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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 1990 no levy is payable by single people earning less than $11,745 per annum or by sole parents and married couples with combined income of less than $19,045 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 one 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 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 and community health centres. The Schedule is constantly being reviewed through ongoing consultation with the medical profession and it is updated twice yearly to reflect current medical practice.

Medicare benefits are payable at the rate of 85 per cent of the Schedule fee for services, except those to hospital in-patients with a maximum payment by the patient of $20 ($26, from 1 January 1991) 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 ($26) '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 ($240 from 1 January 1991) 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 has been recognised by the Minister for Community Services and Health as a Specialist or Consultant Physician (or Psychiatrist) and the patient has been referred by another practitioner. Similar arrangements apply to general practitioners who are vocationally registered.

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 the host country's public health system for immediately necessary medical and hospital treatment.

In 1989–90 claims associated with 145 million services were processed by the Health Insurance Commission involving benefit payments of $3,805 million. Summary statistics on benefits paid for medical services are provided below.

MEDICARE BENEFITS: NUMBER OF SERVICES, BENEFITS PAID, PERCENTAGE OF SERVICES DIRECT BILLED AND SCHEDULE FEE OBSERVANCE, STATES AND TERRITORIES, 1989–90

	NSW	Vic.	Qld	SA	WA	Tas.	NT	ACT	O'seas	Aust.
					—'000—					
Number of services	56,405	34,651	24,647	11,710	11,642	3,503	826.0	1,981	32.0	145,398
					—$ million—					
Benefits paid	1,478.5	911.0	639.2	314.1	299.3	89.5	20.2	52.7	0.7	3,805.4
					—per cent—					
Direct billed	64.1	52.1	59.8	53.7	56.8	46.5	63.1	42.5	68.0	58.4
Schedule Fee Observance*(a)*	76.3	68	72.8	70.4	68.8	65.9	71.1	50.8	n.a.	72.0

(a) Services direct billed and patient billed at or below the Schedule fee.

MEDICARE BENEFITS: AMOUNT PAID BY BROAD SERVICE TYPE, STATES AND TERRITORIES, 1989–90
($ million)

Type of service	NSW	Vic.	Qld	SA	WA	Tas.	NT	ACT	O'seas	Aust.
GP attendances	575.0	358.1	250.2	127.3	116.2	37.4	7.7	20.3	0.3	1,492.5
Specialist attendances	224.7	150.4	86.9	52.7	38.6	12.6	2.0	8.2	0.1	576.2
Obstetrics	17.8	13.7	6.9	3.6	4.8	1.4	0.4	1.0	0.0	49.7
Anaesthetics	32.3	25.2	14.7	8.4	7.7	2.5	0.5	1.2	0.0	92.5
Pathology	222.2	118.8	106.5	37.8	45.3	12.6	4.3	7.3	0.1	555.1
Radiology	143.7	83.0	57.9	28.5	31.6	7.8	2.0	4.5	0.1	359.0
Operations	137.7	91.0	70.1	33.0	29.6	8.7	1.9	4.9	0.1	376.9
Assistance at Operations	4.7	4.1	3.5	2.1	0.6	0.2	0.1	0.2	0.0	15.5
Optometry	32.0	20.4	13.8	6.4	7.0	2.5	0.7	1.3	0.0	84.2
Cleft Lip and Palate	0.2	0.1	0.0	0.1	0.0	0.0	0.0	0.0	0.0	0.5
Miscellaneous	88.3	46.2	28.6	14.0	17.9	3.7	0.8	3.8	0.0	203.3
Total	**1,478.5**	**911.0**	**639.2**	**314.1**	**299.3**	**89.5**	**20.2**	**52.7**	**0.7**	**3,805.4**

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 and out-patient services. The scheme does not cover hospital charges for private accommodation in a public hospital, private hospital treatment, nor care in a public hospital by a doctor of the patient's choice. It is possible however for persons to take out hospital insurance with registered health benefits organisations to cover these situations and Medicare benefits are available for private medical practitioners' charges in respect of those medical services provided in hospital.

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

Where a patient's doctor considers that a patient has continuing need of acute care, the doctor may issue a certificate under section 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 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 1989–90 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; and
- *$11 per benefit item*—all other people pay a contribution of $11 per benefit item.

The scheme also provided 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 used 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 the year.

Under the Pharmaceutical Benefits Scheme the total cost, including patient contribution of prescriptions processed for payment, was $1,311.3 million in 1989–90. This figure does not include the cost of drugs supplied through special arrangements, such as the Royal Flying Doctor Service (RFDS), Colostomy and Ileostomy Associations, methadone maintenance programs and hormone treatment programs.

