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.

ACT Community and Health Service — ACTC&HS

In addition to its national responsibilities, the Commonwealth Government, through the ACTC&HS, has special responsibility for health services in the Australian Capital Territory. The Service, a statutory authority, was formed on 1 July 1988 as part of the changed administrative arrangements for the ACT. The Service is an integration of the ACTC&HS Division of the former Department of Territories. It is primarily funded through Commonwealth appropriations and provides a full range of health, hospital and welfare services in the ACT.

Services provided include:

- Hospital services—the Service provides hospital in-patient and outpatient services which include medical, surgical, psychiatric, nursing and other professional support services. The Ambulance Service provides treatment and transport for emergencies and inter-hospital transfers.

- The major locations for providing these services are the two public hospitals, Royal Canberra Hospital and Woden Valley Hospital, the Mitchell Health Services and Supply Centre and the four ambulance stations.
- Community services—the Service provides environmental and public health services as well as regional services covering illness, family, or individual problems and financial hardships. Health care delivery facilities include health centres, child health clinics and home nursing services. Other community health services provided by the Service include health education, school dental and speech therapy services, and health and pharmaceutical inspection services. The Service also provides a range of programs to service the mental health needs of the community, and the special health needs of other groups in the community such as the elderly, the physically handicapped, the intellectually handicapped and those with alcohol or drug dependence.
- Other services—the Service provides juvenile justice facilities and other welfare and corrective services. The major locations providing these services are the community centres, Quamby Youth Centre, Belconnen Remand Centre, Jindalee Nursing Home and child day care centres.

At 30 June 1988, the ACT Health Authority, before its integration into the ACT Community and Health Service, had a staff of 3,607 full-time and 1,086 part-time employees.

Further information about the operations of the Service and the services it provides is contained in Service annual reports.

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. No levy is payable by single people earning $8,980 per annum or less, or by married couples and sole parents with a combined income of $15,090 per annum or less, 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.

Medicare benefits are payable at the rate of 85 per cent of the Schedule fee for out-of-hospital services 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.

New arrangements were introduced on 1 August 1987 for the payment of Medicare benefits for pathology services. The revised 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 and Malta whereby Australian visitors to those countries, and from those countries to Australia, are entitled to access to the host countries public health system for immediately necessary medical and hospital treatment.

In 1987–88, $3,096 million was paid by the Health Insurance Commission for Medicare Benefits in respect of 135 million services. 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, 1987–88

	NSW	*Vic.*	*Qld*	*SA*	*WA*	*Tas.*	*ACT*	*NT*	*O'seas*	*Aust.*
					—'000—					
Number of services	53,857.2	31,704.6	21,800.3	11,147.0	10,720.5	3,266.2	1,769.4	680.0	194.9	135,140.2
					—$ million—					
Benefits paid	1,229.5	734.3	492.9	263.6	242.2	71.5	44.0	13.7	3.9	3,095.6
					—per cent—					
Billing services—										
Direct billing	60.0	46.1	52.4	48.8	51.7	41.5	28.8	61.6	0	53.0
Lower than Schedule fee	3.5	7.6	7.6	4.0	5.7	11.5	4.6	2.2	36.2	5.6
Equal to Schedule fee	3.2	13.1	9.6	18.9	12.6	15.1	9.1	4.3	1.0	13.0
Greater than Schedule fee	23.3	33.1	30.4	28.3	30.0	31.9	57.6	31.9	62.9	28.5
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, 1987–88
($ million)

Type of service	*NSW*	*Vic.*	*Qld*	*SA*	*WA*	*Tas.*	*ACT*	*NT*	*O'seas*	*Aust.*
GP consultation	471.6	280.8	186.0	101.9	91.5	30.3	15.2	6.1	1.4	1,184.8
Specialist consultation	189.1	120.8	70.5	44.2	31.2	9.7	8.2	1.1	0.7	475.5
Obstetrics	16.4	12.6	5.8	3.6	4.3	1.4	1.1	0.4	0.1	45.7
Anaesthetics	28.7	21.3	11.8	7.5	6.8	2.1	1.3	0.3	0.1	79.7
Pathology	193.1	100.3	87.0	32.9	39.3	10.1	4.9	2.5	0.6	470.6
Diagnostic imaging	138.7	78.9	49.2	28.5	29.3	6.9	5.4	1.7	0.5	338.9
Operations	123.6	80.4	59.0	31.7	25.7	7.4	5.1	1.0	0.5	334.3
Optometry	24.8	16.0	10.5	5.5	5.9	2.0	0.9	0.5	0	66.0
Other	43.4	23.3	13.1	7.8	8.4	1.7	2.0	0.1	0.2	100.0
Total	**1,229.5**	**734.3**	**492.9**	**263.6**	**242.2**	**71.5**	**44.0**	**13.7**	**3.9**	**3,095.6**

