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 1984), 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 1984, the Commission had a staff of 3,537 full-time and 793 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

Details of the health financing arrangements under the Medicare program introduced by the Commonwealth Government in February 1984 are available in Year Book 68—1984.

Since the introduction of the Medicare program the income thresholds on which the levy is payable have been revised. From 1 July 1984 no levy was payable by single people earning $7,110 per annum or less or by married couples and sole parents with a combined income of $11,803 per annum or less, with a further $1,330 per annum allowed for each dependent child. With effect from 1 November 1984 the maximum levy payable is reached where a single or combined husband and wife taxable income is $75,000 per annum.

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

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 practitioners, 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 payments under this program increased from $86.5m in 1982–83 to $103.6m in 1983–84, reflecting the increased commitment under Medicare. The full year estimate under Medicare is $140m.

The States have the primary responsibility for the arrangement and provision of health services within their respective States. In recognition of this, the relevant Commonwealth legislation requires the Commonwealth Minister for Health to consult with his counterparts in the States and have regard to their views in respect of the major issues affecting private hospitals, such as approvals to build or extend, categorisation criteria, determination of the initial category of individual hospitals and proposals to change the categories determined for individual hospitals.

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 1 November 1984, the maximum amount of basic nursing home benefit payable per day in each State and Territory was: New South Wales and Australian Capital Territory $33.35; Victoria $48.50; Queensland $28.10; South Australia and Northern Territory $39.05; Western Australia $27.55; and Tasmania $27.80.

(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 at 1 November 1984 was $12.75 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 1984

	N.S.W.	*Vic.*	*Qld*	*S.A.*	*W.A.*	*Tas.*	*N.T.*	*A.C.T.*	*Aust.*
Approved nursing homes—									
Deficit financed(*a*)	133	73	72	58	28	28	1	–	393
Government(*b*)	32	75	22	5	25	5	1	2	167
Other(*c*)	353	238	112	94	70	18	2	2	889
Total	**518**	**386**	**206**	**157**	**123**	**51**	**4**	**4**	**1,449**

APPROVED NURSING HOMES AND BEDS—STATES AND TERRITORIES, 30 JUNE 1984—*continued*

	N.S.W.	*Vic.*	*Qld*	*S.A.*	*W.A.*	*Tas.*	*N.T.*	*A.C.T.*	*Aust.*
Beds in—									
Deficit financed nursing homes	6,590	2,950	3,656	2,703	1,230	904	55	–	18,088
Government nursing homes	3,384	5,260	2,485	1,141	1,810	840	24	274	15,218
Other nursing homes	19,489	7,951	5,883	3,536	3,573	629	50	166	41,277
Total	**29,463**	**16,161**	**12,024**	**7,380**	**6,613**	**2,373**	**129**	**440**	**74,583**
Beds per 1000 population	*5.5*	*4.0*	*4.8*	*5.5*	*4.8*	*5.4*	*0.9*	*1.8*	*4.8*

(*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

See also Special Article *History of Home Nursing in Australia*, at the end of this chapter.

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 1983–84, subsidies totalling $22.8m were paid to 199 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 medical treatment from the nearest suitable specialist medical practitioner. Benefits are also available for journeys associated with certain medical services provided in hospitals by oral surgeons and in respect of orthodontic and associated dental care to cleft lip and palate patients under 22 years of age. In 1983–84 Government expenditure on the Scheme totalled $11.79m assisting some 116,000 people. An amount of $15.0m has been allocated for 1984–85.

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 $1,103,200 in 1981–82, $945,630 in 1982–83 and $823,682 in 1983–84.