BENEFIT PRESCRIPTIONS AND COST OF MORE FREQUENTLY PRESCRIBED DRUG GROUPS, AUSTRALIA, 1989–90

	Prescriptions		*Total cost of prescriptions(a)*	
Drug group	*Number*	*Percentage*	*Amount*	*Percentage*
	'000	%	$'000	%
Non-steroidal anti-inflammatory drugs	9,036	8.6	98,840	7.5
Anti-asthmatics and anti-bronchitics	9,252	8.8	119,828	9.1
Benzodiazepines, sedatives and hypnotics	7,213	6.9	32,658	2.5
Penicillins	6,195	5.9	75,333	5.7
Diuretics	4,266	4.1	41,881	3.2
Beta-blockers	4,491	4.3	51,345	3.9
Anti-hypertensives	5,765	5.5	170,614	13.1
Anti-anginals	4,117	3.9	73,383	5.6
Oral contraceptives	3,476	3.3	39,742	3.0
Antidepressants	3,332	3.2	21,341	1.6
Water, salts and electrolytes	2,841	2.7	19,896	1.5
Non-narcotic analgesics	3,501	3.3	18,351	1.4
Topical corticosteroids	2,449	2.3	13,954	1.1
Antacids	2,099	2.0	15,125	1.2
Tetracyclines	2,182	2.1	19,116	1.5
Sulphonamides and urinary antiseptics	1,430	1.4	16,153	1.2
Anti-emetics	1,861	1.8	9,827	0.8
Narcotic analgesics	1,940	1.9	12,064	0.9
Eye anti-irritants and anti-allergics	1,517	1.5	9,590	0.7
Other eye preparations	1,438	1.4	14,271	1.1
Gastric and Duodenal Ulcers	1,415	1.4	58,723	4.5
Topical Antifungals	1,320	1.3	8,121	0.6
Vaccines	1,288	1.2	20,378	1.6
Other Anti-diabetics	1,051	1.0	13,244	1.0
Systemic Corticosteroids	1,031	1.0	9,177	0.7
Other drug groups	20,462	19.5	328,380	25.0
Total	**104,969**	**100.0**	**1,311,332**	**100.0**

(*a*) Includes patients' contributions. Excludes Government expenditure on miscellaneous items.
Source: Commonwealth Department of Community Services and Health.

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 $3,370 million to the States and Territories in 1989–90, provided $3,304 million for hospital and related services, $39 million for incentives in the areas of post-acute and palliative care and day surgery procedures, $23 million towards hospital care for AIDS patients and $4.6 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 five 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.

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.

Organisations currently approved included a number of State controlled pathology services and two hour vision clinics. Health Program Grants are also paid to approved radiation oncology services in lieu of receiving a capital reimbursement through the fee-for-service arrangements under Medicare. Funds appropriated for these grants amounted to $38.4 million in 1989–90.

Community Organisations Support Program—COSP

The Community Organisations Support Program (COSP) was formed in April 1990 following an amalgamation of several smaller grants programs to community organisations.

The primary objective of the program is to fund initiatives which will support the infrastructure needs of community based non-profit organisations and groups whose activities are deemed to relate to the interests of the Community Services and Health portfolio.

Homeless youth

The innovative Health Services for Homeless Youth Program was established with funding in the 1989–90 Budget as part of the $100 million strategy 'Towards Social Justice for Young Australians'. The Program aims to develop and implement innovative primary health care services for homeless youth in major metropolitan areas. The Commonwealth has allocated $5 million over three years to this program ($10 million when cost-shared with States and Territories).

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

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

Women's health

In April 1989 the Prime Minister launched the National Women's Health Policy. In 1990–91 funds will be provided for the second year of the implementation of the Policy through:

- the National Women's Health Program, a four year cost shared program (commenced in 1989–90) totalling $33.72 million, for continued provision of women's health services and information and education to women; and for provision of training and education for health care providers and other professionals;
- the Alternative Birthing Services program, a $6.44 million four year program to encourage State and Territory Governments to provide a range of alternative birthing options; and
- the Women's Health Services (rural) Program, totalling $0.438 million over three years to enable Frontier Services, in conjunction with the Royal Flying Doctor Service, to extend services in rural areas in New South Wales, Queensland and Western Australia.

National Health Promotion Program—NHPP

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

Projects funded under NHPP must be national in application and focus and be consistent with national health goals. Projects funded in 1989–90 included the Campbelltown Asthma project and prevention of falls and musculo-skeletal injuries among older adults. Other projects focused on diabetes, dental disease and targetted people from non-English speaking backgrounds, children and adolescents and the socially disadvantaged.

Funds appropriated to this program during 1989–90 amounted to $2.5 million including $1 million for the promotion of immunisation against childhood diseases.

Public Health Education Program (Kerr-White)

The Public Health Education Program funds seven universities and two research institutions to conduct public health training and research. Under this Program, approximately 300 full-time students have enrolled in postgraduate public health courses.

National Better Health Program—NBHP

The NBHP is a four year, $41 million program, which aims to achieve a better standard of health for all Australians, with an emphasis on low socio-economic groups and the reduction of health status inequities. Funds are provided by the Commonwealth and States/Territories on a cost-shared basis and administered on a 30:70 ratio respectively.

Preventative strategies are being developed and implemented in five priority areas: nutrition, hypertension, preventable cancers, injury prevention and the health of elderly people.

A National Better Health Plan has been endorsed by the Minister and five national projects have been approved for funding: a National Secretariat for the Healthy Cities Network, the National Injury Surveillance Unit, a consultancy to investigate sporting injuries, a Consumers and Food Labelling project and Phase 1 of the Health Promoting Hospitals project.

National Mental Health Policy

Following the report of the consultants Dr P. Eisen and Mr K. Wolfenden on the national mental health services policy, a Mental Health Working Group was established by the Australian Health Ministers Advisory Council to advise on national mental health policy taking into account public comment.

Subsequently, the Working Group developed the Mental Health Discussion Paper which served as the basis for widespread consultations with interested professional and community groups. These consultations, which were held in all major cities and a number of large provincial towns, were completed by February 1990.

At the June 1990 meeting of the Australian Health Minister's Conference, the final report of the Working Group—the National Mental Health Strategy Statement—outlining major components, mechanisms and a timeframe for a national mental health policy, was endorsed. The major components of this policy include:

- a National Charter of Consumer Outcomes;
- policy and service delivery models to achieve positive consumer outcomes; and
- a national mental health data strategy.

