9

HEALTH

This chapter is primarily concerned with the activities of the Commonwealth relating to health. There is, however, government responsibility for health at the State and local levels. There are constitutional limits on the Commonwealth Government's role in the health care field, and the primary responsibility for planning and provision of health services is with the State and Territory governments.

At the national level, health services in Australia are administered by the Commonwealth Government. The Government appoints two Ministers to the Portfolio of Community Services and Health. The Minister for Community Services and Health exercises overall responsibility over the Commonwealth Department of Community Services and Health, represents the portfolio in Cabinet and has particular responsibility for Budget matters and major policy decisions. The Minister for Housing and Aged Care has responsibility for the development and administration of particular health matters, including the Pharmaceutical Benefits Scheme and Therapeutic Goods. The Commonwealth Government is primarily concerned with the formation of broad national policies, and influences policy making in health services through its financial arrangements with the State and Territory governments, through the provision of benefits and grants to organisations and individuals, and through the regulation of health insurance.

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

Health care is also delivered by local government, semi-voluntary agencies, and profit making non-governmental organisations.

Medicare

Details of the health financing arrangements under the Medicare program introduced by the Commonwealth Government in February 1984 are available in *Year Book* No. 68.

Since the introduction of the Medicare Program the income thresholds on which the levy is payable have been revised. From 1 July 1989 no levy is payable by single people earning less than $10,330 per annum or by sole parents and married couples with combined income less than $17,400 per annum, with a further $2,100 per annum allowed for each dependent child.

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

The levy was increased from 1 per cent to 1.25 per cent of taxable income on 1 December 1986.

Medicare benefits

The Health Insurance Act provides for a Medicare Benefits Schedule which lists medical services and the Schedule (standard) fee applicable in respect of each medical service. The Schedule covers services attracting Medicare benefits rendered by legally qualified medical practitioners, certain prescribed services rendered by approved dentists and optometrical consultations by participating optometrists. Up to 1985 Schedule fees were set and updated by independent fee tribunals appointed by the Government and in which the Australian Medical Association (AMA) participated: the Government has determined the increase in Schedule fees since 1986. Medical services in Australia are generally delivered by either private medical practitioners on a fee-for-service basis, or medical practitioners employed in hospitals. The Schedule is constantly being reviewed through ongoing consultation with the medical profession and it is updated twice yearly to reflect current medical practice.

Medicare benefits are payable at the rate of 85 per cent of the Schedule fee for services, except those to hospital inpatients with a maximum payment by the patient of $20 for each service where the Schedule fee is charged. Where a doctor charges above the Schedule fee, the patient is responsible for any amount in excess of the Schedule fee in addition to the 15 per cent/$20 'patient gap'.

For medical Services rendered in hospitals or day-hospital facilities to private in-patients, the level of Medicare benefit is 75 per cent of the Schedule fee for each item with no maximum patient gap. The private health insurance funds cover the remaining 25 per cent (i.e. up to the level of the Schedule fee) for insured patients.

Gap benefits are not payable for out-of-hospital medical services. However, where accumulated gap payments for these services exceed $150 in a year, further services attract Medicare benefits equal to 100 per cent of the Schedule fee.

Under Medicare, medical practitioners may choose to bill the Commonwealth directly rather than billing the patient. In so doing, they accept the Medicare benefit as full payment.

Fee-for-service rebates are paid at differential rates if a medical practitioner had been recognised by the Minister for Community Services and Health as a Specialist or Consultant Physician (or Psychiatrist) and the patient has been referred by another practitioner.

Revised arrangements were introduced on 1 August 1987 for the payment of Medicare benefits for pathology services. These arrangements included the Commonwealth Pathology Accreditation Scheme which was introduced to ensure quality of pathology services throughout Australia. The Principles of Accreditation incorporated the standards recognised by the National Pathology Accreditation Advisory Council.

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

In 1988–89 claims associated with 143 million services were processed by the Health Insurance Commission involving benefit payments of $3,401 million. Summary statistics on benefits paid for medical services are provided below.

MEDICARE BENEFITS: NUMBER OF SERVICES, AMOUNT OF BENEFITS PAID AND BILLING SERVICES, STATES AND TERRITORIES, 1988–89

	NSW	*Vic.*	*Qld*	*SA*	*WA*	*Tas.*	*ACT*	*NT*	*O'seas*	*Aust.*
					—'000—					
Number of services	55,676.5	33,810.1	24,058.0	11,818.2	11,543.0	3,528.0	1,885.5	807.8	183.2	143,310.4
					—$ million—					
Benefits paid	1,322.2	808.6	562.0	289.7	270.0	79.7	48.3	16.8	3.8	3,401.0
					—per cent—					
Billing services—										
Direct billing	61.9	48.9	55.7	50.6	53.7	45.1	35.1	66.2	0	55.4
Lower than Schedule fee	3.4	6.6	6.8	4.1	5.1	11.1	4.5	1.7	40.2	5.2
Equal to Schedule fee	10.3	11.1	7.9	14.8	9.7	10.3	7.9	3.4	0.9	10.3
Greater than Schedule fee	24.4	33.4	29.5	30.5	31.6	33.5	52.5	28.8	58.9	29.1
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

MEDICARE BENEFITS: AMOUNT PAID BY BROAD SERVICE TYPE, STATES AND TERRITORIES, 1988–89
($ million)

Type of service	*NSW*	*Vic.*	*Qld*	*SA*	*WA*	*Tas.*	*ACT*	*NT*	*O'seas*	*Aust.*
GP consultation	511.0	317.9	216.7	114.4	103.8	34.2	17.3	6.9	1.4	1,323.6
Specialist consultation	210.7	139.7	81.8	51.3	36.6	11.3	9.1	1.7	0.7	542.9
Obstetrics	16.4	12.7	6.0	3.5	4.4	1.3	1.1	0.4	0.1	45.9
Anaesthetics	24.4	18.4	10.5	6.3	5.7	1.8	1.0	0.2	0.1	68.5
Pathology	203.8	107.0	97.1	35.9	42.7	11.5	5.0	3.7	0.5	507.2
Diagnostic imaging	149.1	85.1	58.2	30.4	33.3	7.8	6.0	2.0	0.5	372.3
Operations	123.7	79.9	60.6	30.7	26.3	7.5	5.1	1.2	0.4	335.4
Optometry	27.5	17.7	11.7	5.9	6.4	2.2	1.1	0.5	0	73.0
Other	55.5	30.4	19.4	11.3	10.8	2.0	2.6	0.2	0.2	132.3
Total	**1,322.2**	**808.6**	**562.0**	**289.7**	**270.0**	**79.7**	**48.3**	**16.8**	**3.8**	**3,401.0**

Hospital care

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

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

reduced to $100 a day, less the amount of the patient contribution. Any charges by private hospitals in excess of available benefits plus the statutory patient contribution become the responsibility of the patient.

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

Private hospitals

During the period 1 February 1984 to 30 September 1986, the Commonwealth subsidised patients in private hospitals by making bed-day payments. Three levels of bed-day payments were made. These were aligned to the particular category of hospital in which the patient was treated. Health insurance benefits were similarly aligned.

Commencing 1 March 1987, and extended from 1 October 1987, a system of patient classification for payment of basic health fund benefits was applied. Under this system, five classes of hospital patients were identified. These were: advanced surgical, surgical/obstetric, psychiatric, rehabilitation and other 'medical' patients. Differential levels of basic health fund benefits are payable according to each patient's classification, and step-down periods (i.e. lengths of stay in hospitals) also apply for each classification.

The States have always had primary responsibility for the planning and provision of health services and facilities within their respective boundaries. However, associated with private hospital categorisation, the Commonwealth also had a responsibility, in consultation with the States, for the approval and categorisation of private hospital facilities. Because of this overlap of responsibilities, the Commonwealth decided to discontinue its regulatory controls in the private hospital sector from 1 October 1986, leaving the States with the sole authority over such matters. Also, in the context of budgetary considerations, Commonwealth subsidisation of the private hospital sector through bed-day subsidies ceased from 1 October 1986.

Acting on the recommendations of a joint industry working party, comprised of representatives of the private hospital and health insurance industries and the Australian Medical Association, the Commonwealth approved a system of classifying patients in private hospitals for health insurance benefits purposes. The patient classification system was introduced on 1 March 1987 and replaced the private hospital categorisation arrangements. Patient classification more appropriately relates basic health insurance benefits more directly to the actual costs of providing hospital services necessary to the treatment of patients' conditions.