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 contribution of prescriptions processed for payment was $591.5 million in 1982–83 and $649.6 million in 1983–84. 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, 1983–84

	Benefit prescriptions		*Total cost of benefit prescriptions(a)*	
Drug group	*Number*	*Percentage of total*	*Amount*	*Percentage of total*
	'000	%	$'000	%
Analgesics	14,229	13.05	80,030	12.32
Diuretics	9,311	8.54	44,204	6.80
Heart—Drugs acting on	8,434	7.73	75,216	11.58
Penicillins	7,633	7.00	44,029	6.78
Bronchial spasms—Preparations for	7,089	6.50	44,300	6.82
Anovulants	5,585	5.12	26,175	4.03
Blood vessels—Drugs acting on	4,502	4.13	39,448	6.07
Tetracyclines	4,109	3.77	24,399	3.76
Tranquillisers	4,059	3.72	17,607	2.71
Sulphonamides	3,953	3.62	19,977	3.08
Antidepressants	3,598	3.30	16,633	2.56
Hypnotics and sedatives	2,785	2.55	9,839	1.51
Eye Drops	2,615	2.40	14,120	2.17
Antacids	2,447	2.24	10,548	1.62
Erythromycin	2,417	2.22	13,108	2.02
Water and electrolyte replacement	2,377	2.18	12,668	1.95
Skin sedative applications	2,373	2.18	9,788	1.51
Vagina-urethra—Drugs acting on	1,852	1.70	9,486	1.46
Antihistamines	1,640	1.50	6,172	0.95
Anti-emetics	1,358	1.25	4,788	0.74
Expectorants—cough suppressants	1,317	1.21	4,416	0.68
Skin fungicides	3,316	1.21	7,204	1.11
Other drug groups	14,064	12.88	115,433	17.77
Total	**109,063**	**100.00**	**649,588**	**100.00**

(*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, and basic home modifications (ramps, hand rails, 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 which are responsible for the day to day operation of the Program, including the purchase and issue of aids.

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 1982-83.

COMMONWEALTH AUTHORITIES: PERSONAL BENEFIT PAYMENTS—HEALTH 1982–83 ($'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	53,109	26,701	12,397	6,675	954	—	—	—	99,836
Private hospital daily bed payments	23,600	24,642	16,987	8,668	8,219	2,487	855	1,034	86,492
Nursing home benefits	265,000	208,000	101,000	83,000	54,000	20,000	—	—	731,000
Total	*341,709*	*259,343*	*130,384*	*98,343*	*63,173*	*22,487*	*855*	*1,034*	*917,328*
Other health services—									
Medical benefits	395,190	213,918	132,614	81,939	68,192	20,942	746	3,268	916,809
Isolated patients travel and accommodation assistance	1,903	400	3,040	774	1,436	446	1,200	—	9,199
Pharmaceutical benefits for pensioners	117,123	67,675	43,941	24,233	21,350	7,483	323	1,681	283,809
Pharmaceutical benefits, n.e.c.	56,706	38,325	21,732	11,426	11,772	3,503	572	2,422	146,458
Domiciliary care	8,173	5,685	4,273	1,839	1,967	1,431	—	—	23,368
Tuberculosis campaign allowances	230	433	206	20	14	13	24	6	946
Rehabilitation of ex-servicemen	673	349	183	24	90	33	—	69	1,421
Total	*579,998*	*326,785*	*205,989*	*120,255*	*104,821*	*33,851*	*2,865*	*7,446*	*1,382,010*
Total health	**921,707**	**586,128**	**336,373**	**218,598**	**167,994**	**56,338**	**3,720**	**8,480**	**2,299,338**

(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 the hospital cost sharing arrangements between the Commonwealth and South Australia and Tasmania terminated 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.

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 1983-84 amounted to $1,412,000.

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 National Community Health Program, 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 for new and expanded community health services within their borders. These grants amounted to $7.3m in 1983–84 and $18.0m in 1984–85.

For new projects at the national level, the Government also provided a further $0.8m in 1983–84 and $2.0m in 1984–85.

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 1984 the Commonwealth Government paid grants totalling $5,158,000 towards operational costs and assistance of $490,000 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 and the Northern Territory are met by the State Governments and the Northern 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 $1 per $1 basis with the States and the Northern Territory Government. Commonwealth

Government expenditure for each State and the Northern Territory during 1983-84 was $11,630,000, made up as follows: New South Wales, $3,101,941; Victoria, $3,854,289; Queensland, $1,578,023; Western Australia, $1,267,600; South Australia, $1,338,815; Tasmania, $342,364; and Northern Territory, $146,968.

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 1983 was $7,581,706 of which $6,538,277 was from public donations and bequests. Federal, State and Semi-Government authorities made grants of $106,359 for specific projects conducted by the Foundation. Since the inception of the Foundation research has been a major function and a total of $18,429,000 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 1983 the expenditure on research was $2,357,217 while expenditure on education and community service was $1,825,766.