The National Mental Health Policy which results from this process is expected to be considered at the Australian Health Ministers' Conference in 1992.

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

The Royal Flying Doctor Service is a non-profit organisation providing medical and emergency evacuation services in remote areas of Australia. It is distinct from, but coordinates with, the Aerial Medical Service which is operated by the Northern Territory Government. The Royal Flying Doctor Service is financed mostly from donations and government contributions. For the year ended 30 June 1990 the Commonwealth Government paid grants totalling $9.3 million towards operational costs and assistance of $1.1 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 Territories are met by the State or Territory Government paying 60 per cent, the Society 10 per cent of donations, and the Commonwealth Government meeting the balance. Approved capital expenditure by the Service is shared on a dollar for dollar basis with the State and Territory Governments. Commonwealth Government expenditure for all States and Territories during 1989–90 was $24 million being $21.4 million for operating costs and $2.6 million for capital costs.

National Heart Foundation of Australia

The Foundation is a voluntary organisation, supported almost entirely by public donations, established with the objective of reducing the toll of heart disease in Australia. It approaches this objective by programs sponsoring research in cardiovascular disease, community and professional education directed to prevention, treatment and rehabilitation of heart disease and community service programs including rehabilitation of heart patients, risk assessment clinics and surveys and documentation of various aspects of heart disease and treatment of heart disease in Australia. The Foundation's income in 1989 was $17.8 million of which $14.03 million was from public donations and bequests. Commonwealth, State and semi-government authorities made grants of $0.5 million for specific projects conducted by the Foundation. Since the inception of the Foundation,

research has been a major function and a total of $4.97 million was expended in 1989 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 1989 the expenditure on research, education and community service totalled $9.43 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 1990 was $3 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 1990 was $0.9 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 the Commonwealth Government, the State and Territory Governments to discuss matters of mutual interest concerning health policy, services and programs. Neither the Conference nor the Council has statutory powers, and decisions are reached on the basis of consensus. Their constitution rests on the formal agreement by the Commonwealth Government, the 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 Subcommittee on Women and Health, Australian Coordinating Committee on Organ Registries and Australian Health Technology Advisory Council.

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 by the end of 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; and
- in support of the above activities, undertakes research and development in the fields of ionising and non-ionising radiations which have implications for public and occupational health.

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 1989–90 was $80.3 million. The Commonwealth Government also appropriated $2.6 million to the Public Health Research and Development Committee for disbursement to priority research areas. Expenditure for 1989–90 was $2.6 million. 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 Inc., 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 Monitoring Division, Health Technology Unit and Corporate Services Division. A small Secretariat provides support for the Board and Institute Committees and coordinates liaison with other organisations.

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

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. In addition, work is undertaken and advice given on a number of health economics issues.

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 which is being undertaken by the Division;

- 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 has provided 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 peripheral angioplasty, cardiac imaging, renal stone therapy, bone thermography, cardiac defibrillators and cochlear implants;
- trials of the use of dry-chemistry pathology equipment in general practice and of biliary lithotripsy; and
- the preparation of guidelines on services for renal dialysis, sleep centres, refractory epilepsy and neonatal intensive care.

The Health Monitoring 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 Clearing house and an asthma-related deaths collection;

- operation of a national nosology reference centre, which is the designated point of contact with the WHO on matters relating to the classification of diseases; and
- an epidemiological study of the carcinogenicity of the antimalarial agent, dapsone, in Australian Vietnam veterans.

The National Injury Surveillance Unit is based in Adelaide, where it developed out of the three year National Injury Surveillance and Prevention Project, a joint activity of the Institute and the Child Accident Prevention Foundation of Australia. The Unit is developing and monitoring statistical collections relating to injury, under a grant from the National Better Health Program. It will also play a major role in monitoring new initiatives in road safety.

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 the Commonwealth Government, the 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, safe 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;
- administration of the National Industrial Chemicals Notification and Assessment Scheme;
- national statistical responsibilities in the field of occupational health and safety;
- multidisciplinary research (including epidemiology, biostatistics, work physiology, occupational psychology, ergonomics and toxicology), and through research grants;
- teaching responsibilities through a Master of Occupational Health and Safety course and several non-academic short courses;
- training and education through the development of national skill standards and teaching resource materials, study awards, and by encouraging the inclusion of training in occupational health in school and post secondary courses; and
- 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—ADEC

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 through 1989–90. Sixty one applications for approval for general marketing of new drugs were considered, resulting in 33 recommendations for approval, 23 for rejection and eight for deferral. There were a further 33 applications for extension of therapeutic indications, or amended dosage regimens of which 21 were approved, eight rejected and four deferred.

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, manufacture and distribution of therapeutic devices in Australia. It has powers to appoint subcommittees and establishes these to provide advice on specialist issues and to develop detailed and complex proposals for consideration.

The Committee met on three occasions in 1989–90 with three additional subcommittee meetings. Major activities included the exemption of generic intra-ocular lenses from pre market evaluation, the re-evaluation of all intra-uterine devices for supply in Australia along with the production of a pre-inserting information leaflet, the development of guidelines for evaluating on the basis of substantial equivalence, and the registration and listing of therapeutic devices. TDEC also recommended that an embargo be placed on the importation of implantable material of cattle (and sheep and goat) origin sourced from the United Kingdom and the Republic of Ireland until the significance of Bovine Spongiform Encephalopathy in humans was established.