From 1 March 1987, three classes of private hospital patients were declared for health insurance benefits purposes. These are: advanced surgical, surgical/obstetric and 'other' patients. Differential levels of benefits are payable in relation to a patient's classification and step–down periods (i.e. lengths of stay in hospitals) also apply to each classification. Advanced surgical patients, and surgical/obstetric patients, are defined according to specified medical procedures as contained in the Medicare Benefits Schedule. From 1 October 1987, the patient classification arrangements were expanded to accommodate higher, distinct basic benefits for psychiatric and rehabilitation patients.

Pharmaceutical Benefits Scheme

The Pharmaceutical Benefits Scheme, established under the provisions of the National Health Act, provides a comprehensive range of drugs and medicinal preparations which may be prescribed by medical practitioners for persons receiving medical treatment in Australia. In addition, there is a limited range of antibiotic, antibacterial, analgesic and antifungal preparations which may be prescribed by dental practitioners for the treatment

of patients. The drugs and medicines are supplied by an approved pharmacist upon presentation of a prescription from the patient's medical or dental practitioner.

During 1988–89 patient contribution arrangements were as follows:

- *free of charge*—the holders of a Pensioner Health Benefits Card, Health Benefits Card, Dependant Treatment Entitlement Card or Service Pension Benefits Card and their dependants receive benefit items free of charge;
- *$2.50 per benefit item*—people in special need who hold a Health Care Card and their dependants, and those Social Security pensioners and Veterans' Affairs service pensioners who do not hold a PHB Card and their dependants, pay a contribution of $2.50 per benefit item;
- *$11 per benefit item*—all other people pay a contribution of $11 per benefit item.

At the same time, a scheme was introduced to provide protection for the chronically ill high drug user by placing a ceiling on the amount which could be paid by an individual or family for pharmaceutical benefits in a calendar year. Under the new arrangements, a person or family group who uses more than 25 pharmaceutical benefit prescriptions after the start of a calendar year qualifies for an entitlement to free pharmaceutical benefits for the remainder of that year.

In order to qualify for free pharmaceutical benefits under the 'safety net' arrangements, general or concessional patients may record each pharmaceutical benefit supplied on a prescription record form, obtainable from any pharmacy. After the supply of 25 prescriptions has been recorded, the form or forms may be presented to a pharmacy or any office of the Commonwealth Department of Community Services and Health for issue of a Pharmaceutical Benefits Entitlement Card conveying entitlement to free pharmaceutical benefits for the remainder of the year.

Under the Pharmaceutical Benefits Scheme the total cost, including patient contribution of prescriptions processed for payment, was $1,157.5 million in 1988–89. This figure does not include the cost of drugs supplied in certain psychiatric centres and geriatric centres or the cost of pharmaceutical benefits supplied through special arrangements, such as the Royal Flying Doctor Service (RFDS), Bush Nursing Centres and hormone treatment programs. As of 30 June 1988, arrangements for payments of some of these costs have been transferred to those States which were administering the services. The Commonwealth will continue to administer the RFDS and hormone treatment programs.

BENEFIT PRESCRIPTIONS AND COST OF MORE FREQUENTLY PRESCRIBED DRUG GROUPS, AUSTRALIA, 1988–89

	Benefit prescriptions		*Total cost of benefit prescriptions (a)*	
Drug group	*Number*	*Percentage of total*	*Amount*	*Percentage of total*
	'000	%	$'000	%
Non-steroidal anti-inflammatory drugs	8,862	8.8	94,152	8.1
Anti-asthmatics and antibronchitics	8,328	8.3	96,376	8.3
Benzodiazepines, sedatives and hypnotics	7,052	7.0	30,949	2.7
Penicillins	5,600	5.6	65,190	5.6
Diuretics	5,444	5.4	45,137	3.9
Beta-blockers	5,222	5.2	61,878	5.4
Antihypertensives	4,918	4.9	140,804	12.2
Anti-anginals	3,911	3.9	67,117	5.8
Oral contraceptives	3,351	3.3	38,567	3.3
Antidepressants	3,221	3.2	20,716	1.8
Water, salts and electrolytes	3,102	3.1	19,997	1.7
Non-narcotic analgesics	2,927	2.9	14,287	1.2
Topical corticosteroids	2,282	2.3	12,474	1.1
Antacids	2,249	2.2	14,839	1.3
Tetracyclines	2,083	2.1	17,686	1.5
Sulphonamides and urinary antiseptics	1,840	1.8	23,387	2.0
Anti-emetics	1,711	1.7	8,646	0.8
Narcotic analgesics	1,510	1.5	9,160	0.8
Eye anti-irritants and anti-allergics	1,369	1.4	7,982	0.7
Other eye preparations	1,353	1.3	13,293	1.2
Other drug groups	24,252	24.1	354,847	30.7
Total	**100,586**	**100.0**	**1,157,484**	**100.0**

(a) Includes Patients' contributions. Excludes Government expenditure on pharmaceutical benefits provided through miscellaneous services.

Source: Commonwealth Department of Community Services and Health.

Summary of personal benefit payments

For an analysis by purpose and economic type of expenditure by all Commonwealth Government authorities *see* Chapter 24, Public Finance.

Most Commonwealth Government health benefits are financed through the National Welfare Fund and the Health Insurance Commission. The following table shows personal benefit payments by Commonwealth Authorities for 1987–88.

COMMONWEALTH AUTHORITIES: PERSONAL BENEFIT PAYMENTS—HEALTH, 1987–88
($ million)

	NSW (a)	*Vic.*	*Qld*	*SA (a)*	*WA*	*Tas.*	*Total*
Hospital and other institutional services and benefits	*457.4*	*324.8*	*163.1*	*136.2*	*91.4*	*28.5*	*1,201.4*
Nursing homes	447.1	312.7	160.5	133.7	90.5	28.1	1,172.6
Hospital benefits	10.3	12.1	2.6	2.5	0.9	0.4	28.8
Clinic and other non-institutional services and benefits	*1,325.3*	*763.5*	*516.4*	*285.7*	*253.5*	*76.2*	*3,220.6*
Clinic and other non-institutional services n.e.c.	13.1	8.1	5.8	2.0	3.6	1.2	33.8
Medical benefits *(b)*	1,312.2	755.4	510.6	283.7	249.9	75.0	3,186.8
Public health	0.2	0.1	0.1	0.7	—	—	1.1
Pharmaceuticals, medical aids and appliances	385.3	236.9	150.1	81.0	71.1	24.2	948.6
Total	**2,168.2**	**1,325.3**	**829.7**	**503.6**	**416.0**	**128.9**	**5,371.7**

(a) State totals for New South Wales and South Australia include expenditure on personal benefit payments to residents in the Australian Capital Territory and the Northern Territory respectively. *(b)* Excludes $3.9 million for payments made overseas.

Commonwealth Government Subsidies and Grants to States

Hospital funding grants

New State and Territory funding arrangements were introduced on 1 July 1988. The former Identified Health Grants and Medicare Compensation Grants were terminated on 30 June 1988.

The new Hospital Funding Grants, totalling $3,406 million to the States and Territories in 1989–90, provide $3,341 million for hospital and related services, $38 million for incentives in the areas of post-acute and palliative care and day surgery procedures, $22 million towards hospital care for AIDS patients and $5.5 million to enable the development of a case mix based system as a management information system and potentially as a prospective payment system.

Hospital Funding Grants will operate in the first instance for the 5 year period 1988–89 to 1992–93 and be indexed each year to take account of population growth and adjusted for age and sex-weighted changes as well as price changes. The AIDS component is also indexed to take account of any increase in the number of AIDS patients. The 1989–90 Grant includes $24 million of payments to the States and Territories for a number of miscellaneous pharmaceutical benefits items supplied through special arrangements.

Commonwealth Government Subsidies and Grants to Organisations

Health program grants

Health program grants are authorised under Part IV of the Health Insurance Act. The scheme involves payments to approved organisations in respect of the costs or part thereof, incurred by those organisations in providing approved health services or an approved health service development project. The grants were first introduced in 1975 with the intention of establishing a scheme for funding a wide range of health services on other than a fee-for-service basis.

In 1987–88, a number of organisations previously funded under the Health Program Grants (HPG) arrangements commenced receiving funding under other arrangements. However, in 1988–89 additional organisations which had been funded under the Medicare Hospital Grants were included under HPG arrangements.

Funds appropriated for these grants amounted to $11.9 million in 1986–87, $4.2 million in 1987–88 and $31.9 million for 1988–89.

National Community Health Program—NCHP

The Commonwealth provides funding through the NCHP in order to promote community health-care principles by encouraging self-help and advocacy groups at the national level.

Fifty-nine projects received funding under the NCHP in 1988–89. The largest of these projects is the Family Medicine Program (FMP) of the Royal Australian College of General Practitioners, which provides vocational training for young doctors who intend to enter general practice. The trainees receive their training through attachments to participating private general practitioner practices and by attendance at educational events organised by the FMP.