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 1983-84 was $4,359,599.

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 1983-84 was $713,474.

National Health Services and Advisory Organisations

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 Agreements 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.

Health Services Organisations

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 1983-84, these laboratories carried out approximately 6.4 million pathology tests and investigations in respect of 0.8 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 1983–84 the number of appointments provided was 167,737 and the number of hearing aids fitted was 59,610.

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 1983–84 was $37.979 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 is a multidisciplinary national health resource, which undertakes teaching, research and consultation towards preserving health and preventing disease or injury in groups of people in the Australian community, the workplace and in tropical and developing countries. 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 is endeavouring to promote health and a better understanding of health care, and its delivery, throughout Australia and neighbouring countries. In July 1984 the Torres Strait Malaria Field Station was officially opened by the Director-General of Health. The field station is a laboratory and field station base, for assistance to Queensland in malaria vigilance activities in North Queensland, and a training facility for health personnel and students in malaria procedures. The field station is managed by the Commonwealth Institute of Health. Costs for the field station, paid by the Commonwealth Government during 1983–84 were $49,840.00 for administration and $74,990.00 for plant and equipment.

The Asbestos Assessment Program, for public health risk in buildings containing asbestos products, is now providing expert advice on matters relating to health aspects for occupants of those buildings, and technical advice on correct methods of containment and removal of asbestos products. Four new staff members were recruited during early 1984 to act as service consultants to Government and industry.

Postgraduate and undergraduate training is provided at the Institute in a wide range of public health specialities. The largest programme conducted is the Master of Public Health degree course, which offers options in Public Health, Occupational Health and Tropical Health.

Administration costs for the Institute during 1983–84 totalled $3,652,488.00, and plant equipment expenses totalled $186,620.00 (including $34,630.00 for Asbestos Assessment).

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 Pharmacopoeia is the primary source of standards under the Therapeutic Goods Act. In addition, the Minister has powers to make orders specifying standards for general classes of goods and specific goods which are imported, the subject of interstate trade or supplied to the Commonwealth Government. Policy on standards for therapeutic goods is developed by the Therapeutic Goods Standards Committee, which is a statutory committee, and is implemented by the National Biological Standards Laboratory. The Therapeutic Goods Advisory Committee, which is also a statutory committee, advises the Minister on standards and their implementation.

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 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 co-opt and seek advice from specialist medical colleges and associations and from the medical and allied professions, drug manufacturers and other sources. During 1983–84 fifty-one applications for approval to market new drugs and thirty-three applications to extend the indications or amend dosage regimes for currently marketed drugs were considered by the Committee. Fifty applications were approved, thirty rejected and four 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 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 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 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 and through inspection and treatment procedures on arrival.

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. The importation into Australia of plant materials is subject to strict quarantine controls. 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 1983, 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 1983

Disease	*N.S.W.*	*Vic.*	*Qld*	*S.A.*	*W.A.*	*Tas.*	*N.T.*	*A.C.T.*	*Aust.*
Amoebiasis	6	–	19	26	3	–	2	1	57
Ankylostomiasis	–	–	10	77	1	–	–	–	88
Arbovirus infection	22	–	–	9	–	–	2	–	33
Brucellosis	10	1	2	1	1	–	1	–	16
Cholera	–	1	3	–	–	–	–	–	4
Diphtheria	–	1	–	–	–	–	–	–	1
Gonorrhoea	3,284	2,417	1,426	834	1,729	107	780	69	10,646
Hepatitis A (infectious)	205	260	152	153	57	20	123	21	991
Hepatitis B (serum)	309	334	145	107	15	7	14	12	943
Hydatid disease	2	–	2	1	–	3	–	2	10
Leprosy	14	7	16	4	17	1	2	1	62
Leptospirosis	32	94	88	17	9	2	–	–	242
Malaria	146	80	223	43	33	2	27	16	570
Ornithosis	1	5	1	9	–	3	–	–	19
Salmonella infections	1,178	258	447	478	93	110	373	52	2,989
Shigella infections	65	–	74	72	89	8	257	2	567
Syphilis	1,906	174	388	107	287	3	681	10	3,556
Tetanus	–	2	6	1	–	1	–	–	10
Tuberculosis (all forms)	408	296	159	129	151	–	44	31	1,218
Typhoid fever	13	1	6	1	–	–	–	1	22
Typhus (all forms)	–	1	20	–	–	–	–	–	21