TDEC provides policy and program management advice for the therapeutic device program carried out by the Therapeutic Goods Administration. The program gave some 87 pre market approvals in 1989–90 of which 30 were biomaterials. There were 177 problem investigations completed in the same period.

The Therapeutic Goods Committee—TGC

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.

TGC subcommittees active during 1989-90 included those on Child Resistant Packaging, General Requirements for Labels for Medicines and General Requirements for Labels for Therapeutic Devices. A new Therapeutic Goods Order (No. 32) on General Requirements for Labels for Therapeutic Goods came into effect in September 1989 and Therapeutic Goods Order (No. 33) on Child Resistant Packaging was signed by the Minister in February 1990.

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 Services 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, 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.

National Campaign Against Drug Abuse—NCADA

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

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

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

The Campaign is ongoing and is oversighted by a Ministerial Council on Drug Strategy (MCDS), comprising the Commonwealth Government, and the State and Territory Governments.

The Commonwealth contributed $30 million in 1989–90, of which $18.8 million was allocated to the States and Territories which matched it on a dollar for dollar basis, and $11.2 million to national initiatives in the areas of prevention, including The Drug Offensive, 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 drug abuse problems in Australia, and the recognition by NCADA of the special needs of groups within the community such as youth, Aboriginal people, prisoners, women, intravenous drug users and people of non-English speaking background.

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

- a national media information campaign, 'The Drug Offensive', which is aimed at increasing public awareness of the harm caused by drugs and providing information on them through campaigns such as the pharmaceutical campaign and the young women and smoking campaign;
- provision of almost $5.8 million in support of 102 research projects since 1985;
- establishment of two national centres for drug research: the Commonwealth in 1989–90 allocated $1.4 million per annum to a Sydney-based centre for drug treatment and rehabilitation, and a Perth-based centre on research into the prevention of drug abuse;

- support of a major project to enhance the teaching of drug and alcohol issues in the undergraduate medical curricula-funding totalling $0.6 million has been offered to the 10 university medical schools by the Department of Employment, Education and Training for this project; and
- proposed establishment of a national Centre for Education and Training on Addictions (CETA) to undertake training and research activities to meet the needs of those involved in the treatment/rehabilitation of people with drug and alcohol addiction problems. Funding is initially for three years from 1990 and will be reviewed by the Australian Research Council at three-yearly intervals for a total period of nine years.

The first three years of the Campaign were evaluated by an independently led review team in 1988. This evaluation found that:

> "... the campaign to date has been a major success, having in three years made considerable progress towards its goal of minimising the harm caused by drugs in Australian society..."

In general terms the great majority of those consulted believed that the investment of money and the effort that had been made in NCADA to date were worthwhile. Following this report a second evaluation is being planned to cover the period from 1985 to 30 June 1991.

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

Supply reduction strategies are also being funded under the Campaign. Increases in computer and staff capacity were provided to the Australian Federal Police to strengthen its ability to deal with drug trafficking. Similarly, the Australian Customs Service, already hard-pressed dealing with a large coastline, received substantial increases in equipment and human resources to improve its capacity to prevent drugs from illegally entering Australia.

Associated legislative developments have sought to bring a consistency of approach among the States and the Commonwealth and to introduce legislation to enable the forfeiture and confiscation of assets of convicted drug dealers.

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. Legislation now enables Australia to grant and request mutual assistance in criminal matters, 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, confiscation and recovery of the proceeds of drug trafficking. In addition, Australia has undertaken an extensive program of negotiation of modern extradition treaties, based on newly enacted extradition legislation. This is intended to facilitate the return of fugitives (including alleged drug offenders) for prosecution in the country where the offence occurred. With over 30 modern extradition and mutual assistance treaties already in force, there is also a significant number in which negotiations are substantially completed.

Legislation has now also been introduced in most States and Territories to allow law enforcement and drug problem treatment agencies to work cooperatively. Under this legislation, persons convicted of offences which were motivated by drug dependence are able to apply to the court to receive treatment for their problem in lieu of a gaol term. Subject to continuous review of the progress of offenders, this approach is both cheaper than gaol and has the potential to shorten the criminal career of drug dependents.

The international aspects of drug trafficking are also being addressed. The United Nations Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances was

adopted at Vienna on 19 December 1988, and on 14 February 1989, Australia became a signatory, subject to ratification.

When this Convention enters into force, it will become the third international instrument adopted to combat drug abuse. Whilst the earlier two, the Single Convention on Narcotic Drugs, 1961, and the Convention on Psychotropic Substances, 1971, had the principal aim of controlling the manufacture, distribution and use of LICIT narcotic drugs and psychotropic substances for medical and scientific use, the purpose of this treaty is to curb the synthesis and traffic in ILLICIT recreational drugs, to assist in bringing persons involved in these activities to justice, and to enable parties to seize profits arising from the trafficking of these drugs.

The Department of Community Services and Health will have responsibilities in respect of activities which provide for control over movement of materials and equipment used in manufacture and demand reduction programs.

Under Article 12 of the new Convention parties are required to establish and maintain a system to monitor international trade in substances known to be used in the illegal manufacture of drugs of dependence. The implementation of these controls is being negotiated with the Australian Customs Service, the Australian Bureau of Statistics, chemical industry groups and State Governments.

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 six 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.

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 and pests.

Importation of animals is restricted to certain species from designated overseas countries whose disease status and pre-entry quarantine supervision and 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 Sydney, Melbourne, Adelaide and Perth. 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, reproductive material and zoological animals from high risk countries is facilitated.