The other national projects include national coordinating secretariats of voluntary non-profit organisations, health advocacy organisations and specific health-related projects which have national application.

Funds appropriated for this program amounted to $14.0 million in 1988–89.

National Health Promotion Program—NHPP

Under the NHPP the Commonwealth provides funding for projects which develop and promote effective strategies for health promotion and disease prevention, focusing on specific risk factors and different population groups.

Projects funded under the NHPP must be national in application and focus and be consistent with national health goals. Projects funded in 1988–89 included the Healthy Cities Pilot Project coordinated by the Australian Community Health Association, the Health Education and Promotion System (a data-base of health promotion programs) and numerous projects which focus on asthma, heart disease, cholesterol levels and hypertension in the workplace.

Funds appropriated for this program during 1988–89 amounted to $2.5 million including $1 million for the National Campaign Against Measles which promotes immunisation.

Health for All Australians

Following the Health for All Australians report, the National Better Health Program was established in late 1988. It is the most comprehensive health promotion project ever undertaken in Australia. The four year program has an allocation of $41 million and is jointly funded by the Commonwealth and States/Territories.

The Program is initially concerned with five priority areas:

- hypertension;
- nutrition;
- health of the elderly;
- injury;
- preventable cancer.

Projects to be funded in the Program will be based on the recommendations of Project Planning Teams which were appointed in each priority area. Community orientation is the focus of these projects.

Women's Health

The National Women's Health Policy was developed as an initiative within the context of the National Agenda for Women, with a substantial contribution by women through national consultations and over 300 submissions. The report was approved in principle by all Australian health ministers in March 1989 and launched by the Prime Minister in April.

Included in the Women's Health Package announced in the August Budget was a Commonwealth allocation of $16.86 million ($33.72 million when cost-shared with States and Territories) for the establishment of the National Women's Health Program which was a major recommendation arising from the National Women's Health Policy.

Program funding over four years will provide for:

- establishment of approximately 28 multidisciplinary women's community health centres/services nationally;
- development of an education/information strategy relating to the seven priority health issues identified by women during national consultations; and
- expansion of continuing education programs for health care professionals and development of a curriculum module on the health of young women, for use by teachers.

Other grants and subsidies

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

The Royal Flying Doctor Service

A non-profit organisation providing medical services in remote areas of Australia. It is distinct from, but coordinates with, the Aerial Medical Service which, while formerly operated by the Commonwealth Department of Community Services and Health, has been operated by the Northern Territory Government since 1 January 1979. The Royal Flying Doctor Service is financed mostly from donations and government contributions. For the year ended 30 June 1989 the Commonwealth Government paid grants totalling $8.7 million towards operational costs and assistance of $3.0 million towards an approved program of capital expenditure.

The Red Cross Blood Transfusion Service

This Service is conducted by the Australian Red Cross Society throughout Australia. The operating costs of the Service in the States and the Northern Territory are met by the State or Territory Government paying 60 per cent, the Society 5 per cent of net operating cost or 10 per cent of donations, whichever is the lesser, and the Commonwealth Government meeting the balance. Approved capital expenditure by the Service is shared on a dollar for dollar basis with the State and Northern Territory governments. Commonwealth Government expenditure for all States and Territories during 1988–89 was $20.5 million being $18.2 million for operating costs and $2.3 million for capital costs.

The National Heart Foundation of Australia

The Foundation is a voluntary organisation, supported almost entirely by public donations, established with the objective of reducing the toll of heart disease in Australia. It approaches this objective by programs sponsoring research in cardiovascular disease, community and professional education directed to prevention, treatment and rehabilitation of heart disease and community service programs including rehabilitation of heart patients, risk assessment clinics and surveys and documentation of various aspects of heart disease and treatment of heart disease in Australia. The Foundation's income in 1988 was $14.8 million of which $12.2 million was from public donations and bequests. Commonwealth, State and semi-government authorities made grants of $0.2 million for specific projects conducted by the Foundation. Since the inception of the Foundation, research has been a major function and a total of $4.3 million was expended in 1988 in grants to university departments, hospitals and research institutes and for fellowships tenable in Australia and overseas. It is notable however that with increasing opportunities for prevention and control of heart disease, the Foundation's education and community service activities are increasing significantly. In 1988 the expenditure on research, education and community service totalled $5.1 million.

The World Health Organization—WHO

WHO is a specialised agency of the United Nations having as its objective the attainment by all peoples of the highest level of health. Australia is assigned to the Western Pacific Region, the headquarters of which is at Manila, and is represented annually at both the World Health Assembly in Geneva and the Regional Committee Meeting in Manila. Australia's contribution to WHO for 1989 was $5.7 million..

The International Agency for Research on Cancer—IARC

The IARC was established in 1965 within the framework of the World Health Organization. The headquarters of the Agency are located in Lyon, France. The objectives and functions of the Agency are to provide for planning, promoting and developing research in all phases of the causation, treatment and prevention of cancer. Australia's contribution to the IARC for 1989 was $0.8 million.

National Health Services and Advisory Organisations

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

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

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

AHMAC comprises the head and the option of one other senior officer from the Commonwealth, State and Territory health authorities and the Department of Veterans' Affairs. The chairperson of the National Health and Medical Research Council, and the Director of the Australian Institute of Health may attend AHMAC meetings as observers. AHMAC was established by the April 1986 AHMC to replace the Standing Committee of Health Ministers (SCOHM) and the Australian Health Services Council (AHSC).

AHMAC may establish standing committees to serve on-going matters of concern to the Council and the Australian Health Ministers' Conference and ad hoc working parties or subcommittees to investigate and report on specific issues or aspects. The standing committees include the Intergovernmental Committee on Aids, the National Coordination Committee on Therapeutic Goods, the Super Speciality Services Subcommittee, the Subcommittee on Women and Health and the Subcommittee on Breast and Cervical Cancers.

Health services organisations

The Commonwealth Serum Laboratories Commission—CSL

CSL produces pharmaceutical products for human and veterinary use and is one of Australia's foremost scientific institutes. The Commission's main function is to produce and sell prescribed pharmaceutical products used for therapeutic purposes and to ensure the supply of essential pharmaceutical products in accordance with defined national health needs. The Commission's functions also include research and development relating to many kinds of human and veterinary diseases covering the fields of bacteriology, biochemistry, immunology and virology. The Commission's laboratories and central administration are located at Parkville, Victoria, with storage and distribution facilities in all States.

For over seventy years, CSL has been Australia's chief supplier of biological medicines, insulins, vaccines, human blood fractions, diagnostic reagents and an increasing range of veterinary pharmaceutical products needed by Australia's sheep, cattle, pig and poultry industries. The CSL Act now allows CSL to produce, buy, import, supply, sell or export prescribed pharmaceutical products (either of a biological or non-biological nature). It is expected that CSL will be incorporated as a company by legislation scheduled to come into effect in March 1990.

The Australian Radiation Laboratory
The Laboratory is concerned with the development of national policy relating to radiation health and:

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

The National Acoustic Laboratories
The National Acoustic Laboratories (NAL) provide free audiological services and hearing aids for eligible people with a hearing impairment. NAL fits almost 70 per cent of all hearing aids in Australia.

Eligible people include holders of Pensioner Health Benefits cards and their dependants, all persons under 21 years of age, Veterans' Affairs clients, referred clients of the Commonwealth Rehabilitation Service and certain compensation claimants. Services are delivered through a network of 43 NAL Hearing Centres across Australia, plus some 65 visiting centres in rural and remote areas.

The NAL Central Laboratory at Chatswood provides equipment and training and develops procedures to support the delivery of services through the Hearing Centres. It also conducts noise and audiological research, evaluates new devices and techniques, advises on measures to prevent hearing loss and reports on environmental and occupational noise problems.

The Therapeutic Goods Administration Laboratories —TGAL
The TGAL (formerly the National Biological Standards Laboratory) is part of the Therapeutic Goods Administration of the Commonwealth Department of Community Services and Health. TGAL is comprised of the Antibiotics, Microbiology, Pharmacology, Pharmaceutical Chemistry, Virology and Animal Service sections.

TGAL monitors the quality, safety and efficacy of biological and pharmaceutical products and selected therapeutic devices available for use in Australia. The major activities are analysis of therapeutic goods for acceptable quality, developmental research associated with new or improved testing methods and the development of standards, evaluation of the manufacturing aspects of applications for marketing selected therapeutic goods, and provision of relevant advice and training to governments, industry and international organisations.