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 insurance with registered health benefits organisations to cover these situations and medical 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 are, in essence, nursing home-type patients, 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 patient in a public hospital, health benefits paid by registered benefits organisations are reduced to the level of the standard nursing home benefit. However, because of the reduced fees charged by public hospitals, such patients are only liable for the amount of the statutory non-insurable patient contribution. In a private hospital, the benefits are reduced to $100 a day, less the amount of the patient contribution. Any charges by private hospitals in excess of available benefits plus the statutory patient contribution become the responsibility of the patient.

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

Private hospitals

Coinciding with the introduction of Medicare on 1 February 1984, Commonwealth bed-day subsidies and health insurance benefits were paid according to a system of classifying private hospitals into three categories. The three categories of private hospitals were determined on the basis of the services and facilities provided. Those hospitals with more sophisticated services and facilities attracted higher levels of health insurance benefits and Commonwealth bed-day subsidies.

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/obstetrical 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/obstetrical 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 chemist upon presentation of a prescription from the patient's medical or dental practitioner, or by an approved hospital to patients receiving treatment at the hospital.

During 1987–88 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;
- *$10 per benefit item*—all other people pay a contribution of $10 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 $1,047.6 million in 1987–88. 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, 1987–88

	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	9,327	9.3	92,298	8.8
Anti-asthmatics and antibronchitics	8,582	8.5	79,784	7.6
Benzodiazepines, sedatives and hypnotics	7,113	7.1	31,072	3.0
Diuretics	6,831	6.8	45,966	4.4
Beta-blockers	5,796	5.7	68,726	6.6
Penicillins	5,122	5.0	53,059	5.1
Antihypertensives	4,470	4.5	121,829	11.6
Anti-anginals	3,954	3.9	63,955	6.1
Oral contraceptives	3,478	3.4	37,605	3.6
Water, salts and electrolytes	3,412	3.4	19,841	1.9
Antidepressants	3,214	3.2	20,635	2.0
Antacids	2,548	2.5	13,752	1.3
Topical corticosteroids	2,263	2.2	11,971	1.1
Tetracyclines	2,181	2.2	17,618	1.7
Sulphonamides and urinary antiseptics	2,042	2.0	21,054	2.0
Other drug groups	30,568	30.3	348,464	33.2
Total	**100,901**	**100.0**	**1,047,629**	**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 1986–87.

COMMONWEALTH AUTHORITIES: PERSONAL BENEFIT PAYMENTS—HEALTH, 1986–87
($ million)

	NSW (a)	*Vic.*	*Qld*	*SA (a)*	*WA*	*Tas.*	*Total*
Hospital and other institutional services and benefits	*311.4*	*236.1*	*101.4*	*69.9*	*64.2*	*14.1*	*797.1*
Nursing homes	302.1	227.0	98.8	68.2	63.5	13.7	773.3
Hospital benefits	9.3	9.1	2.6	1.7	0.7	0.4	23.8
Clinic and other non-institutional services and benefits	*1,256.0*	*714.2*	*473.9*	*261.7*	*231.9*	*70.1*	*3,007.8*
Clinic and other non-institutional services n.e.c.	12.0	7.7	5.2	1.7	3.0	1.1	30.7
Medical benefits *(b)*	1,244.0	706.5	468.7	260.0	228.9	69.0	2,977.1
Public health	3.2	0.5	3.6	2.9	3.2	0.7	14.1
Pharmaceuticals, medical aids and appliances	297.6	180.1	117.9	68.8	55.9	18.9	739.2
Total	**1,868.2**	**1,130.9**	**696.8**	**403.3**	**355.2**	**103.8**	**4,558.2**

(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 $4.5 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 $3,063 million to the States and Territories in 1988–89, provide $3,007 million for hospital and community health services, $36 million for incentives in the areas of post-acute and palliative care and day surgery procedures, $15 million towards hospital care for AIDS patients and $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 five year period commencing in 1988–89 and will be indexed each year to take account of age- and sex-weighted population changes, any increase in the number of AIDS patients as well as price changes.

Paramedical services

Commonwealth funding to participating States under the *States Grants (Paramedical Services) Act 1969* is to be incorporated in the Home and Community Care Program: *see* Chapter 8, Social Security and Welfare.

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 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. The scheme underwent several modifications in later years to allow for the provision of charges to be imposed, where appropriate, for services rendered to privately insured patients.

Since 1 February 1984, there has been a return to the original concept of health program grants in that they now cover the net costs incurred by the organisations in respect of the approved health services, and no charges are raised for those services.