Measures to prevent the entry of exotic diseases and pests are also applied through the rigorous 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 relevant 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, forests or native vegetation. 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, NUMBER OF CASES NOTIFIED BY STATES AND TERRITORIES, 1989

Disease	*NSW*	*Vic.*	*Qld*	*SA*	*WA*	*Tas.*	*NT*	*ACT*	*Total*
Amoebiasis*(a)*	6	4	8	29	16	—	—	1	64
Ankylostomiasis*(a)*	—	—	—	17	77	12	*(b)*	—	106
Anthrax*(a)*	—	—	—	—	—	—	—	—	—
Arbovirus infection*(a)*	389	77	1,427	115	677	63	61	—	2,809
Brucellosis	—	—	18	1	1	—	—	—	20
Campylobacter infection*(a)*	1,875	57	*(b)*	1,501	497	5	310	34	4,279
Chancroid	1	*(b)*	—	*(b)*	2	*(b)*	—	—	3
Cholera	—	—	—	—	—	—	—	—	—
Congenital rubella syndrome	—	—	—	—	—	*(b)*	—	—	—
Diphtheria*(a)*	—	1	—	—	—	—	—	—	1
Donovanosis*(a)*	—	*(b)*	45	*(b)*	17	—	37	—	99
Giardiasis*(a)*	659	11	*(b)*	972	397	—	—	21	2,060
Genital herpes	876	—	1,660	*(b)*	*(b)*	*(b)*	4	41	2,581
Gonococcal ophthalmia neonatorum	1	*(b)*	—	—	*(b)*	*(b)*	—	*(b)*	1
Gonorrhoea*(a)*	603	—	994	200	741	16	584	15	3,153
Hepatitis A (infectious)	63	14	127	36	99	6	115	—	460
Hepatitis B (serum)*(a)*	465	149	1,714	48	550	45	27	19	3,017
Hepatitis—unspecified	21	6	9	4	*(b)*	*(b)*	1	2	43
Hydatid disease*(a)*	2	—	5	3	1	3	—	1	15
Lassa Fever	—	—	—	—	—	—	—	—	—
Legionnaires disease*(a)*	52	8	18	12	12	1	—	*(b)*	103
Leprosy	12	5	8	—	4	—	5	—	34
Leptospirosis*(a)*	58	22	—	5	4	10	—	—	99
Lymphogranuloma venereum*(a)*	—	*(b)*	—	*(b)*	*(b)*	*(b)*	*(b)*	—	—
Malaria*(a)*	91	65	487	34	60	9	5	19	770
Marburg disease	—	—	—	—	—	—	—	—	—
Measles	76	*(b)*	51	16	18	*(b)*	*(b)*	8	169
Meningococcal infections*(a)*	58	67	6	27	30	*(b)*	15	1	204
Non-specific urethritis	1,708	*(b)*	1	*(b)*	*(b)*	*(b)*	30	*(b)*	1,739
Ornithosis*(a)*	4	1	—	18	2	—	—	—	25
Pertussis (whooping cough)	202	57	*(b)*	136	204	3	9	3	614
Plague	—	—	—	—	—	—	—	—	—
Poliomyelitis*(a)*	—	—	—	—	—	—	—	—	—
Q-Fever(a)	138	6	181	21	5	(b)	2	(b)	353
Rabies	—	—	—	—	—	—	—	—	—
Salmonella infections(a)	1,333	218	1,223	531	552	167	416	52	4,492
Shigella infections(a)	94	29	125	75	284	6	165	1	779
Smallpox	—	—	—	—	—	—	—	—	—
Syphilis(a)	315	—	1,061	55	200	—	460	8	2,099
Tetanus	—	2	—	—	9	—	—	—	11
Trachoma	—	(b)	1	62	441	—	(b)	—	504
Tuberculosis (all forms)(a)	452	369	163	123	135	13	61	35	1,351
Typhoid fever(a)	19	24	5	5	4	—	—	—	57
Typhus (all forms)(a)	—	—	1	—	1	—	—	—	2
Vibrio parahaemolyticus infections(a)	8	(b)	(b)	2	—	—	—	(b)	10
Yellow Fever	—	—	—	—	—	—	—	—	—
Yersinia infections(a)	116	—	(b)	125	—	(b)	—	(b)	241

