CHAPTER 10

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 controlled by the Commonwealth Government. The Government appoints a Minister for Health, who exercises political control over the Commonwealth Department of Health, headed by the Director-General. 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 of Health 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.

Capital Territory Health Commission.

In addition to its national responsibilities, the Commonwealth Government, through the Capital Territory Health Commission, has special responsibility for health services in the Australian Capital Territory. The Commission, which is primarily funded through Commonwealth appropriations, has the statutory role of providing and monitoring health services in the A.C.T.

Health services provided by the Commission include:

- Hospital services.

The Commission operates Royal Canberra and Woden Valley Hospitals within the A.C.T. public hospital system. These hospitals offer an extensive range of general and speciality medical services. Calvary Hospital and the Queen Elizabeth II Home for Mothers and Babies are funded through the Commission's grant-in-aid program, and function within the public hospital system.

- Community services

The Commission is responsible for health care delivery in the community, including health centres (eleven as at 30 June 1983), child health clinics and home nursing services. Other community health services provided by the Commission include ambulance services, health education, school dental and speech therapy services, health and pharmaceutical inspection services, and services associated with occupational health and safety. The Commission 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 and physically handicapped.

At 30 June 1983, the Commission had a staff of 3,286 full-time and 715 part-time employees.

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

COMMONWEALTH HEALTH BENEFITS AND ASSISTANCE

Medicare

In February 1984 the Commonwealth Government introduced the new Commonwealth financed universal hospital and medical benefits scheme known as Medicare. Details of Commonwealth Medical and Hospital benefits and private health insurance arrangements operating prior to 1 February 1984 are available in Year Book 67—1983. The revised health financing arrangements under the Medicare program feature the following major elements:

- automatic entitlement under a single public health fund to medical and optometrical benefits of 85 per cent of the Medical Benefits Schedule fee, with a maximum patient payment for any service of $10 where the scheduled fee is charged;
- access without direct charge to public hospital accommodation and to inpatient and outpatient treatment by doctors appointed by the hospital;
- the restoration of funds for community health to approximately the same real level as 1975;
- the reduction in charges for private treatment in shared wards of public hospitals to $80 per day; and
- increases in the daily bed subsidy payable to private hospital to an average of $30.

The Medicare program is financed in part by a 1 per cent levy on taxable incomes, with low income cut-off points. The tax rebate formerly paid for basic health insurance contributions ceased from 30 June 1983. In addition, the Commonwealth's annual contribution to the Hospital Benefits Reinsurance Trust Fund was reduced from $100 million to $20 million.

To facilitate the introduction of the Medicare program amendments were necessary to the following Commonwealth legislation:

- National Health Act;
- Health Insurance Act;
- Health Insurance Commission Act; and
- States (Tax Sharing and Health Grants) Act

and certain tax-related legislation.

The Levy

The concept of a 1 per cent levy on all taxable incomes reflects the policy that health care should be related to the individual's ability to pay. As at 1 February 1984 no levy was payable by single people earning less than $128.80 per week or by sole parents (with one dependant child) and married couples with a combined income of not more than $214.25 per week. This latter figure increases by $21.15 per week for each dependant child. There is also a maximum levy payable. This is reached at a single or combined husband and wife income of $70 000 per annum or $1 346 per week. The low income cut-off points were set to ensure that no person who, prior to the introduction of the program, held a Pensioner Health Benefit Card or a Health Care Card, would pay a levy.

Eligibility for Medicare Benefits

Medicare benefits are available to all persons ordinarily resident in Australia with the exception of members of foreign diplomatic missions and their dependants.

Eligibile people include:

- All permanent Australian residents (including Repatriation beneficiaries and Defence Force Personnel);
- people visiting Australia who obtain approval to stay for at least 6 months—with eligibility to date from arrival in Australia;
- people visiting Australia who originally obtain approval to stay less than 6 months, but are granted an extension which makes the total approved stay more than 6 months—with eligibility to date from when the extension was granted;
- people visiting Australia who are residents of countries with whom Australia may negotiate a reciprocal health care agreement;
- Australian residents receiving medical services while travelling overseas.

Short-term visitors to Australia (i.e. less than 6 months) are responsible for the full cost of their medical and hospital treatment. Such people should make some form of private insurance arrangements to cover such costs.

Medical Benefits

The Health Insurance Act provides for a Medical Benefits Schedule which lists medical services and the Schedule (standard) fee applicable in each State in respect of each medical service. The Schedule covers services attracting Medicare Benefits rendered by legally qualified medical pracitioners, certain prescribed medical services rendered by approved dentists in the operating theatres of approved hospitals, and optometrical consultations by participating optometrists. Schedule fees are set and updated by an independent fees tribunal which is appointed by the Government. The fees so determined are to apply for Medicare benefits purposes. Medical services in Australia are generally delivered by either private medical practitioners on a fee-for-service basis, or medical practitioners employed in hospitals.

Where a medical service is provided by a private medical practitioner on a fee-for-service basis, Medicare refunds 85 per cent of the Medical Benefits Schedule fee cost or, the Schedule fee less $10, whichever is the greater. It is not possible to insure with private health insurance organisations to cover the 15 per cent 'gap'. However, should an individual accumulate 'gap' payments in excess of $150 per year, Medicare will pay benefits at 100 per cent of the Schedule fee.

Under Medicare, medical practitioners are able to direct bill for any patient. In such cases, they receive the Medicare benefit as full payment. Previously, direct billing was limited to services rendered to eligible Pensioner Health Benefit and Health Care Cardholders, and their dependants.

Hospital Care

From 1 February 1984, basic public hospital services have been provided free of charge. Through Medicare grants to the States the cost of out-patient treatment and inpatient accommodation and care in a shared ward by a doctor employed by a hospital are covered. The scheme does not cover the cost of private accommodation in a public hospital, charges for 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 private health funds to cover these situations.

Patients who are accommodated in either private or public hospitals for extended periods and who are, in essence, nursing home type patients, are required to make a non-insurable patient contribution in the same way that a patient in a nursing home does. For a private patient in a public hospital, private health fund benefits are reduced to the level of the standard nursing home benefit. In a private hospital, the fund benefits are reduced by the amount of the patient contribution.

Under Medicare, the amended arrangements provide that the period of time of continuous hospitalisation before classification as a nursing home type patient has been reduced from 60 to 35 days.

Where a patient's doctor considers that a patient has continuing need for acute hospital 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 new arrangements provide for a review mechanism in the form of the Acute Care Advisory Committee which may review such certificates and recommend that they be affirmed, varied or revoked.

Private Hospitals

Since 1 February 1984 both the Commonwealth bed day subsidy and the hospital insurance benefit for private hospital accommodation have been paid according to a system of classification consisting of three categories:

Category 1 hospitals receive a $120 basic private fund benefit and a $40 Commonwealth daily bed subsidy;

Category 2 hospitals receive a $100 basic private fund benefit and a $30 Commonwealth daily bed subsidy; and

Category 3 hospitals receive a $80 basic private fund benefit and a $20 Commonwealth daily bed subsidy.

Private hospitals are classified into the three categories according to the services and facilities provided. Those hospitals with more sophisticated services and facilities attract a higher level of insurance benefit and Commonwealth bed day subsidy.