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

NOTIFIABLE DISEASES(*a*), NUMBER OF CASES NOTIFIED: AUSTRALIA, 1978 TO 1983

	1978	*1980*	*1981*	*1982*	*1983*
Amoebiasis	19	53	62	33	57
Ankylostomiasis	238	219	136	110	88
Anthrax	–	2	–	–	–
Arbovirus infection	1	18	17	221	33
Brucellosis	50	49	36	28	16
Cholera	1	3	2	1	4
Diphtheria	3	1	18	2	1
Gonorrhoea	12,352	11,487	11,197	12,805	10,646
Hepatitis A (infectious)	2,661	1,385	1,453	1,046	991
Hepatitis B (serum)	773	646	500	725	943
Hydatid disease	17	41	24	12	10
Leprosy	55	35	38	46	62
Leptospirosis	37	64	95	135	242
Malaria	273	541	408	548	570
Ornithosis	6	17	13	14	19
Poliomyelitis	–	1	–	–	–
Salmonella infections	2,059	2,292	2,269	1,866	2,989
Shigella infections	394	545	424	437	567
Syphilis	3,322	2,902	2,916	3,211	3,556
Tetanus	14	9	12	12	10
Tuberculosis (all forms)	1,363	1,554	1,460	1,363	1,218
Typhoid fever	24	19	26	15	22
Typhus (all forms)	1	–	–	11	21

(*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, mumps, 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

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 full 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 reciprocal treatment arrangements with State health authorities to avoid the unnecessary duplication of hospital facilities and services. All Repatriation General Hospitals are fully accredited by the Australian Council on Hospital Standards, each is affiliated with a university and learned college for the education of medical and allied health professional staff. Schools for nursing education are provided at the major RGHS.

Veterans may also receive treatment in non-departmental public and private hospitals and nursing homes 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 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 1984

	N.S.W.	*Vic.*	*Qld*	*S.A.*	*W.A.*	*Tas.*	*N.T.*	*A.C.T.*	*Aust.*
Approved hospitals—									
Public/Recognised	229	167	143	83	95	22	5	4	748
Private—									
Category 1	7	11	10	7	3	1	—	—	39
Category 2	62	49	21	14	16	4	—	1	167
Category 3	37	59	16	16	3	1	—	—	132
Total private	106	119	47	37	22	6	—	1	338
Total hospitals	**33**	**28**	**19**	**120**	**117**	**28**	**5**	**5**	**10**

APPROVED HOSPITALS (*a*) AND BEDS, STATES AND TERRITORIES, 30 JUNE 1984—*continued*

	N.S.W.	*Vic.*	*Qld*	*S.A.*	*W.A.*	*Tas.*	*N.T.*	*A.C.T.*	*Aust.*
Beds in—									
Public/Recognised	25,615	15,370	13,008	6,513	6,620	2,144	740	1,044	71,054
Private hospitals—									
Category 1	1,230	2,173	1,664	1,025	704	142	—	—	6,938
Category 2	3,915	2,282	1,393	661	1,069	362	—	51	9,733
Category 3	1,169	1,457	742	472	77	12	—	—	3,929
Total private hospitals	6,314	5,912	3,799	2,158	1,850	516	—	51	20,600
Total hospitals	**31,929**	**21,282**	**16,807**	**8,671**	**8,470**	**2,660**	**740**	**1,095**	**91,654**
Beds per 1,000 population	*5.9*	*5.2*	*6.7*	*6.4*	*6.1*	*6.1*	*5.4*	*4.5*	*5.9*

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

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). The statistics in the table below show the number of deaths registered during 1983, 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 1983 were diseases of the circulatory system (accounting for 49.7 per cent), neoplasms (23.5 per cent), diseases of the respiratory system (7.1 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 1983, 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 (58 per cent in 1983) 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, 1983