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

NOTIFIABLE DISEASES, NUMBER OF CASES NOTIFIED: AUSTRALIA, 1985–1989

Disease	*1985*	*1986*	*1987*	*1988*	*1989*
Amoebiasis*(a)*	87	54	58	60	64
Ankylostomiasis*(a)*	43	40	57	35	106
Anthrax*(a)*	1	—	1	—	—
Arbovirus infection*(a)*	660	1,414	1,085	897	2,809
Brucellosis	22	12	12	16	20
Campylobacter infection*(a)*	2,343	2,922	2,923	4,082	4,279
Chancroid	5	12	4	4	3
Cholera	2	—	—	2	—
Congenital rubella syndrome	3	2	3	2	—
Diphtheria*(a)*	17	44	32	61	1
Donovanosis*(a)*	73	185	148	133	99
Giardiasis*(a)*	1,091	1,316	1,508	1,753	2,060
Genital herpes	1,707	2,136	2,359	2,129	2,581
Gonococcal Ophthalmia neonatorum	14	5	5	3	1
Gonorrhoea*(a)*	7,605	6,585	4,979	4,079	3,153
Hepatitis A (infectious)	848	1,685	715	600	460
Hepatitis B (serum)*(a)*	1,645	1,766	1,605	1,683	3,017
Hepatitis—unspecified	122	136	131	69	43
Hydatid disease*(a)*	14	13	17	15	15
Lassa Fever	—	—	—	—	—
Legionnaires disease*(a)*	28	68	96	67	103
Leprosy	38	27	31	20	34
Leptospirosis*(a)*	185	179	133	104	99
Lymphogranuloma venereum*(a)*	5	4	—	—	—
Malaria*(a)*	421	696	574	601	770
Marburg disease	—	—	—	—	—
Measles	*(b)*	*(b)*	—	248	169
Meningococcal infections*(a)*	53	51	96	126	204
Non-specific urethritis	4,872	8,063	7,384	3,210	1,739
Ornithosis*(a)*	17	43	13	21	25
Pertussis (whooping cough)	587	601	291	153	614
Plague	—	—	—	—	—
Poliomyelitis*(a)*	—	1	—	—	—
Q-Fever*(a)*	202	367	355	424	353
Rabies	—	—	—	—	—
Salmonella infections*(a)*	2,668	2,494	2,739	3,484	4,492
Shigella infections*(a)*	734	833	586	581	779
Smallpox	—	—	—	—	—
Syphilis*(a)*	3,523	3,594	3,190	3,056	2,099
Tetanus	11	5	5	5	11
Trachoma	63	233	274	268	504
Tuberculosis (all forms)*(a)*	1,088	1,041	686	1,165	1,351
Typhoid fever*(a)*	31	45	47	40	57
Typhus (all forms)*(a)*	10	11	9	8	2
Vibrio parahaemolyticus infections*(a)*	4	6	6	2	10
Yellow Fever	—	—	—	—	—
Yersinia infections*(a)*	60	78	122	172	241

(a) Confirmed by appropriate diagnostic tests. *(b)* Not notifiable.
NOTE: For some of the diseases shown above information is not available or the diseases are not notifiable in certain States/Territories.
Source: Commonwealth Department of 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 five 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. To date the majority of National Strategy Recommendations have been, or are in the process of being implemented.

The Strategy is coordinated at the national level by the Aids Policy and Programs Branch of the Commonwealth Department of 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 Commonwealth 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 1989–90 the Commonwealth made available over $59 million for the fight against AIDS. This expenditure was divided between the National AIDS Program ($14.5 million), the AIDS Matched Funding Program ($19.5 million) and Medicare payments to the States ($23 million).

The Commonwealth has allocated approximately $79 million to the AIDS program in 1990–91. $24 million is earmarked for the National AIDS Program and $22.1 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 $30.2 million will be paid to the States/Territories under Medicare arrangements for the treatment of HIV/AIDS in public hospitals. This component will be indexed to the actual growth in AIDS cases treated.

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

A major national mass media campaign was developed during the year and launched in June 1990 by the Minister. It targeted intravenous drug users and their sexual partners and aimed to socialise the use of condoms and needle hygiene practices. Advertisements appeared on television, radio and in the cinema and press. Printed materials were produced to complement these and services were supplemented to meet demand created by the campaign.

National educational activities were reinforced by grants to a range of community organisations for AIDS education projects. A new grants scheme was established under the national HIV/AIDS strategy, the Commonwealth AIDS Workforce Information, Standards and Exchange (CAWISE) Program, to ensure that the workforce, particularly in occupations affected by HIV, has access to information and resource materials, retraining and skills development programs and development of guidelines and standards.

Educational Materials on AIDS prevention were also produced and distributed to international travellers.

During 1989–90, the research activities of the National Centres in HIV Virology and Epidemiology and Clinical Research (previously known as the special units) continued and a number of grants and training awards 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).

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

Under the national strategy funding guidelines, the Minister approved an increase in funding to the National HIV Reference Laboratory for 1989–90. The Reference Laboratory is responsible 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 and South East Asian Regions and will contribute a total of $2 million in grants to the WHO global program on AIDS over a 3 year period.

In August 1990 the Department co-hosted an international AIDS conference with the WHO entitled 'AIDS in Asia and the Pacific'. It was held in Canberra and attracted approximately 700 delegates from countries within the region and from other countries.

REPORTED AIDS CASES TO 31 JULY 1990

	NSW	*Vic.*	*Qld*	*SA*	*WA*	*Tas.*	*NT*	*ACT*
Number of cases—								
Males	1,174	386	129	61	81	10	3	25
Females	34	9	6	2	6	1	0	0
Known deaths—								
Number	758	206	88	36	42	6	2	15
Per cent of cases	65.7	17.8	7.6	3.1	3.6	0.5	0.2	1.3

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 and institutions

The Department of Veterans' Affairs administers a national hospital system consisting of six acute-care Repatriation General Hospitals (RGHs) with one in each State capital; three Repatriation Auxiliary Hospitals (RAHs) with one in New South Wales, Victoria and Queensland and Anzac Hostel in Victoria.

A broad range of in-patient and out-patient services is available for the care and treatment of eligible veterans and their dependants. The RGHs contribute to the State health care services by treating members of the general community where capacity exists after the needs of entitled persons have been met. Limits on the level of available beds for community patients are determined by the Repatriation Commission.

The Department of Veterans' Affairs has fostered the development of rationalised treatment arrangements with the State health authorities to avoid the unnecessary duplication of facilities and services. All the RGHs are affiliated with universities.

In certain circumstances veterans may also receive treatment in public and private hospitals and nursing homes at the Department's expense. Under arrangements with State Governments, entitled persons requiring custodial psychiatric care are treated at departmental expense in State psychiatric hospitals.