Commonwealth Nursing Home Benefits

There are two forms of Commonwealth benefit payable in respect of patients accommodated in premises approved as nursing homes under the National Health Act. These benefits are as follows:

(a) **Basic Nursing Home Benefit**

The Commonwealth pays basic nursing home benefits in respect of all qualified nursing home patients other than those who are entitled to damages or compensation. Basic benefit levels are reviewed and adjusted annually in each State to a level whereby the fees charged in respect of 70 per cent of beds in non-Government nursing homes, approved under the National Health Act, (i.e. participating nursing homes) are covered by the sum of the benefit plus statutory minimum patient contribution (explained below). As at 3 November 1983, the maximum amount of basic nursing home benefit payable per day in each State and Territory was: New South Wales and Australian Capital Territory $32.35; Victoria $45.15; Queensland $26.65; South Australia and Northern Territory $37.80; Western Australia $23.40; and Tasmania $27.00.

(b) **Commonwealth Extensive Care Benefit**

The Commonwealth extensive care benefit is payable at the rate of $6 a day, in addition to the Commonwealth basic benefit, in respect of patients who need and receive 'extensive care' as defined in the National Health Act. Application must be made for payment of the extensive care benefit. As in the case of the Commonwealth basic benefit, the extensive care benefit is only payable in respect of qualified patients who are not entitled to damages or compensation.

Minimum Patient Contribution

All participating nursing home patients are normally required to make a statutory minimum contribution towards the cost of their accommodation in the nursing home. Patients are required to make this contribution towards the cost of their accommodation and care in recognition of those costs which would otherwise be incurred outside the nursing home in any alternative long-term residence.

The statutory minimum patient contribution equals 87.5 per cent of the sum of the standard single rate pension plus the supplementary assistance, and at 3 November 1983 was $111.95 a day.

Where the fees charged by a participating nursing home are in excess of the combined total of nursing home benefits plus the statutory minimum patient contribution, the difference must be met by the patient. Conversely, where the nursing home fee is less than this combined total, the basic benefit paid by the Commonwealth is reduced by that amount.

Fees charged to patients in Government nursing homes are determined by State Governments. Patients in these homes also attract basic and extensive care benefits from the Commonwealth Government, and the patient contribution is usually about the same as the statutory minimum patient contribution described above.

Deficit Financing Arrangements

As an alternative to the provision of Commonwealth nursing home benefits under the National Health Act (as outlined above), the *Nursing Homes Assistance Act* 1974 provides for direct funding of nursing homes conducted by local government and charitable and benevolent organisations.

Under the deficit financing arrangements the Commonwealth meets the approved operating deficits and the cost of approved asset replacements of these nursing homes. Financial assistance is provided by way of monthly advances based on a budget approved by the Commonwealth Department of Health. An annual settlement is effected when audited financial statements are forwarded to the Department.

Nursing homes wishing to participate in the deficit financing arrangements must enter into a formal agreement with the Commonwealth Government for that purpose. Patients in deficit-financed nursing homes are required to pay a prescribed fee equivalent to the statutory minimum patient contribution, although provision exists to reduce this contribution in appropriate cases such as homes caring for children. Higher fees are prescribed for patients entitled to damages or compensation.

APPROVED NURSING HOMES AND BEDS—STATES AND TERRITORIES, 30 JUNE 1983

	N.S.W.	*Vic.*	*Qld*	*S.A.*	*W.A.*	*Tas.*	*N.T.*	*A.C.T.*	*Aust.*
Approved nursing homes—									
Deficit financed(*a*)	130	73	71	57	27	28	1	–	387
Government(*b*)	32	70	21	5	25	5	2	2	162
Other(*c*)	352	237	108	88	72	17	2	2	878
Total	514	380	200	150	124	50	5	4	1,427
Beds in—									
Deficit financed nursing homes	6,302	2,898	3,582	2,642	1,206	829	55	–	17,514
Government nursing homes	3,391	5,188	2,445	1,141	1,736	840	54	274	15,069
Other nursing homes	18,991	7,901	5,597	3,248	3,600	611	50	131	40,129
Total	28,684	15,987	11,624	7,031	6,542	2,280	159	405	72,712
Beds per 1000 population	*5.4*	*4.0*	*4.7*	*5.3*	*4.8*	*5.2*	*1.2*	*1.7*	*4.7*

(*a*) Deficit financed homes approved under the Nursing Homes Assistance Act for the payment of their approved operating deficits. (*b*) Government homes approved under the National Health Act for the payment of nursing home benefits. (*c*) Private profit and voluntary non-profit homes approved under the National Health Act for the payment of nursing home benefits.

Source: Commonwealth Department of Health.

Other Commonwealth Nursing Benefits

Domiciliary Nursing Care Benefit

The Commonwealth Government provides a Domiciliary Nursing Care Benefit to assist people who choose to care, in their own homes, for chronically ill or infirm relatives who would require admission to a nursing home if this care in their own home was not available. Patients who qualify for this Benefit are, typically, those people who are incapable of caring for themselves and of being left unsupervised for any significant period.

The basic criteria for the payment of the Benefit are that the patient must be aged 16 years or over and be in need of and in receipt of continuing care, and also be receiving regular visits by a registered nurse. The Benefit is payable at the rate of $42 per fortnight.

Home Nursing Subsidy Scheme

The Scheme was introduced in 1956 to encourage the growth and development of home nursing services in Australia. The subsidy is paid in respect of each eligible nurse employed. An organisation must be a non-profit service to be eligible for the subsidy.

It is a condition of subsidy that the State and/or local government provide at least matching assistance. If they pay less the Commonwealth subsidy is reduced accordingly. During 1982–83, subsidies totalling $19.9m were paid to 196 approved organisations providing home nursing services in the States.

Other Commonwealth Benefits Schemes

Assistance to Isolated Patients

The *Isolated Patients Travel and Accommodation Assistance Scheme*, which is wholly funded by the Commonwealth Government, provides partial financial assistance to residents of isolated areas required to travel in excess of 200 kilometres to obtain specialist medical practitioner treatment, not locally available. Benefits are also available in certain circumstances for hospital treatment by oral surgeons, and in respect of cleft lip and palate patients under 22 years of age for journeys associated with orthodontic and associated dental care. In 1982–83 Government expenditure on the Scheme totalled $9.2 million, which involved the payment of benefits to some 70,000 persons. These figures represent increases of 46 per cent and 29 per cent respectively over those for 1981–82.

Tuberculosis

An arrangement between the Commonwealth and the States under which the Commonwealth reimbursed the States for all approved capital expenditure on tuberculosis and for net maintenance expenditure to the extent that it exceeded that for 1947–48 was discontinued from 31 December 1976. The National Tuberculosis Advisory Council, however, has been retained to keep abreast of advances and to advise the Minister for Health and, through him, the State Ministers for Health on the best means of prevention, diagnosis and control of tuberculosis. There are eleven members of the Council, the chairman being the Director-General of the Commonwealth Department of Health.

To reduce the spread of infection the Commonwealth Government pays allowances to persons suffering from infectious tuberculosis so that they may give up work and undergo treatment. Commonwealth Government Expenditure on Tuberculosis Allowances over the last three years has been $1,317,000 in 1980–81, $1,103,200 in 1981–82 and $945,630 in 1982–83.

Pharmaceutical Benefits Scheme

Under the Pharmaceutical Benefits Scheme, assistance is provided towards the cost of a comprehensive range of drugs and medicines to persons receiving treatment from a medical practitioner. From 1 April 1979, the Scheme was expanded to allow dentists, who are approved as participating dental practitioners, to prescribe a limited range of drugs for dental treatment of their 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.

From 1 January 1983 patient contribution arrangements are applicable as follows:

- *free of charge*—pensioners with Pensioner Health Benefits cards and their dependants receive benefit items free of charge;
- *$2 per benefit item*—people in special need who hold Health Care cards 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 per benefit item;

• *$4 per benefit item*—all other people pay a contribution of $4 per benefit item.