Funds appropriated for these grants amounted to $7.162 million in 1984–85, $8.086 million in 1985–86 and $11.951 million in 1986–87.

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.

Forty-two projects are presently funded under the NCHP. 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 $12.856 million in 1987–88.

Medicare grants for community health

The Medicare agreements, which commenced on 1 February 1984, were used as vehicles for delivering additional Commonwealth funds to the States and Territories in block grants for new or expanded services within their borders. These grants amounted to $19.263 million in 1985–86, $20.071 million in 1986–87 and $21.358 million in 1987–88.

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, focussing 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 1987–88 included the Healthy Cities Project coordinated by the Australian Community Health Association, the Health Education and Lifestyle Project conducted by the Australian Council for Health, Physical Education and Recreation and several projects which focus on cholesterol levels and hypertension in the workplace.

Funds appropriated for this program amounted to $2.55 million which included $1 million for the 'Just One Shot' Measles Campaign.

Health for All Australians

Australian Health Ministers endorsed a report 'Health for All Australians' in March 1988, which set a series of national goals and targets for improving health and reducing inequalities in health status among population groups in Australia. The focus of the report is on prevention.

Bicentennial Public Health Program

Under the Bicentennial Public Health Program, the Government is providing $26 million over three years to strengthen public health and tropical health teaching and research in Australia.

The program has three components:

- grants to eight universities and one research institute (these grants have been extended to cover seven years and now total approximately $41.5 million);

- the expansion of the Australian Institute of Health;
- the creation of the National Health and Medical Research Council (NH&MRC) Public Health Research and Development Committee which allocates funds for research and awards fellowships.

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 1988 the Commonwealth Government paid grants totalling $7.25 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 1987–88 was $18.567 million being $16.369 million for operating costs and $2.198 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 1987 was $12.3 million of which $10.6 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 $3.8 million was expended in 1987 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 1987 the expenditure on research, education and community service totalled $4.6 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 1987 was $5.807 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 1987 was $0.548 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, and the Commonwealth Minister responsible for Health in the ACT. Other Commonwealth Ministers may be invited to speak on items relevant to their portfolio. The New Zealand Health Minister may attend meetings as an observer.

AHMAC comprises the head and one other senior officer from the Commonwealth, State and Territory health authorities and the Department of Veterans' Affairs. 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 ongoing 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 AIDS Task Force, the Commonwealth–State Advisory Committee on Nursing Issues, the Health Targets and Implementation Committee, the Subcommittee on Breast and Cervical Cancers and the Task Force on National Hospital Statistics.

Health services organisations

The Commonwealth Pathology Laboratory Service

This service provides clinical diagnostic and investigational facilities at laboratories situated in Albury, Bendigo, Cairns, Lismore, Rockhampton, Tamworth, Toowoomba and Townsville. Their primary role is to assist medical practitioners in the diagnosis of illness and disease and to provide facilities for investigations into public health and aspects of preventive medicine. During 1987–88, these laboratories carried out approximately 7.5 million examinations, tests and investigations in respect of 0.7 million patient requests.

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 sixty 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).

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

- undertakes research and development in the fields of ionising and non-ionising radiations which have implications for public and occupational health;
- 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;
- undertakes research and provides advice in relation to the quality and use of radiopharmaceutical substances.

The National Acoustic Laboratories
The Laboratories undertake scientific investigations into hearing and problems associated with noise as it affects individuals, and advise Commonwealth Government departments and instrumentalities on hearing conservation and the reduction of noise. A free audiological service is provided for pensioners with medical benefit entitlements and their dependants, persons under 21, war widows, Social Security rehabilitees and Veterans' Affairs patients. During 1987–88 the number of appointments provided was 183,532 and the number of hearing aids fitted was 67,520.

The National Biological Standards Laboratory—NBSL
The NBSL is comprised of the Pharmaceutical Laboratories, the Biological Laboratories and the Medical Devices and Dental Products Branches of the Commonwealth Department of Community Services and Health. The Sections are generally organised along scientific disciplinary lines and include the Virology, Microbiology, Antibiotics, Pharmaceutical Chemistry, Pharmacology, Dental Materials and Medical Engineering Sections.

The NBSL monitors the quality, safety and efficacy of biological and pharmaceutical products and therapeutic devices available for use in Australia. Its major activities are analysing therapeutic goods for compliance with standards, giving advice on the adequacy of information provided to support marketing applications, implementing the Codes of Good Manufacturing Practice applicable to manufacturers of therapeutic goods, developing standards, providing education and training, maintaining a register of therapeutic goods, investigating problems and coordinating product recalls.

