24*	*25–44*	*45–64*	*65–74*	*>74*	*Males*	*Females*	*Persons*
Vitamin and mineral supplements	147.5	180.7	223.5	261.8	261.1	251.0	227.4	190.7	275.3	233.1
Medication for cough or cold	265.9	149.5	121.2	98.0	90.6	91.3	94.3	119.5	119.6	119.5
Medication for allergy	36.6	69.7	54.9	63.8	63.5	58.7	31.7	53.9	65.1	59.5
Skin ointments	247.6	140.2	177.5	172.3	173.6	229.4	259.6	171.3	192.3	181.8
Stomach medicines or laxatives	27.0	21.0	39.0	65.3	118.8	191.1	227.3	64.0	91.0	77.5
Medications for fluid, heart, blood pressure	. .	. .	2.6	31.8	224.9	463.7	542.2	88.5	128.3	108.4
Pain relievers	279.3	207.0	344.0	402.5	402.1	386.1	408.2	289.5	419.1	354.4
Sleeping medications	27.0	2.5	11.1	26.9	80.7	171.7	233.7	34.1	65.3	49.7
Tranquillisers or sedatives	*2.3	*0.9	3.2	17.6	45.3	66.9	58.5	17.0	27.3	22.2
Other medications	123.9	119.7	145.7	146.9	253.5	394.7	437.9	161.2	220.4	190.8
Total persons(b)	**656.1**	**548.3**	**654.4**	**701.7**	**782.6**	**880.6**	**912.2**	**644.9**	**761.9**	**703.6**

(a) Rate per 1,000 population of same age and sex. (b) Each person may have reported taking more than one type of medication and therefore components do not add to totals.

Source: National Health Survey: Summary of Results, 1989–90 (4364.0).

When compared with information recorded in the 1983 Australian Health Survey, results show that the usage of medications has increased. The proportion of persons using vitamin and mineral supplements has increased from 19.1 per cent in 1983 to 23.3 per cent in 1989–90 and persons using all other medications from 47.7 per cent to 64.1 per cent over the same period.

708,100 persons (9.1% of total employed people) reported days away from work due to illness or injury. On average they reported three days away during the two week reference period. The most frequently reported reasons for days away from work were respiratory conditions (including common cold, influenza, asthma, etc.) reported by 34.9 per cent of persons who took days away from work through illness/injury.

Approximately 2.3 million people (13.7% of the population) reported having one or more hospital episodes in the 12 months prior to interview, of whom 41.9 per cent were males and 58.1 per cent were females. This difference is largely attributable to the number of female hospital episodes associated with pregnancy and childbirth.

Health risk factors

Results of the survey show that over 3.5 million people aged 18 years and over smoke, which is equivalent to 28.4 per cent of the adult population. A further 23.2 per cent reported they were ex-smokers. The proportion of smokers is highest in the younger age groups; 36.0 per cent of those aged 18 to 24 reported being smokers compared with 29.6 per cent of those aged 35 to 44 years, and only 8.1 per cent of those aged 75 years and over. Figures also show that more males than females smoked (32.1% and 24.7% respectively), although the difference was less marked in the younger age groups.

PERSONS AGED 18 YEARS AND OVER: SMOKER STATUS BY AGE AND SEX, 1989–90
(per cent)

	Age group (years)								
Smoker status	*18–24*	*25–34*	*35–44*	*45–64*	*65–74*	*>74*	*Males*	*Females*	*Persons*
Smokers									
Manufactured cigarettes only	34.6	32.1	26.8	22.4	13.3	5.9	27.0	24.2	25.6
Manufactured cigarettes and cigars or pipes	0.6	0.7	0.8	0.7	*0.2	. .	1.2	0.1	0.6
Roll your own cigarettes only	0.8	1.8	1.5	2.0	2.0	1.4	2.9	0.4	1.6
Cigars or pipes and roll your own only	. .	*0.2	*0.1	0.2	*0.2	. .	0.2	. .	0.1
Total smokers	*36.0*	*34.9*	*29.6*	*26.0*	*16.5*	*8.1*	*32.1*	*24.7*	*28.4*
Ex-smoker	10.4	19.5	22.7	28.1	36.0	31.2	28.8	17.8	23.2
Never smoked	53.7	45.6	47.7	45.9	47.5	60.7	39.1	57.4	48.4
Total persons									
Per cent	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Number ('000)	**1,937.3**	**2,799.9**	**2,561.2**	**3,248.7**	**1,209.0**	**688.1**	**6,144.7**	**6,299.5**	**12,444.2**

Source: National Health Survey: Smoking, 1989–90 (4382.0) and National Health Survey: Summary of Results, 1989–90 (4364.0).

62.5 per cent of people aged over 18 years reported having an alcoholic drink during the week prior to interview: 73.5 per cent of males and 51.8 per cent of females. 8.9 per cent of persons reported they had never consumed alcohol.

People who consumed alcohol in the reference week were grouped by health risk level according to the quantity of alcohol they consumed. These levels are based on the standards adopted by the National Health and Medical Research Council. In total, 82.2 per cent of drinkers were grouped as at low risk level, 10.9 per cent at medium risk level and 6.9 per cent at high risk level. High risk drinkers amongst males outnumbered females in this category by more than three to one.

PERSONS AGED 18 YEARS AND OVER WHO CONSUMED ALCOHOL IN THE WEEK PRIOR TO INTERVIEW: HEALTH RISK LEVEL OF ALCOHOL INTAKE(a) BY AGE AND SEX, 1989–90
(per cent)

	Age group (years)								
Risk level	*18–24*	*25–34*	*35–44*	*45–64*	*65–74*	*>74*	*Males*	*Females*	*Total*
Low	49.6	56.0	55.8	50.9	43.4	37.0	58.6	44.3	51.5
Medium	7.9	7.5	7.3	7.0	5.0	1.9	7.8	5.9	6.8
High	6.0	4.9	4.1	4.5	2.3	0.4	7.1	1.6	4.3
Total persons who consumed alcohol(b)	*63.4*	*68.5*	*67.1*	*62.4*	*50.8*	*39.4*	*73.5*	*51.7*	*62.5*
Total persons who did not consume alcohol(b)	36.6	31.5	32.9	37.6	49.2	60.6	26.5	48.3	37.5
Total persons									
Per cent	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Number ('000)	**1,937.3**	**2,799.9**	**2,561.2**	**3,248.7**	**1,209.0**	**688.1**	**6,144.7**	**6,299.5**	**12,444.2**

(a) Based on the average daily consumption during the week prior to interview and grouped according to standards adopted by the National Health and Medical Research Council. (b) In the reference week.

Source: National Health Survey: Alcohol Consumption, 1989–90 (4381.0).

Based on self-reported height and weight, 35.3 per cent of males and 20.5 per cent of females aged 18 years and over were classified as overweight, and a further 8.2 per cent of males and 9.1 per cent of females were classified obese based on standards adopted by the National Health and Medical Research Council.

PERSONS AGED 18 AND OVER: RELATIVE WEIGHT(a) BY AGE AND SEX, 1989–90
(per cent)

	Age group (years)						
Relative weight	*18–24*	*25–34*	*35–44*	*45–64*	*65–74*	*>74*	*Total*
Males							
Underweight	13.4	5.8	4.2	3.4	5.2	11.5	6.2
Acceptable weight	56.9	52.8	45.3	40.7	43.4	51.4	47.7
Overweight	21.2	32.5	38.8	43.0	40.4	27.8	35.3
Obese	3.7	6.7	10.1	11.0	9.4	4.2	8.2
Not available	4.8	2.2	1.5	1.9	1.6	5.1	2.5
Total males							
Per cent	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Number ('000)	**983.7**	**1,410.8**	**1,291.7**	**1,651.3**	**548.6**	**258.5**	**6,144.7**
Females							
Underweight	31.0	22.1	14.8	9.0	11.4	17.4	17.2
Acceptable weight	49.0	52.8	52.3	45.7	43.9	42.1	48.7
Overweight	10.4	14.9	20.3	28.7	27.5	20.6	20.5
Obese	3.8	7.0	9.2	13.5	11.2	7.2	9.1
Not available	5.8	3.2	3.4	3.1	5.9	12.7	4.5
Total females							
Per cent	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Number ('000)	**953.6**	**1,389.1**	**1,269.5**	**1,597.4**	**660.3**	**429.6**	**6,299.5**

(a) Derived from reported height and weight, and grouped based on standards adopted by the National Health and Medical Research Council.

Source: National Health Survey: Summary of Results, 1989–90 (4364.0).