Under the Pharamecutical Benefit Scheme the total cost, including patient contributions, for prescription drugs was $526.0 million in 1981–82 and $591.5 million in 1982–83. These figures do not include benefits supplied by certain hospitals and miscellaneous services or retrospective adjustments of chemists' remunerations.

BENEFIT PRESCRIPTIONS AND COST OF MORE FREQUENTLY PRESCRIBED DRUG GROUPS, AUSTRALIA, 1982–83

	Benefit prescriptions		*Total cost of benefit prescriptions(a)*	
Drug group	*Number*	*Percentage of total*	*Amount*	*Percentage of total*
	'000	%	$'000	%
Analgesics	13,053	12.4	71,003	12.0
Diuretics	9,086	8.6	42,173	7.1
Heart—Drugs acting on	7,773	7.4	66,183	11.2
Penicillins	7,696	7.3	41,922	7.1
Bronchial spasms—Preparations for	6,232	5.9	37,408	6.3
Anovulants	5,378	5.1	24,125	4.1
Tranquillisers	4,438	4.2	17,996	3.0
Blood vessels—Drugs acting on	4,208	4.0	34,082	5.8
Sulphonamides	3,921	3.7	18,883	3.2
Tetracyclines	3,907	3.7	21,840	3.7
Antidepressants	3,534	3.4	15,416	2.6
Hypnotics and sedatives	2,795	2.7	9,352	1.6
Eye Drops	2,593	2.5	12,823	2.2
Antacids	2,295	2.2	9,428	1.6
Water and electrolyte replacement	2,243	2.1	11,282	1.9
Skin sedative applications	2,234	2.1	8,738	1.5
Erythromycin	2,208	2.1	11,424	1.9
Antihistamines	2,056	2.0	7,299	1.2
Vagina-urethra—Drugs acting on	1,793	1.7	8,745	1.5
Anti-emetics	1,412	1.3	4,856	0.8
Expectorants—cough suppressants	1,270	1.2	4,036	0.7
Skin fungicides	1,258	1.2	6,558	1.1
Other drug groups	14,202	13.5	105,936	17.9
Total	105,585	100.0	591,508	100.0

(*a*) Includes patients' contributions. Excludes Government expenditure in relation to pharmaceutical benefits provided through miscellaneous services.

Source: Commonwealth Department of Health.

Program of Aids for Disabled People

The principal aim of the Program of Aids for Disabled People (PADP) is to enable people with disabilities of a permanent or indefinite duration to live more independently in a domestic situation, with a consequent reduction in demand for more costly institutional care. Under the program, certain aids to daily living including wheelchairs, surgical shoes, braces, splints, calipers, surgical wigs, aids for incontinence, walking aids, personal aids (eating and cooking utensils, toilet articles) and basic home modifications (ramps, rails, grips, door widenings, etc.) may be provided to eligible people. PADP, which is wholly funded by the Commonwealth, is operated through health services networks administered by the State and Territory health authorities.

Summary of personal benefit payments

For an analysis by purpose and economic type of expenditure by all Commonwealth Government authorities *see* Chapter 22, 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 1981–82.

COMMONWEALTH AUTHORITIES: PERSONAL BENEFIT PAYMENTS—HEALTH 1981–82 ($'000)

	N.S.W. (a)	Vic.	Qld	S.A. (a)	W.A.	Tas.	N.T. (a)	A.C.T. (a)	Total
Hospital and clinical services—									
Hospital benefits reinsurance	35,468	31,300	14,400	16,100	1,200	1,100	—	1,537	101,105
Private hospital daily bed payments	23,548	23,615	16,332	8,876	7,686	2,489	786	1,021	84,353
Nursing home benefits	201,630	155,381	77,327	58,046	45,754	16,642	5,513	8,739	569,034
Tuberculosis campaign allowances	303	525	180	22	37	9	18	8	1,103
Rehabilitation of ex-servicemen	442	229	101	24	65	28	—	61	949
Total	*261,391*	*211,050*	*108,340*	*83,068*	*54,742*	*20,268*	*6,317*	*11,366*	*756,544*
Other health services—									
Medical benefits	321,628	189,286	106,288	68,537	55,945	17,857	3,902	9,384	772,826
Isolated patients travel and accommodation assistance	1,366	307	2,273	446	1,065	300	542	—	6,298
Pharmaceutical benefits for pensioners	98,481	57,410	38,907	20,263	16,939	6,356	213	1,325	239,895
Pharmaceutical benefits, n.e.c.	57,417	40,093	23,187	11,986	11,558	3,750	593	2,341	150,925
Domiciliary care	7,176	5,116	3,985	1,760	1,769	1,365	—	—	21,172
Total	*486,068*	*292,212*	*174,640*	*102,992*	*87,276*	*29,628*	*5,250*	*13,050*	*1,191,116*
Total health	**747,459**	**503,262**	**282,980**	**186,060**	**142,018**	**49,896**	**11,567**	**24,416**	**1,947,660**

(a) State totals for New South Wales and South Australia also include most of the unallocatable expenditure on personal benefit payments to residents in the Australian Capital Territory and the Northern Territory respectively.

Commonwealth Government subsidies and grants to States

General Revenue Grants

The Commonwealth provides untied identifiable health grants within general revenue grants to the States and the Northern Territory as a contribution towards the cost of health programs. These arrangements, which are authorised by the States (Tax Sharing and Health Grants) Act 1981, are designed to replace previous specific purpose health payments for public hospital operating costs (under expired Hospital Cost Sharing Agreements), community health and school dental service programs and apply fully to all States.

Medicare Grants to the States

Under the Medicare program, all States (including South Australia and Tasmania), the Northern Territory and the Australian Capital Territory, have been compensated by Medicare grants outside the identified health grants and tax sharing arrangements for:

- revenue losses and additional medical costs directly attributable to the provision of free public hospital accommodation and treatment; and
- a reduction to $80 per day in the fee charged for those persons who seek 'doctor of choice' or private ward accommodation in public hospitals.

As part of the Medicare arrangements, South Australia and Tasmania agreed to terminate their hospital cost sharing arrangements with the Commonwealth on 1 February 1984 and have been funded thereafter on the same basis as other States. Commonwealth hospital payments to both States in 1983-84 have, therefore, comprised:

- specific purpose assistance (hospital cost sharing agreements) for the period 1 July 1983 to 31 January 1984;
- since 1 February 1984, an additional component to their existing identified health grants (in respect of the community health program and school dental scheme) equal to the amount of grants they would otherwise have received had the cost sharing agreements continued; and
- since 1 February 1984, additional Medicare grants as outlined above.

As stated earlier the Medicare grants to the States and Northern Territory also include an additional community health component to restore the level of Community Health Grants to 1975-76 levels in real terms.

Under the Medicare arrangements, Queensland also received an additional special public hospital payment of $15m in 1983-84.

Paramedical services

The *States Grants (Paramedical Services) Act* 1969 provides for the Commonwealth Government to share on $1 for $1 basis with participating States the cost of approved paramedical services such as chiropody, occupational therapy, physiotherapy and speech therapy provided wholly or mainly for aged persons in their homes. Matching grant payments during 1982-83 amounted to $1,241,000.

Commonwealth Government subsidies and grants to organisations

Health Program Grants

Health Program Grants are lump sum payments to approved organisations in respect of the costs incurred by those organisations in providing approved health services. 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 entire costs incurred by approved health services, and no charges are raised for those services.

Community Health Program—National Projects

Under the Community Health Program National Projects arrangements, the Commonwealth provides funding to organisations in respect of specific activity which has been approved for the purpose of the Program.

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 are either national co-ordinating secretariats of voluntary non-profit organisations operating in more than one State or specific health-related projects which have national application.