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. As part of these reviews the Minister for Veterans' Affairs, Ben Humphreys, announced on 14 August 1988, that subject to meeting certain guarantees to veterans and staff, the RGHs were to be integrated into the State hospital system by 1 July 1995. Veterans and war widows will have a wider choice of hospital and doctor than under the current arrangements which support a centralised RGH in each capital city. This offers advantages medically and for personal convenience. Integration will also ensure the RGHs continue to operate as acute care hospitals attracting high quality professional staff.

Details of patients, staff and expenditure on repatriation hospitals, institutions and other facilities 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 some ABS State Offices, and the relevant worker's compensation agencies. 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 comprehensive 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' in April 1987, which proposed the collection of a standardised set of data items with associated concepts, classifications and definitions. It is proposed that once the National Data Set is fully implemented from 1 July 1990, by the State, Territory and Commonwealth workers' compensation systems, Worksafe Australia will publish comprehensive national employment injuries statistics.

Worksafe Australia released the first national occupational injuries statistics, in relation to the 1986–87 financial year, in 1990. The national data was compiled from State based workers' compensation data. Commonwealth data is not included.

In 1990 Worksafe Australia and Standards Australia jointly released the 'Workplace injury and disease recording standard'. The Standard was developed to provide individual workplaces with a guide on how to establish an inexpensive and easy to use method of recording information on work injury and disease.

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 WHO. The statistics in the table below show the number of deaths registered during 1989, 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 1989 were diseases of the circulatory system (accounting for 45.7 per cent), neoplasms (24.5 per cent), diseases of the respiratory system (8.5 per cent) and accidents, poisonings and violence (6.6 per cent). In 1989, fewer than one per cent of all deaths were due to infections and parasitic diseases.

The relative importance of groups of causes of death varies with age. Diseases of the circulatory system and neoplasms are predominant in middle and old age. Accidents, particularly those involving motor vehicles, are the primary cause of death in childhood and early adulthood. The majority of infant deaths (58.8 per cent in 1989) occur within 28 days after birth (*see* table on perinatal deaths within this chapter).

CAUSES OF DEATH IN EACH AGE GROUP, AUSTRALIA, 1989

	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	18	30	20	30	33	48	85	145	352	761
Neoplasms	7	150	153	364	1,083	2,517	5,979	9,284	10,887	30,424
Endocrine, nutritional and metabolic diseases and immunity disorders	9	26	25	112	172	162	366	695	1,422	2,989
Diseases of the nervous system and sense organs	47	64	68	68	100	112	185	475	1,271	2,390
Diseases of the circulatory system	13	23	72	208	669	1,805	5,492	13,172	35,375	56,829
Diseases of the respiratory system	47	35	71	66	120	279	1,095	2,744	6,154	10,611
Diseases of the digestive system	4	9	9	58	148	312	611	929	2,163	4,244
Congenital anomalies	493	99	37	26	18	21	35	26	18	773
All other diseases*(b)*	849	19	98	202	130	141	343	873	3,571	6,226
Signs, symptoms and ill-defined conditions	474	26	14	21	33	25	36	35	149	814
Accidents, poisonings and violence	43	440	1,703	1,556	1,022	708	659	710	1,327	8,171
All causes	**2,004**	**921**	**2,270**	**2,711**	**3,528**	**6,130**	**14,886**	**29,088**	**62,689**	**124,232**

For footnotes *see* end of table.

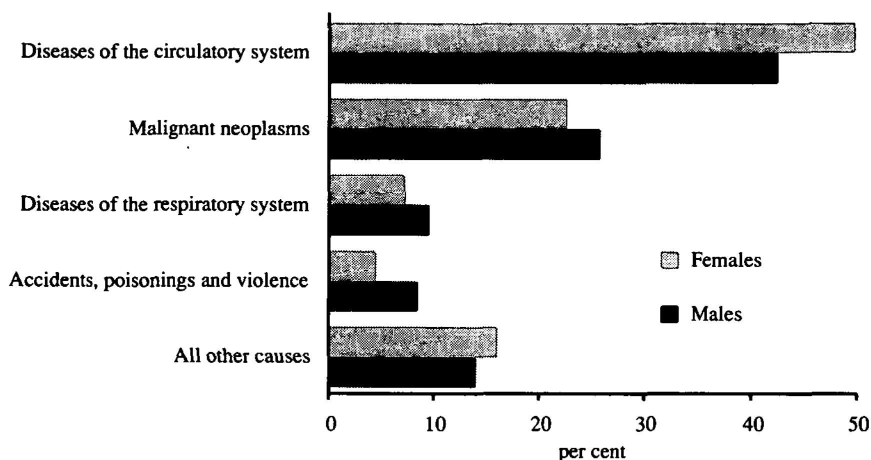
CAUSES OF DEATH IN EACH AGE GROUP, AUSTRALIA, 1989—*continued*