The Ultrasonic Institute
The Institute conducts research and provides advisory services on the use of ultrasonic radiation in the diagnosis and treatment of disease. The Institute is recognised as a world leader in its field.

Commonwealth Government Health Advisory Organisations

The National Health and Medical Research Council—NH&MRC

The NH&MRC 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 1987–88 was $64.365 million. The Commonwealth Government also appropriated $1.258 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 AIH was established by Federal Cabinet in August 1984 and was made an independent statutory body in July 1987. It is the health research and statistics arm of the Commonwealth Community Services and Health portfolio, and also provides research and statistical support to the States and Territories through the Australian Health Ministers' Advisory Council (AHMAC). The Institute aims to contribute to improvements in the nation's health by:

- collecting and providing assistance in the production of health related statistics;
- conducting and promoting research into the health of the people of Australia;
- undertaking studies into the provision and effectiveness of health services and health technology;
- providing advice to the Minister on strategies for improving the health of the Australian people.

It is required to report to the Minister and Parliament every two years accordingly.

The AIH has given priority to the improvement of the national health data base. This includes developing a National Death Index, a National Cancer Statistics Clearing House, a National Nosology Reference Centre and national Aboriginal health statistics. It has undertaken a major study of differences in health in different subgroups of the population, and, in cooperation with the States and Territories, has established a National Injury Surveillance and Prevention system. Research studies are being undertaken into the provision and use of health services. These include investigations into hospital usage and costs, storage and wastage of medicines in households, medical workforce supply and demand, discretionary surgery usage and quality assurance. The Institute publishes information on national health expenditure, analyses of the major health workforce groups, and statistics on hospital and other health care facilities.

The Institute incorporates the Secretariat of the National Health Technology Advisory Panel (NHTAP) which undertakes the evaluation of new and existing health care technologies and is involved in the work of the mammography screening subcommittee of AHMAC. The Institute also supports the National Perinatal Statistics Unit at the University of Sydney and the Dental Statistics and Research Unit at the University of Adelaide.

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, chemicals, 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; and
- the collection 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 1987–88. Seventy-four applications for approval for general marketing of new drugs were considered, resulting in twenty-nine recommendations for approval, thirty-nine for rejection and six for deferral. There were a further twenty-three approvals for extensions of therapeutic indications or amended dosage regimens for drugs already on the market.

The Therapeutic Device Evaluation Committee—TDEC

The Committee became a statutory committee in December 1987. It makes medical and scientific evaluations of devices (including non-drug substances) for therapeutic use and it furnishes advice to the Minister of Community Services and Health on the importation, production and distribution of devices which have been the subject of evaluation. It has the power to form advisory panels to develop complex and detailed proposals for consideration.

The Committee met three times in 1987–88 and considered guidelines for evaluating Bedside Drug Infusion Systems, Intraocular Lenses, and Substantial Equivalence. It also considered the approach to be taken in assessing device materials (non-drug therapeutic substances); the latter formerly being undertaken by the Australian Drug Evaluation Committee. The TDEC is responsible for the oversight of the device evaluation program, which considered 36 submissions in 1987–88, and a device problem reporting program which received 151 reports, contributing to 55 product recalls, in the same period.

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. The Committee replaces the Therapeutic Goods Standards Committee and the Therapeutic Goods Advisory Committee both of which have been abolished.

National Campaign Against Drug Abuse—NCADA

Australia's NCADA, which was launched in April 1985, is a comprehensive, integrated and ongoing 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 has been formed by the Commonwealth, State and Territory governments to establish, fund, maintain and evaluate the Campaign.

The Commonwealth will contribute $26.6 million in 1988–89, of which $16.8 million is allocated to the States and Territories who match it on a dollar-for-dollar basis, and $9.8 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 1987–88, over 350 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 and women.

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

- a national media/information campaign, 'The Drug Offensive'. This includes the second stage of the anti-heroin campaign which commenced in December 1987, and a national campaign on alcohol which was launched in March 1988;
- research under the Research into Drug Abuse Program. Since its inception in 1985, the Program has provided over $3.1 million in support of 67 projects;
- the establishment of two national centres for drug research. The Commonwealth in 1988–89 has allocated $1.2 million per annum for the funding of these centres. The Sydney-based centre is concentrating its work in the areas of drug treatment and rehabilitation. The Perth-based centre is concentrating 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 $0.55 million has been offered to the ten University Medical Schools by the Department of Employment, Education and Training to implement 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 recently enacted a package of legislation which provides a range of new 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 targetting 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.

Many of the Extradition and Mutual Assistance Treaties arrangements are now signed and in force. Others will soon be in force. The remainder are yet to be signed and are in various stages of negotiation.