Commonwealth Government Health Advisory Organisations

The National Health and Medical Research Council—NHMRC

The NHMRC advises the Commonwealth Government and State governments on matters of public health administration and the development of standards for food, pesticides, agricultural chemicals, water and air for consideration by the States for inclusion in their legislation. It also advises the Commonwealth Government and State governments on

matters concerning the health of the public and on the merits of reputed cures or methods of treatment which are from time to time brought forward for recognition. The Council advises the Commonwealth Minister for Community Services and Health on medical research and on the application of funds from the Medical Research Endowment Fund which provides assistance to Commonwealth Government departments, State departments, universities, institutions and persons for the purposes of medical research and for the training of persons in medical research. The Commonwealth Government makes annual appropriations to the fund. Expenditure for 1988–89 was $78.2 million. The Commonwealth Government also appropriated $2.4 million to the newly established Public Health Research and Development Committee for disbursement to priority research areas. The secretariat for the Council and its Committees is provided by the Commonwealth Department of Community Services and Health and is located in Canberra.

The Australian Institute of Health—AIH

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

The Institute is governed by a 12-member Board including nominees of the Minister for Community Services and Health, AHMAC, the Public Health Association of Australia, and the Consumers' Health Forum of Australia. Other members are the Australian Statistician, the Secretary of the Department of Community Services and Health and the Director of the Institute.

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

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

There are four major components to the Institute—Health Services Division, Health Status Division, Health Technology Unit and Corporate Services. A small Secretariat provides support for the Board and Institute Committees and coordinates liaison with other organisations.

Two external units are currently funded by the Institute—the National Perinatal Statistics Unit at the University of Sydney and the Dental Statistics and Research Unit at the University of Adelaide.

In investigating and documenting Australia's health services and programs, the Health Services Division mainly focuses on the traditional matters relating to health services—costs, use, access, facilities, resources and efficiency. It is also examining quality of care, the effects of ageing on the demand for health services, and the changing demands for services over the past 10 to 15 years. The Division's work includes the development of statistical and information systems on, and research into, the provision and use of health services.

The Division's major activities include:

- the development of databases to describe components of the health services system. These include health expenditure, the health labour force, use and costs of hospitals and other health related institutions, medical service use. The production of comparable statistics on the use, costs, revenues and staffing levels of various institutional health services will be assisted by the development of a national minimum data set;
- the development of models of health services demand and supply, including models to project the health labour force and to project the demand for hospitals services as the population ages;
- the development of measures of casemix—the types of cases treated in acute hospitals—and the dissemination of ideas and research related to casemix; and
- organisation of workshops on issues in the evaluation of health services, and other activities to promote research into health services.

The Health Technology Unit provides the major Australian focus for health technology assessment. Partly through its support for the National Health Technology Advisory Panel, and partly through its own work, the Unit promotes, undertakes and coordinates assessments of new and established health care technologies, paying particular attention to their costs and effectiveness. It publishes assessments and reviews of health care technology, carried out by or in association with the Unit, and collects appropriate statistics.

The Unit also provides support for the Super Speciality Services Subcommittee of AHMAC, a body responsible for the preparation of guidelines on certain expensive or specialised services.

Major projects include:

- an assessment of magnetic resonance imaging (MRI). The Unit is analysing data collected from five MRI units installed in teaching hospitals in Australia;
- the preparation of reports on technologies with major implications for health care. At present, studies are in progress on developments in high energy radiotherapy, coronary and peripheral angioplasty, cardiac imaging, renal stone therapy, dynamometry, bone mineral assessment and thermography;
- trials of the use of dry-chemistry pathology equipment in general practice and of biliary lithotripsy; and
- the preparation of guidelines on the management of spinal trauma, renal dialysis, refractory epilepsy and cardiac surgery.

The Health Status Division is responsible for improving statistical and related information on the nation's health, including the development of databases, and for monitoring, investigating and reporting on the health of the Australian people. It collates and analyses national data, with special attention to identifying differences in health status between different segments of the population.

Major projects include:

- participation in the monitoring and data components of the National Better Health Program, a cooperative Commonwealth–State/Territory health promotion and disease prevention program;
- the Risk Factor Prevalence Survey, 1989, in conjunction with the National Heart Foundation and the Department of Community Services and Health;
- collection and dissemination of information on Aboriginal health, and the development of national Aboriginal health statistics;
- investigation of the feasibility and cost-effectiveness of providing a comprehensive, coordinated nation-wide program of breast and cervical cancer screening;

- development of the National Death Index, a mortality database, the National Cancer Statistics Clearinghouse and an asthma-related deaths collection; and
- operation of a national nosology reference centre, which is the designated point of contact with the World Health Organization (WHO) on matters relating to the classification of diseases.

The Institute is also undertaking two special projects:

- an investigation of a possible cluster of cancer cases in a CSIRO workplace; and
- an epidemiological study of the carcinogenicity of the antimalarial agent, dapsone, in Australian Vietnam veterans.

The National Perinatal Statistics Unit, based at the University of Sydney, collects national data on perinatal health and mortality and on congenital anomalies, and conducts epidemiological studies in this field. The Unit's activities include analytical studies of selected congenital malformations and Caesarian births, and the development of a national perinatal data system and a national congenital malformation monitoring system. It also operates a register of IVF (in vitro fertilisation) pregnancies.

The Dental Statistics and Research Unit at the University of Adelaide is developing information and statistics on the dental labour force and on dental health status. The Unit is currently negotiating with State and Territory Dental Registration Boards to gain access to relevant information.

The National Occupational Health and Safety Commission—NOHSC

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

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

NOHSC has specified six priority areas for immediate attention and towards which the resources of the organisation are being directed. These issues are occupational back pain, noise-induced hearing loss, management of chemicals used at work, occupational skin disorders, occupational cancer and mechanical equipment injuries.

The activities of the organisation include the following:

- the development of national standards and codes of practice;
- national statistical responsibilities in the field of occupational health and safety;
- multidisciplinary research (including epidemiology, biostatistics, work physiology, occupational psychology, ergonomics and toxicology);
- teaching responsibilities through a Master of Public Health course and several non-academic short courses;
- training and education by the offer of research grants and study awards, and by encouraging the inclusion of intrinsic training in occupational health in tertiary courses;
- the collection, analysis and dissemination of information.

Individuals and groups with specialist knowledge or requirements in the field of occupational health and safety assist through their participation in various committees of the Commission.

The Australian Drug Evaluation Committee

The Committee makes medical and scientific evaluations of such goods for therapeutic use as the Minister for Community Services and Health refers to it for evaluation, and of other goods for therapeutic use which, in the opinion of the Committee, should be so

evaluated. It advises the Minister for Community Services and Health as it considers necessary on matters relating to the importation into, and the distribution within, Australia of goods for therapeutic use that have been the subject of evaluation by the Committee. It has the powers to coopt and seek advice from specialist medical colleges and associations and from the medical and allied professions, drug manufacturers and other sources.

The Committee met on six occasions throughout 1988–89. One hundred and six applications for approval for general marketing of new drugs were considered, resulting in 41 recommendations for approval, 62 for rejection and 3 for deferral. There were a further 10 approvals for extensions of therapeutic indications or amended dosage regimens for drugs already on the market.

The Therapeutic Device Evaluation Committee—TDEC

The Committee makes medical and scientific evaluations of therapeutic devices and advises the Minister for Community Services and Health on the importation, production and distribution of therapeutic devices in Australia. It has powers to appoint subcommittees which are usually formed to provide advice on specialised issues and to develop detailed and complex proposals for consideration.

The Committee met three times in 1988–89 and there were three full meetings of subcommittees. Topics of significance were the development of a priority model for device evaluation, intra-uterine contraceptive devices and guidelines for implantable materials. TDEC provides policy advice and oversights the Department's Therapeutic Device Program, which processed 28 full premarket evaluations and 156 through substantial equivalence and reviewed 140 problem reports in 1988–89.

The Therapeutic Goods Committee

The Committee provides advice to the Minister regarding the standards applicable to goods for therapeutic use including the requirements for packaging and labelling of such goods. Members of the Committee are selected for their individual expertise in pharmaceutics, pharmaceutical chemistry, pharmacology, microbiology, virology, veterinary science, medical devices, the manufacture of pharmaceuticals and therapeutic devices and consumer affairs.

National Campaign Against Drug Abuse—NCADA

Australia's NCADA, which was launched in April 1985, is a comprehensive, integrated and on-going campaign, combining the resources of all Australian governments and the community to minimise the harm caused to Australian society by the misuse of drugs, both licit and illicit. A Ministerial Council on Drug Strategy was also established by the Commonwealth, State and Territory governments to establish, fund, maintain and evaluate the Campaign.