	Age group (years)									
Causes of death	*Under one*	*1–14*	*15–24*	*25–34*	*35–44*	*45–54*	*55–64*	*65–74*	*75 and over*	*Total (a)*
	NUMBER OF DEATHS									
Infectious and parasitic diseases	24	32	15	22	29	42	72	115	227	578
Neoplasms	14	154	166	358	849	2,376	5,884	7,941	8,102	25,845
Endocrine, nutritional and metabolic diseases and immunity disorders	15	42	25	23	52	135	293	592	991	2,168
Diseases of the nervous system and sense organs	46	79	71	70	58	104	187	319	573	1,507
Diseases of the circulatory system	14	36	96	207	748	2,386	7,062	13,965	30,139	54,661
Diseases of the respiratory system	65	46	46	61	109	284	882	2,179	4,105	7,778
Diseases of the digestive system	13	9	19	52	155	415	664	792	1,528	3,647
Congenital anomalies	712	109	27	22	10	21	42	23	15	981
All other diseases (*b*)	912	27	80	124	75	148	369	710	2,173	4,619
Signs, symptoms and ill-defined conditions	452	16	8	12	14	13	21	34	139	711
Accidents, poisonings and violence	59	547	1,735	1,355	809	728	773	643	936	7,589
All causes	**2,327**	**1,097**	**2,288**	**2,306**	**2,908**	**6,652**	**16,249**	**27,313**	**48,928**	**110,084**

CAUSES OF DEATH IN EACH AGE GROUP, AUSTRALIA, 1983—*continued*

Causes of death	*Age group (years)*									
	Under one	*1–14*	*15–24*	*25–34*	*35–44*	*45–54*	*55–64*	*65–74*	*75 and over*	*Total (a)*
					RATE(*c*)					
Infectious and parasitic diseases	10	1	1	1	1	3	5	12	41	4
Neoplasms	6	4	6	14	42	157	417	814	1,458	168
Endocrine, nutritional and metabolic diseases and immunity disorders	6	1	1	1	3	9	21	61	178	14
Diseases of the nervous system and sense organs	19	2	3	3	3	7	13	33	103	10
Diseases of the circulatory system	6	1	4	8	37	157	501	1,432	5,424	355
Diseases of the respiratory system	27	1	2	2	5	19	63	223	739	51
Diseases of the digestive system	5	—	1	2	8	27	47	81	275	24
Congenital anomalies	294	3	1	1	—	1	3	2	3	6
All other diseases(*b*)	376	1	3	5	4	10	26	73	391	30
Signs, symptoms and ill-defined conditions	186	—	—	—	1	1	1	3	25	5
Accidents, poisonings and violence	11	16	66	54	40	48	55	66	168	49
All causes	**959**	**31**	**87**	**92**	**143**	**439**	**1,152**	**2,800**	**8,806**	**716**
					PERCENTAGE(*d*)					
Infectious and parasitic diseases	1.0	2.9	0.7	1.0	1.0	0.6	0.4	0.4	0.5	0.5
Neoplasms	0.6	14.0	7.3	15.5	29.2	35.7	36.2	29.1	16.6	23.5
Endocrine, nutritional and metabolic diseases and immunity disorders	0.6	3.8	1.1	1.0	1.8	2.0	1.8	2.2	2.0	2.0
Diseases of the nervous system and sense organs	2.0	7.2	3.1	3.0	2.0	1.6	1.2	1.2	1.2	1.4
Diseases of the circulatory system	0.6	3.3	4.2	9.0	25.7	35.9	43.5	51.1	61.6	49.7
Diseases of the respiratory system	2.8	4.2	2.0	2.6	3.7	4.3	5.4	8.0	8.4	7.1
Diseases of the digestive system	0.6	0.8	0.8	2.3	5.3	6.2	4.1	2.9	3.1	3.3
Congenital anomalies	30.6	9.9	1.2	1.0	0.3	0.3	0.3	0.1	—	0.9
All other diseases(*b*)	39.2	2.5	3.5	5.4	2.6	2.2	2.3	2.6	4.4	4.2
Signs, symptoms and ill-defined conditions	19.4	1.5	0.3	0.5	0.5	0.2	0.1	0.1	0.3	0.6
Accidents, poisonings and violence	2.5	49.9	75.8	58.8	27.8	10.9	4.8	2.4	1.9	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 16 deaths where age is not known. (*b*) Includes 913 deaths from conditions originating in the perinatal period and 1,712 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 1,726 suicides in 1983, which represented 1.6 percent of all deaths registered in that year, and a rate of 11 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 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 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 slightly in 1983, to 12.16 per 1,000 total births compared with 13.39 in 1982.

