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# Introduction

This chapter provides information on various aspects of the health of the Australian population and the activities of government and other bodies relating to health.

At the national level, health services in Australia are administered by the Commonwealth Government, through two ministers appointed to the Portfolio of Health and Family Services. The Minister for Health and Family Services takes an overview role for the whole portfolio and is responsible for most of the health services, including Medicare benefits, pharmaceutical benefits, hospitals, private health insurance and medical workforce issues, public health, and Aboriginal health issues. The Minister for Family Services is responsible for certain services, including family and children's services, aged and community care services, and disability programs.

The Minister for Veterans' Affairs also administers health services for ex-service personnel and their dependants.

The State and Territory Governments are heavily involved in the direct provision of health services. 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 States/Territories, the responsibility for health services is shared by several authorities, while in others one authority is responsible for all these functions.

Local governments are also involved in the delivery of some health services. Private, non-governmental organisations (both non-profit and for profit) also provide health services. Most medical and dental care is provided by private, non-salaried practitioners.

The reform agenda of the Council of Australian Governments (COAG), agreed to at a meeting of Commonwealth and State/Territory Health and Community Services Ministers in June 1996, aims to shift the focus of health and community services from programs to people, through a partnership between the Commonwealth and the States/Territories. This process is likely to see a change in the role of the Commonwealth, with direct service provision becoming more commonly the preserve of the States and Territories, while the Commonwealth's role will lie more in setting directions, approving methods to measure and report on outcomes and providing leadership in the sector as a whole.

The COAG reforms will be consistent with the principles of Medicare (Australia's universal system of health insurance), including universal coverage, bulk billing, free access to public hospital care, access to doctor of choice for out of hospital care, and (within the scope of accepted clinical practice) maintenance of the general professional freedom of medical practitioners to identify the appropriate treatment for their patients.

The Commonwealth will take a national leadership role in relation to public health standards and health research, with the States/Territories primarily responsible for managing and co-ordinating the provision of services and for maintaining direct relationships with most providers. Five National Health Priority Areas have been agreed between the Commonwealth and the States/Territories cancer, diabetes, cardiovascular disease, injury prevention and mental health.

The chapter uses data from the most up-to-date sources available. For data from the 1989–90 National Health Survey, readers are referred to the *Health Chapter* of *Year Book Australia*, 1995. Data from the 1995 National Health Survey will be available from late 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.

	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 and over	45.0	49.2

#### 8.1 PERSONS WHO WERE OVERWEIGHT OR OBESE, 18 Years and Over

Source<sup>-</sup> 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 a 1994–95 survey, 64% of respondents aged 18 years and over reported that they exercised regularly. An estimated 36% or 4.5 million people 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 five years between 1989–90 and 1994–95, 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	ADULTS	WHO	EXERCISE	
-----	--------	-----	----------	--

	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 and 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%). Twice as many young adults (aged 18–34 years) were smokers (31.2%) as adults aged 55 years and over (15.5%).

8.3 ADULTS	S WHO 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 and 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, nearly twice as many men drank 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 ADULTS WHO DRINK AT RISK LEVEL
------------------------------------

	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 and over	7.7	5.3

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

#### Use of illicit drugs

The 1995 National Drug Strategy Household Survey found that, of persons aged 14 years and over, respondents were most likely to have ever tried marijuana/hash (31%). The next highest category was amphetamines (6%). About 13% of respondents had used marijuana/hash in the 12 months prior to the Survey and 2% had used amphetamines. In the 12 months before the Survey each of the following drugs had been used by less than 1% of respondents: cocaine/crack, hallucinogens, inhalants, ecstasy/designer drugs and injected drugs.

The 1995 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 28% and 31% respectively of respondents. 13% mentioned alcohol, 7% mentioned cocaine, 4% mentioned amphetamines and 5% mentioned tobacco.

#### **Use of medication**

The Drug Utilization Sub-Committee (DUSC), which maintains a database that estimates community use of prescription drugs in Australia, reports that 173 million prescriptions were dispensed in 1995. Of the 10 most commonly used prescription drugs in the community, two were antibiotics, two were pain relievers, and two were used in the management of high blood pressure. Other commonly prescribed types of medication were for the treatment of asthma, the management of duodenal and gastric ulcers, insomnia and a cholesterol-lowering drug.

Drug	Description	No. of prescriptions
Amoxycillin	Antibiotic	5 486 899
Paracetamol(a)	Pain relief	4 481 606
Salbutamol(b)	Used in the management of asthma	4 443 674
Codeine with paracetamol(a)	Pain relief	3 992 924
Amoxycillin with clavulanic acid	Antibiotic	3 406 177
Enalapril	Used in the management of high blood pressure	3 263 712
Ranitidine	Used in the treatment of duodenal and gastric ulcers	3 226 265
Temazepam	Sedative commonly used in the treatment of insomnia	3 166 052
Atenolol	Used primarily in the management of high blood pressure	2 821 407
Simvastatin	Cholesterol-lowering drug	2 756 541

#### 8.5 MOST COMMONLY USED PRESCRIPTION DRUGS - 1995

(a) This drug is available without a prescription, therefore the number of prescriptions for this drug understates actual community use. (b) Includes an estimate of over the counter use in those States where it is an S3 recordable drug.

Source: Department of Health and Family Services, Drug Utilization Sub-Committee (DUSC) database, 1995.

# **Children's health**

#### Children's immunisation

Immunisation coverage goals for Australia for the year 2000, recommended by the National Health and Medical Research Council (NH&MRC), call for 90% or more coverage of children at two years of age and near universal coverage of children at school-entry age against Diphtheria, Tetanus, Pertussis (Whooping cough), Poliomyelitis, Measles, Mumps, Rubella and Hib (*Haemophilus influenzae* type b).

A national survey conducted by the Australian Bureau of Statistics in April 1995 collected information about the coverage and practices associated with the immunisation of children against those diseases. Immunisation levels were calculated using the NH&MRC's current Standard Childhood Vaccination Schedule (August 1994). To be considered fully immunised against a particular condition, a child must have received the specified number of vaccinations against that disease appropriate for his/her age. To be classified as fully immunised against all conditions, a child must have received the specified number of vaccinations against all conditions listed on the recommended vaccination schedule, appropriate for his/her age. The majority of information collected related to children aged three months to six years.

As shown in table 8.6, levels of fully immunised cover were generally similar for males and females but differed between conditions, in part reflecting the single or multiple dose vaccines involved. The relatively low proportions of children fully immunised against Hib may reflect its recent inclusion in the recommended schedule.

For most conditions, the proportion of children fully immunised declined sharply with age, from high levels at infancy. In part this reflects a failure to obtain the follow-up/booster vaccinations as recommended in the schedule, and in part it reflects changes to the schedule which have been introduced in recent years.

8.6	FULLY IMMUNISED CHILDREN,	3 Months-6 Years,	Condition by Sex
	Apr	il 1995	

Total	68.6	59.9	82.6	91.6	89.6	75.5	50.2
Females	69.4	60.4	83.4	92.0	90.6	80.3	50.5
Males	67.9	59.5	81.8	91.2	88.6	71.0	49.9
	Diptheria/ Tetanus %	Pertussis %	Polio %	Measles %	Mumps %	Rubella %	Hib %

Source: Children's Immunisation, Australia (4352.0).

#### 8.7 FULLY IMMUNISED CHILDREN, 3 Months–6 Years, Condition by Age — April 1995

	Diptheria/ Tetanus	Pertussis	Polio	Measles	Mumps	Rubelia	Hib
Age	%	%	%	%	%	%	%
36 months	92.5	92 0	92 0				76 3
Total less than 1 year	84.0	82 7	83.1				55.4
1 year	88.5	86.2	86 3	85.5	84.7	79.6	62.3
2 years	63.0	57.5	86 9	91.4	90.1	81.1	52 4
3 years	61.5	55 6	87.9	92.8	90.7	79.7	54.7
4 years	64.5	57 4	86.9	93.9	90.7	77.6	578
5 years	77.3	68.4	86.5	93.7	92.2	72.5	43.2
6 years	45.2	17 2	60.2	91.7	88.4	62.8	26.6

Source: Children's Immunisation. Australia (4352.0).

Children of couple families with higher weekly income and who spoke English at home were more likely to be fully immunised than children of other families.

#### Children's health screening

Screening of children for particular disorders is important as early detection may enable preventive measures to be taken to stop or slow further development of a problem, or facilitate early intervention to minimise the effects of a

disorder. The national survey conducted by the Australian Bureau of Statistics in April 1995 also identified the levels and patterns of testing of sight and hearing, consultations with dental professionals and visits to baby health clinics.

As shown in table 8.8, 63% of children aged 0-14 years were reported as having had their sight tested, and 66% as having had their hearing tested at some time in their lives, and 75% of children 2-14 years had visited a dental professional.