Under the Medicare arrangements which commenced on 1 February 1984, the Commonwealth government expressed a renewed interest in community health services and provided block grants to the States and Territories amounting to an additional $7.3m in 1983-84 for new and expanded community health services within their borders.

For new projects at the national level, the Government also provided a further $0.8m in 1983-84.

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:

The *Royal Flying Doctor Service* is a non-profit organisation providing medical services in remote areas of Australia. It is distinct from, but co-ordinates with, the Aerial Medical Service which, while formerly operated by the Commonwealth Department of 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 1983 the Commonwealth Government paid grants totalling $4,198,000 towards operational costs and matching assistance of $785,000 towards an approved program of capital expenditure.

The *Red Cross Blood Transfusion Service* is conducted by the Australian Red Cross Society throughout Australia. The operating costs of the Service in the States are met by the State Governments 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. In the Northern Territory the Society contributes to operating costs as it does in the States, and the Commonwealth met the balance prior to 1 January 1979. After this date the Northern Territory is in the same position as the States. Approved capital expenditure by the Service in the States is shared on a $1 per $1 basis with the States and the Northern Territory Government. Commonwealth Government expenditure for each State and the Northern Territory during 1982-83 was $10,899,092, made up as follows: New South Wales, $3,076,781; Victoria, $3,682,000; Queensland, $1,402,071; South Australia, $1,359,513; Western Australia, $1,077,550; Tasmania, $182,222; and Northern Territory, $118,955.

The *National Heart Foundation of Australia* is a voluntary organisation, supported almost entirely by public donations, established with the objective of reducing the toll of heart disease in Australia. It 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 1982 was $5,794,000 of which $4,728,000 was from public donations and bequests. Federal, State and Semi-Government authorities made grants of $65,691 for specific projects conducted by the Foundation. Since the inception of the Foundation research has been a major function and a total of $16,072,000 has been expended 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 1982 the expenditure on research was $1,786,773 while expenditure on education and community service was $1,326,000.

The *World Health Organization* (WHO) is a specialised agency of the United Nations having as the 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 1982-83 was $4,090,410.

The *International Agency for Research on Cancer* (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 1982-83 was $568,225.

National Health Services and Advisory Organizations

The Australian Health Services Council

A national council, the Australian Health Services Council, together with bilateral Commonwealth/State Health Committees, was established under the Medicare Heads of Government Agreement between the Commonwealth and the States.

The Council and the Committees report to the respective Health Ministers and provide advice on policy and administrative and financial arrangements. The Council and the Committees endeavour to apply principles aimed at achieving operating economies in recognised hospitals and central services consistent with maintaining or achieving an acceptably high standard of health care.

The Health Committees also consider adjustments to Commonwealth and State health programs that may be in the mutual interests of the Commonwealth and the States. They also agree to alterations in payments to the States under the Agreements. These alterations are subsequently considered by the Commonwealth and State Ministers.

Health Services Organizations

The *Commonwealth Department of Health Pathology Laboratory Service* provides clinical diagnostic and investigational facilities at laboratories situated in Albury, Bendigo, Cairns, Hobart, Launceston, Lismore, Port Pirie, 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 1982-83, these laboratories carried out approximately 5.8 million pathology tests and investigations in respect of 0.7 million patient requests.

The *Commonwealth Serum Laboratories Commission* (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 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, Bacillus Calmette-Guerin (BCG) and an increasing range of

veterinary pharmaceutical products needed by Australia's sheep, cattle, pig and poultry industries. The role of CSL has expanded as a result of amendments to the CSL Act from 1 July 1980 that allow CSL to produce, buy, import, supply, sell or export prescribed pharmaceutical products (either of a biological or non-biological nature).

'The *Australian Radiation Laboratory* is concerned with the development of national policy relating to radiation health. The Laboratory

- 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; and
- maintains national standards of radiation exposure and radioactivity.'

The *National Acoustic 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 1982-83 the number of appointments provided was 154,702 and the number of hearing aids fitted was 53,126.

The *Ultrasonic 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* advises the Commonwealth Government and State Governments on matters of public health legislation and administration, on matters concerning the health of the public and on medical research. It also advises the Commonwealth Government and State Governments 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 Health 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 1982–83 was $29.6 million. The secretariat for the Council and its Committees is provided by the Commonwealth Department of Health and is located in Canberra.

The *Commonwealth Institute of Health* is located in the University of Sydney and provides teaching, research and consultation in all fields relating to health and its maintenance and promotion including resources devoted to the study of health problems of work, the tropics and developing nations. The Institute's academic functions are under the direction of the University, whilst its various training, research and consultative roles are maintained by the Commonwealth Department of Health which funds the Institute's activities.

The Institute has an important role as a resource and data collection centre for the nation and it is endeavouring to promote health and a better understanding of health care and its delivery throughout Australia and neighbouring countries.

The Institute offers postgraduate and undergraduate training in a wide range of Public Health specialities, the largest programme being the Master of Public Health.

Costs for the Institute paid by the Commonwealth Government during 1982–83 were $3,340,064 for administration and $99,753 for plant and equipment.

The *National Biological Standards Laboratory*, including the *Australian Dental Standards Laboratory*, is responsible for the development of standards for therapeutic goods and for testing such products for compliance with standards to ensure that they are safe, pure, potent and efficacious. Other responsibilities, including the inspection of manufacturing premises, the evaluation of new and modified products and the investigation of complaints, make it the linchpin of a uniform national system of control over therapeutic goods.

The British Pharmacopoepia, the British Pharmaceutical Codex and the British Veterinary Codex are specified as primary standards. In addition, the Minister has powers to make orders setting standards for specific types of goods and general classes of goods which are imported, or the subject of interstate trade, or supplied to the Commonwealth Government. Standards developed by the National Biological Standards Laboratory are submitted to a statutory committee, the Therapeutic Goods Standards Committee, which advises the Minister on their suitability.

The Laboratory, jointly with State officials and the pharmaceutical industry, prepares and revises an Australian Code of Good Manufacturing Practice which is the criterion employed by inspectors for the licensing of pharmaceutical manufacturers.

The Laboratory has sections which deal with viral products, bacterial products, pharmaceutical products, antibiotics and pharmacology, testing dental products and some medical devices.

The *Australian Drug Evaluation Committee* makes medical and scientific evaluations both of such goods for therapeutic use as the Minister for 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 Health as it considers necessary, 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 co-opt and seek advice from specialist medical colleges and associations and from the medical and allied professions, drug manufacturers and other sources. During 1982–83 sixty-five applications for approval to market new drugs and thirty-nine applications to extend the indications or amend dosage regimes for currently marketed drugs were considered by the Committee. Sixty-three applications were approved, thirty-three rejected and eight deferred pending production of further information on safety and efficacy. Under the Committee's control are the Australian Registry of Adverse Reactions to Drugs, which provides an early warning system based on reports of reactions to drugs forwarded voluntarily by medical practitioners, pharmacists, hospitals, etc.; the Adverse Drug Reaction Advisory Committee, which gives initial consideration to the adverse drug reaction reports received by the Registry and arranges feedback to the medical profession; the Vaccines Sub-committee; the Endocrinology Sub-committee; the Congenital Abnormalities Sub-committee; the Parenteral Nutrition Sub-committee; the Anti-cancer Drugs Sub-committee; the Radiopharmaceuticals Sub-committee; and the National Drug Information Advisory Sub-committee, formed to oversight administrative aspects of the technical input to the National Drug Information Service.