The Commonwealth will contribute $30 million in 1989–90, of which $18.8 million is allocated to the States and Territories who match it on a dollar-for-dollar basis, and $11.2 million to national programs and to locally based pilot and demonstration initiatives in the areas of prevention, treatment, early intervention, data management and research. During 1988–89, over 380 separate projects were funded under the Commonwealth–State cost-sharing arrangements. These projects cover such areas as education, training, residential and non-residential treatment, community development and consultancy, research, evaluation and monitoring.

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

Information research and evaluation are central parts of the NCADA and activities have included:

- a national media/information campaign, 'The Drug Offensive', which was aimed at increasing public awareness of drugs and provided information on them through campaigns such as the pharmaceutical campaign and the young women and smoking campaign;
- research under the Research on Drug Abuse Program. Since its inception in 1985, the Program has provided over $5.7 million in support of 98 projects;
- the establishment of two national centres for drug research. The Commonwealth in 1989–90 has allocated $1.4 million per annum for the funding of these centres. The Sydney-based centre concentrates its work in the areas of drug treatment and rehabilitation. The Perth-based centre concentrates on research into the prevention of drug abuse;
- the establishment of a National Drug Abuse Data System based on a network of state and Territory data collection agencies;
- support of a major project to improve the teaching of drug and alcohol issues in the undergraduate medical curricula. Funding totalling $0.6 million has been offered to the ten University Medical Schools by the Department of Employment, Education and Training for this project.

Another aspect of the NCADA strategy is aimed at reducing the supply of drugs. A considerable effort has been made in recent years to strengthen the capabilities of Australian federal law enforcement agencies (i.e. the Australian Federal Police (AFP), National Crime Authority (NCA) and the relevant areas of the Australian Customs Service (ACS)). High priority is placed on the investigation of drug trafficking and organised crime. Additional funds have been invested in improved equipment (e.g. computers) and trained personnel.

In addition, the Commonwealth Government has enacted a package of legislation which provides a range of powers to law enforcement agencies which will assist in the investigation and recovery of the proceeds of organised crime, including drug trafficking. This approach is consistent with the policy of targeting those who control finance and benefit from major crime, particularly drug trafficking.

The international aspects of drug trafficking are also being addressed. The experience to date with tracing assets has highlighted the problems that arise where assets are transferred overseas or change hands before a suspect is convicted, thus making it very difficult for law enforcement agencies to recover the profits of criminal activity. The legislative package enables Australia to grant and request mutual assistance in criminal matters and extradition, usually subject to a treaty with the country concerned. The Mutual Assistance Treaties will enhance the ability of Australian and overseas law enforcement agencies to assist each other in the investigation and prosecution of drug crimes and will, in most cases, allow for the tracing, freezing, confiscating and the recovery of the proceeds of drug trafficking.

There are a number of Extradition and Mutual Assistance Treaties already in force. Others will soon be in force, while a third group is being negotiated.

An evaluation of the Campaign was undertaken in 1988 by an independent task force. The evaluation report was positive in its findings, concluding that while the fight against drug abuse must be long term, the Campaign was a 'major success' in its first three years and had made significant progress towards achieving its goals.

The Commonwealth Government has agreed to an extension of funding for another triennium until 1991–92.

Communicable Diseases

Quarantine

The *Quarantine Act 1908* is administered jointly by the Commonwealth Departments of Community Services and Health and Primary Industries and Energy and provides for the taking of measures to prevent the introduction or spread of diseases affecting humans, animals and plants.

Human quarantine

The masters of all ships and aircraft arriving in Australia from overseas are required to notify medical officers acting on behalf of the Commonwealth Department of Community Services and Health of all cases of illness on board at the time of arrival. Passengers or crew members who are believed to be suffering from a quarantinable illness may be examined by Quarantine Medical Officers located at all ports of entry.

The main concern of examining officers is the detection of quarantinable diseases including cholera, yellow fever, plague, typhus fever and viral haemorrhagic fevers. These diseases are not endemic to Australia and it is of great importance to prevent their entry. Sufferers or suspected sufferers may be isolated to prevent the possible spread of the disease.

A valid International Certificate of Vaccination is required of travellers to Australia over one year of age who have been in *yellow fever* infected areas within the past 6 days.

All passengers, whether they arrive by sea or air, are required to give their intended place of residence in Australia so that they may be traced if a case of disease occurs among the passengers on the ship or aircraft by which they travelled to Australia.

Isolation

Under the Quarantine Act, airline and shipping operators are responsible for the expenses of isolation of all travellers who disembark from their aircraft or ship and who fail to meet Australia's vaccination requirements.

Animal quarantine

The Department of Primary Industries and Energy, in consultation with the States and Australia's agricultural and livestock groups, seeks to satisfy the need for animal derived goods and to provide improved genetic material for Australia's livestock industries, while ensuring the maximum practical protection against the entry of exotic livestock diseases.

Importation of animals is restricted to certain species from designated overseas countries whose diseases status and pre-entry quarantine facilities meet Australia's stringent requirements. With few exceptions all imported animals are required to serve a period in quarantine on arrival.

Animal quarantine stations are located at most capital cities. A high security animal quarantine station on the Cocos (Keeling) Islands provides the means whereby the safe importation of a wide range of commercial livestock is facilitated.

Measures to prevent the entry of exotic diseases are also applied through the rigourous screening of applications to import biological materials and animal products and through inspection and treatment procedures on arrival.

Plant quarantine

Australia is free of numerous plant pests and diseases that occur elsewhere in the world. The importation into Australia of plant material is therefore subject to strict quarantine control.

The Department of Primary Industries and Energy has responsibility, in consultation with the States and agricultural and plant groups, for administering these controls. Some materials are admitted only under certain conditions while others are prohibited altogether.

However, the facilitation of safe importation is considered to be the best available means of reducing pest and disease risk involved in illegal importation.

The general objective is to keep out of the country any pest or disease which could cause serious economic losses to Australia's agriculture, horticulture or forests. Measures to prevent the entry of unwanted exotic plant pests and diseases involve careful screening of applications to import plant material and inspection and treatment procedures on arrival.

Notifiable diseases

Although State and Territory health authorities are responsible for the prevention and control of infectious diseases within their areas of jurisdiction, certain powers and responsibility may be delegated to local authorities within each State. These usually involve such activities as personal health services, environmental sanitation and local communicable disease control.

The Commonwealth Department of Community Services and Health receives notification figures from the States and Territories on a monthly basis which are published in *Communicable Diseases Intelligence*. The national totals for the year are published in the annual report of the Department, and are reproduced in the following tables.

Not all diseases are notifiable in all States and Territories and factors such as the availability of medical and diagnostic services, varying degrees of attention to disease notification and the source of notifications (i.e. whether notified by medical practitioners or by diagnostic laboratories), and the enforcement and follow-up of notifications by health authorities, affect both the completeness and the comparability of the figures between States and from year to year.

NOTIFIABLE DISEASES (a), NUMBER OF CASES NOTIFIED, 1988

Disease	*NSW*	*Vic.*	*Qld*	*SA*	*WA*	*Tas.*	*NT*	*ACT*	*Aust.*
Amoebiasis	8	6	2	38	4	—	2	—	60
Ankylostomiasis	—	—	1	17	15	2	n.a.	—	35
Arbovirus infection	136	150	511	8	63	—	29	—	897
Brucellosis	1	—	13	1	1	—	—	—	16
Campylobacter infection	1,875	n.a.	n.a.	1,560	372	n.a.	265	10	4,082
Chancroid	—	n.a.	1	n.a.	2	n.a.	—	1	4
Cholera	1	—	—	—	1	—	—	—	2
Congenital rubella syndrome	—	—	2	—	—	n.a.	—	—	2
Diphtheria	1	—	—	—	—	—	60	—	61
Donovanosis	1	n.a.	62	n.a.	46	—	24	—	133
Giardiasis	497	n.a.	n.a.	967	284	n.a.	n.a.	5	1,753
Genital herpes	954	227	852	n.a.	n.a.	n.a.	34	62	2,129
Gonococcal ophthalmia neonatorum	—	n.a.	—	—	n.a.	n.a.	3	n.a.	3
Gonorrhoea	746	629	831	278	979	28	569	19	4,079
Hepatitis A (infectious)	89	65	87	101	231	3	23	1	600
Hepatitis B (serum)	388	185	555	43	443	28	23	18	1,683
Hepatitis—unspecified	15	16	24	11	n.a.	n.a.	1	2	69
Hydatid disease	5	1	3	2	1	2	—	1	15
Legionnaires disease	26	8	4	26	2	n.a.	1	n.a.	67
Leprosy	7	—	3	1	5	—	4	—	20
Leptospirosis	36	25	22	6	4	11	—	—	104
Malaria	84	65	332	30	42	2	20	26	601
Measles	43	n.a.	174	14	16	n.a.	n.a.	1	248
Meningococcal infections	18	20	21	29	13	n.a.	23	2	126
Non-specific urethritis	3,136	n.a.	1	n.a.	n.a.	n.a.	73	n.a.	3,210
Ornithosis	5	5	1	8	—	—	—	2	21
Pertussis (whooping cough)	25	40	n.a.	57	31	n.a.	—	—	153
Q-Fever	232	1	167	21	3	—	—	—	424
Salmonella infections	1,048	179	1,116	398	366	113	240	24	3,484
Shigella infections	99	16	152	53	76	3	181	1	581
Syphilis	1,158	65	939	92	194	2	598	8	3,056
Tetanus	1	—	1	2	1	—	—	—	5
Trachoma	—	n.a.	n.a.	130	138	—	n.a.	—	268
Tuberculosis (all forms)	406	307	167	95	127	19	26	18	1,165
Typhoid fever	25	8	4	—	3	—	—	1	40
Typhus (all forms)	—	1	3	1	3	—	—	—	8
Vibrio parahaemolyticus infections	1	n.a.	n.a.	—	1	n.a.	—	n.a.	2
Yersinia infections	124	—	n.a.	44	3	n.a.	1	n.a.	172