8.8 CHILDREN AGED 0–14, Type of Test by Age — April 1995											
-	Less than 2 years %	2–4 years %	5–9 years %	10-14 years % 63.1 16.2 7 5 11.8 1.4 96.6 3.3 *0 1	Total %						
Whether has ever had sight and/or hearing tests											
Both sight and hearing tests	28.4	33.7	63.1	63.1	52.6						
Sight tests only	4.9	4.7	9.1	16.2	10.0						
Hearing tests only	17.3	22.6	12.0	7 5	13.3						
Neither sight nor hearing	48.7	38.2	14.9	11.8	23.1						
Other(a)	0.7	0.9	0.9	1.4	1.0						
Whether has ever visited a dentist or dental professional(b)											
Has visited		22.5	85.1	96.6	75.0						
Has not visited		77.3	14.7	3.3	24.8						
Not known		*0.2	0.2	*0.1	0.2						

(a) Includes not known if tested, and type of test not stated. (b) Data relating to dental visits refers to children aged 2-14 years. Source: Children's Health Screening, Australia (4337.0).

For children aged 0–3 years, a large proportion of health screening procedures is undertaken at baby health clinics (centres). The National Health and Medical Research Council recommends checks at 6–8 weeks, 4 months, 6 months and 12–18 months of age.

About 90% of children aged 0–3 years had visited a baby health clinic at some stage in their life, the majority (69%) had visited prior to age 4 weeks. 'Check-up' was the most commonly reported reason for visiting a baby health clinic (90%). For those children who had never visited a baby health clinic, the more commonly reported reasons for not doing so were 'no perceived need' (38.5%) and the 'use of other services' (30.4%).

# **Dental health**

According to the 1996 National Dental Telephone Interview Survey, an estimated 9.7 million people aged five years and over had a dental consultation in the 12 months prior to survey interview. The most common types of treatment or service received were teeth cleaned and scaled (65.6%) and teeth filled (41.4%).

Males (44.2%) were more likely than females (38.9%) to have had teeth filled. The type of treatment or service provided varied with age. Those aged 5 to 4 years were less likely to have teeth filled than older age groups (table 8.9).

Edentulism (no natural teeth) is most prevalent among older adults. However, it 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 19.9% in 1996 (table 8.10).

					Treatment/service	
	Unit	Tooth/teeth extracted(b)	Tooth/teeth filled(b)	Teeth cleaned and scaled(b)	Other treatment(b)	Total who had a dental consultation(c)
Age group (years)						
5–14	%	8.4	27.1	50.9	19.7	81.8
15–24	%	14.1	28.5	68.3	23.6	55.5
25–44	%	14.1	48.0	72.2	22.1	53.6
45-64	%	12.5	52.2	70.3	27.9	58.0
65–74	%	12.0	50.8	61.3	27.6	47.4
>74	%	11.1	45.9	64.0	24.0	40.7
Males	%	13.2	44.2	63.7	22.5	55.2
Females	%	11.4	38.9	67.3	24.5	60.7
Persons						
Proportion	%	12.2	41.4	65.6	23.5	58.0
Number	'000	1 186.2	4 025.3	6 378.2	2 284.9	9 722.9

#### 8.9 DENTAL CONSULTATION, Persons Aged 5 and Over(a) — 1996

(a) In the 12 months prior to the interview. (b) Percentages of people receiving treatments or services among people who had a dental consultation in the 12 months prior to the interview. (c) Each person may have reported more than one type of treatment or service and therefore components do not add to totals.

Source: 1996 National Dental Telephone Interview Survey, Australian Institute of Health and Welfare, Dental Statistics and Research Unit.

					_		A	ge group
Year	Unit	15–24 years	25–34 years	35–44 years	45–54 years	55–64 years	65–74 years	>74 years
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
1996	%	0.1	0.6	2.0	8.1	19.9	32.7	48.7
Mean number of missing teeth(b)								
1994	no.	1.8	2.6	4.3	7.1	9.7	12.5	15.4
1996	no.	2.0	2.6	4.2	6.2	8.7	11.9	14.7

#### 8.10 PREVALENCE OF TOOTH LOSS

(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); 1994 National Dental Telephone Interview Survey, Australian Institute of Health and Welfare, Dental Statistics and Research Unit; 1996 National Dental Telephone Interview Survey, Australian Institute of Health and Welfare, Dental Statistics and Research Unit; 1996

In 1996, approximately 3.7 million people (27.9%) aged 18 years and over had dentures or false teeth, and 9.8% had full sets in both jaws. and the likelihood of having dentures or false teeth increased markedly with age, with 83.1% of persons aged 75 years and over having false teeth (table 8.11).

Females (30.7%) were more likely than males (24.8%) to report having dentures or false teeth,

8.11	PERSONS WHO HAD DENTURES OR FALSE TEETH, Aged 18 years and Over —
	1996

			1330			
			Has dentures	or false teeth		
	Unit	Full sets in both jaws	Other(a)	Total with dentures or false teeth	Does not have dentures or false teeth	Total
Age group (years)						
18-24	%	0.0	2.1	2.1	97.9	100.0
25–34	%	0.6	4.3	4.9	95.1	100.0
35–44	%	2.0	14 0	16.0	84.0	100.0
45–54	%	7.8	26 1	33.9	66.1	100.0
55-64	%	19.2	33 7	52.9	47.1	100.0
65–74	%	32.2	37.8	70.0	30.0	100.0
>74	%	45.9	37.2	83.1	16.9	100.0
Males	%	6.9	17 9	24.8	75.2	100.0
Females	%	12.5	18 2	30.7	69.3	100.0
Persons						
Proportion	%	9.8	18.1	27.9	72.1	100.0
Number	'000	1 316.5	2 431 5	3 748.0	9 685.7	13 433.7

(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: 1996 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 (need for assistance, difficulty and/or use of aids in the areas of self-carc, mobility or verbal communication, or limitations in employment or schooling, because of disability). The distribution of the population according to disability, handicap and severity of handicap is illustrated in the diagram 8.12.



#### 8.12 NUMBER OF PERSONS WITH A DISABILITY AND/OR HANDICAP — 1993

Source: Survey of Disability, Ageing and Carers, 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 syndrome. Among all births in Australia in 1993 and 1994, 4,331 and 4,298 infants respectively, 1.7% of the total in both years, were 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 8.13). The most common specific malformations were hypospadias, congenital dislocation of the hip, ventricular septal defect, cleft lip and palate and Down syndrome.

	System(a)										
		No.	Rate per 10	000 births							
Anatomical system	1993	1994	1993	1994							
Nervous system	377	338	14.5	13.0							
Eye	78	76	3.0	2.9							
Ear, face and neck	44	48	1.7	1.8							
Heart	887	914	34.0	35.1							
Circulatory system	318	286	12.2	11.0							
Respiratory system	78	58	3.0	2.2							
Cleft palate/lip	402	381	15.4	14.6							
Digestive system	303	270	11.6	10.4							
Genital organ	664	626	25.5	24.1							
Urinary system	432	514	16.6	19.8							
Limbs	415	380	15.9	14.6							
Other musculoskeletal	902	802	34.6	30.8							
Integument	29	66	1.1	2.5							
Chromosomal	543	605	20.8	23.3							
Other and unspecified	129	104	5.0	4.0							
All foetuses and infants	4 331	4 298	166.2	165.2							

# 8.13 MAJOR CONGENITAL MALFORMATIONS, By Anatomical

(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 Health and Family Services. Case definitions for the diseases have varied from State to State and with time, as have the diseases included in the system. Since 1991, 42 diseases and disease groups 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 8.14).

# **HIV and AIDS**

Human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (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 19,453 HIV diagnoses had been reported to 31 December 1995. Of these, 6,567 cases had been diagnosed as having AIDS and 4,723 of those had died (table 8.15). Of all persons who were diagnosed as having HIV, 12,776 reported the source of exposure to the virus. Of these, 80.5% reported male homosexual/bisexual contact as the exposure category (table 8.16). In the 12 month period from January to December 1995, there were 816 reports of HIV diagnosis, 648 reports of AIDS and 593 deaths from AIDS.