The *Therapeutic Goods Advisory Committee* considers, and advises the Minister for Health on, any matters relating to standards applicable to goods for therapeutic use and the administration of the Therapeutic Goods Act. The *Therapeutic Goods Standards Committee*, under the same Act, advises the Minister for Health on standards applicable to goods for therapeutic use and requirements relating to the labelling and packaging of any such goods.

The *National Therapeutic Goods Committee* comprises Federal and State representatives. Its function is to make recommendations to the Commonwealth and State Governments on action necessary to bring about co-ordination of legislation and administrative controls on therapeutic goods. Sub-committees have been formed to consider specific matters, notably advertising, establishment of a National Product Register, a Code of Good Manufacturing Practice, and standards for disinfectants.

The *Standing Committee of the Health Ministers' Conference* was established by the 1980 Australian Health Ministers' Conference to carry out any tasks or directions referred to it by the Conference. The Committee's membership consists of representatives from the Commonwealth Departments of Health and Veterans' Affairs, each State health authority, the Northern Territory Department of Health and the Capital Territory Health Commission.

COMMUNICABLE DISEASES

Quarantine

The *Quarantine Act 1908* is administered by the Commonwealth Department of Health 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 Health of all cases of illness on board their vessel at the time of arrival. Passengers or crew members who are believed to be suffering from a quarantine 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* endemic zones 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 Health, in consultation with Australia's agricultural and livestock groups, seeks to satisfy the need 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 requirement. 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 Northern Surveillance program and the rigorous screening of applications to import biological materials and animal products.

Plant quarantine

Arising from both its dependence upon exotic plant species for agriculture, horticulture and forestry and its island continental isolation, Australia is free of numerous plant pests and diseases that occur elsewhere in the world. Since 1 July 1909, the importation into Australia of plant materials has been subject to an increasingly stringent quarantine: some materials are admitted only under certain conditions while others are prohibited altogether. The quarantines are designed to exclude from the country unwanted pests and plant diseases. It is not possible to predict how a new plant pest or disease will perform when introduced to a new environment free of its natural enemies. Hence 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.

For further details *see* Year Book No. 61, page 449.

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 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 Director-General of Health.

The following table shows, by State and Territory, the number of cases notified in 1982, 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 following affect both the completeness of the figures and the comparbility from State to State and from year to year: availability of medical and diagnostic services; varying degrees of attention to notification of diseases; and enforcement and follow up of notifications by health authorities.

NOTIFIABLE DISEASES(*a*), NUMBER OF CASES NOTIFIED 1982

Disease	*N.S.W.*	*Vic.*	*Qld*	*S.A.*	*W.A.*	*Tas.*	*N.T.*	*A.C.T.*	*Aust.*
Amoebiasis	6	1	14	10	–	–	1	1	33
Ankylostomiasis	1	–	13	3	–	–	93	–	110
Arbovirus infection	22	18	164	17	–	–	–	–	221
Brucellosis	16	2	1	8	–	–	1	–	28
Cholera	1	–	–	–	–	–	–	–	1
Diphtheria	–	–	–	–	–	–	1	1	2
Gonorrhoea	4,652	3,381	1,360	887	1,420	117	839	149	12,805
Hepatitis A (infectious)	215	320	227	136	64	29	34	21	1,046
Hepatitis B (serum)	174	307	81	114	20	–	15	14	725
Hydatid disease	2	2	1	2	–	2	–	3	12
Leprosy	11	3	9	1	14	–	8	–	46
Leptospirosis	57	32	28	7	5	6	–	–	135
Malaria	142	92	219	39	20	1	15	20	548
Ornithosis	4	3	–	5	–	1	–	1	14
Salmonella infections	441	222	419	333	97	42	267	45	1,866
Shigella infections	40	23	87	30	87	3	165	2	437
Syphilis	1,691	262	514	109	222	1	410	2	3,211
Tetanus	–	6	1	5	–	–	–	–	12
Tuberculosis (all forms)	459	414	195	110	136	–	28	21	1,363
Typhoid fever	7	3	2	–	2	–	–	1	15
Typhus (all forms)	1	–	9	–	1	–	–	–	11

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

NOTIFIABLE DISEASES(*a*), NUMBER OF CASES NOTIFIED: AUSTRALIA, 1976 TO 1982

	1976	*1978*	*1980*	*1981*	*1982*
Amoebiasis	59	19	53	62	33
Ankylostomiasis	463	238	219	136	110
Anthrax	–	–	2	–	–
Arbovirus infection	–	1	18	17	221
Brucellosis	47	50	49	36	28
Cholera	–	1	3	2	1
Diphtheria	3	3	1	18	2
Gonorrhoea	11,479	12,352	11,487	11,197	12,805
Hepatitis A (infectious)	3,067	2,661	1,385	1,453	1,046
Hepatitis B (serum)	442	773	646	500	725
Hydatid disease	10	17	41	24	12
Leprosy	39	55	35	38	46
Leptospirosis	60	37	64	95	135
Malaria	253	273	541	408	548
Ornithosis	2	6	17	13	14
Poliomyelitis	–	1	–	–	–
Salmonella infections	815	2,059	2,292	2,269	1,866
Shigella infections	396	394	545	424	437
Syphilis	3,182	3,322	2,902	2,916	3,211
Tetanus	3	14	9	12	12
Tuberculosis (all forms)	1,436	1,363	1,554	1,460	1,363
Typhoid fever	22	24	19	26	15
Typhus (all forms)	1	1	–	–	11

(*a*) No cases of smallpox were notified. Plague and yellow fever were not notifiable for 1976 and 1978—no cases have since been notified.
Source: Commonwealth Department of Health.

Immunisation campaigns

Continuing immunisation programs against poliomyelitis, measles, rubella, diphtheria, tetanus, and whooping cough are maintained in all States and Territories. Mumps immunisation programs commenced late in 1982.

Mass campaigns for rubella immunisation are routinely undertaken only on girls aged between 10 and 14 years. Rubella immunisation is also available when appropriate to females during their reproductive years. Whooping cough immunisation is currently given only to infants less than 1 year of age.

HOSPITALS

Repatriation hospitals

A full range of services for the medical care and treatment of eligible veterans and certain dependants is available from the Department of Veterans' Affairs hospital system. Patients from the general community may also receive treatment at Repatriation hospitals provided bed capacity is available above the needs of the entitled veteran and the hospital facilities are appropriate to the treatment required.

In-patient treatment is provided at the six acute-care Repatriation General Hospitals (one in each State) and three auxiliary hospitals. In-patient treatment may also be provided in non-departmental public and private hospitals at the Department's expense in certain circumstances.

Mental patients requiring custodial care are, by agreement with the State Governments, accommodated at the expense of the Department in mental hospitals administered by the State authorities.

Details of patients, staff and expenditure on Repatriation institutions and other medical services are given in Chapter 9, Social Security and Welfare.

Hansenide hospitals

The two isolation hospitals in Australia for the care and treatment of persons suffering from Hansen's Disease (leprosy) are at Little Bay in New South Wales and Derby in Western Australia. In North Queensland, a leprosy annexe is attached to the Palm Island Hospital near Ingham and in the Northern Territory leprosy sufferers are treated and cared for at the East Arm Hospital in Darwin. Treatment is also provided at a number of other hospitals in Australia which do not have facilities set aside specifically for leprosy patients.

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, Queensland, South Australia, Western Australia and Tasmania, however, have been published in the ABS publications *Hospital and Nursing Home Inpatients* (4306.1), *Patients Treated in Hospitals* (4303.3), *Hospital Morbidity* (4302.4), *Hospital In-patient Statistics* (4301.5) and *Hospital Morbidity* (4301.6) respectively.