Women respondents to the survey who were aged 18 to 64 years were invited to complete a small additional questionnaire about specific women's health issues. Results of this component of the survey showed that 85.5 per cent of women in this age group reported they had at some time had a Pap Smear Test, for evidence of cervical cancer, and 42.5 per cent had last been tested in the twelve months prior to interview. An estimated 29.3 per cent of women aged 18 to 64 years had never had a Pap Smear Test or had not been tested within the last three years. Results of the survey also showed a tendency for older women to have tests less frequently than women in younger age groups.

Of women aged 18 to 64 years, 62.8 per cent regularly examine their own breasts for lumps, and 70.9 per cent reported having had a breast examination by a doctor or nurse. One third (32.9%) of women aged 45 to 54 years reported having had a mammogram, and 17.8 per cent of women overall in the age group 18 to 64 years had been tested. Of those women who reported having had a mammogram, 74.0 per cent had last been screened within the three years prior to interview.

Communicable diseases

Notifiable diseases

State and Territory health authorities submit notifiable disease data to the Commonwealth Department of Health, Housing and Community Services for publication in Communicable Diseases Intelligence.

NOTIFIABLE DISEASES, NUMBER OF CASES NOTIFIED, 1990

Disease	*NSW*	*Vic.*	*Qld*	*WA*	*SA*	*Tas.*	*NT*	*ACT*	*Total*
AIDS	366	108	55	25	21	4	2	10	591
Amoebiasis(a)	—	—	6	1	—	—	—	1	8
Ankylostomiasis(a)	—	—	—	—	—	2	(b)	—	2
Anthrax(a)	—	—	—	—	—	—	—	—	—
Arbovirus infection(a)	289	78	1,484	30	23	12	92	—	2,008
Brucellosis	5	—	41	—	—	—	—	—	46
Campylobacter infection(a)	1,917	396	561	820	1,296	264	324	105	5,683
Chancroid	—	—	(b)	—	13(b)	(b)	—	—	13
Cholera	1	—	—	—	—	—	—	—	1
Congenital rubella syndrome	—	—	—	—	2	(b)	—	—	2
Diphtheria(a)	—	—	3	—	—	—	4	—	7
Donovanosis(a)	—	(b)	49	—	(b)	—	42	—	91
Giardiasis(a)	621	174	(b)	—	—	—	—	22	817
Genital herpes	972	n.a.	1,436	(b)	(b)	(b)	22	40	2,470
Gonococcal ophthalmia neonatorum	—	(b)	—	—	—	(b)	—	(b)	—
Gonorrhoea(a)	403	n.a.	489	275	173	3	558	18	1,919
Hepatitis A (infectious)	36	41	196	—	99	6	145	7	530
Hepatitis B (serum)(a)	426	583	1,783	—	36	57	27	58	2,970
Hepatitis — unspecified	54	47	569	(b)	5	11	7	14	707
Hydatid disease(a)	2	—	8	1	2	2	—	1	16
Lassa fever	—	—	—	—	—	—	—	—	—
Legionnaires disease(a)	27	13	24	4	19	—	—	3	90
Leprosy	5	13	1	3	1	—	8	—	31
Leptospirosis(a)	49	37	22	4	6	3	—	—	121
Lymphogranuloma venereum(a)	—	(b)	—	(b)	(b)	(b)	(b)	—	—
Malaria(a)	193	87	499	28	33	5	13	24	882
Marburg disease	—	—	—	—	—	—	—	—	—
Measles	388	342	47	27	43	(b)	3	30	880
Meningococcal infections(a)	84	83	19	47	21	12	26	3	295
Non-specific urethritis	1,479	(b)	1	(b)	(b)	(b)	10	63	1,553
Ornithosis(a)	1	—	3	—	15	—	—	4	23
Pertussis (whooping cough)	149	75	159	251	172	2	11	43	862
Plague	—	—	—	—	—	—	—	—	—
Poliomyelitis(a)	—	—	—	—	—	—	—	—	—
Q-fever(a)	156	18	235	—	21	(b)	—	1	431
Rabies	—	—	—	—	—	—	—	—	—
Salmonella infections(a)	1,486	487	1,357	—	636	155	404	39	4,564
Shigella infections(a)	146	64	92	—	94	3	209	2	610
Smallpox	—	—	—	—	—	—	—	—	—
Syphilis(a)	333	n.a.	729	49	83	2	437	10	1,643
Tetanus	2	2	—	—	2	—	(b)	—	6
Trachoma	2	(b)	—	—	3	—	—	—	5
Tuberculosis (all forms)(a)	—	353	136	—	89	17	62	27	684
Typhoid fever(a)	44	22	—	—	3	—	—	1	70
Typhus (all forms)(a)	—	—	4	—	—	—	—	—	4
Vibrio parahaemolyticus infections(a)	22	—	(b)	—	1	—	—	(b)	23
Yellow fever	—	—	—	—	—	—	—	—	—
Yersinia infections(a)	133	27	67	3	197	(b)	6	(b)	433

(a) Confirmed by appropriate diagnostic tests. (b) Not notifiable.
NOTE: For some of the diseases shown above information is not available or the diseases are not notifiable in certain States/Territories.

Source: Commonwealth Department of Health, Housing and Community Services.

Childhood immunisation

Immunisation is recommended for all Australian children as a protection against childhood diseases such as poliomyelitis, diphtheria, measles, mumps, tetanus and whooping cough. Immunisation programs are implemented in all States and Territories of Australia. The childhood immunisation schedule, as recommended by the National Health and Medical Research Council, is available from the Commonwealth Department of Health, Housing and Community Services.

Results of the 1989–90 National Health Survey show that the immunisation status of children varies with the type of immunisation involved. For example, while 86.3 per cent of children were protected against diptheria and tetanus, only 70.9 per cent of those in the same age group were immunised against whooping cough and 72.1 per cent against polio, although a further 19.3 and 15.3 per cent

respectively were partially immunised against the latter two diseases (i.e., they had received less than the number of vaccinations recommended for their age).

Of children in the 1 to 6 years age group 86.0 per cent (1.3 million) were immunised against measles and 80.5 per cent (1.2 million) against mumps.

CHILDREN AGED 0 TO 6 YEARS: TYPE OF IMMUNISATION BY IMMUNISATION STATUS(a), 1989–90 ('000)

	Immunisation status				
Type of immunisation	*Fully immunised*	*Partly immunised*	*Not immunised*	*Not known whether immunised*	*Total*
Diptheria/Tetanus	1,508.9	95.5	65.4	77.8	1,747.7
Whooping cough	1,238.7	337.3	93.8	77.8	1,747.7
Polio	1,260.8	278.4	101.3	107.2	1,747.7
Measles(b)	1,276.9	..	163.9	44.0	1,484.8
Mumps(b)	1,195.7	..	221.8	67.3	1,484.8

(a) Based on the number of vaccinations received compared with levels recommended by the National Health and Medical Research Council. Children who had received the recommended number of vaccinations for their age are classified as fully immunised; those who had received some, but less than the number recommended for their age are classified as partly immunised. (b) Excludes children aged less than one year.

Source: National Health Survey: Summary of Results, 1989–90 (4364.0).

Hepatitis B vaccine is currently offered to neonates born to mothers belonging to community groups in which the carrier rate for Hepatitis B is estimated to exceed five per cent.

NOTIFIABLE DISEASES, NUMBER OF CASES NOTIFIED, 1986–1990

Disease	*1986*	*1987*	*1988*	*1989*	*1990*
AIDS	228	371	522	568	591
Amoebiasis(a)	54	58	60	64	8
Ankylostomiasis(a)	40	57	35	106	2
Anthrax(a)	—	1	—	—	—
Arbovirus infection(a)	1,414	1,085	897	2,809	2,008
Brucellosis(a)	12	12	16	20	46
Campylobacter infection(a)	2,922	2,923	4,082	4,279	5,683
Chancroid(a)	12	4	4	3	13
Cholera	—	—	2	—	1
Congenital rubella syndrome	2	3	2	—	2
Diphtheria(a)	44	32	61	1	7
Donovanosis(a)	185	148	133	99	91
Giardiasis(a)	1,316	1,508	1,753	2,060	817
Genital herpes	2,136	2,359	2,129	2,581	2,470
Gonococcal Ophthalmia neonatorum(a)	5	5	3	1	—
Gonorrhoea(a)	6,585	4,979	4,079	3,153	1,919
Hepatitis A (infectious)	1,685	715	600	460	530
Hepatitis B (serum)(a)	1,766	1,605	1,683	3,017	2,970
Hepatitis — unspecified	136	131	69	43	707
Hydatid disease(a)	14	17	15	15	16
Lassa fever	—	—	—	—	—
Legionnaires disease(a)	68	96	67	104	90
Leprosy	27	31	20	34	31
Leptospirosis(a)	179	133	104	99	121
Lymphogranuloma venereum(a)	4	—	—	—	—
Malaria(a)	696	574	601	770	882
Marburg disease	—	—	—	—	—
Measles	(b)	(b)	248	169	880

For footnotes *see* end of table.