8.14 NUTIFIA	BLE DISEA	SES, Cas	es noun	ea		
	1989	1990	1991	1992	1993	1994
Disease	no.	no.	<u></u>	no.	no.	no.
Arbovirus Infection						
Arbovirus infection n.e.c.	2 809	2 008	199	303	578	587
Dengue(b)	(c)	(c)	46	366	690	17
Ross River infection(b)	(c)	(c)	3 532	5 630	5 425	3 974
Botulism	(c)	(C)	(C)	—	—	
Brucellosis	20	46	28	29	20	34
Campylobacteriosis	4 279	5 683	8 672	9 135	8 102	10 117
Chancroid	3	13	-	5	1	_
Cholera	_	1		3	6	3
Chlamydial infection(a)	504	5	4 044	6 293	6 493	6 519
Diphtheria	1	7	8	14	1	_
Donovanosis	99	91	72	78	67	117
Gonococcal infection	3 153	1 919	2 530	2 908	2 805	2 971
Haemophilus influenzae type b infection	(c)	(c)	549	501	397	169
Hepatitis A	460	530	2 195	2 109	2 002	1 894
Henatitis B	3 017	2 970	3 652	5 219	2 254	970
Henatitis C	(c)	(c)	4 116	8 812	7 573	8 941
Henatitis(a)	/3	707	338	70	72	42
HIV infection(d)	40 (c)	(0)	53	n 9	470	033
Hydatid infection	(0)	16	33	11.a. 20	20	555
	104	10	44	105	170	170
Legionneilosis	104	90	110	160	1/0	119
Leptosy	34	31	13	10	15	11
Lieptospirosis	99	121	169	159	1/8	123
	(C)	(C)	44	38	53	34
Lymphogranuloma venereum				3	1	2
Malaria	770	882	790	712	684	703
Measles	169	880	1 380	1 425	4 536	4 895
Meningococcal infections	204	295	285	292	378	383
Mumps	(c)	(c)	(c)	23	28	94
Ornithosis	25	23	136	94	98	85
Pertussis	614	862	337	739	3 990	5 633
Plague	<u> </u>		—	-	—	
Poliomyelitis	_	—	—	—	—	—
Q fever	353	431	595	543	889	667
Rabies	_			—	_	_
Rubella(e)		2	620	3 810	3 812	3 315
Salmonellosis(a)	4 492	4 564	5 440	4 614	4 727	5 283
Shigellosis	779	610	902	694	706	724
Syphilis	2 099	1 643	2 053	2 695	2 293	2 324
Tetanus	11	6	7	14	10	15
Tuberculosis	1 351	684	590	970	1 073	1 0 2 4
Typhoid(f)	57	70	88	50	72	50
Viral haemorrhagic fever				_		_
Yellow fever				-	_	_
Yersiniosis(a)	241	433	515	567	459	414
	271		515		-55	714

8.14 NOTIFIABLE DISEASES, Cases Notified

(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 8.15 and 8.16.
(e) Notified only as Congenital Rubella Syndrome from 1988–90. (f) Includes paratyphoid in some States and Territones.

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

					-				
1	NSW	Vic.	Qld	SA	WA	Tas.	NT	ACT	Aust.
HIV diagnoses								_	
Males	9 906	3 323	1 549	557	748	70	79	166	16 398
Females	550	164	94	44	69	4	3	15	943
Sex not reported	2 048	42	_	_	_	_	_	_	2 090
Persons(a)	12 511	3 537	1 648	601	819	74	82	181	19 453
AIDS diagnoses									
Males	3 708	1 307	626	260	270	32	25	71	6 299
Females	130	47	28	18	17	2	_	5	247
Persons(a)	3 848	1 361	656	278	289	34	25	76	6 567
AIDS deaths									
Males	2 610	1 024	432	177	199	21	20	50	4 533
Females	96	32	21	13	9	2	_	2	175
Persons(a)	2 712	1 062	455	190	209	23	20	52	4 723

#### 8.15 DIAGNOSES OF HIV INFECTION AND AIDS AND DEATHS FROM AIDS to 31 December 1995

(a) Includes persons whose sex was reported as transsexual.

Source: Australian HIV Surveillance Report, National Centre in HIV Epidemiology and Clinical Research.

	Males	Females	Persons(a)	
	no.	no.	no.	%
Male homosexual/bisexual contact	10 279	n.a.	10 279	80.5
Male homosexual/bisexual contact and ID use	393	n.a.	393	3.1
ID use				
Heterosexual	119	53	175	1.4
Not further specified	346	97	461	36
Total	465	150	636	50
Heterosexual contact				
Sex with ID user	17	29	46	04
Sex with bisexual male	n.a.	26	26	0 2
From specified country	48	33	81	0.6
Sex with person from specified country	55	34	89	07
Sex with person with medically acquired HIV	4	6	10	0.1
Sex with HIV-infected person, exposure not specified	31	28	59	0.5
Not further specified	428	239	670	5.2
Total	583	395	981	7.7
Haemophilia/coagulation disorder	188	3	191	1.5
Receipt of blood transfusion, blood components or tissue	107	65	172	1.3
Health care setting(b)	3	7	10	01
Total adults/adolescents(a)	12 018	620	12 662	99.1
Children under 13 years at diagnosis of HIV				
Mother with/at risk for HIV infection	23	20	43	03
Haemophilia/coagulation disorder	54	0	54	0.4
Receipt of blood transfusion, blood components or tissue	12	5	17	01
Total children(a)	89	25	114	0.9
Total(a)	12 107	645	12 776	100.0
Other/undetermined(c)	4 291	298	6 677	

#### 8.16 DIAGNOSES OF HIV INFECTION --- to 31 December 1995

(a) Total column includes cases for which sex was not reported. (b) The category 'Health care setting' includes five cases of occupationally acquired HIV infection and four cases of transmission in surgical rooms. (c) The 'Other/undetermined' category includes 6 659 adults/adolescents and 18 children. Twenty two 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: Australian HIV Surveillance Report, National Centre in HIV Epidemiology and Clinical Research.

# Health of Indigenous Australians

Selected results from the first National Aboriginal and Torres Strait Islander Survey (NATSIS) are described below. This survey, completed by the ABS in 1994, was the first national survey of Australia's Indigenous people. Among other topics, it has provided nation-wide Indigenous health information for the first time.

See also Aboriginal health, under *Health Programs* later in this chapter.

# Self-reported health status

About 40% of males and 42% of females reported that they had experienced an illness, injury or disability in the two weeks before being interviewed. People aged 5–24 years were less likely to report recent illness (34%) than people aged 55 years and older (68%). Of those who said they had experienced a recent illness, 34% reported that they had been affected by respiratory disease, making it the most commonly reported illness overall and for all age groups up to 45 years of age, after which diseases of the circulatory system were more commonly reported.

The most commonly reported long-term conditions were asthma (13%) and ear or hearing problems (9%). Asthma was more commonly reported in capital cities than in rural areas, which may be due to differences in environmental factors or other exposures, or to different access to care and opportunity for diagnosis. Diabetes was reported by 4% of the Indigenous population overall and was more commonly reported by females than males. Over the age of 45, about one in five people said that they suffered from diabetes.

Although the health status of Indigenous people continues to be much worse than that of other Australians, some 88% of survey participants described themselves to be in good, very good or excellent health while another 10% described their health as fair and only 2% considered themselves to be in poor health. People who reported a long-term condition-were more likely to say that their health was fair or poor than those without a long-term condition. Over the age of 45, about one in five people said that they suffered from diabetes.

Although the health status of Indigenous people continues to be much worse than that of other Australians, some 85% of survey participants described themselves to be in good, very good or excellent health while another 10% described their health as fair and only 2% considered themselves to be in poor health. People who reported a long-term condition were more likely to say that their health was fair or poor than those without a long-term condition.

# **Health-related actions**

Almost half (44%) of survey participants reported taking a health-related action in the two weeks before the survey. Table 8.17 shows the types of actions people took, by part of State.

Consulting a doctor was more commonly reported in capital cities than in other urban or rural areas, while the opposite was true for consulting a nurse or an Aboriginal Health Worker, Females were more likely than males to report taking a health-related action and, after the age of five years, the reporting of health-related actions increased with age.

# Access to services

Distance to services is an important potential barrier to Indigenous peoples' access to and use of health facilities, health services and health professionals. Nationally, a large proportion of the Indigenous population was estimated to live in close proximity to the services that they might require, but this varied according to place of residence.

In each State, fewer than 10% of people did not have a doctor, either permanent or visiting, within 25 km although only one in three people living in rural areas had a permanent doctor (i.e. available at least three days per week) within this range. Aboriginal Health Workers were located within 25 km of 83% of the population, but this varied from 53% in Tasmania to 93% in the Northern Territory.

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	Capital city %	Other urban %	Rural %	Total %
Took an action	53.0	42.1	39.8	44.4
Type of action taken(a)				
Visited emergency/outpatients clinic	5.8	8.5	8.8	7.8
Admitted to hospital	1.8	2.4	3.1	2.5
Consulted doctor	26.3	17.9	13.1	18.8
Consulted Aboriginal Health Worker	2.7	4.8	10.6	6.0
Consulted nurse	3.5	4.1	8.6	5.3
Used medication	40.9	30.9	25.8	32.1
Used bush medicine	3.0	2.5	6.1	3.7
Reduced daily activities	16.8	12.2	9.2	12.6
Total ('000)	82.5	129.7	91.0	303.3

# 8.17 REPORTED HEALTH RELATED ACTIONS, In the Two Weeks Prior to Interview(a)

(a) Persons may have reported more than one type of action.

Source: Australian Bureau of Statistics National Aboriginal and Torres Strait Islander Survey 1994.

There were large differences in distance to hospitals across the country. While about 95% of Indigenous people in Victoria were reported to be living within 25 km of the nearest hospital, one in two Indigenous people in the Northern Territory had to travel over 100 km.