Of the conditions in the child, the two main groups responsible for perinatal deaths were *Hypoxia, birth asphyxia and other respiratory conditions* (37.3 per cent of the total) and *Congenital anomalies* (25.8 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, 48.1 per cent were reported as being due to *Complications of placenta, cord and membranes.*

PERINATAL DEATHS BY CAUSE, AUSTRALIA, 1983

	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	79	143	222	0.32	0.59	0.91
Birth trauma	4	35	39	0.02	0.14	0.16
Hypoxia, birth asphyxia and other respiratory conditions	762	345	1,107	3.12	1.42	4.59
Fetal and neonatal haemorrhage	30	101	131	0.12	0.42	0.54
Haemolytic disease of fetus and newborn	16	9	25	0.07	0.04	0.10
Other conditions originating in the perinatal period	482	117	599	1.97	0.48	2.45
Congenital anomalies	238	529	767	0.98	2.18	3.14
Infectious and parasitic diseases	3	4	7	0.01	0.02	0.03
All other causes	5	67	72	0.02	0.28	0.29
Conditions in mother—						
Maternal conditions which may be unrelated to present pregnancy	176	89	265	0.72	0.37	1.09
Maternal complications of pregnancy	170	380	550	0.70	1.57	2.25
Complications of placenta, cord and membranes	723	166	889	2.96	0.68	3.64
Other complications of labour and delivery	37	108	145	0.15	0.43	0.59
No maternal condition reported	513	607	1,120	2.10	2.50	4.59
All causes—1983	**1,619**	**1,350**	**2,969**	**6.63**	**5.57**	**12.16**
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

(*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 1978 in this table are also based on the revised definition.

Cremations

State/Territory	1981 Number of cremations (b)	1981 Number of deaths	1982 Number of cremations (b)	1982 Number of deaths	1983 Number of crematoria (a)	1983 Number of cremations (b)	1983 Number of deaths
N.S.W.	21,182	39,959	21,821r	42,352	17	21,443	40,323
Vic.	11,597	29,034	12,234	30,611	4	11,865	29,320
Qld	8,047	17,175	8,547	18,149	9	8,073	17,200
S.A.	4,335	9,706	4,723	10,457	2	4,514	9,882
W.A.	4,306	7,993	4,415	8,187	3	4,496	8,359
Tas.	1,352	3,320	1,476	3,432	2	1,489	3,311
N.T.	—	854	—	573	—	—	738
A.C.T.	643	962	595	1,010	1	661	951
Australia—							
number	**51,462**	**109,003**	**53,811r**	**114,771**	**38**	**52,541**	**110,084**
per cent (c)	47.2	..	46.9	..	..	47.7	..

(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.

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) and preliminary results are available in *Australian Health Survey, 1983 (Preliminary)* (4348.0).

Health Insurance Surveys

These surveys have been conducted in March for the years 1979–1983. In 1984 the survey was conducted in May and covered wage and salary earners in capital cities only.

The 1984 survey sought information on hospital and ancillary insurance taken out over and above that which is available under Medicare. Results are published in *Health Insurance of Wage and Salary Earners in Capital Cities, May 1984* (4335.0).

No Health Insurance Survey was conducted in 1985.

Hearing Survey

In September 1978 the ABS conducted a survey to obtain information about hearing problems of persons aged 15 years or more. 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).

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. Results of the survey have been published in the publication *Sight, Hearing and Dental Health (persons aged 2 to 14 years) February–May 1979* (4337.0).