Causes of death	*Age group (years)*									*Total*
	Under one	*1–14*	*15–24*	*25–34*	*35–44*	*45–54*	*55–64*	*65–74*	*75 and over*	*(a)*
				RATE*(c)*						
Infectious and parasitic diseases	7	1	1	1	1	3	6	13	48	5
Neoplasms	3	4	6	13	43	145	408	822	1,497	181
Endocrine, nutritional and metabolic diseases and immunity disorders	4	1	1	4	7	9	25	62	196	18
Diseases of the nervous system and sense organs	19	2	2	2	4	6	13	42	175	14
Diseases of the circulatory system	5	1	3	7	27	104	375	1,166	4,864	338
Diseases of the respiratory system	19	1	3	2	5	16	75	243	846	63
Diseases of the digestive system	2	*(d)*	*(d)*	2	6	18	42	82	297	25
Congenital anomalies	197	3	1	1	1	1	2	2	2	5
All other diseases*(b)*	338	1	4	7	5	8	23	77	491	37
Signs, symptoms and ill-defined conditions	189	1	1	1	1	1	2	3	20	5
Accidents, poisonings and violence	17	13	62	56	41	41	45	63	182	49
All causes	**799**	**27**	**82**	**97**	**140**	**353**	**1,017**	**2,575**	**8,620**	**738**
				PERCENTAGE*(e)*						
Infectious and parasitic diseases	0.9	3.3	0.9	1.1	0.9	0.8	0.6	0.5	0.6	0.6
Neoplasms	0.3	16.3	6.7	13.4	30.7	41.1	40.2	31.9	17.4	24.5
Endocrine, nutritional and metabolic diseases and immunity disorders	0.4	2.8	1.1	4.1	4.9	2.6	2.5	2.4	2.3	2.4
Diseases of the nervous system and sense organs	2.3	6.9	3.0	2.5	2.8	1.8	1.2	1.6	2.0	1.9
Diseases of the circulatory system	0.6	2.5	3.2	7.7	19.0	29.4	36.9	45.3	56.4	45.7
Diseases of the respiratory system	2.3	3.8	3.1	2.4	3.4	4.6	7.4	9.4	9.8	8.5
Diseases of the digestive system	0.2	1.0	0.4	2.1	4.2	5.1	4.1	3.2	3.5	3.4
Congenital anomalies	24.6	10.7	1.6	1.0	0.5	0.3	0.2	0.1	*(f)*	0.6
All other diseases*(b)*	42.4	2.1	4.3	7.5	3.7	2.3	2.3	3.0	5.7	5.0
Signs, symptoms and ill-defined conditions	23.7	2.8	0.6	0.8	1.0	0.4	0.2	0.1	0.2	0.7
Accidents, poisonings and violence	2.1	47.8	75.0	57.4	29.0	11.5	4.4	2.4	2.1	6.6
All causes	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

(a) Total includes 5 deaths where age is not known. *(b)* Includes 853 deaths from conditions originating in the perinatal period and 1,929 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, 1989



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

The perinatal death rate for Australia decreased from 10.65 per 1,000 total births in 1988 to 9.9 in 1989.

Of the conditions in the child, the three main groups responsible for perinatal deaths were *Hypoxia, birth asphyxia and other respiratory conditions* (38.2 per cent of the total), *Other conditions originating in the perinatal period* (22.1 per cent) and *Congenital anomalies* (22.0 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, 28.8 per cent were reported as being due to *Complications of placenta, cord and membranes.*

PERINATAL DEATHS BY CAUSE, AUSTRALIA, 1989

Cause of death	Number of deaths			Rate		
	Fetal	Neonatal	Perinatal	Fetal(a)	Neonatal (b)	Perinatal (a)
Conditions in fetus/infant—						
Slow fetal growth, fetal malnutrition and immaturity	135	130	265	0.54	0.52	1.05
Birth trauma	8	20	28	0.03	0.08	0.11
Hypoxia, birth asphyxia and other respiratory conditions	642	315	957	2.55	1.26	3.79
Fetal and neonatal haemorrhage	25	84	109	0.10	0.34	0.43
Haemolytic disease of fetus or newborn	12	5	17	0.05	0.02	0.07
Other conditions originating in the perinatal period	463	88	551	1.84	0.35	2.18
Congenital anomalies	161	354	515	0.64	1.41	2.04
Infectious and parasitic diseases	1	4	5	(c)	0.02	0.02
All other causes	4	58	62	0.02	0.23	0.25
Conditions in mother—						
Maternal conditions which may be unrelated to present pregnancy	163	94	257	0.65	0.37	1.02
Maternal complications of pregnancy	160	305	465	0.63	1.22	1.84
Complications of placenta, cord and membranes	587	136	723	2.33	0.54	2.87
Other complications of labour and delivery	25	25	50	0.10	0.10	0.20
No maternal condition reported	516	498	1,014	2.05	1.99	4.02
All causes—						
1989	**1,451**	**1,058**	**2,509**	**5.75**	**4.22**	**9.95**
1988	1,473	1,164	2,637	5.95	4.73	10.65
1987	1,432	1,159	2,591	5.84	4.75	10.56
1986	1,585	1,227	2,812	6.47	5.04	11.48
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

(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

General health surveys

During the twelve months ended September 1990, the ABS conducted a survey to determine how healthy Australia is as a nation, how we use health services and facilities and how aspects of our lifestyle affect our health. This survey was the first in a new series of five-yearly health surveys to be conducted by the ABS. Similar surveys were conducted in 1977–78 and 1983.

Information was obtained by personal interview with members of 21,000 households selected at random throughout Australia. Topics covered included:

- recent illness/injury and long term conditions experienced;
- episodes in hospitals;
- consultations with doctors, dentists and other health professionals;
- use of medications;
- smoking, alcohol consumption and exercise patterns;
- height, weight and dietary indicators;
- children's health; and
- women's health.

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

Selected results of the survey will be published progressively from April 1991. An extensive range of unpublished data from the survey are also available on request to the ABS. Details of planned publications and other releases of survey results are contained in *1989–90 National Health Survey: Products and Services* (4362.0)

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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