NOTIFIABLE DISEASES, NUMBER OF CASES NOTIFIED, 1986–1990 — *continued*

Disease	*1986*	*1987*	*1988*	*1989*	*1990*
Meningococcal infections(a)	51	96	126	204	295
Non-specific urethritis	8,063	7,384	3,210	1,739	1,553
Ornithosis(a)	43	13	21	25	23
Pertussis (whooping cough)	601	291	153	614	862
Plague	—	—	—	—	—
Poliomyelitis(a)	1	—	—	—	—
Q-fever(a)	367	355	424	353	431
Rabies	—	—	—	—	—
Salmonella infections(a)	2,494	2,739	3,484	4,492	4,564
Shigella infections(a)	833	586	581	779	610
Smallpox	—	—	—	—	—
Syphilis(a)	3,594	3,190	3,056	2,099	1,643
Tetanus	5	5	5	11	6
Trachoma	233	274	268	504	5
Tuberculosis (all forms)(a)	1,041	686	1,165	1,351	684
Typhoid fever(a)	45	47	40	57	70
Typhus (all forms)(a)	11	9	8	2	4
Vibrio parahaemolyticus infections(a)	6	6	2	10	23
Yellow fever	—	—	—	—	—
Yersinia infections(a)	78	122	172	241	433

(a) Confirmed by appropriate diagnostic tests. (b) Not notifiable.
NOTE: For some of the diseases shown above information is not available or the diseases are not notifiable in certain States/Territories.

Source: Commonwealth Department of Health, Housing and Community Services.

Acquired Immune Deficiency Syndrome (AIDS)

The National HIV/AIDS Strategy was launched in August 1989. The Strategy outlines the direction of AIDS policy and the specific programs to be put in place to manage the epidemic into the 1990s. It was developed following extensive national community consultations and release of the Policy Discussion Paper *AIDS: A Time to Care, A Time to Act — Towards a Strategy for Australians* in November 1988. To date the majority of National Strategy Recommendations have been, or are in the process of being implemented.

The Strategy is coordinated at the national level by the Aids Policy and Programs Branch of the Commonwealth Department of Health, Housing and Community Services. An evaluation of the Programs outlined and funded through the National Strategy is being undertaken jointly by the Commonwealth and States. The Branch has the responsibility for coordinating and evaluating community AIDS projects, assessing the funding of these initiatives, and undertaking liaison with a wide range of Australian and overseas agencies. In addition, the Department closely monitors medical and scientific developments in relation to the disease. It also provides executive support for national AIDS Committees which have been established to consider and advise on all aspects of AIDS, including the Australian National Council on AIDS (ANCA), the Parliamentary Liaison Group on AIDS, and the Intergovernmental Committee on AIDS.

In 1990–91 the Commonwealth made available approximately $78 million for the fight against AIDS. The expenditure was divided between the National AIDS Program ($24 million), the AIDS Matched Funding Program ($24 million) and Medicare payments to the States ($30 million).

The Commonwealth has allocated approximately $88 million to the AIDS program in 1991–92. Over $28 million is earmarked for the National AIDS Program and approximately $22 million will be made available under the Matched Funding Program. The Commonwealth has continued assistance to maintain the safety of our blood supply by supporting the screening of blood transfusion services throughout Australia. A further $35 million will be paid to the States and Territories under the Medicare arrangements for the treatment of HIV/AIDS in public hospitals. This component will be indexed to the actual growth of AIDS cases treated.

Activities under the National AIDS Program include research, the national AIDS education campaign, grants to community-based organisations and to develop educational resources for health care workers, exchange of information both within Australia and internationally and support of national AIDS advisory committees.

The third National Centre, the National Centre in HIV Social Research was established in 1990. The purpose of this Centre is to conduct and coordinate research into the effects of the epidemic, to identify educational and training needs and to evaluate specific social aspects of transmission and the impact of education and prevention programs and policy initiatives.

Australia's contribution to the WHO global program on AIDS has been a total of $2 million spread over the past three years.

Australia has moved to increase its international activity in AIDS programs, through direct bilateral programs in our region. The National Strategy, through the Australian International Development Assistance Bureau, has established a short-term program of support for regional education and community development.

REPORTED AIDS CASES TO 30 JUNE 1991

	NSW	*Vic.*	*Qld*	*SA*	*WA*	*Tas.*	*NT*	*ACT*	*Total*
Number of cases									
Males	1,615	531	190	89	116	14	7	35	2,597
Females	48	12	8	3	8	1	—	1	81
Known deaths									
Number	1,065	322	131	44	77	8	3	22	1,672
Per cent of cases	63.7	19.3	7.8	2.6	4.6	0.5	0.2	1.3	100.0

Source: Australian HIV Surveillance Report.

CASES OF AIDS AND KNOWN DEATHS FROM AIDS BY TRANSMISSION CATEGORY TO 30 JUNE 1991

	Cases				*Known deaths*			
Transmission category	*Males*	*Females*	*Total*	*Per cent of all cases*	*Males*	*Females*	*Total*	*Per cent of cases by category*
Homo-bisexual	2,317	—	2,317	86.5	1,457	—	1,457	87.1
Homo-bisexual IDU(a)	66	—	66	2.5	42	—	42	2.5
Heterosexual contact	27	20	47	1.8	6	9	15	0.9
Heterosexual IDU(a)	25	16	41	1.5	12	7	19	1.1
Haemophilia	39	—	39	1.5	25	—	25	1.5
Blood transfusion(b)	44	34	78	2.9	33	32	65	3.9
Other/undetermined	63	6	69	2.6	35	1	36	2.1
Children under 13								
Mother to child	3	4	7	0.3	—	3	3	0.2
Haemophilia	4	—	4	0.1	2	—	2	0.1
Blood transfusion	9	1	10	0.4	8	—	8	0.5
Total	**2,597**	**81**	**2,678**	**100.0**	**1,620**	**52**	**1,672**	**100.0**

(a) Intravenous drug user. (b) Includes receipt of blood products or tissue.
Source: Australian HIV Surveillance Report.

Employment injuries

The National Occupational Health and Safety Commission (Worksafe Australia) is giving the highest priority in the development of suitable national statistics on work injuries to the implementation of the National Data Set for Compensation-based Statistics (NDS). The NDS recommends a standard set of data items to be collected via the compensation based

collections administered by State/Territory and Commonwealth agencies. It will be substantially implemented in respect of 1991–92 data but full implementation is not expected until July 1992. The Type of Occurrence Classification System, which was developed as part of the NDS, for use in coding details of workers' compensation cases, was released in 1991.

Causes of death

Information relating to crude death rates and life expectancy is contained in the chapter, Demography.

All ages

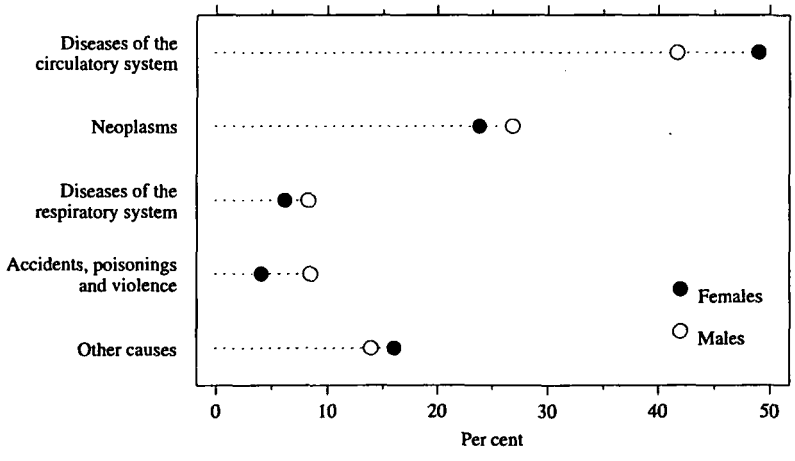
Causes of death in Australia are classified according to the Ninth Revision of the International Classification of Diseases (ICD) produced by the WHO. The statistics in the table below show the number of deaths registered during 1990, classified to broad groupings of causes of death.

The major causes of death in the community in 1990 were diseases of the circulatory system (accounting for 45.2%), neoplasms (25.6%), diseases of the respiratory system (7.5%) and accidents, poisonings and violence (6.6%). In 1990, fewer than one per cent of all deaths were due to infections and parasitic diseases.