The number of hospitals and beds in each State and Territory, as approved under the Health Insurance Act, is provided in the table below.

APPROVED HOSPITALS (*a*) AND BEDS, STATES AND TERRITORIES, 30 JUNE 1983

	N.S.W.	*Vic.*	*Qld*	*S.A.*	*W.A.*	*Tas.*	*N.T.*	*A.C.T.*	*Aust.*
Approved hospitals—									
Public	247	170	143	83	95	23	6	4	771
Private	107	119	46	37	23	8	—	1	341
Total	**354**	**289**	**189**	**120**	**118**	**31**	**6**	**5**	**1,112**
Beds in—									
Public hospitals	28,101	15,456	13,115	6,513	6,859	2,351	790	1,044	74,229
Private hospitals	6,262	5,629	3,646	2,143	1,882	519	—	51	20,132
Total	**34,363**	**21,085**	**16,761**	**8,656**	**8,741**	**2,870**	**790**	**1,095**	**94,361**
Beds per 1,000 population	*6.4*	*5.2*	*6.8*	*6.5*	*6.5*	*6.6*	*5.9*	*4.7*	*6.2*

(*a*) Includes Veterans' Affairs hospitals.
Source: Commonwealth Department of Health.

An examination of the New South Wales figures for 1981, which include psychiatric hospitals, indicates that the largest numbers of patients were treated for conditions of pregnancy, childbirth and the puerperium (10.6 per cent), genito-urinary diseases (9.5 per cent) and injury (9.4 per cent) but, in terms of hospital bed-days, the greatest occupancy rate was caused by mental disorders (27.2 per cent) followed by diseases of the circulatory system (15.6 per cent) and injury (6.8 per cent). Of the principal operations performed the largest number was for female genital organ surgery (13.2 per cent) followed by digestive system surgery (9.6 per cent) and obstetric surgery (8.5 per cent).

People in Health Occupations

Information concerning the number of people employed in selected health occupations and/or industries in Australia as derived from responses to the occupation and industry questions in the Census of Population and Housing 30 June 1981 was published in *Persons in Health Occupations and Industries* (4345.0). This information is summarized in the table below.

PERSONS IN HEALTH OCCUPATIONS AND INDUSTRIES: AUSTRALIA, CENSUS OF POPULATION AND HOUSING 30 JUNE 1981.

	Industry of employment(a)						
Occupation(a)	*Hospitals and nursing homes*	*Medicine*	*All other health industries(b)*	*Total health industries*	*All other industries*	*Total* *Number*	*Rate(c)*
Medical practitioners	8,531	15,913	1,010	25,454	1,673	27,127	18.6
Dentists	233	70	5,027	5,330	256	5,586	3.8
Nurses—							
Certificated	83,959	4,748	8,823	97,530	9,035	106,565	73.1
Other(*d*)	27,467	316	3,302	31,085	1,783	32,868	22.5
Nursing aides(*d*)	19,016	136	475	19,627	1,501	21,128	14.5
Total	130,442	5,200	12,600	148,242	12,319	160,561	110.2
Pharmacists (incl. assistants)	1,253	21	63	1,337	8,852	10,189	7.0
Optometrists	26	7	1,056	1,089	189	1,278	0.9
Physiotherapists	2,261	148	1,601	4,010	468	4,478	3.1
Radiographers	1,979	694	155	2,828	189	3,017	2.1
Chiropodists	112	50	547	709	201	910	0.6
Chiropractors	11	31	849	891	65	956	0.7
Dieticians	454	10	55	519	166	685	0.5
Occupational therapists	1,682	19	342	2,043	484	2,527	1.7
Speech therapists	369	8	212	589	486	1,075	0.7
Other professional medical workers	171	109	803	1,083	555	1,638	1.1
Medical science technologists	1,925	660	169	2,758	1,040	3,798	2.6
Medical science technicians	4,962	1,743	5,247	11,952	3,493	15,445	10.6
Ambulance officers	35	2	4,267	4,304	247	4,551	3.1
Attendants—hospital, other medical	20,235	228	4,015	24,478	3,188	27,666	19.0
Health inspectors	15	—	124	139	2,097	2,236	1.5
Total health occupations	174,697	24,913	38,145	237,755	35,968	273,723	187.8
Total all other occupations	100,838	24,181	17,430	142,449	5,876,460	6,018,909	..
Grand total	**275,535**	**49,094**	**55,575**	**380,200**	**5,912,432**	**6,292,632**	..

(a) Occupation and industry of main job held during the week prior to the census as reported and described by respondents. (b) Includes dentistry, dental laboratories, optometry, optical dispensers, community health centres, ambulance services, and other and undefined health services. (c) Rate per 10,000 of total population as derived from census count. (d) Includes trainees.

Discrepancies between the sum of components and the totals shown are due to random adjustment. Information about the random adjustment process is contained in the ABS publication *Census 81—Effects of Introduced Random Error* (2156.0).

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). A summary of age-specific death rates for major cause groups in this period was published in *Causes of Death: Age-specific Death Rates, Australia, 1968 to 1978* (3308.0). Detailed statistics are published in the publication *Causes of Death, Australia* (3303.0), and only broad groupings of causes of death are shown in the table below. The statistics in the table relate to 1982 and represent the number of deaths registered that year rather than the number of deaths which actually occurred in 1982.

The major causes of death in the community in 1982 were diseases of the circulatory system (accounting for 50.3 per cent), neoplasms (21.9 per cent), diseases of the respiratory system (7.8 per cent) and accidents, poisonings and violence (7.2 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 1982, 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 (65 per cent in 1982) occur within 28 days after birth (see table on perinatal deaths). Nearly all of these neonatal deaths are due to congenital anomalies, birth injury or other conditions present from birth.