(a) There were no cases of anthrax, lassa fever, marburg disease, plague, rabies, smallpox or yellow fever.

NOTIFIABLE DISEASES, NUMBER OF CASES NOTIFIED: AUSTRALIA

Disease	*1984*	*1985*	*1986*	*1987*	*1988*
Amoebiasis	46	87	54	58	60
Ankylostomiasis	75	43	40	57	35
Anthrax	—	1	—	1	—
Arbovirus infection	1,577	660	1,414	1,085	897
Brucellosis	15	22	12	12	16
Campylobacter infection	1,779	2,343	2,922	2,923	4,082
Chancroid	14	5	12	4	4
Cholera	—	2	—	—	2
Congenital rubella syndrome	1	3	2	3	2
Diphtheria	—	17	44	32	61
Donovanosis	201	73	185	148	133
Giardiasis	1,025	1,091	1,316	1,508	1,753
Genital herpes	1,330	1,707	2,136	2,359	2,129
Gonococcal Ophthalmia neonatorum	9	14	5	5	3
Gonorrhoea	8,894	7,605	6,585	4,979	4,079
Hepatitis A (infectious)	674	848	1,685	715	600
Hepatitis B (serum)	1,559	1,645	1,766	1,605	1,683
Hepatitis—unspecified	134	122	136	131	69
Hydatid disease	9	13	14	17	15
Legionnaires disease	13	28	68	96	67
Leprosy	28	38	27	31	20
Leptospirosis	227	185	179	133	104
Lymphogranuloma venereum	2	5	4	—	—
Malaria	640	421	696	574	601
Measles *(a)*	—	—	—	—	248
Meningococcal infections	59	53	51	96	126
Non-specific urethritis	4,383	4,872	8,063	7,384	3,210
Ornithosis	42	17	43	13	21
Pertussis (whooping cough)	261	587	601	291	153
Poliomyelitis	—	—	1	—	—
Q-Fever *(b)*	262	202	367	355	424
Salmonella infections	2,092	2,668	2,494	2,739	3,484
Shigella infections	420	734	833	586	581
Syphilis	3,323	3,523	3,594	3,190	3,056
Tetanus	7	11	5	5	5
Trachoma	4	63	233	274	268
Tuberculosis (all forms)	1,299	1,088	1,041	686	1,165
Typhoid fever	50	31	45	47	40
Typhus (all forms)	8	10	11	9	8
Vibrio parahaemolyticus infections	9	4	6	6	2
Yersinia infections	8	60	78	122	172

(a) Not notifiable until 1988. *(b)* Not notifiable in all States and Territories until 1986.

Source: Commonwealth Department of Community Services and Health

Childhood immunisation

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

A new measles/mumps/rubella (MMR) vaccine has been introduced to replace the measles/mumps vaccine for all children aged 12 to 15 months. Rubella immunisation remains routinely offered to all females between their 10th and 15th birthdays through the Schoolgirl Rubella Immunisation programs, in addition to their MMR immunisation at 12 to 15 months.

Hepatitis B vaccine is currently offered to neonates born to mothers belonging to community groups in which the carrier rate for Hepatitis B is estimated to exceed 5 per cent.

Acquired Immune Deficiency Syndrome—AIDS

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

The Strategy is coordinated at the national level by the Aids Policy and Programs Branch of the Commonwealth Department of Community Services and Health. The Branch has the responsibility for coordinating and evaluating community AIDS projects, assessing the funding of these initiatives, and undertaking liaison with a wide range of Australian and overseas agencies. In addition, the Department closely monitors medical and scientific developments in relation to the disease. It also provides executive support for national AIDS Committees which have been established to consider and advise on all aspects of AIDS.

These committees include:

- the Australian National Council on AIDS (ANCA), established in March 1988 to combine the functions of the former AIDS Task Force and NACAIDS, to advise the Commonwealth Minister for Community Services and Health on all aspects of AIDS;
- the National AIDS Forum, also established in March 1988, to ensure that ANCA and the Minister maintain close communication with, and receive advice from, individuals and organisations involved in the fight against AIDS;
- the Parliamentary Liaison Group on AIDS, established to bring together Federal parliamentarians to enable them to keep abreast of AIDS issues and to provide advice on community attitudes to the disease; and
- the Intergovernmental Committee on AIDS, established to bring together the States and the Commonwealth to discuss AIDS policy and financial matters.

In 1988–89 the Commonwealth made available over $42.4 million for the fight against AIDS. This expenditure was divided between the National AIDS Program ($14.5 million), the AIDS Matched Funding Program ($12.7 million) and Medicare payments to the States ($15.1 million).

The Commonwealth has allocated approximately $59.7 million to the AIDS program in 1989–90. Of this, $18 million is earmarked for the National AIDS Program and $19.4 million will be made available under the Matched Funding Program. Under the Matched Funding Program, the Commonwealth has continued assistance to maintain the safety of our blood supply by supporting the screening of blood transfusion services

throughout Australia. A further $21.7 million will be paid to the States under Medicare arrangements for the treatment of HIV/AIDS in public hospitals.

Activities under the National AIDS Program included research, the national AIDS education campaign, grants to community-based organisations, exchange of information both within Australia and internationally and support of national AIDS advisory committees.

Brochures and posters, as well as radio and television commercials, were produced as part of the education campaign. Specific materials were developed for youth, intravenous drug users and Aboriginal communities.

A major AIDS information campaign for people from non-English speaking backgrounds was launched in early August 1989 by the Minister. The campaign, conducted in 16 community languages, is one of the few national advertising campaigns designed specifically for ethnic communities. The impetus for the campaign was the lack of accurate AIDS information available to people with a limited proficiency in English.

Educational material on AIDS prevention was also produced and distributed to international travellers.

These national education activities were reinforced by grants to a range of community organisations for AIDS education projects. Australia has received international recognition for its innovative use of community organisations as peer educators.

During 1988–89, the research activities of the National Centres in HIV Virology Research and Epidemiology and Clinical Research (previously known as the Special Units) continued, and a number of grants were awarded to both individuals and groups for biomedical and behavioural research into AIDS. The Special Unit in Epidemiology continues its research into the clinical aspects of the drug Azidothymidine (AZT).

A third Unit, the National Centre in HIV Social Research, is to be established in 1989–90. The purpose of this unit will be to conduct and coordinate research into the effects of the epidemic, to identify educational and training needs, and to evaluate specific social aspects of transmission and the impact of education and prevention programs and policy initiatives.

Funding is also provided to the National Reference Laboratory for evaluation of new diagnostic kits for HIV infection and quality control of HIV testing programs in Australia.

On the international front, Australia will provide assistance to countries in the western Pacific region and will contribute a total of $2 million in grants to the WHO Global Program on AIDS.

REPORTED AIDS CASES TO 31 OCTOBER 1989

	NSW	*Vic.*	*Qld*	*SA*	*WA*	*Tas.*	*NT*	*ACT*	*Aust.*
Number of cases—									
Males	923	317	98	51	70	4	2	16	1,481
Females	30	7	4	2	4	1	—	—	48
Persons	953	324	102	53	74	5	2	16	1,529
Known deaths—									
Number	546	143	63	21	28	2	1	10	814
Per cent of cases	57.3	44.1	61.8	39.6	37.8	40.0	50.0	62.5	53.2

Source: Commonwealth Department of Community Services and Health.