The relative importance of groups of causes of death varies with age. Diseases of the circulatory system and neoplasms are predominant in middle and old age. Accidents, particularly those involving motor vehicles, are the primary cause of death in childhood and early adulthood. The majority of infant deaths (59.4% in 1990) occur within less than 28 days of birth.

As well as differing by age, the relative significance of certain causes of death also varies by sex, as illustrated below.

CAUSES OF DEATH: PERCENTAGE DISTRIBUTION, 1990



Source: Causes of Death, Australia (3303.0).

CAUSES OF DEATH IN EACH AGE GROUP, 1990

Causes of death	Age group (years) <1	1–14	15–24	25–34	35–44	45–54	55–64	65–74	>74	Total (a)
NUMBER										
Infectious and parasitic diseases	27	25	21	32	49	52	75	147	374	803
Neoplasms	12	131	147	374	1,112	2,498	5,923	9,462	11,084	30,744
Endocrine, nutritional and metabolic diseases and immunity disorders	10	29	40	159	176	182	386	751	1,434	3,167
Diseases of the nervous system and sense organs	42	66	66	76	69	110	170	422	1,247	2,268
Diseases of the circulatory system	13	27	89	202	621	1,751	5,124	12,399	34,059	54,285
Diseases of the respiratory system	49	37	56	60	111	244	890	2,405	5,147	9,001
Diseases of the digestive system	7	11	7	63	162	290	557	896	2,100	4,094
Congenital anomalies	537	93	45	33	25	22	25	34	26	840
All other diseases(b)	897	11	104	213	141	144	329	803	3,470	6,112
Signs, symptoms and ill-defined conditions	501	17	18	17	22	25	25	30	154	813
Accidents, poisonings and violence	50	444	1,596	1,445	1,039	712	707	688	1,252	7,935
All causes	**2,145**	**891**	**2,189**	**2,674**	**3,527**	**6,030**	**14,211**	**28,037**	**60,347**	**120,062**
RATE(c)										
Infectious and parasitic diseases	10	1	1	1	2	3	5	13	50	5
Neoplasms	5	4	5	13	43	138	406	821	1,472	180
Endocrine, nutritional and metabolic diseases and immunity disorders	4	1	1	6	7	10	26	65	190	19
Diseases of the nervous system and sense organs	16	2	2	3	3	6	12	37	166	13
Diseases of the circulatory system	5	1	3	7	24	97	351	1,076	4,524	318
Diseases of the respiratory system	19	1	2	2	4	13	61	209	684	53
Diseases of the digestive system	3	(d)	(d)	2	6	16	38	78	279	24
Congenital anomalies	204	3	2	1	1	1	2	3	3	5
All other diseases(b)	342	(d)	4	8	5	8	23	70	461	36
Signs, symptoms and ill-defined conditions	191	(d)	1	1	1	1	2	3	20	5
Accidents, poisonings and violence	19	13	58	51	40	39	48	60	166	46
All causes	**817**	**26**	**79**	**95**	**137**	**333**	**974**	**2,433**	**8,015**	**703**
PERCENTAGE(e)										
Infectious and parasitic diseases	1.3	2.8	1.0	1.2	1.4	0.9	0.5	0.5	0.6	0.7
Neoplasms	0.6	14.7	6.7	14.0	31.5	41.4	41.7	33.7	18.4	25.6
Endocrine, nutritional and metabolic diseases and immunity disorders	0.5	3.3	1.8	5.9	5.0	3.0	2.7	2.7	2.4	2.6
Diseases of the nervous system and sense organs	2.0	7.4	3.0	2.8	2.0	1.8	1.2	1.5	2.1	1.9
Diseases of the circulatory system	0.6	3.0	4.1	7.6	17.6	29.0	36.1	44.2	56.4	45.2
Diseases of the respiratory system	2.3	4.2	2.6	2.2	3.1	4.0	6.3	8.6	8.5	7.5
Diseases of the digestive system	0.3	1.2	0.3	2.4	4.6	4.8	3.9	3.2	3.5	3.4
Congenital anomalies	25.0	10.4	2.1	1.2	0.7	0.4	0.2	0.1	(f)	0.7
All other diseases(b)	41.8	1.2	4.8	8.0	4.0	2.4	2.3	2.9	5.8	5.1
Signs, symptoms and ill-defined conditions	23.4	1.9	0.8	0.6	0.6	0.4	0.2	0.1	0.3	0.7
Accidents, poisonings and violence	2.3	49.8	72.9	54.0	29.5	11.8	5.0	2.5	2.1	6.6
All causes	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

(a) Total includes 11 deaths where age is not known. (b) Includes 901 deaths from conditions originating in the perinatal period and 1,888 deaths from diseases of the genitourinary system. (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) Less than 0.5. (e) Percentage of all deaths within each age group. (f) Less than 0.05.

Source: Causes of Death, Australia (3303.0).

Perinatal deaths

Since deaths within less than 28 days of birth (neonatal deaths) are mainly due to conditions originating before or during birth, and the same conditions can cause fetal death (stillbirth), special tabulations are prepared combining the two. These are termed 'perinatal deaths'. The statistical definition of perinatal deaths in Australia was amended in 1979 from that previously used, in accordance with a recommendation of the Ninth Revision Conference (1975) of the WHO 'that national perinatal statistics should include all fetuses and infants delivered weighing at least 500 grams (or, when birth-weight is unavailable, the corresponding gestational age (22 weeks) or body length (25 cm crown–heel)), whether alive or dead'. The table below incorporates a further recommendation of the Conference in that it shows the number of fetal, neonatal and total perinatal deaths in Australia classified by both the main condition in the fetus/infant and the main condition in the mother.

The perinatal death rate for Australia increased from 9.95 per 1,000 total births in 1989 to 10.27 in 1990.

Of the conditions in the child, the three main groups responsible for perinatal deaths were *Hypoxia, birth asphyxia and other respiratory conditions* (36.4% of the total), *Other conditions originating in the perinatal period* (25.7%) and *Congenital anomalies* (20.8%). 41 per cent of all perinatal deaths did not mention any condition in the mother as contributing to the death. Where maternal conditions were reported, 27.6 per cent of all perinatal deaths were reported as being due to *Complications of placenta, cord and membranes.*

PERINATAL DEATHS BY CAUSE, 1990

	Number of deaths			*Rate*		
Cause of death	*Fetal*	*Neonatal*	*Perinatal*	*Fetal(a)*	*Neonatal (b)*	*Perinatal (a)*
Conditions in fetus/infant						
Slow fetal growth, fetal malnutrition and immaturity	100	138	238	0.38	0.53	0.90
Birth trauma	3	27	30	0.01	0.10	0.11
Hypoxia, birth asphyxia and other respiratory conditions	666	322	988	2.52	1.23	3.74
Fetal and neonatal haemorrhage	34	80	114	0.13	0.30	0.43
Haemolytic disease of fetus or newborn	9	4	13	0.03	0.02	0.05
Other conditions originating in the perinatal period	583	113	696	2.21	0.43	2.64
Congenital anomalies	183	381	564	0.69	1.45	2.14
Infectious and parasitic diseases	6	3	9	0.02	0.01	0.03
All other causes	6	54	60	0.02	0.21	0.23
Conditions in mothe						
Maternal conditions which may be unrelated to present pregnancy	221	108	329	0.84	0.41	1.25
Maternal complications of pregnancy	158	321	479	0.60	1.22	1.81
Complications of placenta, cord and membranes	604	144	748	2.29	0.55	2.83
Other complications of labour and delivery	32	23	55	0.12	0.09	0.21
No maternal condition reported	575	526	1,101	2.18	2.00	4.17
All causes						
1990	1,590	1,122	2,712	6.02	4.27	10.27
1989	1,451	1,058	2,509	5.75	4.22	9.95
1988	1,473	1,164	2,637	5.95	4.73	10.65
1987	1,432	1,159	2,591	5.84	4.75	10.56
1986	1,585	1,227	2,812	6.47	5.04	11.48

(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: Causes of Death, Australia (3303.0).

HOSPITALS

Repatriation hospitals and institutions

Details of repatriation hospitals, institutions and other facilities are given in the chapter, Social Security and Welfare.

Mental health institutions

The emphasis has shifted from institutions for care of patients certified insane to a range of mental health services provided for in-patients and out-patients at psychiatric hospitals, admission and reception centres, day hospitals, out-patient clinics, training centres, homes for the mentally ill and geriatric patients, psychiatric units in general hospitals, and the like. The presentation of meaningful statistics of mental health services has become increasingly difficult because of a shift since the 1970s away from institutional care of mental patients. Statistics relating to mental health institutions are available from relevant agencies in most States.