In 1987–88, the final year of the first triennium, approval was given by the Government and the Ministerial Council on Drug Strategy for a further three year program.

An evaluation of NCADA is being undertaken by an independent Task Force. It has examined all aspects of the Campaign and will critically assess current activities and suggest options for the future to improve the effectiveness of the campaign.

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 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 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.

The following table shows, by State and Territory, the number of cases notified in 1987, for those diseases which are notifiable in all States and Territories. The table does not include diseases which are notifiable only in certain States or Territories. Factors such as the availability of medical and diagnostic services, varying degrees of attention to disease notification, 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, 1987

Disease	*NSW*	*Vic.*	*Qld*	*SA*	*WA*	*Tas.*	*NT*	*ACT*	*Aust.*
Acquired immune deficiency syndrome (AIDS)	221	70	21	9	10	—	1	3	335
Amoebiasis	12	3	15	17	3	—	1	7	58
Ankylostomiasis	1	—	1	34	21	—	—	—	57
Arbovirus infection	84	3	996	2	—	—	—	—	1,085
Brucellosis	3	—	7	1	—	—	—	1	12
Diphtheria	1	—	—	—	—	—	31	—	32
Gonorrhoea	875	633	999	546	1,078	44	764	40	4,979
Hepatitis A (infectious)	180	72	82	145	137	9	86	4	715
Hepatitis B (serum)	417	276	350	76	408	18	32	28	1,605
Hydatid disease	8	1	1	3	1	3	—	—	17
Leprosy	10	3	2	—	7	—	8	1	31
Leptospirosis	19	25	69	4	6	10	—	—	133
Malaria	89	95	268	45	23	4	23	27	574
Ornithosis	—	2	—	8	1	2	—	—	13
Pertussis (whooping cough)	43	21	—	61	148	—	17	1	291
Q-Fever	150	3	179	18	4	—	1	—	355
Salmonella infections	835	116	666	342	342	160	251	27	2,739
Shigella infections	109	29	82	61	127	2	176	—	586
Syphilis	1,271	90	570	102	262	2	880	13	3,190
Tetanus	1	—	2	1	1	—	—	—	5
Tuberculosis (all forms)	—	247	176	75	117	17	34	20	686
Typhoid fever	21	12	3	2	2	3	1	3	47
Typhus (all forms)	2	—	6	—	—	1	—	—	9

(a) There were no cases of anthrax, cholera, plague, poliomyelitis, smallpox or yellow fever.

NOTIFIABLE DISEASES, NUMBER OF CASES NOTIFIED: AUSTRALIA

Disease	*1983*	*1984*	*1985*	*1986*	*1987*
Acquired immune deficiency syndrome (AIDS)	6	42	113	223	335
Amoebiasis	57	46	87	54	58
Ankylostomiasis	88	75	43	40	57
Arbovirus infection	33	1,577	660	1,414	1,085
Brucellosis	16	15	22	12	12
Diphtheria	1	—	17	44	32
Gonorrhoea	10,646	8,894	7,605	6,585	4,979
Hepatitis A (infectious)	985	674	848	1,685	715
Hepatitis B (serum)	944	1,559	1,645	1,766	1,605
Hydatid disease	10	9	14	13	17
Leprosy	62	28	38	27	31
Leptospirosis	242	227	185	179	133
Malaria	571	640	421	696	574
Ornithosis	19	42	17	43	13
Pertussis (whooping cough)	332	261	587	601	291
Poliomyelitis	—	—	—	1	—
Q-Fever *(a)*	208	262	202	367	355
Salmonella infections	2,989	2,092	2,668	2,494	2,739
Shigella infections	567	420	734	833	586
Syphilis	3,556	3,323	3,523	3,594	3,190
Tetanus	10	7	11	5	5
Tuberculosis (all forms)	1,219	1,299	1,088	1,041	686
Typhoid fever	22	50	31	45	47
Typhus (all forms)	21	8	10	11	9

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

Source: Commonwealth Department of Community Services and Health

Immunisation campaigns

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 Medicine Research Council, is available from the Commonwealth Department of Community Services and Health.

Rubella immunisation is routinely offered to all females between their 10th and 15th birthdays through the School Girl Rubella Immunisation Program. Rubella immunisation is also recommended for all non-immune females of child bearing age.

Measles immunisation is currently promoted through the National Campaign Against Measles. This Campaign aims to increase community awareness of the potential seriousness of the disease and to encourage measles vaccination with the ultimate goal of eradicating measles in Australia.

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

Australian governments have put in place a range of education, prevention and research programs directed at minimising the spread of AIDS in Australia.