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 by children aged 2 to 14 years. The main features of the survey results are:

- An estimated 2,616,900 (80.0 per cent) of children aged 2 to 14 years in Australia had had a dental consultation at some time in their life. Of these, 391,100 (14.9 per cent) had their first consultation when aged less than 3 years, 1,088,400 (41.6 per cent) when aged 3 or 4 years, 831,300 (31.8 per cent) when aged 5 or 6 years, 266,000 (10.2 per cent) when aged 7 to 14 years and it was not known when 40,000 (1.5 per cent) had their first dental consultation.
- An estimated 2,252,800 (68.9 per cent) of children aged 2 to 14 years had had a dental consultation in the previous twelve months. Of these, 1,145,900 (50.9 per cent) had their most recent consultation at a private dental surgery and 929,200 (41.2 per cent) at a school dental clinic. However, it was only in New South Wales and Victoria that the majority of the most recent consultations took place at a private dental surgery.
- Of the estimated 1,655,700 children aged 4 to 11 years at school, 1,140,600 (68.9 per cent) said that the School Dental Service was available through their school. Of these, 922,200 (80.8 per cent) had used the Service, 211,700 (18.6 per cent) had never used it and it was not known whether 6,800 (0.6 per cent) had ever used it.

Results are published in *Children's Dental Health Survey, Australia, November 1983* (4349.0).

PERSONS AGED 2 TO 14 YEARS: AGE AT WHICH THEY FIRST HAD A DENTAL CONSULTATION BY CURRENT AGE, AUSTRALIA, NOVEMBER 1983

	Age group (years)				
	2-4	*5-9*	*10-14*	*Total*	*Total*
		('000)			per cent
Age first had a dental consultation					
Less than 3 years	99.8	139.2	152.2	391.1	12.0
3 years but under 5 years	99.3	481.1	508.0	1,088.4	33.3
5 years but under 7 years	..	388.9	442.4	831.3	25.4
7 years old or more	..	55.0	211.1	266.0	8.1
Not known how old	*	7.5	32.5	40.0	1.2
Total having a consultation	*199.2*	*1,071.6*	*1,346.1*	*2,616.9*	*80.0*
Never had a consultation	491.8	137.2	23.4	652.5	20.0
Total	**691.0**	**1,208.9**	**1,369.5**	**3,269.3**	**100.0**

PERSONS AGED 2 TO 14 YEARS WHO HAVE HAD A DENTAL CONSULTATION IN THE LAST 12 MONTHS: PLACE OF MOST RECENT CONSULTATION BY TIME SINCE MOST RECENT CONSULTATION, AUSTRALIA, NOVEMBER 1983

	Place of most recent consultation					
Time since most recent consultation	*Private Dental Surgery*	*School Dental Clinic*	*Hospital*	*Dental Clinic*	*Other*	*Total*
			('000)			
2 weeks or less	140.3	121.2	9.5	10.8	4.9	286.7
More than 2 weeks to 6 months	697.5	588.7	40.9	49.4	21.0	1,397.5
More than 6 months to 12 months	308.1	219.3	13.4	22.7	5.2	568.6
Total	**1,145.9**	**929.2**	**63.8**	**82.9**	**31.1**	**2,252.8**
			Per cent			
Total	**50.9**	**41.2**	**2.8**	**3.7**	**1.4**	**100.0**

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, Diphtheria, 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 information on the immunisation status of persons aged 0-6 years against Poliomyelitis, Diphtheria, Whooping Cough and Tetanus. The main features from this survey are:

- At November 1983, an estimated 505,700 (54.7 per cent) of children aged 2 to 5 years in Australia had received a total of 4 or more doses of Triple Antigen (TA) and Combined Diphtheria and Tetanus (CDT), and 19,900 (2.2 per cent) had received three or more doses of CDT only, as recommended by the National Health and Medical Research Council (NH & MRC). A further 165,300 (17.9 per cent) had received 4 or more doses of TA only.
- 12,400 (1.3 per cent) had received neither TA nor CDT and it was not known whether 7,100 (0.8 per cent) had received either TA or CDT.
- An estimated 35,400 (3.8 per cent) of persons aged 2 to 5 years were not immunised against Whooping Cough (i.e. they had not received any Triple Antigen vaccine).
- 783,600 (84.8 per cent) of children aged 2 to 5 years had received three or more doses of Polio vaccine and 38,400 (4.2 per cent) had not received any Polio vaccine. It was not known whether 14,600 (1.6 per cent) of children aged 2 to 5 years had received any Polio vaccine.
- An estimated 631,500 (68.4 per cent) of persons aged 2 to 5 years had been vaccinated against Measles, and 207,600 (22.5 per cent) had been vaccinated against Mumps.