Hospital statistics

A major factor in the cost of health care in Australia is hospital treatment of patients. Attempts to measure the number of in-patients treated and bed-days involved for each disease or injury have been going on for some years, but as coverage is incomplete it is not possible to present national statistics. Figures for New South Wales, Victoria, Queensland, and South Australia however, are published in the ABS publications *Hospital In-patients New South Wales* (4306.1), *Public Hospital Morbidity Victoria* (4301.2), *Hospital Morbidity Queensland* (4303.3) and *In-patient Separations from Recognised Hospitals South Australia* (4308.4) (ABS/SAHC). Statistics for Western Australia, the Northern Territory and the Australian Capital Territory are available from the relevant State and Territory health authorities.

In 1992, the Australian Bureau of Statistics plans to introduce a new national statistical collection to obtain information on facilities, activities, staffing and expenses from all private hospitals in Australia. The first collection will be for the 1991–92 financial year. This information will contribute to the first comprehensive set of national statistics relating to hospitals. The collection is based on the National Minimum Dataset for Institutional Health Care developed by the Australian Institute of Health through the Australian Health Ministers' Advisory Council.

HEALTH INSURANCE AND BENEFITS

Medicare

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 one per cent to 1.25 per cent of taxable income on 1 December 1986.

From 1 July 1991 no levy is payable by single people earning less than $11,745 per annum or by sole parents and married couples with combined income of less than $19,674 per annum, with a further $2,100 per annum allowed for each dependent child.

'Shading-in' arrangements apply in respect of persons with taxable incomes marginally above the threshold.

Medicare benefits

The Health Insurance Act provides for a Medicare Benefits Schedule which lists medical services and a schedule fee applicable in respect of 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 being reviewed through ongoing consultation with the medical profession and it is updated twice yearly to reflect current medical practice.

Medicare benefits are payable at the rate of 85 per cent of the schedule fee services except those to hospital in-patients and for out-of-hospital general practice attendances.

For medical services rendered to private in-patients in hospitals or day-hospital facilities, the level of Medicare benefit is 75 per cent of the schedule fee for each item with no maximum patient gap. The private

health insurance funds cover the remaining 25 per cent (i.e., up to the level of the schedule fee) for insured patients.

Fee-for-service rebates are paid at differential rates if a medical practitioner has been recognised by the Minister for Community Services and Health as a specialist or consultant physician (or psychiatrist) and the patient has been referred by another practitioner. Similar arrangements apply to general practitioners who are vocationally registered.

Currently, Australia has reciprocal health care agreements with the United Kingdom, New Zealand, Italy, Sweden, Malta and the Netherlands whereby Australian visitors to those countries, and from those countries to Australia, are entitled to access the host country's public health system for immediately necessary medical and hospital treatment.

In 1990–91 claims associated with 147 million services were processed by the Health Insurance Commission involving benefit payments of $4,238 million. Summary statistics on benefits paid for medical services are provided below.

MEDICARE: NUMBER OF SERVICES, BENEFITS PAID AND PERCENTAGE OF SERVICES DIRECT BILLED, 1990–91

	NSW	*Vic.*	*Qld*	*SA*	*WA*	*Tas.*	*NT*	*ACT*	*O'seas*	*Aust.*
					— '000 —					
Number of services	56,328	35,178	24,817	11,862	12,008	3,533	840	2,039	12	146,616.7
					— $ million —					
Benefits paid	1,633.0	1,019.5	713.7	351.4	338.6	98.9	23.1	59.9	0.3	4,238.4
					— per cent —					
Direct billed	65.6	55.1	62.9	56.1	60.6	49.8	64.6	46.7	46.2	60.8

Source: Commonwealth Department of Health, Housing and Community Services.

MEDICARE BENEFITS BY BROAD TYPE OF SERVICE, 1990–91
($ million)

Type of service	*NSW*	*Vic.*	*Qld*	*SA*	*WA*	*Tas.*	*NT*	*ACT*	*O'seas*	*Aust.*
GP attendances										
VRGP(a)	244.3	143.5	142.5	76.3	48.4	22.5	2.2	13.7	—	693.4
Non-VRGP	352.5	233.8	121.5	55.5	76.9	17.3	5.9	8.9	0.1	872.3
Other GP	19.9	15.7	10.2	9.3	6.4	1.6	0.2	0.6	—	64.0
Total	*616.7*	*393.0*	*274.3*	*141.1*	*131.7*	*41.5*	*8.4*	*23.2*	*0.1*	*1,629.7*
Specialist attendances	249.8	172.1	96.1	59.9	44.5	14.1	2.2	8.9	—	647.5
Obstetrics	21.0	16.7	8.3	4.5	5.6	1.7	0.6	1.3	—	59.5
Anaesthetics	29.3	24.1	13.7	7.8	6.8	2.2	0.4	1.2	—	85.5
Pathology	251.5	134.7	121.8	42.6	52.6	13.9	5.3	8.5	0.1	630.9
Diagnostic imaging	218.5	122.3	83.9	40.4	46.2	10.9	3.0	8.0	—	533.3
Operations	154.0	101.7	78.1	36.3	32.5	9.3	2.0	5.6	—	419.6
Assistance at operations	5.3	4.7	3.9	2.4	0.7	0.2	0.1	0.2	—	17.5
Radio and nuclear med. therapy	6.6	3.3	2.0	1.5	1.3	0.4	—	0.3	—	15.5
Optometry	36.5	22.8	16.3	7.4	8.5	2.8	0.8	1.5	—	96.7
Miscellaneous	43.8	24.1	15.2	7.6	8.3	1.8	0.3	1.4	—	102.4
Total	**1,633.0**	**1,019.5**	**713.7**	**351.4**	**338.6**	**98.9**	**23.1**	**59.9**	**0.3**	**4,238.0**

(a) Vocationally Registered General Practitioners.
Source: Commonwealth Department of Health, Housing and Community Services.

Hospital benefits

From 1 February 1984, basic public hospital services have been provided free of charge. Under Medicare, in-patient accommodation and care in a shared ward by a doctor employed by a public hospital are provided free of charge, together with a range of casualty and out-patient services. The scheme does not cover hospital charges for private accommodation in a public hospital, private hospital treatment, nor care in a public hospital by a doctor of the patient's choice. It is possible, however, for persons to take out hospital insurance with registered health benefits organisations to cover these situations and Medicare benefits are available for private medical practitioners' charges in respect of those medical services provided in hospital.

Patients who are accommodated in either private or public hospitals for continuous periods in excess of 35 days and who have not been certified as acute care patients, are in essence nursing home-type patients and are required to make a statutory non-insurable patient contribution in the same way that a patient in a nursing home does. For a private nursing home-type patient in a public hospital, fees are reduced and hospital benefits paid by registered health benefits organisations are decreased accordingly. These patients are also required to make the patient contribution. In a private hospital, the benefits are reduced to $100 a day, less the amount of the patient contribution. Any charges by private hospitals in excess of available benefits plus the statutory patient contribution become the responsibility of the patient.

Where a patient's doctor considers that a patient has continuing need of acute care, the doctor may issue a certificate under section 3B of the Health Insurance Act to that effect, and the nursing home-type patient arrangements do not apply. The arrangements also provide for a review mechanism in the form of the Acute Care Advisory Committee which, when requested (e.g., by a private health fund) to do so, may review such certificates and recommend that they be varied or revoked.

Since 1 October 1986 basic health insurance benefits for patients in private hospitals have been structured according to a system of patient classification. Under this system, basic health insurance benefits are set to more appropriately relate hospital costs to the actual medical needs (i.e., complexity of service) of patients. Initially there were three classification groupings: advanced surgical, surgical/obstetric and other (medical) patients. These groupings were expanded from 1 March 1987 to include psychiatric and rehabilitation patients. Additional supplementary health insurance benefits for higher private hospital charges are similarly orientated towards the patient classification model.

Health insurance coverage

Surveys about the levels and types of private health insurance cover in the Australian community have been conducted for the years 1979–84, 1986, 1988 and 1990. The 1984 survey covered employed wage and salary earners in capital cities only.

Results of the June 1990 survey showed that 52.0 per cent of the population was covered by private health insurance, with 47.7 per cent covered for hospital expenses and 41.9 per cent for expenses associated with ancillary services such as dental, physiotherapy and ambulance. However, as shown below the proportion covered and the types of cover held differed markedly according to the type of contributor unit to which the persons belonged.