These strategies are coordinated at the national level by the Commonwealth Department of Community Services and Health. The AIDS Policy and Program Administration Branch has the responsibility for coordinating and evaluating community AIDS projects, assessing the funding necessary for 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;
- the Intergovernmental Committee on AIDS, established to bring together the States and the Commonwealth to discuss AIDS policy and financial matters.

In 1987–88 the Commonwealth Government made available over $21 million for the fight against AIDS. This expenditure was divided between the National AIDS Program ($11 million) and the AIDS Matched Funding Program ($10 million).

Initiatives 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.

During 1987–88, the research activities of the Special Units on AIDS Virology and on AIDS Epidemiology and Clinical Research continued, and a number of grants were awarded to both individuals and groups for biomedical and behavioural research into AIDS.

Funding was also provided for testing carried out by the National Reference Laboratory and the development and funding of blood screening kits by the Commonwealth Serum Laboratories.

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

On the international front, Australia hosted the WHO Inter-regional Ministerial Conference on AIDS, and also provided assistance to countries in the Western Pacific Region. Australia will contribute a total of $2 million in grants to the WHO Global Program on AIDS over the next three financial years. Educational material on AIDS prevention was also produced and distributed to international travellers.

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. Clinical trials and evaluation of the drug Azidothymidine (AZT) have also been financed along with non-hospital treatment and support services and further education grants to community groups.

REPORTED AIDS CASES TO 30 JUNE 1988

	NSW	*Vic.*	*Qld*	*SA*	*WA*	*Tas.*	*NT*	*ACT*	*Aust.*
Number of cases—									
Males	577	174	56	21	37	2	2	11	880
Females	23	3	4	1	2	1	—	—	34
Persons	600	177	60	22	39	3	2	11	914
Known deaths—									
Number	331	67	37	10	17	2	1	5	470
Per cent of cases	55.2	37.9	61.7	45.5	43.6	66.7	50.0	45.5	51.4

Source: Commonwealth Department of Community Services and Health.

REPORTED AIDS CASES TO 30 JUNE 1988 BY TRANSMISSION CATEGORY

	Cases	
Transmission category	*Number*	*Per cent*
Homo/Bisexual men	802	87.7
Intravenous drug users	6	0.7
Homo/Bisexual drug users	24	2.6
Blood transfusion recipients	49	5.4
Persons with haemophilia	12	1.3
Heterosexual transmission	8	0.9
Others	13	1.4
Total	**914**	**100.0**

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.

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 changes in recent years in the institutions and services for the 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 retarded 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.

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 and Queensland however, are published in the ABS publications *Hospital and Nursing Home Inpatients* (4306.1), *Public Hospital Morbidity* (4301.2) and *Hospital Morbidity* (4303.3) respectively. Statistics for South Australia, 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 have 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. The recommendations contained in the report have, in principle, been accepted by the relevant authorities concerned and are expected to be incorporated into the State and Territory workers' compensation systems from 1988–89.

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 1987, 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 1987 were diseases of the circulatory system (accounting for 47.5 per cent), neoplasms (24.3 per cent), diseases of the respiratory system (7.2 per cent) and accidents, poisonings and violence (6.9 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 1987, only 0.5 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 (54.8 per cent in 1987) occur within 28 days after birth (*see* table on perinatal deaths within this chapter).

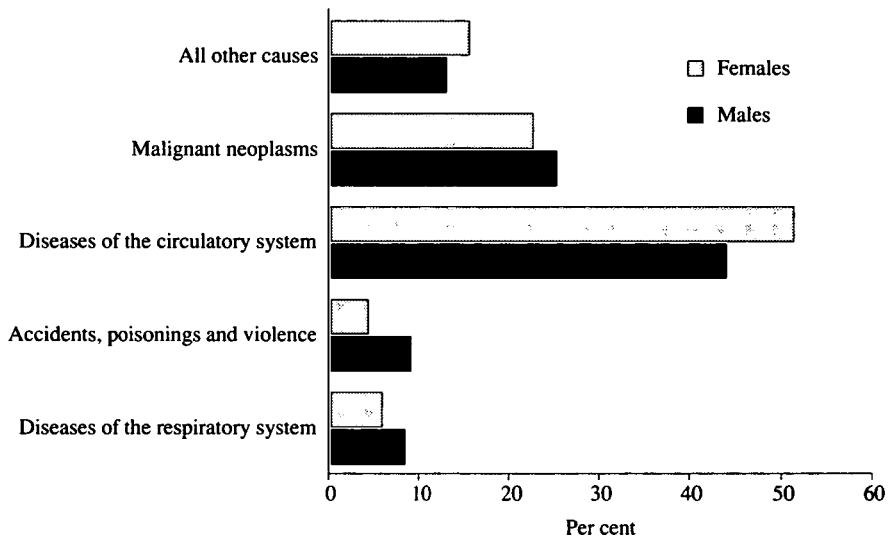
CAUSES OF DEATH IN EACH AGE GROUP, AUSTRALIA, 1987