Close to 90% of Indigenous people were located within 25 km of the nearest community health centre, and about half lived within this distance of an Aboriginal Medical Service.

# Perceived health-related and substance use problems

Nationally, alcohol was seen as the main health problem. About 58% of Indigenous people aged 13 years and older thought that alcohol was a health problem in their area. Drugs and diabetes were the next most commonly reported problems, followed by diet/nutrition, heart problems and skin problems. Alcohol was considered by 75% of respondents to be a substance use problem followed by marijuana (52%). In the Northern Territory, petrol sniffing was of similar concern to marijuana. The proportions varied according to place of residence.

# **Health risk factors**

# **Relative weight**

The results from the NATSIS indicate that overweight and obesity are far more common problems among Aboriginal and Torres Strait Islander people than among the Australian community in general. A body mass index (BMI) was calculated for the 78% of adult men and 71% of adult women whose height and weight were measured. Of these people, 60% of men and 57% of women were overweight or obese. Substantially lower figures were recorded for all men (44%) and women (30%) in the 1989–90 National Health Survey.

# Smoking

Rates of smoking varied considerably across the country from 29% in the Alice Springs ATSIC region to 61% in the Jabiru ATSIC region (both in the Northern Territory). Overall, smoking was reported by 54% of men and 46% of women aged 13 years and over, and 10% of children aged 13–14 years reported that they smoked. Smoking was most commonly reported for people aged 25–44 years.

# Alcohol

Australia wide, about half of males and about one third of females aged 13 and over said they had consumed alcohol within a week of being interviewed. However, a large proportion of Indigenous people in all States reported that they had never drunk alcohol. This was highest in the Northern Territory where 30% of males and 62% of females said they had never drunk alcohol, and 38% of males and 19% of females reported drinking within a week of interview.

# Breastfeeding

Breastfeeding was most commonly reported in the Northern Territory where some 90% were currently being breastfed. In New South Wales, Victoria and South Australia, however, over one third of children had not been breastfed.

# **Disability and handicap**

In the NATSIS, 1% of respondents aged 15–24 and 2.8% of those aged 25–44 reported a severe or profound handicap resulting from a disability or condition, increasing to 13% for those aged 55 and over.

# Mortality

Studies conducted for the period from 1992 to 1994 showed that Indigenous Australians in Western Australia, South Australia and the Northern Territory experienced higher rates of death than did non-Indigenous Australians (the identification of Indigenous status in the death records of the other States was not of sufficient quality to permit adequate analysis). There were about 3.5 times more deaths than expected for males and about four times more deaths than expected for females, based on comparisons with non-Indigenous rates: Diseases of the circulatory system, injury and poisoning, respiratory diseases, neoplasms and endocrine diseases accounted for about three-quarters of all deaths of Indigenous people.

Life expectancy in the three States studied was 14–18 years lower for Indigenous males and

16–20 years lower for Indigenous females, compared with their non-Indigenous counterparts.

Over the ten-year period from 1985 to 1994, there was very little improvement in the mortality experience of Indigenous people in these three States. Overall death rates for Indigenous males declined by an estimated 1.5% per year, but this fall was not enough to reduce the gap between Indigenous and non-Indigenous males because the death rates for non-Indigenous males also fell by similar amounts. No decline in death rates for Indigenous females was evident.

Mortality rates did drop for some causes of death such as for infectious and parasitic disease, circulatory disease, and alcohol dependence syndrome in Indigenous males, and chronic rheumatic fever in Indigenous females. However, there were many times more deaths than expected for all these diseases and large gaps between Indigenous and non-Indigenous people still remain. For diabetes mellitus, there was a striking deterioration in the mortality experience over the ten years, death rates increasing by almost 10% per year for Indigenous males and by over 5% for Indigenous females.

# **Causes of death**

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

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

Two causes accounted for 70% of the 125,124 deaths in Australia in 1995. Diseases of the circulatory system were the underlying cause for 42.6% of deaths and neoplasms were the underlying cause for 27.5%. The third largest group of deaths was those due to diseases of the respiratory system (7.5%) and the fourth largest group was accidents, poisonings and violence (5.9%), to which suicide (1.9% of all deaths) and motor vehicle accidents (1.6%) were the greatest contributors.

The relative importance of different causes of death varies with age. The majority of infant deaths (63% in 1995) occur within 28 days of birth and most are due to conditions present since birth. For those aged from 1 to 44 years, external causes (accidents, poisonings and violence) are the leading cause and neoplasms the second. For those aged 45 years and over, neoplasms and diseases of the circulatory system are the leading causes, with the latter more significant than neoplasms in those aged 65 years and over.

# **Perinatal deaths**

In 1995 the perinatal death rate was 8.1 per 1,000 total births, little changed from the rate of 8.0 in 1994. The slight increase reflected a rise in the number of foetal deaths, which increased the foetal death rate from 4.7 to 5.0 deaths per 1,000 total births. The neonatal death rate fell from 3.4 to 3.2 deaths per 1,000 live births.

The three main causes of death in the foetus or infant were other conditions originating in the

perinatal period (31.7%), hypoxia, birth asphyxia and other respiratory conditions (27.7%) and congenital anomalies (20.4%). In 61% of perinatal deaths a maternal condition was reported. The most common maternal condition was complications of the placenta, cord and membranes, reported for 30.5% of perinatal deaths.

									Age grou		
Cause of death	<1	1–14	15-24	25–34	35-44	45–54	55-64	65-74	75-84	>84	Total
Number											
Infectious and parasitic											
diseases	13	24	16	44	62	58	97	195	308	252	1 069
Neoplasms	7	144	143	345	1 008	2 7 4 8	5 491	10 781	9 763	3 937	34 367
Endocrine, nutritional and metabolic											
immunity disorders	24	30	39	189	246	271	453	955	1 164	729	4 100
nervous system and sense organs	39	76	86	65	78	118	191	502	1 010	813	2 978
Diseases of the circulatory system	14	28	62	171	625	1 586	3 727	10 910	19 345	16 932	53 402
Diseases of the							• • • • •				
respiratory system	52	46	29	44	83	221	749	2 494	3 422	2 290	9 431
digestive system	3	6	6	46	143	269	478	791	1 171	958	3 871
Congenital anomalies	394	80	42	27	26	24	30	21	29	5	678
All other diseases(b)	663	18	121	282	203	174	267	806	2 176	2 559	7 282
Signs, symptoms and ill-defined conditions	205	10	12	26	44	18	23	30	58	120	533
Accidents, poisonings and violence	35	342	1 359	1 357	1 124	826	557	582	645	585	7 413
All causes	1 4 4 9	804	1 915	2 596	3 642	6 313	12 063	28 067	39 091	29 180	125 124
Rate(c)		•••					• • •		** ***		
Infectious and parasitic											
diseases	5	1	1	2	2	3	6	15	45	133	6
Neoplasms	3	6	5	12	37	123	364	838	1 435	2 085	190
Endocrine, nutritional and metabolic diseases and											
immunity disorders	9	1	1	7	9	12	30	74	171	386	23
nervous system and sense organs	15	3	3	2	3	5	13	39	148	431	17
Diseases of the											
circulatory system	5	1	2	6	23	71	247	848	2 844	8 968	296
Diseases of the respiratory system	20	2	1	2	3	10	50	194	503	1 213	52
Diseases of the											
digestive system	1	_	-	2	5	12	32	61	172	507	21
Congenital anomalies	154	3	2	1	1	1	2	2	4	3	4
All other diseases(b)	259	1	4	10	7	8	18	63	310	1 355	40
Signs, symptoms and ill-defined conditions	80	_	—	1	2	1	2	2	9	64	3
Accidents, poisonings and violence	14	14	50	48	41	37	37	45	95	310	41
All causes	566	35	71	91	133	283	801	2 181	5 746	15 456	693

#### 8.18 CAUSES OF DEATH - 1995

For footnotes see end of table.