CONTRIBUTORS: COMPOSITION OF UNIT(a) BY TYPE OF PRIVATE HEALTH INSURANCE JUNE 1990

Composition of contributor unit	With private health insurance: Hospital and ancillary	Hospital only	Ancillary only	Type of insurance not known	Total	Without private health insurance	Total
				— '000 —			
Contributor only	1,117.2	365.3	124.1	39.0	1,645.5	2,568.6	4,214.2
Contributor and dependant children	188.7	23.8	30.7	18.4	261.5	824.2	1,085.7
Contributor and partner only	1,383.5	460.7	97.8	19.7	1,961.7	1,631.3	3,593.0
Contributor, partner and dependant children	3,868.9	772.0	376.2	30.9	5,048.0	3,196.2	8,244.2
Total(b)	**6,558.3**	**1,621.7**	**628.8**	**108.0**	**8,916.7**	**8,220.4**	**17,137.1**
				— per cent —			
Contributor only	26.5	8.7	2.9	0.9	39.0	61.0	100.0
Contributor and dependant children	17.3	2.2	2.8	1.7	24.1	75.9	100.0
Contributor and partner only	38.5	12.8	2.7	0.5	54.6	45.4	100.0
Contributor, partner and dependant children	46.9	9.4	4.6	0.4	61.2	38.8	100.0
Total(b)	**38.3**	**9.5**	**3.7**	**0.6**	**52.0**	**48.0**	**100.0**

(a) A contributor unit consists of a contributor plus all persons in the same family who are covered by the health insurance arrangements of the contributor. The term also applies to those families or members within families not covered by private health insurance. (b) Includes dependant members or contributor units reporting single rate insurance who were not therefore covered by that insurance and are not included elsewhere in the table.

Source: Health Insurance Survey, Australia (4335.0).

COMPARISON OF NUMBER OF PERSONS WITH PRIVATE HEALTH INSURANCE 1983 TO 1990

	March 1983	March 1986	June 1988	June 1990
		— '000 —		
With private health insurance	9,671.1	8,208.1	8,302.1	8,916.7
Without private health insurance	4,904.9	7,170.1	7,650.9	8,220.4
Total(a)	**14,781.2**	**15,457.2**	**15,967.4**	**17,160.2**
		— per cent —		
With private health insurance	65.4	53.1	52.0	52.0
Without private health insurance	33.2	46.4	47.9	47.9
Total(a)	**100.0**	**100.0**	**100.0**	**100.0**

(a) Includes persons for whom insurance details were unknown.

Source: Health Insurance Survey, Australia (4335.0).

Pharmaceutical Benefits Scheme (PBS)

The Scheme was established under the provisions of the *National Health Act 1953* and provides a large range of drugs and medicinal preparations. These can be prescribed by medical and dental practitioners for Australian residents. 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 should pay no more than $15.70, for the same medicine. (These figures are adjusted for inflation once a year.)

If the patient is a pensioner or other client of either the Department of Social Security, or the Department of Veterans' Affairs they should have one of the following approved concession cards:

- Pensioner Health Benefits Card;
- Health Benefits Card;
- Pharmaceutical Benefits Concession Card;
- Health Care Card; and
- Veterans' Affairs Lilac or Red Cards.

These cards entitle the pensioner to pay no more than $2.60 for each prescription item. A compensatory payment of $2.60 per week is added to the pension to cover this cost.

There is a safety net limit on payments for PBS medicines. It is especially designed for people who are chronically ill and for families who have a lot of unexpected sickness in a particular year.

The safety net limit varies according to the patient's circumstances, but for most families it is $350 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 $300 on PBS medicines in a year, they need only pay $2.60 for additional PBS items. When they have spent another $50 in this way they will be able to get PBS medicines free for the rest of the calendar year.

If the patient holds one of the special concession cards listed earlier, the safety net limit is $130 per calendar year similarly adjusted for inflation. When the patient has spent $130 on PBS medicines for themselves or his/her dependants they can get further PBS medicines free for the rest of the year.

In 1990–91, the total cost of the PBS, including patient contribution of prescriptions processed for payment, was $1,315 million. This figure does not include the cost of drugs supplied through special arrangements, such as the Royal Flying Doctor Service, methadone maintenance programs and hormone treatment programs.

BENEFIT PRESCRIPTIONS AND COST OF MORE FREQUENTLY PRESCRIBED DRUG GROUPS 1990–91

	Prescriptions		*Total cost of prescriptions(a)*	
Drug group	*('000)*	*Per cent*	*$'000*	*Per cent*
Anti-asthmatics and anti-bronchitics	9,116	9.65	131,535	10.00
Non-steroidal anti-inflammatory drugs	7,304	7.73	81,835	6.22
Benzodiazepines, sedatives and hypnotics	6,498	6.88	30,577	2.32
Antihypertensives	6,194	6.56	194,377	14.78
Penicillins	5,449	5.77	68,423	5.20
Beta-blockers	4,257	4.51	46,585	3.54
Anti-anginals	4,177	4.42	79,096	6.01
Diuretics	3,574	3.78	35,458	2.70
Anti-depressants	3,247	3.44	21,349	1.62
Non-narcotic analgesics	3,243	3.43	18,624	1.42
Water, salts and electrolytes	2,517	2.66	18,274	1.39
Topical corticosteroids	2,270	2.40	13,266	1.01
Narcotic analgesics	2,013	2.13	13,146	1.00
Oral contraceptives	1,931	2.04	22,115	1.68
Tetracyclines	1,830	1.94	16,569	1.26
Antacids	1,739	1.84	13,203	1.00

For footnotes *see* end of table.

BENEFIT PRESCRIPTIONS AND COST OF MORE FREQUENTLY PRESCRIBED DRUG GROUPS 1990–91 — *continued*

	Prescriptions		*Total cost of prescriptions(a)*	
Drug group	*'000*	*Per cent*	*$'000*	*Per cent*
Drugs for gastric and duodenal ulcers	1,709	1.81	73,520	5.59
Anti-emetics	1,655	1.75	9,360	0.71
Eye anti-irritants and anti-allergics	1,512	1.60	10,520	0.80
Other eye preparations	1,498	1.59	15,661	1.19
Topical antifungals	1,287	1.36	7,972	0.61
Anti-hyperlipidaemics	1,230	1.30	49,765	3.78
Sulphonamides and urinary antiseptics	1,182	1.25	10,052	0.76
Other sex hormones	1,163	1.23	22,548	1.71
Other anti-diabetics	1,102	1.17	14,551	1.11
Cephalosporins	1,017	1.08	11,012	0.84
Systemic corticosteroids	1,016	1.07	9,229	0.70
Other drug groups	14,755	15.62	276,768	21.04
Total	**94,484**	**100.00**	**1,315,389**	**100.00**

(a) Includes patients' contributions. Excludes government expenditure on miscellaneous items. Excludes prescriptions for extemporaneously prepared items.

Source: Commonwealth Department of Health, Housing and Community Services.

NATIONAL HEALTH STRATEGY

The Minister for Health, Housing and Community Services, announced the establishment of the National Health Strategy on 21 August 1990. The aim of the strategy is to refine and improve Medicare, deal with pressures in the health system, and combat future problems.

The strategy's terms of reference cover:

- the distribution of health costs and their impact on individuals and families;
- factors creating demand for medical services, and options to contain costs at reasonable levels;
- identification of the causes of the increasing demand for and costs of hospital services and of options to contain demand and cost while maintaining accepted standards of quality and access;
- the role of the private sector, particularly private hospitals and private health insurance, in relation to Medicare and the Australian health care delivery system;
- methods to stimulate an increased focus on preventive services and integrate them with community services and hospital and medical services;
- service delivery systems that better integrate health and community services;
- the effect of current financial and organisational arrangements on effective health care delivery; and
- the balance between supply and demand for health workers.

The strategy is exploring the arrangements under which health services are funded by a variety of measures involving the Commonwealth Government, State and Territory Governments, private health insurance and patient contributions. In particular, the strategy is examining how fragmentation of responsibility, uncertainty due to artificial boundaries, historical arrangements, and undefined roles between the Commonwealth, the States and Territories, and the public and private sectors have hindered efficient health care planning and delivery.

The strategy will be developed over two years and will report progressively to the Government.

COMMONWEALTH GOVERNMENT SUBSIDIES AND GRANTS TO ORGANISATIONS

The Commonwealth Government gives financial assistance to certain organisations concerned with public health. Examples of organisations included in this category are outlined below.

Commonwealth Government funding of hospitals

In 1990–91 hospital funding grants by the Commonwealth Government, totalling $3,617 million to the States and Territories, provided $3,542 million for hospital and related services; $41 million for incentives in the areas of post-acute and palliative care and day surgery procedures; $29 million towards hospital care for AIDS patients; and $4 million to enable the development of a case mix based system as a management information system and potentially as a prospective payment system.