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)*
					NUMBER					
Infectious and parasitic diseases	20	27	20	28	37	37	72	136	267	644
Neoplasms	13	128	137	362	980	2,365	6,029	8,763	9,780	28,557
Endocrine, nutritional and metabolic diseases and immunity disorders	18	36	29	67	135	147	347	656	1,359	2,794
Diseases of the nervous system and sense organs	41	66	71	58	81	85	215	411	950	1,978
Diseases of the circulatory system	7	22	60	191	632	1,986	6,014	13,492	33,262	55,678
Diseases of the respiratory system	39	50	66	69	119	239	978	2,345	4,585	8,491
Diseases of the digestive system	4	4	13	58	157	334	623	872	1,946	4,013
Congenital anomalies	578	91	42	28	12	18	26	18	4	817
All other diseases *(b)*	817	16	99	166	92	143	351	799	2,990	5,473
Signs, symptoms and ill-defined conditions	522	20	19	21	23	20	26	27	126	806
Accidents, poisonings and violence	57	468	1,784	1,361	1,033	713	734	690	1,224	8,070
All causes	**2,116**	**928**	**2,340**	**2,409**	**3,301**	**6,087**	**15,415**	**28,209**	**56,493**	**117,321**
					RATE *(c)*					
Infectious and parasitic diseases	8	1	1	1	2	2	5	13	40	4
Neoplasms	5	4	5	14	42	146	410	815	1,468	176
Endocrine, nutritional and metabolic diseases and immunity disorders	7	1	1	3	6	9	24	61	204	17
Diseases of the nervous system and sense organs	17	2	3	2	3	5	15	38	143	12
Diseases of the circulatory system	3	1	2	7	27	123	409	1,254	4,993	342
Diseases of the respiratory system	16	1	2	3	5	15	67	218	688	52
Diseases of the digestive system	2	—	—	2	7	21	42	81	292	25
Congenital anomalies	237	3	2	1	1	1	2	2	1	5
All other diseases *(b)*	335	—	4	6	4	9	24	74	449	34
Signs, symptoms and ill-defined conditions	214	1	1	1	1	1	2	3	19	5
Accidents, poisonings and violence	23	14	66	51	44	44	50	64	184	50
All causes	**867**	**27**	**86**	**90**	**140**	**376**	**1,049**	**2,623**	**8,480**	**721**
					PERCENTAGE *(d)*					
Infectious and parasitic diseases	0.9	2.9	0.9	1.2	1.1	0.6	0.5	0.5	0.5	0.5
Neoplasms	0.6	13.8	5.9	15.0	29.7	38.9	39.1	31.1	17.3	24.3
Endocrine, nutritional and metabolic diseases and immunity disorders	0.9	3.9	1.2	2.8	4.1	2.4	2.3	2.3	2.4	2.4
Diseases of the nervous system and sense organs	1.9	7.1	3.0	2.4	2.5	1.4	1.4	1.5	1.7	1.7
Diseases of the circulatory system	0.3	2.4	2.6	7.9	19.1	32.6	39.0	47.8	58.9	47.5
Diseases of the respiratory system	1.8	5.4	2.8	2.9	3.6	3.9	6.3	8.3	8.1	7.2
Diseases of the digestive system	0.2	0.4	0.6	2.4	4.8	5.5	4.0	3.1	3.4	3.4
Congenital anomalies	27.3	9.8	1.8	1.2	0.4	0.3	0.2	0.1	—	0.7
All other diseases *(b)*	38.6	1.7	4.2	6.9	2.8	2.3	2.3	2.8	5.3	4.7
Signs, symptoms and ill-defined conditions	24.7	2.2	0.8	0.9	0.7	0.3	0.2	0.1	0.2	0.7
Accidents, poisonings and violence	2.7	50.4	76.2	56.5	31.3	11.7	4.8	2.4	2.2	6.9
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 23 deaths where age is not known. *(b)* Includes 816 deaths from conditions originating in the perinatal period and 1,724 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)* Percentage of all deaths within each age group.

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, 1987



Suicides

A range of statistics relating to deaths by suicide in Australia was published by the ABS in *Suicides, Australia, 1961–1981 (Including historical series 1881–1981)* (3309.0). Statistics for later years are available on request.

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 fell from 11.48 per 1,000 total births in 1986 to 10.56 in 1987.