...continued

									Age group	(years)	
Cause of death	<1	1–14	15–24	25-34	35-44	45-54	55-64	65-74	75-84	>84	Total
Percentage(d)				-							
Infectious and parasitic											
diseases	0.9	3.0	0.8	1.7	1.7	0.9	0.8	0.7	0.8	0.9	0.9
Neoplasms	17.9	7.5	13.3	27.7	43.5	45.5	38.4	25.0	13.5	27.5	27.0
Endocrine, nutritional and metabolic											
immunity disorders	1.7	3.7	2.0	7.3	6.8	4.3	3.8	3.4	3.0	2.5	3.3
Diseases of the nervous system and	27	95	45	25	21	10	16	1.8	26	28	24
Discasses of the	2.1	5.5	4.5	2.5	2.1	1.5	1.0	1.0	2.0	2.0	2.7
circulatory system	1.0	3.5	3.2	6.6	17.2	25.1	31.0	38.9	49.5	58.0	42.7
Diseases of the				÷							
respiratory system	3.6	5.7	1.5	1.7	2.3	3.5	6.2	8.9	8.8	7.9	7.5
Diseases of the											
digestive system	0.2	0.8	0.3	1.8	3.9	4.3	4.0	2.8	3.0	3.3	3.1
Congenital anomalies	27.2	10.0	2.2	1.0	0.7	0.3	0.3	0.1	0.1		0.5
All other diseases(b)	45.8	2.2	6.3	10.9	5.6	2.8	2.2	2.9	5.6	8.8	5.8
Signs, symptoms and ill-defined conditions	14.2	1.2	0.6	1.0	1.2	0.3	0.2	0.1	0.2	0.4	0.4
Accidents, poisonings and violence	2.4	45.5	71.0	52.3	30.9	13.1	4.6	2.1	1.7	2.0	5.9
All causes	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

8.18	CAUSES	OF	DEATH	- 1995 —	continued
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(a) Total includes 4 deaths where age is not known. (b) Includes 675 deaths from conditions originating in the perinatal period, 2 075 deaths from diseases of the genitourinary system, and 3 178 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, 1995.

		Numbe	r of deaths		Rat		
Cause of death	Foetal	Neonatal	Perinatal	Foetal(a)	Neonatal(b)	Perinatal(a)	
Conditions in foetus/infant							
Slow foetal growth, foetal malnutrition							
and immaturity	104	130	234	0.4	0.5	09	
Birth trauma	1	43	44	_	0.2	0 2	
Hypoxia, birth asphyxia and other							
respiratory conditions	431	149	580	1.7	0.6	2.3	
Foetal and neonatal haemorrhage	20	52	72	01	0.2	0.3	
Haemolytic disease of foetus or newborn	10	_	10	_	_	_	
Other conditions originating in the							
perinatal period	560	104	664	2 2	0.4	2.6	
Congenital anomalies	143	285	428	06	1.1	1.7	
All other causes	12	48	60	0.1	0.2	0.2	
Conditions in mother							
Maternal conditions which may be							
unrelated to present pregnancy	142	64	206	0.6	0.3	0.4	
Maternal complications of pregnancy	128	220	348	0.5	0.9	14	
Complications of placenta, cord and							
membranes	532	107	639	2.1	0.4	2.5	
Other complications of labour and delivery	58	27	85	0.2	0.1	0.3	
No maternal condition reported	423	393	816	1.6	1.5	32	
All causes							
1995	1 283	811	2 0 <del>9</del> 4	5.0	3.2	8.1	
1994	1 207	868	2 075	4.7	3.4	8.0	
1993	1 245	886	2 131	4.8	3.4	8.2	
1992	1 493	1 015	2 508	5.6	3.8	9.4	
1991	1 478	1 012	2 490	5.7	3.9	9.6	
1990	1 590	1 122	2 712	6.0	4.3	10.3	

8.19 CAUSES OF PERINATAL DEATHS - 1995

(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, 1995.

# **External causes**

There were 7,413 deaths due to external causes in 1995, 3% higher than the number in 1994. This represents a death rate of 40.4 per 100,000 of the mid-year population after adjusting for changes in the age and sex structure of the population, which is 2% higher than the 1994 death rate.

External causes was the leading cause of death in younger age groups. In 1995 external causes accounted for 40.5% of all deaths of persons between the ages of 1 and 45 years. They contributed 15% of total 'years of potential life lost' — a measure of premature mortality, where a death before the age of 76 years is presumed to be premature. They were the second highest contributor to years of potential life lost, after cancer (30.5%). Injury is more significant as a cause of death for males than for females — ranking as the fourth leading cause of death for males (of all ages) but as the fifth leading cause of death for females Males made up 69.5% of all deaths due to external causes, and the standardised death rate for males was 58.9 per 100,000 compared with 22.6 for females.

The leading causes of injury deaths were suicide (31.9%) and motor vehicle accidents (27.4%). The crude rate of suicide deaths for males was almost four times that for females, and the crude death rate from motor vehicle accidents for males was twice that for females. Accidental falls were the only external cause with a higher rate for females.

			Crude death					
Cause of death	no.	%	rate(a)					
MA	LES							
Suicide	1 872	36.3	20.8					
Motor vehicle traffic accidents	1 398	27.1	15.6					
Accidental falls	457	8.9	5.1					
Homicide	204	4.0	2.3					
Drowning and submersion	190	3.7	2.1					
Poisoning by drugs/medications	201	3.9	2.2					
Other	831	16.1	9.2					
All external causes	5 153	100.0	57.3					
FEM	FEMALES							
Suicide	495	21.9	5.5					
Motor vehicle traffic accidents	631	27.9	7.0					
Accidental falls	538	23.8	5.9					
Homicide	129	5.7	1.4					
Drowning and submersion	69	3.1	0.8					
Poisoning by drugs/medications	97	4.3	1.1					
Other	301	13.3	3.3					
All external causes	2 260	100.0	24.9					
PERS	SONS							
Suicide	2 367	31.9	13.1					
Motor vehicle traffic accidents	2 029	27.4	11.2					
Accidental falls	995	13.4	5.5					
Homicide	333	4.5	1.8					
Drowning and submersion	259	3.5	1.4					
Poisoning by drugs/medications	298	4.0	1.7					
Other	1 132	15.3	6.3					
All external causes	7 413	100.0	41.1					

8.20 EXTER	NAL CAUSES	OF DEATH	1995
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(a) Deaths per 100 000 mid-year population.

Source: Derived from ABS Causes of Death data 1995.

# **Dementia deaths**

The last 15 years have seen a rapid increase in the numbers of deaths of elderly people ascribed to dementia ---- a condition associated with various chronic organic brain disorders and characterised by loss of memory and intellectual faculties, reasoning power and will. Dementia can affect young adults but is much more common in the elderly, and its prevalence increases with age, affecting an estimated 2% of the population aged 65 to 70, increasing to 20% of the population aged above 80 years. In an ageing population and with average life spans increasing, dementia can be expected to become more significant as a cause of illness and death. The increase in the numbers of deaths ascribed to dementia, however, has occurred at a much faster rate than would be explained by the ageing of the population.

Between 1981 and 1995 there has been a 48% increase in the population aged 65 years and over but a six fold increase in the numbers of deaths ascribed to dementia in this age group, from 582 in 1981 to 3,313 in 1995. When

standardised to take account of the year to year changes in the age and sex structure within the elderly population, the death rate for 1995 was 140.3 deaths per 100,000 of those aged 65 years and over, more than three times higher than the 1981 rate of 43.7. Expert opinion suggests that this rapid rise in the rate is partly due to an increased tendency for dementia to be diagnosed as the underlying cause of death among elderly people.

The death rate from Alzheimer's disease has increased at a much faster rate than that from the other conditions causing dementia. Deaths from Alzheimer's disease increased as a proportion of total dementia deaths from 11% in 1981 to 33% in 1995.

As with other conditions, the number of dementia deaths increases rapidly with age, doubling every 5.1 years. As well as suggesting increased risk of dementia with age, this could also reflect the increased likelihood of dementia being diagnosed in the elderly, due to the substantial time lag between onset and diagnosis.

The overall age-standardised death rate for males has generally been higher than the female rate. However, whereas age-specific death rates have been higher for males in the earlier age groups, they are higher for females in the upper age groups. The excess dementia mortality among females in the upper age groups could reflect the later onset (or slower progression) of dementia conditions in females. The Australian population is ageing and this process will continue as the post-war 'baby boomers' reach age 65 from the year 2011 on. The total number of persons aged 65 years and over is estimated to almost double between 1989 and 2011, and to increase by 234% between 1989 and 2031. If the age-specific death rates remained stable at 1995 rates, the number of deaths due to dementia could be expected to increase in line with population changes. If the upward trend in diagnosis continues, even greater increases will occur.

8.21 DEMENTIA DEATH RATES(a) - 1995									
Age group (years)	Males	Females	Persons						
65-69	13.4	12 1	10.7						
70–74	32.3	32.0	32.2						
75–79	106.5	97.9	96.3						
8084	302.3	285.5	268.2						
85–89	677 3	704.1	624.8						
90–94	1 134 2	1 306.0	1 123.1						
95+	1 864 5	2 389.3	2 037.0						
Total 65+	115 9	183 0	133.6						
Total 65+ SDR(b)	137 6	140 7	140.3						

8.21 DEMENTIA DEATH RATES(a)	- 1995
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(a) Unless otherwise specified, dementia deaths per 100 000 mid-year population of the same age and sex. (b) Standardised death rate — direct standardisation based on the age structure of the 1991 total population.

Source: Unpublished ABS Causes of Death data, 1995.

# **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 1993–94 there were an estimated 702 public acute care and Department of Veterans Affairs hospitals, 30 public psychiatric hospitals, 1,457 nursing homes and 1,365 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 2 hospital beds available for acute care per 1,000 population in Australia in 1993–94. 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 0.3 in 1993–94. 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 about 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 240 in 1991–92 and again to 261 in 1993–94.