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 in major metropolitan areas. The Commonwealth has allocated $7 million over four years to this program ($14 million when cost shared with States and Territories).

Emphasis is being placed on community involvement in service delivery, and on the coordination of this Program with other Commonwealth and State programs directed at homeless youth.

The ultimate objective of the Program is to encourage a more positive attitude among homeless young people towards their personal health care.

Family planning program

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; seminars; conferences; and research. The Commonwealth allocation for family planning in 1991–92 will be $13.9 million.

Women's health

In addition to the following, the section on the national health survey earlier in this chapter contains statistics on certain women's health issues.

National Women's Health Program

This Program, which commenced in 1989–90, is a four year, $33.7 million program which 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. The Program is cost shared with the States and Territories on a dollar for dollar basis. The Program provides funding to the following components: improvements in health services for women, establishment of an information and education strategy and for the provision of training and education on women's health issues for health care professionals.

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.

Women's Health Services (Rural) Program

$0.4 million has been provided over three years, 1989–92, to enable Frontier Services in conjunction with the Royal Flying Doctor Service to develop a program to improve access to health services for women in western New South Wales, south-west Queensland and north-west Western Australia.

National Program for the Early Detection of Breast Cancer

In 1990, the Commonwealth Government committed $64 million in the first three years of the program to be implemented over five years. The goal of the program is to reduce mortality and morbidity from breast cancer which is a major cause of death amongst women.

A national network of dedicated and accredited breast cancer screening and assessment services is being established within each participating State or Territory to provide screening to women over 40 years of age.

Following a start-up phase in which the Commonwealth provided $11.4 million to establish or expand screening services, the Program will be cost shared equally between the Commonwealth Government and State/Territory Governments.

National Health Promotion Program

Under the National Health Promotion Program (NHPP), the Commonwealth provides funding for projects which develop and promote effective strategies for health promotion and disease prevention, focusing on special risk factors and different population groups.

Projects funded under NHPP must be national in application and focus and be consistent with national health goals. Projects funded in 1990–91 included the development of a post-graduate health promotion course and prevention of falls and musculoskeletal injuries among older adults. Other projects focused on asthma, diabetes, dental disease and targeted people from non-English speaking backgrounds, children and adolescents and the socially disadvantaged.

Funds appropriated to this program during 1990–91 amounted to $1.7 million.

National Better Health Program

The National Better Health Program (NBHP) is a health promotion program currently being implemented across Australia by the Commonwealth Government, State and Territory Governments.

The current NBHP agreement began in July 1988 and will run to June 1992. The funds are cost shared between the Commonwealth and States/Territories and total $39 million over the four years of the Program. In the first four years it has focused on action in five priority areas:

- injury;
- hypertension;
- health of the elderly;
- nutrition; and
- preventable cancers.

The Program is aiming to develop innovative projects and strategies in the five priority areas which can be used by States/Territories and community organisations as model intervention programs.

Royal Flying Doctor Service

The Royal Flying Doctor Service is a non-profit organisation providing medical and emergency evacuation services in remote areas of Australia. It is distinct from, but coordinates with, the Aerial Medical Service which is operated by the Northern Territory Government. The Royal Flying Doctor Service is financed mostly from donations and government contributions. For the year ended 30 June 1991 the Commonwealth Government paid grants totalling $10.7 million towards operational costs and assistance of $1.8 million towards an approved program of capital expenditure.

Red Cross Blood Transfusion Service

This service is conducted by the Australian Red Cross Society throughout Australia. The operating costs of the service in the States and Territories are met by the State or Territory Government paying 60 per cent, the Society five per cent of donations, and the Commonwealth Government meeting the balance. Approved capital expenditure by the service is shared on a dollar for dollar basis with the State and Territory Governments. Commonwealth Government expenditure for all States and Territories during 1990–91 was $29.7 million being $26.7 million for operating costs and $3.0 million for capital costs.

National Heart Foundation of Australia

The Foundation is a voluntary organisation, supported almost entirely by public donations, established with the objective of reducing the toll of heart disease in Australia. It approaches this objective 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 1990 was $25.9 million of which $19.9 million was from public donations and bequests. Commonwealth, State and semi-government authorities made grants of $0.6 million for specific projects conducted by the Foundation. Since the inception of the Foundation, research has been a major function and a total of $5.4 million was expended in 1990 in grants to university departments, hospitals and research institutes and for fellowships tenable

in Australia and overseas. It is notable however that with increasing opportunities for prevention and control of heart disease, the Foundation's education and community service activities are increasing significantly. In 1990 the expenditure on research, education and community service totalled $10.8 million.

In 1989 the National Heart Foundation repeated its 1980 and 1983 surveys of risk factor prevalence in Australia. The 1989 Risk Factor Prevalence Survey asked over 9,000 randomly selected adults aged 20 to 69 living in Australian capital cities about factors related to heart health, such as exercise, smoking and dietary habits. They also had their weight, blood pressure and blood cholesterol levels checked. The survey was undertaken in collaboration with the Australian Institute of Health and Commonwealth Department of Health, Housing and Community Services. A major analysis of trends in risk factor prevalence over the three surveys is in progress. Copies of the report of the 1989 survey can be obtained from National Heart Foundation offices.

World Health Organization (WHO)

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 contribution to WHO for 1991 was $US4,782,650.

International Agency for Research on Cancer (IARC)

The IARC was established in 1965 within the framework of the World Health Organization. The headquarters of the agency are located in Lyon, 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 1991 was $US755,639.

NATIONAL HEALTH SERVICES AND ADVISORY ORGANISATIONS

Australian Health Ministers' Conference and the Australian Health Ministers' Advisory Council

The Australian Health Ministers' Conference (AHMC) and its advisory body, the Australian Health Ministers' Advisory Council (AHMAC) provide a mechanism for the Commonwealth Government, and State and Territory Governments to discuss matters of mutual interest concerning health policy, services and programs. Neither the Conference nor the Council has statutory powers, and decisions are reached on the basis of consensus. Their constitution rests on the formal agreement by the Commonwealth Government, and State and Territory Governments of the membership and functions.

The AHMC comprises the Commonwealth, State and Territory Health Ministers. Other Commonwealth Ministers may be invited to speak on items relevant to their portfolio. The New Zealand and Papua New Guinea Health Ministers may attend meetings as observers.

Health services organisations

Australian Radiation Laboratory

The Laboratory is concerned with the development of 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 radioactivity;
- 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 ionising and non-ionising radiations which have implications for public and occupational health.

Therapeutic Goods Administration

The Therapeutic Goods Administration (TGA) is an organisation within the Department of Health, Housing and Community Services. 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 the development of standards.

In 1990–91 tests were performed on 1,212 products for human use to check compliance with official standards. A total of 170 of these products failed to comply. Investigations were also conducted on 592 reported drug and device problems. These investigations resulted in the recall of 45 drug products and 102 device products.

National Health and Medical Research Council (NHMRC)

The NHMRC advises the Commonwealth Government and State Governments on matters of public health administration and the development of standards and guidelines for pesticides, agricultural chemicals, water and air. It also advises the Commonwealth Government and State Governments on matters concerning the health of the public and on the merits of reputed cures or methods of treatment which are from time to time brought forward for recognition. The objective of the NHMRC is to advise the Australian community on the achievement and maintenance of the highest practicable standards of individual and public health and to foster research in the interests of improving those standards.

The Council has nominees of State and Territory health authorities, professional and scientific colleges and associations, unions, universities, business, consumer groups, welfare organisations, the Commonwealth administration, including the Aboriginal and Torres Strait Islander Commission, and conservation groups. The Council meets twice a year to consider and make decisions on reports from committees and working parties.

The NHMRC funds medical and public health research in Australia and supports many of the medical advances made by Australians. NHMRC is currently funding 948 research projects as well as providing block funding for several major research centres and institutes.

The Council advises the Commonwealth Minister for Health, Housing and Community Services on medical research and on the application of funds from the Medical Research Endowment Fund. NHMRC research funding is on a triennial arrangement. Expenditure for 1990–91 for medical research was $95 million. Funds are also appropriated for public health research through the Public Health Research and Development Committee. Expenditure in 1990–91 was $3.7 million. Expenditure on priority research areas for 1991 totalled $1.8 million.

Communicable Diseases Network—Australia

The Communicable Diseases Network—Australia was established in 1990 under the auspices of the National Health and Medical Research Council and the Australian Health Ministers' Advisory Council to enhance the national capability in communicable disease control. The Network's functions include: the collection, analysis and dissemination of surveillance information on communicable diseases, the coordination of responses to epidemic or endemic problems, development of policy recommendations for the NHMRC and AHMAC, and the training of public health professional staff.