CASES OF AIDS AND KNOWN DEATHS FROM AIDS BY TRANSMISSION CATEGORY, AUSTRALIA, TO 31 OCTOBER 1989

	Cases				*Known deaths*			
Transmission category—	*Males*	*Females*	*Total*	*Per cent of all cases*	*Males*	*Females*	*Total*	*Per cent of cases by category*
Homo-Bisexual	1,352	0	1,352	88.4	711	0	711	52.6
Heterosexual IVDU *(a)*	10	8	18	1.2	4	1	5	27.8
Homo-Bisexual IVDU *(a)*	42	0	42	2.7	20	0	20	47.6
Haemophilia	17	0	17	1.1	8	0	8	47.1
Heterosexual contact	12	12	24	1.6	7	3	10	41.7
Blood transfusion *(b)*	36	24	60	3.9	28	23	51	85.0
Other	8	2	10	0.7	4	1	5	50.0
Under investigation	4	2	6	0.4	4	0	4	66.7
Total	**1,481**	**48**	**1,529**	**100.0**	**786**	**28**	**814**	**n.a.**

(a) Intravenous drug user. *(b)* Includes receipt of blood products or tissue.
Source: Commonwealth Department of community Services and Health.

Hospitals

Repatriation hospitals

The Department of Veterans' Affairs administers the only national hospital system in Australia, consisting of six acute-care Repatriation hospitals (one in each State), three auxiliary hospitals, and the Anzac Hostel in Brighton, Victoria.

A broad range of in-patient and out-patient services is available for the care and treatment of eligible veterans and their dependants. Patients from the general community may also receive treatment at Repatriation hospitals provided bed capacity is available after the needs of entitled veterans have been met and the hospital facilities are appropriate to the treatment required.

The Department of Veterans' Affairs has fostered the development of rationalised treatment arrangements with State health authorities to avoid the unnecessary duplication of hospital facilities and services. Repatriation General Hospitals (RGHs) are affiliated with a university and learned colleges for the education of medical and allied health professional staff.

Veterans may also receive treatment in non-departmental public and private hospitals and nursing homes at the Department's expense in certain circumstances. Entitled patients with psychiatric conditions requiring custodial care are, by agreement with the State governments, accommodated at the expense of the Department in mental hospitals administered by State authorities.

The increasing age and frailty of the entitled veteran population has led the government to undertake a series of reviews of the Repatriation Hospital System. These reviews have resulted in a proposal to integrate Repatriation General Hospitals into the State health systems by 1 July 1995, subject to agreement by the ex service community, staff associations and State governments on issues such as veteran access to hospitals after transfer and the maintenance of staff rights and conditions of service.

Integration will allow veterans and war widows to be treated at local public or private hospitals. These arrangements will remove the need for veterans, families and friends to travel to the central RGH and will result in better local coordination of treatment.

Details of patients, staff and expenditure on Repatriation institutions and other medical services are given in Chapter 8, Social Security and Welfare.

Mental health institutions

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

A National Minimum Dataset for Institutional Care is presently being developed by the Australian Institute of Health through the Australian Health Ministers' Advisory Council.

Hospital statistics

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

Employment Injuries

Annual statistics on employment injuries are collected and published by most ABS State Offices. However, these statistics rely upon administrative by-product data generated under the differing provisions of workers' compensation legislation in each State. Legislative differences, coverage and reporting deficiencies of the by-product source data and the absence of comparable data for the Commonwealth employee sector have to date prevented the production of national employment injuries statistics.

The collection of statistics on occupational health and safety has undergone significant change following the Commonwealth Government's establishment of the National Occupational Health and Safety Commission (Worksafe Australia). This body is responsible for the facilitation and coordination of action, in collaboration with unions, business and State governments, aimed at improving working conditions and reducing the incidence and severity of injury and illness in the workplace. The overall objectives of Worksafe Australia include plans to develop and implement improved systems for the recording and collection of statistical and other information. To this end, Worksafe Australia released a report 'National Data Set for Compensation-Based Statistics, April 1987' which proposed the collection of a standardised set of data items with associated concepts, classifications, etc. It is proposed that once this National Data Set is fully implemented by both the private and public sectors, Worksafe will commence publication of national employment injury statistics.

In 1989 Worksafe Australia released the results of a study of work-related fatalities which occurred during the three years 1982–84. The study was based on a detailed examination of coroners' files.

Deaths

Information relating to crude death rates and life expectancy is contained in Chapter 6, Demography (Vital Statistics).

Causes of death and perinatal deaths

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 (WHO). The statistics in the table below show the number of deaths registered during 1988, classified to broad groupings of causes of death. More detailed statistics are contained in *Causes of Death, Australia* (3303.0).

The major causes of death in the community in 1988 were diseases of the circulatory system (accounting for 46.0 per cent), neoplasms (24.9 per cent), diseases of the respiratory system (7.5 per cent) and accidents, poisonings and violence (7.1 per cent). Infectious diseases have caused few deaths in Australia in recent years, largely as a result of quarantine activities, immunisation campaigns and similar measures. In 1988, fewer than one per cent of all deaths were due to such diseases.

The relative importance of groups of causes of death varies with age. Diseases of the circulatory system and neoplasms are predominant in middle and old age. Accidents, particularly those involving motor vehicles, are the primary cause of death in childhood and early adulthood. The majority of infant deaths (54.6 per cent in 1988) occur within 28 days after birth (*see* table on perinatal deaths within this chapter).

CAUSES OF DEATH IN EACH AGE GROUP, AUSTRALIA, 1988

	Age group (years)									
Causes of death	*Under one*	*1–14*	*15–24*	*25–34*	*35–44*	*45–54*	*55–64*	*65–74*	*75 and over*	*Total (a)*
	NUMBER									
Infectious and parasitic diseases	24	37	21	28	41	55	69	138	320	733
Neoplasms	8	130	150	337	1,041	2,445	6,148	9,120	10,506	29,887
Endocrine, nutritional and metabolic diseases and immunity disorders	26	29	30	82	107	140	376	663	1,311	2,764
Diseases of the nervous system and sense organs	36	76	74	63	82	93	194	411	1,128	2,157
Diseases of the circulatory system	9	27	85	216	723	1,855	5,668	13,224	33,271	55,080
Diseases of the respiratory system	47	48	62	79	121	266	1,000	2,409	5,002	9,036
Diseases of the digestive system	5	6	8	64	174	313	631	902	2,049	4,154
Congenital anomalies	559	98	47	28	28	18	37	27	22	864
All other diseases *(b)*	892	18	118	222	138	117	343	766	3,317	5,932
Signs, symptoms and ill-defined conditions	470	20	34	34	25	18	31	18	132	783
Accidents, poisonings and violence	56	473	1,884	1,552	1,046	786	728	686	1,263	8,476
All causes	**2,132**	**962**	**2,513**	**2,705**	**3,526**	**6,106**	**15,225**	**28,364**	**58,321**	**119,866**
	RATE *(c)*									
Infectious and parasitic diseases	10	1	1	1	2	3	5	13	46	4
Neoplasms	3	4	5	12	43	146	419	826	1,513	181
Endocrine, nutritional and metabolic diseases and immunity disorders	11	1	1	3	4	8	26	60	189	17
Diseases of the nervous system and sense organs	15	2	3	2	3	6	13	37	162	13
Diseases of the circulatory system	4	1	3	8	30	111	386	1,198	4,791	333
Diseases of the respiratory system	19	1	2	3	5	16	68	218	720	55
Diseases of the digestive system	2	*(d)*	*(d)*	2	7	19	43	82	295	25
Congenital anomalies	227	3	2	1	1	1	3	2	3	5
All other diseases *(b)*	363	1	4	8	6	7	23	69	478	36
Signs, symptoms and ill-defined conditions	191	1	1	1	1	1	2	2	19	5
Accidents, poisonings and violence	23	14	69	57	43	47	50	62	182	51
All causes	**866**	**28**	**92**	**99**	**144**	**366**	**1,037**	**2,570**	**8,397**	**725**

For footnotes *see* end of table.