CAUSES OF DEATH IN EACH AGE GROUP, AUSTRALIA, 1982

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 OF DEATHS										
Infectious and parasitic diseases	40	36	15	23	13	34	59	112	205	537
Neoplasms	17	171	178	313	867	2,484	5,570	7,844	7,709	25,153
Endocrine, nutritional and metabolic diseases and immunity disorders	22	36	28	28	45	108	285	562	1,009	2,123
Diseases of the nervous system and sense organs	57	90	72	66	67	99	215	328	499	1,494
Diseases of the circulatory system	12	29	73	238	744	2,677	7,301	14,882	31,725	57,686
Diseases of the respiratory system	56	66	57	68	104	306	1,046	2,443	4,763	8,910
Diseases of the digestive system	12	10	19	65	193	428	743	859	1,580	3,909
Congenital anomalies	751	113	41	22	18	31	35	28	13	1,052
All other diseases(*b*)	1,000	25	63	107	74	174	406	770	2,235	4,854
Signs, symptoms and ill-defined conditions	452	27	17	21	11	26	29	29	145	759
Accidents, poisonings and violence	63	651	1,917	1,411	881	808	782	696	1,080	8,294
All causes	**2,482**	**1,254**	**2,480**	**2,362**	**3,017**	**7,175**	**16,471**	**28,553**	**50,963**	**114,771**
RATE(*c*)										
Infectious and parasitic diseases	17	1	1	1	1	2	4	12	38	4
Neoplasms	7	5	7	13	45	164	404	817	1,438	166
Endocrine, nutritional and metabolic diseases and immunity disorders	9	1	1	1	2	7	21	59	188	14
Diseases of the nervous system and sense organs	24	3	3	3	3	7	16	34	93	10
Diseases of the circulatory system	5	1	3	10	38	177	529	1,549	5,919	380
Diseases of the respiratory system	23	2	2	3	5	20	76	254	889	59
Diseases of the digestive system	5	–	1	3	10	28	54	89	295	26
Congenital anomalies	313	3	2	1	1	2	3	3	2	7
All other diseases(*b*)	417	1	2	4	4	12	29	80	417	32
Signs, symptoms and ill-defined conditions	188	1	1	1	1	2	2	3	27	5
Accidents, poisonings and violence	26	19	73	57	45	53	57	72	202	55
All causes	**1,035**	**36**	**95**	**95**	**156**	**474**	**1,194**	**2,973**	**9,509**	**756**
PERCENTAGE(*d*)										
Infectious and parasitic diseases	1.6	2.9	0.6	1.0	0.4	0.5	0.4	0.2	0.4	0.5
Neoplasms	0.7	13.6	7.2	13.3	28.7	34.6	33.8	27.5	15.1	21.9
Endocrine, nutritional and metabolic diseases and immunity disorders	0.9	2.9	1.1	1.2	1.5	1.5	1.7	2.0	2.0	1.8
Diseases of the nervous system and sense organs	2.3	7.2	2.9	2.8	2.2	1.4	1.3	1.1	1.0	1.3
Diseases of the circulatory system	0.5	2.3	2.9	10.1	24.7	37.3	44.3	52.1	62.3	50.3
Diseases of the respiratory system	2.3	5.3	2.3	2.9	3.4	4.3	6.4	8.6	9.3	7.8
Diseases of the digestive system	0.5	0.8	0.8	2.8	6.4	6.0	4.5	3.0	3.1	3.4
Congenital anomalies	30.3	9.0	1.7	0.9	0.6	0.4	0.2	0.1	–	0.9
All other diseases(*b*)	40.3	2.0	2.5	4.5	2.5	2.4	2.5	2.7	4.4	4.2
Signs, symptoms and ill-defined conditions	18.2	2.2	0.7	0.9	0.4	0.4	0.2	0.1	0.3	0.7
Accidents, poisonings and violence	2.5	51.9	77.3	59.7	29.2	11.3	4.7	2.4	2.1	7.2
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 14 deaths where age is not known. (*b*) Includes 1,006 deaths from conditions originating in the perinatal period and 1,717 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.

Suicides

A range of statistics relating to deaths by suicide (as determined by coroner's inquests) in Australia was published by the ABS during 1983 in *Suicides, Australia 1961–1981 (Including historical series 1881–1981)* (3309.0).

In brief, the statistics indicate that

- Suicide accounted for over 1,500 deaths in Australia in each of the years 1971 to 1981. While this represents a small proportion of all deaths (only 1.5 percent of the total in 1981), it has considerable significance as a cause of death at ages between 15 and 44 years. For example, in 1981, suicide accounted for 15.2 per cent of all deaths at ages 25–34 years.
- While the suicide rate per 100,000 population in 1981 (11.2) is little different from 100 years earlier (11.0), there have been considerable fluctuations during the intervening years. Particularly significant for males is the high rate in 1930 (24.0), and the low rates during World War II. The period 1963 to 1967 showed the highest rates for females, as well as higher than average rates for males.
- In most years of the period 1881 to 1981, male suicide rates have been more than double those of females (16.9 and 5.5 respectively in 1981).
- Firearms and explosives were the methods of suicide most frequently used by males over the period 1968 to 1981. Poisoning by solid or liquid substances was the most frequent for females over this period.

There were 1,777 suicides in 1982, which represented 1.5 percent of all deaths registered in that year, and a rate of 12 per 100,000 population.

Perinatal deaths

Since deaths within the first four weeks 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

PERINATAL DEATHS BY CAUSE, AUSTRALIA, 1982

	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	122	171	293	0.51	0.71	1.21
Birth trauma	6	40	46	0.02	0.17	0.19
Hypoxia, birth asphyxia and other respiratory conditions	798	424	1,222	3.30	1.77	5.06
Fetal and neonatal haemorrhage	39	134	173	0.16	0.56	0.72
Haemolytic disease of fetus and newborn	22	8	30	0.09	0.03	0.12
Other conditions originating in the perinatal period	497	108	605	2.06	0.45	2.50
Congenital anomalies	208	565	773	0.86	2.36	3.20
Infectious and parasitic diseases	4	4	8	0.02	0.02	0.03
All other causes	9	75	84	0.04	0.31	0.35
Conditions in mother—						
Maternal conditions which may be unrelated to present pregnancy	185	108	293	0.77	0.45	1.21
Maternal complications of pregnancy	197	455	652	0.82	1.90	2.70
Complications of placenta, cord and membranes	752	177	929	3.11	0.74	3.85
Other complications of labour and delivery	39	127	166	0.16	0.53	0.69
No maternal condition reported	532	662	1,194	2.20	2.76	4.94
All causes—1982	**1,705**	**1,529**	**3,234**	**7.06**	**6.38**	**13.39**
1981	1,706	1,440	3,146	7.18	6.11	13.25
1980	1,708	1,503	3,211	7.52	6.67	14.14
1979	1,757	1,605	3,362	7.82	7.20	14.96
1978	1,904	1,737	3,641	8.43	7.75	16.11
1977	1,896	1,869	3,765	8.31	8.26	16.51

(*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

Note: The statistics for the years 1977 and 1978 in this table are also based on the revised definition.

weighing at least 500 grams (or, when birthweight is unavailable, the corresponding gestational age (22 weeks) or body length (25 cm crown-heel)), whether alive or dead". The above table incorporates a further recommendation of the Conference in that it shows for 1982 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 rose slightly in 1982, to 13.39 per 1,000 total births compared with 13.25 in 1981. This was the first time the rate (on the new definition) had not shown a decrease over the last 10 years.

Of the conditions in the child, the two main groups responsible for perinatal deaths were *Hypoxia, birth asphyxia and other respiratory conditions* (37.8 per cent of the total) and *Congenital anomalies* (23.9 per cent). Thirty-seven 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, 45.5 per cent were reported as being due to *Complications of placenta, cord and membranes.*

Cremations

State/Territory	1980		1981		1982		
	Number of cremations (b)	Number of deaths	Number of cremations (b)	Number of deaths	Number of crematoria (a)	Number of cremations (b)	Number of deaths
N.S.W.	20,797	40,282	21,182	39,959	17	21,819	42,352
Vic.	11,804	29,374	11,597	29,034	4	12,234	30,611
Qld	7,821	16,497	8,047	17,175	9	8,547	18,149
S.A.	4,136	9,580	4,335	9,706	2	4,723	10,457
W.A.	4,270	8,166	4,306	7,993	3	4,415	8,187
Tas.	1,401	3,392	1,352	3,320	2	1,476	3,432
N.T.	—	512	—	854	—	—	573
A.C.T.	514	892	643	962	1	595	1,010
Australia—							
number	**50,743**	**108,695**	**51,462**	**109,003**	**38**	**53,809**	**114,771**
per cent (c)	..	46.7	..	47.2	..	46.9	..

(a) At 31 December. (b) Cremations are not necessarily carried out in the State or Territory where the death was registered. (c) Cremations as a percentage of all deaths.

Source: Services and Investment Ltd. (Cremation Society of Australia (ACT) Ltd)

Health-Related Surveys Conducted by the ABS

Australian Health Surveys

A survey was conducted by ABS during the period July 1977–June 1978 to obtain information on the health of Australians and the use of and need for various health services and facilities. Topics covered by the survey included recent and chronic illness, accidents, use of medicines, and use of doctors, dentists, and other health workers and facilities, as well as a range of personal characteristics. The items are described more fully in *Australian Health Survey Information Paper* (4340.0). Summary results of the survey have been published in *Australian Health Survey 1977–1978* (4311.0); detailed results are published in a series of publications (4313.0 to 4322.0) dealing with the special topics of the survey. The survey is explained in detail in *Outline of Concepts, Methodology and Procedures Used* (4323.0).