Surveillance of communicable diseases is conducted using data derived from four major sources: notifiable diseases surveillance carried out by States and Territories, the Communicable Diseases Intelligence laboratory reporting schemes, reports from sentinel general practices (Australian Sentinel Practice Research Network of the RACGP), and from specialised schemes such as the Central Malaria Register.

Quarantine and inspection

The Australian Quarantine and Inspection Service (AQIS) carries significant health related responsibilities in export inspection and quarantine administration.

Export inspection activities devolve from the *Inspection Export Act 1982*. 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. It aims at ensuring that exported foodstuffs meet overseas health and food safety requirements where these require official monitoring in the country of origin and that such foods are generally wholesome, fit for consumption and accurately described. It also aims at ensuring inspected products meet overseas quarantine provisions imposed for human, animal and plant health protection. AQIS provides a domestic inspection role for most meat produced for domestic consumption, except production in Queensland and Western Australia, and for dried fruits produced for domestic consumption. The total value of products inspected annually is over $9 billion, exports making up over $8 billion of this.

AQIS' quarantine activities devolve from the *Quarantine Act 1908* and the *Biological Control Act 1984*. Human health quarantine functions are administered on behalf of the Commonwealth Department of Health, Housing and Community Services.

Quarantine activities are contracted to State Departments of Agriculture on the Commonwealth's behalf, and include both monitoring and surveillance elements. Monitoring covers incoming passengers, live animals, cargo and mail as well as incoming ships and aircraft. In summary, it involves clearance of over 4.8 million passengers arriving in Australia each year (growing at an annual rate of 6%) and over 32 million tonnes of sea and air cargo. The discharge of ballast water from overseas shipping, estimated at some 66 million tonnes annually, poses a particular quarantine risk which is subject to specific control arrangements. Imports of biological materials for research, diagnosis and industry are also controlled.

Consignments of all judged high risk imported foods are also subject to food inspection. Since July 1990, AQIS sampled over 2,500 consignments of risk-categorised foods with over 200 failing to meet Australian food safety standards. Principal problems have been microbiological problems in cooked prawns and other crustaceans, molluscs, coconut and black pepper; high aflatoxins levels in peanuts; and heavy metal and pesticide residues in fish, peanuts and seaweed. The results have been used to target problem overseas suppliers and as a basis for negotiation with overseas authorities on possible actions. Where overseas government inspection systems can be shown to provide equivalent safety assurances to Australia's, food accompanied by that agency's certification, entry is allowed without routine testing on arrival. Three such agreements were finalised in 1990–91.

The Australian National Parks and Wildlife Service coordinates and administers with AQIS the introduction and release of biological control agents aimed at combating existing pest and disease problems in Australia under the Biological Control Act.

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

AQIS has a significant international involvement in the development of international food safety standards and related additions of hygiene and manufacturing practice by the Joint FAO/WHO Food Standards Program (Codex Alimentarius Commission), and in the development of international plant and animal and plant quarantine and disease control approaches and animal welfare protocols in such international bodies as the Office of International des Epizooties (OIE) and the International Plant Protection Convention (IPPC) and its subsidiary bodies.

Australian Institute of Health (AIH)

The Institute, established in 1987, is a statutory authority within the Health, Housing and Community Services portfolio. It is a Commonwealth health statistics and research agency which, as part of its national role, also provides support to the States and Territories in these areas primarily through the Australian Health Ministers' Advisory Council.

The mission of the Institute is to contribute to the improvement of the health of Australians and to the efficient use of resources in the provision of health services, including those directed at health promotion and illness prevention, by pursuing its legislative mandate to:

- collect and assist in the production of health related information and statistics;
- conduct and promote research into the health of Australians and their health services;
- undertake studies into the provision and effectiveness of health services and technologies; and
- make recommendations on the prevention and treatment of diseases and the improvement and promotion of health and health awareness of the people of Australia.

The Institute also has responsibility for collation, analysis and publication of national welfare services, community services, and housing assistance statistics.

In addition, the Institute has four external units.

The AIH National Injury Surveillance Unit is based in Adelaide with affiliation with Flinders University. The Unit's main role is to improve the availability of statistics relating to injury control and for monitoring the effectiveness of new initiatives.

The AIH National Perinatal Statistics Unit, based at the University of Sydney, collects national data on perinatal health and mortality and on congenital anomalies, conducts epidemiological studies in this field, and operates a register of IVF (in-vitro fertilisation) pregnancies.

The AIH Dental Statistics and Research Unit at the University of Adelaide undertakes statistical collection and research on oral health, the dental labour force and on dental health status.

The AIH National Reference Centre for Classification in Health currently being established at the Queensland University of Technology, is a national resource centre for matters relating to disease classification.

Details of the activities of the Institute are available from its annual reports. The Institute also publishes a biennial report entitled *Australia's Health.*

National Occupational Health and Safety Commission (NOHSC)

The National Commission (known by its working title as *Worksafe Australia*) is a tripartite body comprising representatives of the Commonwealth Government, State and Territory Governments, and peak employee and employer bodies.

It is a statutory authority established by the Commonwealth Government to develop, facilitate and implement national occupational health and safety strategies and to seek the development of national uniform occupational health and safety standards.

NOHSC has specified six priority hazard areas — occupational back pain, noise-induced hearing loss, management of chemicals used at work, occupational skin disorders, occupational cancer and mechanical equipment injuries.

The activities of the organisation include the following:

- the development of national occupational health and safety standards and codes of practice;
- administration of the National Industrial Chemicals Notification and Assessment Scheme;
- national statistical responsibilities in the field of occupational health and safety;
- multidisciplinary research (including epidemiology, biostatistics, occupational psychology, ergonomics and toxicology);
- teaching responsibilities through a Master of Occupational Health and Safety course and several non-academic short courses, symposia and workshops for occupational health and safety practitioners;
- training and education through the development of national skills standards and teaching resource materials, study awards, and by encouraging the inclusion of occupational health and safety training in school and post-secondary courses; and
- the collection, analysis and dissemination of occupational health and safety information services and products.

National Campaign Against Drug Abuse (NCADA)

The National Campaign Against Drug Abuse (NCADA), is a program aimed at minimising the harm caused to Australian society by the misuse of drugs, both licit and illicit.

A feature of the Campaign, and one which differentiates it from previous approaches in Australia and the approach used by a number of other nations, is its focus on both the reduction of the demand for drugs and on the control of drug supply.

The Campaign was launched following the special Premiers' Conference on Drugs in April 1985, when all Governments — Commonwealth, State and Territory — committed themselves to this initiative, involving both the allocation of new financial resources and new ways of addressing drug problems in Australia. The strategy addresses alcohol and other drug problems through a partnership of governments and between the government and non-government sectors.

The Commonwealth contributed $38 million in 1991–92, of which $25.3 million was allocated to the States and Territories which matched it on a dollar for dollar basis, and $12.7 million to national initiatives in the areas of prevention, including The Drug Offensive, data management and research.

During 1991–92, over 380 separate projects were funded under the Commonwealth–State cost sharing arrangements. These projects cover such areas as education, training, residential and non-residential treatment, community development and consultancy, research, evaluation and monitoring.

The range of projects involved reflects the diversity of drug abuse problems in Australia, and the recognition by NCADA of the special needs of groups within the community such as youth, Aboriginal people, prisoners, women, intravenous drug users and people of non-English speaking background.

Information research and evaluation are central parts of the national NCADA activities and include:

- a national media information campaign, 'The Drug Offensive', which is aimed at increasing public awareness of the harm caused by drugs and providing information on them through campaigns such as the pharmaceutical campaign and the young women and smoking campaign;
- provision of almost $6.8 million in support of 118 research projects since 1985;
- establishment of two national centres for drug research — the Commonwealth in 1991–92 allocated $1.7 million per annum to a Sydney-based centre for drug treatment and rehabilitation, and to the Perth-based centre on research into the prevention of drug abuse;
- a National Drug Abuse Data System which aims to provide reliable information on the nature and extent of drug abuse in order to help identify needs, priorities and monitor NCADA's achievements; and
- establishment of a national Centre for Education and Training on Addictions to undertake training and research activities to meet the needs of those involved in the treatment/rehabilitation of people with drug and alcohol addiction problems.

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FOR MORE INFORMATION

The ABS has a far wider range of information on Australia than that contained in the *Year Book*. Information is available in the form of regular publications, electronic data services, special tables and from investigations of published and unpublished data.

For further information contact ABS Information Services at one of the addresses listed on the page facing the Introduction to the *Year Book*.