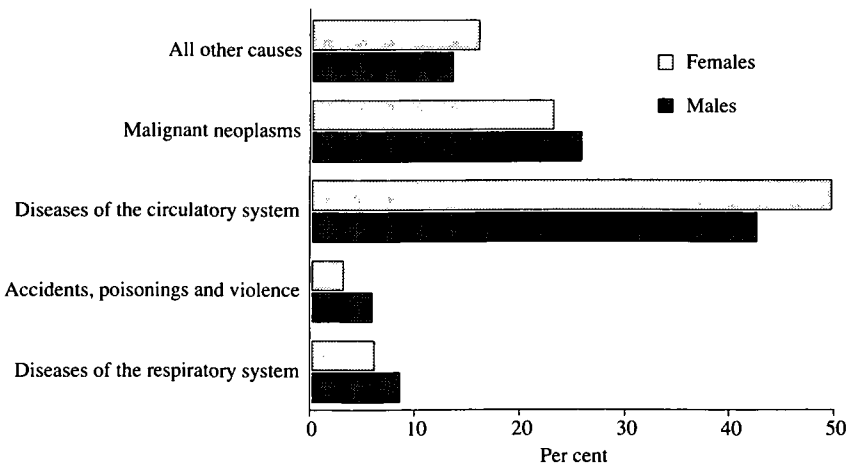
CAUSES OF DEATH IN EACH AGE GROUP, AUSTRALIA, 1988—*continued*

Causes of death	*Age group (years)*									
	Under one	*1–14*	*15–24*	*25–34*	*35–44*	*45–54*	*55–64*	*65–74*	*75 and over*	*Total (a)*
	PERCENTAGE *(e)*									
Infectious and parasitic diseases	1.1	3.8	0.8	1.0	1.2	0.9	0.5	0.5	0.5	0.6
Neoplasms	0.4	13.5	6.0	12.5	29.5	40.0	40.4	32.2	18.0	24.9
Endocrine, nutritional and metabolic diseases and immunity disorders	1.2	3.0	1.2	3.0	3.0	2.3	2.5	2.3	2.2	2.3
Diseases of the nervous system and sense organs	1.7	7.9	2.9	2.3	2.3	1.5	1.3	1.4	1.9	1.8
Diseases of the circulatory system	0.4	2.8	3.4	8.0	20.5	30.4	37.2	46.6	57.0	46.0
Diseases of the respiratory system	2.2	5.0	2.5	2.9	3.4	4.4	6.6	8.5	8.6	7.5
Diseases of the digestive system	0.2	0.6	0.3	2.4	4.9	5.1	4.1	3.2	3.5	3.5
Congenital anomalies	26.2	10.2	1.9	1.0	0.8	0.3	0.2	0.1	*(f)*	0.7
All other diseases *(b)*	41.8	1.9	4.7	8.2	3.9	1.9	2.3	2.7	5.7	4.9
Signs, symptoms and ill-defined conditions	22.0	2.1	1.4	1.3	0.7	0.3	0.2	0.1	0.2	0.7
Accidents, poisonings and violence	2.6	49.2	75.0	57.4	29.7	12.9	4.8	2.4	2.2	7.1
All causes	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

(a) Total includes 12 deaths where age is not known. *(b)* Includes 894 deaths from conditions originating in the perinatal period and 1,850 deaths from diseases of the genito–urinary system. *(c)* Rates are per 100,000 of population at risk, except for children under one year of age which are per 100,000 live births registered. *(d)* Less than 0.5. *(e)* Percentage of all deaths within each age group. *(f)* Less than 0.05.

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

ALL DEATHS: PERCENTAGE DISTRIBUTION BY CAUSE, AUSTRALIA, 1988



Perinatal deaths

Since deaths within the first 28 days of life (neonatal deaths) are mainly due to conditions originating before or during birth, and the same conditions can cause fetal death (stillbirth), special tabulations are prepared combining the two. These are termed 'perinatal deaths'. The statistical definition of perinatal deaths in Australia was amended in 1979 from that previously used, in accordance with a recommendation of the Ninth Revision Conference

(1975) of the World Health Organization 'that national perinatal statistics should include all fetuses and infants delivered weighing at least 500 grams (or, when birth-weight is unavailable, the corresponding gestational age (22 weeks) or body length (25 cm crown–heel)), whether alive or dead'. The table below incorporates a further recommendation of the Conference in that it shows the number of fetal, neonatal and total perinatal deaths in Australia classified by both the main condition in the fetus/infant and the main condition in the mother.

The perinatal death rate for Australia increased marginally from 10.56 per 1,000 total births in 1987 to 10.65 in 1988.

Of the conditions in the child, the three main groups responsible for perinatal deaths were *Hypoxia, birth asphyxia and other respiratory conditions* (37.0 per cent of the total), *Other conditions originating in the perinatal period* (22.4 per cent) and *Congenital anomalies* (21.7 per cent). Forty per cent of all perinatal deaths did not mention any condition in the mother as contributing to the death. Of those deaths where maternal conditions were reported, 28.6 per cent were reported as being due to *Complications of placenta, cord and membranes.*

PERINATAL DEATHS BY CAUSE, AUSTRALIA, 1988

	Number of deaths			*Rate*		
Cause of death	*Fetal*	*Neonatal*	*Perinatal*	*Fetal (a)*	*Neonatal (b)*	*Perinatal (a)*
Conditions in fetus/infant—						
Slow fetal growth, fetal malnutrition and immaturity	113	166	279	0.46	0.67	1.13
Birth trauma	1	28	29	*(c)*	0.11	0.12
Hypoxia, birth asphyxia and other respiratory conditions	641	336	977	2.59	1.37	3.95
Fetal and neonatal haemorrhage	36	71	107	0.15	0.29	0.43
Haemolytic disease of fetus and newborn	9	3	12	0.04	0.01	0.05
Other conditions originating in the perinatal period	501	89	590	2.02	0.36	2.38
Congenital anomalies	160	413	573	0.65	1.85	2.31
Infectious and parasitic diseases	3	4	7	0.01	0.02	0.03
All other causes	9	54	63	0.04	0.22	0.25
Conditions in mother—						
Maternal conditions which may be unrelated to present pregnancy	178	84	262	0.72	0.34	1.06
Maternal complications of pregnancy	153	343	496	0.62	1.39	2.00
Complications of placenta, cord and membranes	585	170	755	2.36	0.69	3.05
Other complications of labour and delivery	28	34	62	0.11	0.14	0.25
No maternal condition reported	529	533	1,062	2.14	2.17	4.29
All causes—						
1988	**1,473**	**1,164**	**2,637**	**5.95**	**4.73**	**10.65**
1987	1,432	1,159	2,591	5.84	4.75	10.56
1986	1,585	1,227	2,812	6.47	5.04	11.48
1985	1,518	1,416	2,934	6.10	5.73	11.79
1984	1,593	1,204	2,797	6.76	5.15	11.87
1983	1,619	1,349	2,968	6.63	5.56	12.20

(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. *(c)* Less than 0.01

Health-Related Surveys Conducted by the ABS

National Health Surveys

A National Health Survey (NHS) is being conducted throughout the twelve month period October 1989 to September 1990. Previous surveys were conducted in 1977–78 and 1983.

The 1989–90 survey is the first of a new series of five-yearly health surveys providing baseline and trend information on a range of health status indicators and health-related behaviours of Australians. Surveys in this series will comprise a core data set, which will be repeated in successive surveys to provide comparable data over time, and a supplementary component which can be varied from survey to survey to address key health issues of the day.

The 1989–90 NHS is obtaining information about the health status of Australians, their use of health services and facilities, and health-related aspects of their lifestyle. In particular, the survey will provide:

- prevalence data on major recent and long-term illness and conditions suffered;
- information about people's response to illness in terms of the health services used (e.g. hospitalization, doctor consultations) and other actions taken (e.g. medications used, days lost from work or school);
- information about selective preventive health actions taken (e.g. immunization, use of vitamin/mineral supplements, exercise) indicating levels of health risk awareness; and
- prevalence data on lifestyle behaviours such as smoking and alcohol consumption, enabling assessment of the potential heath risks involved.

The design of the survey enables linkages between these elements to be described and analysed. A range of demographic and socioeconomic items will also be available for cross classification with health data, enabling an assessment to be made of the health service needs of groups such as the elderly, migrants and low income families and to identify those with special needs.

Aspects of women's health are addressed in all topics contained in the NHS. In addition, the survey is obtaining information on specific women's health issues in order to:

- determine awareness and use of screening techniques and services for breast and cervical cancer;
- establish the prevalence of women who have had a hysterectomy which will help assess data relating to cervical cancer screening services;
- investigate the relationship between health risk and use of oral contraceptives and IUDs; and
- establish the relationship between breast-feeding and the health of children.

These issues are among the highest priority issues identified in the development of the National Women's Health Policy.

About 21,000 households throughout Australia, covering about 57,000 persons will be included. Preliminary results from the survey are expected to be available early in 1991. In addition to published material the ABS expects to release special tabulations and unidentifiable unit record information in response to user requests.

Health Insurance Surveys

These surveys have been conducted for the years 1979–84, 1986, 1988 and 1990. The 1984 survey covered employed wage and salary earners in capital cities only.

These surveys obtain information on the levels and types of private health insurance cover in the Australian community. Results are published in *Health Insurance Survey, Australia* (4335.0).

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