During the period February 1983–January 1984 a survey was conducted to obtain information on the actions people had taken about their health in the two weeks before interview and the medical conditions which underline those actions. The actions covered included hospitalisations; consultation with doctors, dentists and other health professionals; reduced activity and medicine taking. For some topics such as hospitalisations and dental consultations, details of the action related to the 12 months before interview. The survey methodology allowed for the identification of conditions for which multiple actions had occurred. Further explanation is given in *Australian Health Survey, 1983, Outline of Concepts, Methodology and Procedures Used* (4323.0).

Health Insurance Surveys

These surveys have been conducted in March for the years 1979–1983.

In March 1983 the ABS conducted a survey throughout Australia to obtain information about levels of health insurance cover in the Australian community. The survey obtained, in respect of contributor units, details of the hospital and medical insurance arrangements they had at the time of the survey. The survey found that as at March 1983, 63.9 per cent of all possible contributor units had some type of private health insurance. A further 21.3 per cent were identified as being covered by special Commonwealth health benefits, leaving 14.8 per cent of all possible contributor units without health insurance nor identified access to special Commonwealth health benefits.

Compared with an estimate of 65.8 per cent obtained in a similar survey in March 1982, the above estimate represents a net decrease of 1.9 percentage points in the previous twelve months in the proportion of possible contributor units with some type of health insurance cover. An estimated 1,826,300 persons were without health insurance or identified access to special Commonwealth health benefits, at March 1983.

Results of the survey showing such details as type and level of health insurance cover; income and composition of contributor unit; age of head of contributor unit; special Commonwealth health benefits, and an outline of the medical and hospital benefits schemes 1 November 1978 to 30 June 1983 are published in *Health Insurance Survey, Australia, March 1983* (4335.0).

In May 1984 a survey was conducted seeking information on hospital and ancillary insurance taken out over and above that which is available under Medicare. This survey covered wage and salary earners in capital cities only.

Hearing Survey

In September 1978 the ABS conducted a survey to obtain information about hearing problems for persons aged 15 years or more. Details included the cause and extent of their problem, whether a hearing aid was used, and if not, the reason for not using an aid. It also contained data on whether persons have had their hearing tested in the last 5 years.

Results of the survey have been published in the publication *Hearing and the Use of Hearing Aids (Persons aged 15 years or more) September 1978* (4336.0).

A similar survey was conducted for persons aged 2 to 14 years but contained data only on cause of hearing problem and whether persons have had their hearing tested in the last 5 years. Results of this survey are contained in the publication *Sight, Hearing and Dental Health (Persons aged 2 to 14 years) February–May 1979* (4337.0).

Sight Survey

During February to May 1979 the ABS conducted a survey to obtain information on sight problems and the use of glasses/contact lenses for the Australian population aged 2 years or more. Details included type of sight problems, reason glasses/contact lenses are worn, how often they are worn and whether persons have had their sight tested in the last 5 years.

Results of the survey for persons aged 2 to 14 years have been published in the publication *Sight, Hearing and Dental Health (persons aged 2 to 14 years) February–May 1979* (4337.0). For persons aged 15 years or more the relevant publication is *Sight Problems and the Use of Glasses/Contact Lenses (persons aged 15 years or more) February–May 1979* (4338.0).

Dental Surveys

During February to May 1979 the ABS conducted a survey to obtain information on the dental health of the Australian population aged 2 years or more. Information collected included time since last visit to a dentist; number of visits in last 12 months, treatment received at last visit and usual number of check-ups per year. Data were also collected for persons aged 15 years or more as to whether false teeth were worn.

Results of the survey for persons aged 2 to 14 years have been published in the publication *Sight, Hearing and Dental Health (persons aged 2 to 14 years) February–May 1979* (4337.0). For persons aged 15 years or more the relevant publication is *Dental Health (persons aged 15 years or more) February–May 1979* (4339.0).

A survey was conducted during November 1983 to obtain information on the usage of dental services at schools and at private practices. Results are published in *Children's Dental Health Survey, Australia* (4349.0).

Immunisation Surveys

Data was collected during the Australian Health Survey 1977-78 on the immunisation status of persons aged 2 to 5 years in relation to Poliomyelitis, Diptheria, Whooping Cough and Tetanus and results were published in *Australian Health Survey, Sabin and Triple Antigen Vaccination, 1977-78* (4316.0).

In November 1983, a survey was held to obtain infomation on the immunisation status of persons aged 0-6 years against Poliomyelitis, Diptheria, Whooping Cough and Tetanus. Results are available in *Childrens Immunisation Survey, Australia* (4351.0).

Information about the immunisation status of females aged 15 to 34 years in relation to Rubella was obtained during a survey conducted throughout Australia in March 1983. The survey results indicated that of the Australian female population aged 15 to 34 years, 69.5 per cent had obtained immunisation against Rubella; 23.6 per cent had not received any immunisation and 6.9 per cent did not know whether or not they had been immunised against Rubella. The most frequently reported reason for not obtaining immunisation was that they had 'had Rubella'. This was reported by 32.1 per cent of females aged 15-34 years who had not received the vaccination. Another 28.4 per cent were reported as having never 'bothered or thought about it'.

Results of the survey are published in *Rubella Immunisation Survey (females aged 15 to 34 years) March 1983* (4353.0).

Survey of Handicapped Persons

During February to May 1981 a survey was conducted thoughout Australia to obtain infomation about the nature and extent of various disabilities and handicaps in the Australian community.

The survey examined the needs of and the kinds of problems experienced by persons with different types of handicaps. The areas examined in respect of handicapped persons included causes, disabling conditions, services, aids, accommodation, employment, education, income, transport, recreation and institutionalised care.

The sample for the survey consisted of two distinct parts. In the first part, a sample of 33,000 households was selected from all households in Australia and in the second part, a sample of 5,300 patients or residents was selected from 723 randomly selected health establishments throughout Australia.

For the purposes of the survey, a disabled person was defined as a person who had one or more of a set of selected disabilities or impairments (e.g. loss of sight, loss of hearing, slowness at learning or understanding, incomplete use of arms and fingers, restriction in physical activities). These had to have lasted or be likely to last for 6 months or more.

A handicapped person was defined as a disabled person who was further identified as being limited to some degree in his/her ability to perform certain activities or tasks in relation to one or more of the following five areas: self care, mobility, communication, schooling, employment. Since the measurement of handicap could not be readily applied to children under 5 years of age, all disabled persons in this age group were regarded as being handicapped.

The main features of the survey results are:

- 1,264,600 Australians or 8.6 per cent of the population are handicapped. A further 4.6 per cent of the population are disabled but suffer no subsequent handicap.
- Of the 1,264,600 handicapped persons, 295,800 were mildly handicapped, 253,700 were moderately handicapped and 513,900 were severely handicapped. (Severity of handicap was not determined for 201,200 persons with only a schooling or employment limitation, or aged less than 5 years).
- Of those who are handicapped, 111,000 are residents of health establishments and 1,153,600 are resident in households.
- The handicaps of persons in health establishments tended to be more severe than those of persons in households. For example, over 90 per cent of handicapped persons in health establishments were severely handicapped compared with 36 per cent of handicapped persons in households.
- As age increases the likelihood of being handicapped also generally increases. For example, in the age range 15 to 24 years, there were 66,200 handicapped persons (2.6% of persons aged 15 to 24) whilst in the age range 65 to 74 years there were over 220,000 (24.1% of persons aged 65 to 74).