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 1,207. Although the number of separations has increased substantially, the number of bed-days has remained fairly constant, increasing slightly to 1,209 per 1,000 population in 1993–94.

#### 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 31% in 1992–93. In 1992–93, 39% of admissions to private hospitals were same-day patients.

# **Private hospitals**

Information on facilities, patients, staffing and finances was collected from the 328 private

acute and psychiatric hospitals and 125 free-standing day hospital facilities which were in operation throughout Australia during 1994–95. Some of the findings were as follows:

- The average number of beds available for admitted patients increased by 7.2%, to 22,370, between 1992–93 and 1994–95.
- There were 1,536,600 admitted patients who left hospital during 1994–95, of which 87.6% were from private acute and psychiatric hospitals and 12.4% from free-standing day hospital facilities.
- Occupied-bed days for private acute and psychiatric hospitals totalled 5.4 million. The average length of stay per in-patient separation was 4.0 days.
- The number of full-time equivalent staff engaged at all private hospitals was 37,344 of whom 58.7% were nursing staff.
- Total operating expenditure for private acute and psychiatric hospitals during 1994–95 amounted to \$2,503m of which 59.1% was expended on salaries and wages (including on-costs). Revenue received during the year was \$2,763m, nearly all (94.7%) of which was received as payments from or in respect of patients.
- Total operating expenditure for free-standing day hospital facilities during 1994–95 amounted to \$70.0m and revenue received during the year was \$85.8m.

#### 8.22 PUBLIC ACUTE AND PRIVATE ACUTE AND PSYCHIATRIC HOSPITALS AND FREE-STANDING DAY HOSPITAL FACILITIES — 1993–94

	Unit	Public	Private(a)	Total(a)
Bed supply				
Facilities	no.	702	440	1 142
Beds/chairs	no.	56 140	22 158	78 298
Activity				
Total separations	'000	3 387	1 433	4 821
Total occupied bed days	.000	16 289	5 355	21 644
Average length of stay	days	4.8	(b)4.1	(b)4.6
Average length of stay excluding free-standing day hospital facilities	days	4.8	4.1	4.6
Average length of stay excluding all same-day separations	days	6.8	5.8	6.6
Average occupancy rate	%	80	(b)67	(b)77
Average occupancy rate excluding free-standing day hospital facilities	%	80	67	77
Total non-admitted services	.000	30 562	903	31 465

(a) Includes free-standing day hospital facilities. (b) Excludes free-standing day hospital facilities.

Source: Private Hospitals, Australia, 1993–94 (4390.0); National Public Hospital Establishment Data Base, Australian Institute of Health and Welfare; Medicare Agreements Data (Department of Health and Family Services unpublished data).

# Comparison of public and private hospitals

There were 1,142 acute hospitals, psychiatric hospitals and free-standing day hospital facilities with 78,298 available beds in Australia in 1993–94–72% of the beds were in public hospitals.

Total throughput in 1993–94 was 4.8 million separations, or 21.6 million bed days. The public sector accounted for 70% of the separations and 75% of the bed days

# **Health work force**

According to labour force estimates (table 8.23), in 1995–96 there were approximately 268,800 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 (160,500 people), of whom 92.3% were women.

There were approximately 30,800 general medical practitioners in 1995–96 and 15,000 specialist medical practitioners. About 75% of general medical practitioners and 77.3% of specialist medical practitioners were male.

0.25 TEROORD ENH LOTED IN HEALTH OU		1000 00	
	Males '000	Females '000	Persons '000
General medical practitioners	23.1	7.7	30 8
Specialist medical practitioners	11.6	*3.4	15.0
Dental practitioners	6.7	*2.5	91
Pharmacists	7.2	5.8	12.9
Occupational therapists	*0.5	5.3	59
Optometrists	*1.3	*0.9	*2.2
Physiotherapists	*2.7	7.4	10 1
Speech pathologists	*0.2	*3.1	*3 3
Chiropractors and osteopaths	*2.5	*0.9	*3.3
Podiatrists	*1.0	*2.3	*3.2
Radiographers	*1.1	*3.9	50
Other health diagnosis and treatment practitioners	*1.2	6.4	7.5
Registered nurses	12.3	148.2	160 5
Total employed in health occupations	71.3	197.5	268.8
Total employed	4 716.0	3 571.2	8 287.2

#### 8.23 PERSONS EMPLOYED IN HEALTH OCCUPATIONS(a) — 1995–96

(a) Averages calculated on quarterly estimates. Source: Labour Force, Australia (6203.0).

# **Health programs**

# **Aboriginal health**

In July 1995 responsibility for Aboriginal and Torres Strait Islander health transferred from the Aboriginal and Torres Strait Islander Commission (ATSIC) to the then Department of Human Services and Health. The reason for the transfer was twofold: first, to improve the mainstream health sector's performance in providing services to Aboriginal and Torres Strait Islander people, and second, to facilitate better links between mainstream services and Aboriginal community health services.

By 1997 the Commonwealth will have signed Health Framework Agreements with all States and Territories. The Agreements recognise the role of Aboriginal community controlled health services in the health system and the need to improve access of Aboriginal and Torres Strait Islander people to mainstream health services. The Agreements provide for a process of joint planning between the Commonwealth, States/Territories, ATSIC and the Aboriginal community controlled health sector. This will ensure better targeting and coordination of health services for Aboriginal and Torres Strait Islander people as well as the planning of new services. The Agreements also commit the parties to data collection and evaluation, and to maintenance of financial effort.

# Programs for the aged and people with disabilities

Details on these programs are contained in *Chapter 7, Income and welfare*.

# **Homeless youth**

The Innovative Health Services for Homeless Youth Program was established in 1989 as part of the strategy, 'Towards Social Justice for Young Australians'. The Program develops and implements innovative primary health care services for homeless youth. A further \$8.8m over the period 1993–94 to 1996–97 was allocated in the 1993 Budget (\$17.6m 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 \$269m 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 \$189m is available directly to the States and Territories. About \$68m is directed towards national initiatives and \$5.4m is available for supporting 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.

# **National Diabetes Action Plan**

In recognition of the high incidence of diabetes and its associated economic and social costs, the Government has developed a \$7.5m National Diabetes Action Plan which identifies a number of priority areas for action. The Plan will be implemented over three years beginning in 1996–97.

As part of the Plan, Diabetes Mellitus has recently been endorsed by all Health Ministers as the fifth National Health Priority Area, under a new strategy for reporting on changes in the population's health. Governments have undertaken to collect information on the present incidence of diabetes and, as a result of this knowledge, to set up strategies to reduce both the onset of and the complications from this disease.

# Injury prevention and control

Injury is a major public health issue and injury prevention is one of the five National Health Priority Areas. Each year, over 7,000 people die as a result of injury, and the annual direct medical costs of injury exceed \$1b. In 1996 the Commonwealth announced funding of \$0.9m over three years for the establishment of a body with the task of obtaining intersectoral cooperation and action to reduce preventable injuries.

# **Diet and nutrition**

In the 1996–97 Budget, the Commonwealth Government allocated \$1m a year for two years for initiatives aimed at increasing the numbers of Australian women breastfeeding their babies. The funding will be spent on community education, improving support systems for breastfeeding and the monitoring of breastfeeding trends.

A further \$200,000 a year for two years has been provided to encourage women of childbearing age to increase their consumption of folate, either from foods or dietary supplements. The consumption of recommended intakes of folate, a B group vitamin, by women just prior to and in the early stages of pregnancy has been shown to prevent a significant number of babies being born with a defect of the neural tube, such as spina bifida.

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 Health and Family Services, 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 the death rates per 100,000 population attributable to tobacco and alcohol have continued to decline.

# 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 15 donors per million population through concerted public and professional education and information programs.

# **Family planning**

The Commonwealth Government provides direct ongoing funding through the Family Planning Program to selected non-government organisations with the aim of providing a comprehensive range of information, education, professional training, counselling and clinical services in sexual and reproductive health to the Australian community. The allocation for 1996–97 is approximately \$14m.

# 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 almost \$5m 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 \$30m 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**

The National Cancer Prevention and Control Unit was established in April 1996 to develop strategies for the management of preventable cancers and to minimise the adverse impact of cancers on the community. The Unit also has responsibility for the oversight of two national screening programs, BreastScreen Australia and the National Cervical Screening Program.

# **BreastScreen Australia**

In 1990, BreastScreen Australia (formerly the National Program for the Early Detection of Breast Cancer) was established to reduce morbidity and mortality attributable to breast cancer. A network of dedicated and accredited screening and assessment services provides free access to breast screening services for women aged 50 to 69 years.

BreastScreen Australia is cost-shared with State and Territory governments.

# **National Cervical Screening Program**

The National Cervical Screening Program was established in 1991 to further reduce the incidence of and mortality from cervical cancer by encouraging women to have regular biennial Pap smears, and to facilitate improvements in reliability and accessibility of screening services.