Of the conditions in the child, the two main groups responsible for perinatal deaths were *Hypoxia, birth asphyxia and other respiratory conditions* (34.5 per cent of the total) and *Congenital anomalies* (23.8 per cent). Thirty-eight 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, 47.8 per cent were reported as being due to *Complications of placenta, cord and membranes.*

PERINATAL DEATHS BY CAUSE, AUSTRALIA, 1987

	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	130	156	286	0.53	0.64	1.17
Birth trauma	2	22	24	0.01	0.09	0.10
Hypoxia, birth asphyxia and other respiratory conditions	585	310	895	2.38	1.27	3.65
Fetal and neonatal haemorrhage	49	60	109	0.20	0.25	0.44
Haemolytic disease of fetus and newborn	8	3	11	0.03	0.01	0.04
Other conditions originating in the perinatal period	472	101	573	1.92	0.41	2.34
Congenital anomalies	182	435	617	0.74	1.78	2.52
Infectious and parasitic diseases	2	2	4	0.01	0.01	0.02
All other causes	2	70	72	0.01	0.29	0.29
Conditions in mother—						
Maternal conditions which may be unrelated to present pregnancy	195	106	301	0.79	0.43	1.23
Maternal complications of pregnancy	149	316	465	0.61	1.30	1.90
Complications of placenta, cord and membranes	611	161	772	2.49	0.66	3.15
Other complications of labour and delivery	25	52	77	0.10	0.21	0.31
No maternal condition reported	452	524	976	1.84	2.15	3.98
All causes—						
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
1982	1,705	1,529	3,234	7.06	6.38	13.39

(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.

Cremations

CREMATIONS, AUSTRALIA

	1985		*1986*		*1987*		
State/Territory	*Number of cremations (a) (b)*	*Number of deaths*	*Number of cremations (a) (b)*	*Number of deaths*	*Number of crematoria (b)*	*Number of cremations (a)*	*Number of deaths*
NSW	23,108	44,044	22,210	42,036	18	23,062	42,189
Vic.	12,747	31,257	12,457	30,062	5	12,720	31,549
Qld	8,849	18,760	8,682	17,962	10	9,034	18,861
SA	4,879	10,543	5,003	10,377	2	4,737	10,531
WA	4,876	8,863	5,226	9,315	3	5,021	8,880
Tas.	1,634	3,659	1,509	3,435	2	1,592	3,637
NT	—	651	—	671	—	—	676
ACT	722	1,031	805	1,123	1	829	998
Australia	**56,815**	**118,808**	**55,892**	**114,981**	**41**	**56,995**	**117,321**

(a) Cremations are not necessarily carried out in the State or Territory where the death was registered. *(b)* At 31 December.
Source: Services and Investment Ltd.

Health-related Surveys Conducted by the ABS

Australian Health Surveys

The last Australian Health Survey was conducted throughout the twelve month period February 1983 to January 1984. The main objective of the Survey was to obtain information about the health of Australians and their use of and need for various health-related services and facilities. It is the second national survey of its kind to be conducted by the ABS; the first was conducted during 1977–78. It is planned to conduct a third national health survey in 1989–90.

The approach adopted to collect health information in the 1983 survey was to ascertain whether any of a range of health-related actions was taken during the reference period and to record the various reasons for which each action was taken. The actions covered included episodes in hospital; consultations with doctors; dental consultations; consultations with other health professionals; consumption or use of medications; days of reduced activity; and, days away from school or work.

The survey aimed to identify wherever possible the specific illness or injury for which the action was taken. However, some persons may have taken a health-related action for which no specific illness or injury could be identified or for reasons other than illness or injury, such as pregnancy supervision, immunisation, contraception etc. Therefore reasons identified as leading to a health-related action were classified into two broad groups: illness conditions and 'other reasons for action'.

In addition to the reasons for taking a health-related action, further information was obtained about the actions themselves e.g. whether surgery undergone in hospital, type of treatment received during a consultation with doctor or a dental consultation, number of times a particular action was taken during the reference period, whether actions such as use of medication or reduced activity were advised by a doctor etc. Information was also collected on illnesses and injuries experienced for which no action was taken. Summary results of the survey are published in *Australian Health Survey 1983* (4311.0); more detailed results are published in *Illness Conditions Experienced* (4356.0); and *Health Related Actions taken by Australians* (4358.0). A sample file on magnetic tape containing unit record data from the survey is also available. For further information *see Information Paper Australian Health Survey, 1983 Sample File on Magnetic Tape* (4324.0).

Health Insurance Surveys

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

The 1988 survey sought information on levels of private health insurance cover in the Australian community. Results are published in *Health Insurance Survey, Australia, June 1988* (4335.0).

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