The National Cervical Screening Program is cost-shared with State and Territory governments.

In both screening programs, all States and Territories are contributing to the collection and analysis of agreed national minimum datasets to assist revision of policy, monitor program performance and aid the development of targeted strategies.

# National Education Program on Female Genital Mutilation

This program was established in response to increasing numbers of people migrating to Australia, mainly as refugees, from countries where female genital mutilation is traditionally practised, and to concern that the practice does not become established here. It commenced in 1995–96 with funding of approximately \$3m over five years. The program aims to prevent the practice of female genital mutilation in Australia and to assist women and girls who have already undergone this harmful practice primarily through providing financial assistance to the States and Territories to implement culturally sensitive education programs for both affected communities and professionals providing services to these communities.

# **Alternative Birthing Services Program**

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

# **Co-ordinated Care Trials**

The Co-ordinated Care Trials, which are being funded by the Commonwealth Government, will set about testing innovative reforms to health and community services in a variety of community settings throughout Australia. Following an initial 12 month development phase, they will be implemented over two years to July 1999.

The primary aim of the Co-ordinated Care Trials is to test whether co-ordinating care for people with complex needs through individual care plans, and the pooling of funds from existing Commonwealth, State/Territory and joint programs, will result in improved client health and well-being within current resource levels. They will explore ways of: overcoming the barriers that exist between the various funding programs; promoting more choices in services; promoting continuity of care; facilitating better management of clients' needs; and planning services as close to the delivery level as possible.

The Trials are an important part of the overall strategic planning for the future of health and community services in Australia and reflect the commitment of State/Territory governments and the Commonwealth Government to working co-operatively to deliver better outcomes for health and community services consumers.

# Health care financing

# **Total health expenditure**

Total health expenditure (both public and private sectors) in 1994–95 was \$38,500m or \$2,145 per person. Health expenditure per person increased at an average annual rate of 2.8% in real terms between 1982–83 and 1994–95. Health expenditure as a proportion of gross domestic product (GDP) was estimated to be 8.4% in 1994–95.

The average annual growth rate in real health expenditure for the period after the introduction of Medicare from 1984–85 to 1994–95 was 4.4%.

Health expenditure by Australian governments in 1994–95 was \$26,339m or \$1,468 per person.

0.24				GINOTITI
		Expenditure		Rate of growth
		Constant 1989-90		Constant 1989-90
	Current prices	prices(a)	Current prices	prices(a)
Year	\$m	\$m	%	%
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	23 333	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	31 223	29 435	8.4	2.2
1991–92	33 134	30 316	6.1	3.0
1992–93	34 910	31 489	54	3.9
1993–94	36 495	32 602	4.5	3.5
1994–95(b	) 38 479	33 905	5.4	4.0

8.24 TOTAL HEALTH EXPENDITURE(a) AND RATE OF GROWTH

(a) Health expenditure for 1982–83 to 1994–95 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.

The Medicare levy was increased from 1.5% to 1.7% of taxable income for 1996–97 to fund the guns buy back scheme. This one-off measure was expected to raise \$500m to fund the National Firearms Program under which firearm owners, dealers and collectors will receive compensation for surrender of designated guns.

For 1996–97, no levy is payable by single people with income less than \$13,127 per year and by couples and sole parents with income less than \$22,152 per year, with a further \$2,100 per year allowed for each child.

In 1995–96, taxation revenue from the Medicare levy was \$3.4b.

A Medicare levy surcharge of one percentage point is to be introduced from 1 July 1997 for single individuals with taxable incomes in excess of \$50,000 per year, and couples and families with combined taxable incomes in excess of \$100,000, who do not have private hospital cover through private health insurance.

# Commonwealth Government funding of hospitals

In 1995–96, hospital funding grants by the Commonwealth Government to the States and Territories totalled \$4,718m. Other expenditure included \$53.6m on mental health, \$12.3m for the expansion of palliative care and \$72.0m for the treatment of AIDS patients in public hospitals.

Under revised bonus funding arrangements implemented in 1995–96, \$169m of the bonus funds were linked to the achievement of agreed performance targets relating to hospital throughput and waiting times for access to elective surgery and to accident and emergency treatment.

In addition, the Commonwealth outlayed a further \$11m under the terms of the Medicare Agreements with the States on direct expenditure relating to the Casemix Development Program, mental health payments and other incentive programs.

The Commonwealth also outlayed funding to hospitals of \$758.8m to provide hospital services to veterans and their dependents in 1995–96.

# 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 8.25). 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 are relatively low, expenditure is the lowest (\$10.56 per week). As the cycle progresses and household size and income generally increase, expenditure also generally increases, reaching its highest at the stage when the household consists of a couple with non-dependent children (\$43.42 per week). By the time a household comprises one person only, aged 65 and over, expenditure has decreased to \$12.81 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 \$2.70 and need pay no more than \$17.40 for any prescription listed on the Pharmaceutical Benefits Schedule (PBS). The Government pays the remainder of the cost for the patient.

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. Once the patient or their immediate family has spent \$600 on PBS medicines in a year, they need only pay \$2.70 of the full cost for additional PBS items for the rest of the calendar year.

If the patient holds a special concession card, the safety net limit is \$140.40 per calendar year. When the patient has spent \$140.40 on PBS medicines for self and/or dependants they can get further PBS medicines free for the rest of the year.

In 1995–96 the total cost of the Scheme was \$2,669m. This includes \$478.1m 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.

# **Health insurance coverage**

The steady decline in the proportion of the population covered by private health insurance for hospital cover has continued, falling from 44.5% in June 1990 to 33.6% at June 1996 (see table 8.26).

Health funds also offer ancillary cover which provides benefits towards the cost of a range of services not covered under Medicare. These may include ancillary private dental services, optical, chiropractic, podiatry, home nursing and other services. At June 1996, over 6 million people had ancillary cover.

# 8.25 HOUSEHOLD EXPENDITURE, Medical Care and Health Expenses - 1993-94

				Couple v	Couple with dependent		
		Lone	Couple only,		Eldest		
		person	reference	Eldest	child	Eldest	
	Unit	aged	person	child	aged	child aged	
Average weekly household income	\$	476 09	963 91	790.94	842.91	1022.40	
Average number of persons in household	no.	1 00	2.00	3 44	4,54	4.15	
Average weekly household expenditure(a)(b)							
Accident and health insurance							
Hospital, medical and dental insurance	\$	2.99	11.74	13 03	13.95	16.41	
Ambulance insurance (separate insurance)	\$	0 11	0.34	0 39	0.37	0 45	
Sickness and personal accident insurance(c)	\$	1 02	2.38	1.96	1.63	2 40	
Total	\$	4.12	14 46	15.38	15.95	19 26	
Practitioners' fees							
General practitioner doctor's fees	\$	0.24	0 59	1 38	0.90	0 93	
Specialist doctor's fees(c)	\$	0.33	1 19	1.99	1.54	2 02	
Dental charges	\$	2.91	1 79	3.23	4.32	4 87	
Optician's fees (including spectacles)(c)	\$	0.43	0 77	0.34	0.93	1 43	
Practitioner's fees, n.e.c.(c)	\$	0 34	0.81	0.98	0.88	0 97	
Total	\$	4 25	5 13	7.91	8.57	10 22	
Medicines, pharmaceutical products, therapeutic							
appliances and equipment	\$	2 10	4.14	8.84	6.71	7 71	
Other health charges	\$	*0 09	*0.34	*1.06	*0.61	*0.77	
Total medical care and health expenses	\$	10.56	24.08	33.19	31.83	37.96	

			Couple with			
	Unit	Dependent and non- dependent children only	Non- dependent children only	Couple only, reference person aged 55–64	Couple only, reference person aged >65	Lone person aged >65
Average weekly household income	\$	1 332.22	1 109.61	544 63	389.98	213 12
Average number of persons in household	no.	4 57	3 27	2.00	2.00	1.00
Average weekly household expenditure(a)(b) Accident and health insurance						
Hospital, medical and dental insurance	\$	20.36	21.63	16.67	13.26	5 01
Ambulance insurance (separate insurance)	\$	0 39	0 52	0.40	0.30	0.20
Sickness and personal accident insurance(c)	\$	3.01	1.35	0.74	0.11	0 05
Total	\$	23.77	23.50	17.80	13.66	5.26
Practitioners' fees						
General practitioner doctor's fees	\$	1.35	0 79	0.44	0.34	0 06
Specialist doctor's fees(c)	\$	2 02	2.37	1 49	1.90	0.83
Dental charges	\$	4.96	2.94	2.57	1.92	0.69
Optician's fees (including spectacles)(c)	\$	1.61	1.68	1 09	0.85	0.59
Practitioner's fees, n.e.c.(c)	\$	1.07	1 34	0.70	0.53	0.25
Total	\$	11.00	9.11	6 29	5.54	2.42
Medicines, pharmaceutical products, therapeutic appliances and equipment	\$	7,45	9 40	7.40	7.11	4 22
Other health charges	\$	*0 69	*1.4	*0 22	*1.68	*0.91
Total medical care and health expenses	\$	42.91	43.42	31.71	27.9 <del>9</del>	12.81

(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%.

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

	June 1990 %	June 1992 %	June 1994 %	June 1995 %	June 1996 %
With private insurance for hospital cover	44.5	41.0	37.2	35.0	33.6
Without private insurance for hospital cover	55.5	59.0	62.8	65.0	66.4
Total	100.0	100.0	100.0	100.0	100.0

#### 8.26 PERSONS WITH PRIVATE INSURANCE FOR HOSPITAL COVER

Source: Private Health Insurance Administration Council, Coverage of Basic Hospital tables, June 1996.

# **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 1996 was \$8.1m.

# 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 is 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 1995 was \$1.2m.

# 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 AHMC 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 1996, Health Ministers considered a wide range of issues including Aboriginal health, the medical workforce, a national public health partnership, national health goals and targets, private health insurance and quality in Australian health care.

Similarly, the CSMC and its advisory body, the 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 1996, Community Services Ministers discussed a wide range of issues including services to young people with self destructive behaviours, youth homelessness, national child abuse strategies and COAG reforms. Meeting jointly as the Health and Community Services Ministerial Council, Ministers considered COAG reforms of health and related community services, future ageing and mental health.

Ministers with responsibilities for disability services discussed the renegotiation of the Commonwealth State Disability Agreement and future directions for disability services.

# **Department of Health and Family Services**

The Commonwealth Department of Health and Family Services provides policy advice and implements Commonwealth government policies on public health, health care, health care funding, and family services for all Australians, particularly the aged, people with disabilities and those with children.

As the national leader in health and family services and public health measures, the Department

- provides expert policy advice and analysis to government;
- promotes planning by governments focused on outcomes and investment in prevention and early intervention, and incentives for efficient, best practice care;
- works in partnership with others to deliver high quality, cost-effective care designed to meet people's needs better;
- works closely across programs to ensure that the focus is on people and outcomes rather than programs and providers; and
- ensures that, where the Department has a regulatory role, the Department performs it sensitively and objectively.

The Department delivers its services through the following seven Programs.

- Public Health (including Health Regulation, and Health Research and Information)
- Health Care and Access (including Medicare Benefits and General Practice Development, Pharmaceutical Benefits, Acute Care and Mental Health)
- Aboriginal and Torres Strait Islander Health
- Family and Children's Services
- Aged and Community Care
- Disability Programs
- Corporate Leadership and Management

The Department works in association with other agencies in the Portfolio, primarily the Health Insurance Commission, the Australian Hearing Services, the Australia New Zealand Food Authority, the Australian Institute of Health and Welfare and the Australian Institute of Family Studies.

#### Australian Institute of Health and Welfare

The Australian Institute of Health and Welfare (AIHW), is a statutory authority within the Commonwealth Health and Family Services portfolio. The Institute's mission is to inform community discussion and decision making through national leadership in the development and provision of authoritative and timely information and analysis on the health and welfare of Australians.

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 Department of Health and Family Services portfolio, which provides advice to the Commonwealth Government, the State and Territory Governments and the community on matters relating to individual and public health and on health ethics issues. It also advises the Minister for Health and Family Services 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.

# Australian Quarantine and Inspection Service

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 that they are safe and wholesome, are informatively described, meet international requirements and facilitate trade.

In 1995–96, AQIS provided inspection for over \$4b worth of export meat to over 120 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 1995–96, inspections based on risk management principles were undertaken of 10,000 ship arrivals, 52,000 first port aircraft arrivals. 7.3 million passengers and aircrew, approximately 1 million cargo containers (20 foot equivalent units) 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.

All food imported into Australia is also subject to inspection under the provisions of the Imported Food Control Act 1992, which came into force in June 1993 In 1995-96, 35,084 shipments were subject to AQIS clearance, of which 6,695 were automatically released due to the good compliance history of the supplier. The remaining 28,389 shipments were closely inspected and/or analysed, with the result that 1,446 failed to meet the relevant food standards and were denied access to the Australian market place. Where an overseas government's inspection system can be shown to provide safety assurances equivalent to Australia's food inspection system, food accompanied by that agency's certification is allowed entry with minimal inspection and testing on arrival.

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

# Australia New Zealand Food Authority

The Australia New Zealand Food Authority is a statutory authority established by the *Australia New Zealand Food Authority Act 1995*. Its primary function is to develop, vary and review standards for food available in Australia and New Zealand.

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 international alignment of 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 development of joint food standards with New Zealand.

The Authority runs the Imported Food Inspection Program jointly with the Australian Quarantine and Inspection Service, and provides national co-ordination of food recalls in Australia. 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 Government and the 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 seventy 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 1993–94 involving a fatality, a permanent disability or 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, 75% involved males and 25% females, excluding Victoria and the Australian Capital Territory.
- The incidence rate for males for all industries was 40 cases per 1,000 wage and salary

earners; for females, 17 per 1,000 wage and salary earners; and for persons, 30 per 1,000 wage and salary earners, excluding Victoria and the Australian Capital Territory.

- The frequency rate for males for all industries was 20 cases per million hours worked; for females, 11 per million hours worked; and for persons, 17 per million hours worked, excluding Victoria and the Australian Capital Territory.
- Around 1 in 34 workers sustained a work related injury or disease in 1993–94, excluding Victoria and the Australian Capital Territory.
- The average duration was 9.4 weeks per injury or disease case, excluding Victoria and the Australian Capital Territory.
- In 1993–94 the total estimated cost of workers' compensation claims for all of Australia was \$3.7b. This direct cost alone represented 0.9% of non-farm GDP, and 1.8% of non-farm wages, salaries and supplements.

#### **Therapeutic Goods Administration**

The Therapeutic Goods Administration (TGA) within the Department of Health and Family Services is responsible for ensuring that therapeutic products available in Australia are safe, effective and of high quality. Therapeutic goods include prescription drugs, non-prescription medicines, traditional remedies and medical devices.

The TGA conducts audits of manufacturers and pre-market assessments of medicines before they are released into the marketplace, and monitors marketed products through a comprehensive post-market monitoring program.

Pre-market assessment times for new drugs continue to decrease, ensuring early availability in Australia of important new advances for the treatment of serious diseases. The TGA processed 806 prescription drug submissions during 1995–96.

The Therapeutic Goods Administration Laboratories (TGAL) undertake targeted sampling of drug and medical device products on the market. In 1995–96, 1,104 products overall were tested and 169 failed to meet the required standards. This failure rate does not reflect the general quality of available products because the sampling program is largely directed to those products where problems are either known or suspected. Failures which reflect safety concerns result in recall of the batch. In 1995–96, there were 46 recalls of drug products and 117 recalls of medical devices. This represents a very small proportion (0.16% and 0.53% respectively) of the total numbers of these products included in the Australian Register of Therapeutic Goods.

Following the change of government in March 1996, the TGA also acquired responsibility for ensuring the assessment of potential health hazards to the community posed by chemicals and by the use and transport of radioactive material. The former Environmental Health and Safety Unit, the Australian Radiation Laboratory and the Nuclear Safety Bureau became part of the TGA administrative cluster. Additionally, the secretariat for the National Drugs and Poisons Schedule Committee has been located within the TGA to provide a single point for industry to lodge applications for drug product scheduling and registration.

In 1995–96, 203 assessments of agricultural and veterinary chemicals were completed for the National Registration Authority for Agricultural and Veterinary Chemicals, and 173 requests for assessment of industrial chemicals were completed for the National Industrial Chemicals Notification and Assessment Scheme. Policy advice has also been provided to the government on national and international chemicals regulation.

#### 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 a 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.

The Australian Radiation Laboratory continues to have a high standing in international agencies

concerned with radiation safety and has been a substantial contributor to three major guidance documents finalised by the International Commission on Radiological Protection and the International Atomic Energy Agency.

#### **Cancer registries**

Cancer is a major cause of morbidity and mortality. Each year in Australia about 70,000 new cases of cancer are diagnosed and 35,000 people die from cancer. This equates to an average risk of one in three men and one in four 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 co-operative 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 co-ordinates national surveillance of communicable diseases through the National Notifiable Diseases Surveillance System, the National Mycobacterial Surveillance System, the Serious Adverse Events Following Immunisation Surveillance Scheme and the National Acute Hepatitis C Surveillance System. It also facilitates and co-ordinates 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 in Australia.

The Foundation's income in 1995 was \$21.7m of which \$16.0m 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 1995, expenditure on research, education and community service totalled \$14.5m.

# **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 1994–95 was \$111 5m.

Plasma products are manufactured by CSL Limited from plasma from Red Cross blood donors, and these are distributed by Red Cross.

Blood and blood products are provided free of charge to recipients.

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