More detailed results are available in *Childrens Immunisation Survey, Australia* (4351.0) and in the tables set out below.

TRIPLE ANTIGEN AND COMBINED DIPHTHERIA AND TETANUS VACCINATION: NUMBER OF DOSES RECEIVED BY PERSONS AGED 2 TO 5 YEARS, BY STATE OR TERRITORY, NOVEMBER 1983 ('000)

	N.S.W.	*Vic.*	*Qld*	*S.A.*	*W.A.*	*Tas.*	*N.T.*	*A.C.T.*	*Australia*
TA and CDT received(a)									
Number of doses									
Less than four	36.2	17.3	19.1	8.5	5.9	2.0	*	2.0	92.4
Four or more	149.2	143.8	81.8	42.2	59.8	14.2	7.1	7.6	505.7
Not known	2.8	4.3	*	*	1.9	*	*	*	12.1
Total	188.2	165.3	102.4	51.5	67.6	16.9	8.6	9.6	610.1
Per cent	59.4	70.5	65.7	68.8	77.9	62.3	77.7	57.0	66.1
TA only received									
Number of doses									
Less than four	37.2	20.8	19.7	7.3	8.0	2.6	*	*	97.5
Four or more	73.9	37.4	23.1	11.7	7.4	7.1	*	4.4	165.3
Not known	3.9	*	*	*	*	*	*	*	8.1
Total	114.9	59.8	44.3	19.6	15.8	9.7	*	5.4	271.0
Per cent	36.3	25.5	28.4	26.2	18.2	35.8	*	32.4	29.3
CDT only received									
Number of doses									
Less than three	*	*	*	*	*	*	*	*	2.8
Three or more(b)	6.0	4.0	5.2	*	1.5	*	*	1.7	19.9
Not known	*	*	*	*	*	*	*	*	*
Total	6.4	5.0	5.8	1.3	2.0	*	*	1.7	23.0
Per cent	2.0	2.1	3.7	1.8	2.3	*	*	10.0	2.5
Not known whether TA or CDT received	2.8	*	*	*	*	*	*	*	7.1
Per cent	0.9	*	*	*	*	*	*	*	0.8
Neither TA nor CDT received	4.3	*	2.5	1.8	*	*	*	*	12.4
Per cent	1.3	*	1.6	2.4	*	*	*	*	1.3
Total	**316.6**	**234.7**	**155.8**	**74.8**	**86.7**	**27.1**	**11.1**	**16.8**	**923.6**
Per cent	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

(a) Person received both types of vaccination as part of recommended course. (b) Recommended course of CDT only does not include a dose at 6 months.

POLIO VACCINATION: NUMBER OF DOSES RECEIVED BY PERSONS AGED 2 TO 5 YEARS, BY STATE OR TERRITORY, NOVEMBER 1983

('000)

	N.S.W.	Vic.	Qld	S.A.	W.A.	Tas.	N.T.	A.C.T.	Australia
Number of doses									
One	8.7	4.3	3.5	*	2.0	1.2	*	*	21.3
Two	14.5	7.4	5.8	4.2	3.7	2.0	*	*	38.7
Three or more	262.0	201.7	132.0	65.0	75.9	21.6	9.6	15.7	783.6
Not known	10.8	8.2	3.5	1.4	2.3	*	*	*	27.0
Total	*296.0*	*221.6*	*144.9*	*71.6*	*83.8*	*25.4*	*10.7*	*16.7*	*870.6*
Per cent	*93.5*	*94.4*	*93.0*	*95.7*	*96.7*	*93.6*	*96.4*	*99.4*	*94.3*
Not known whether polio vaccination received	8.0	3.0	*	*	*	*	*	*	14.6
Per cent	2.5	1.3	*	*	*	*	*	*	1.6
No polio vaccination received	12.6	10.1	9.2	2.5	2.2	1.5	*	*	38.4
Per cent	4.0	4.3	5.9	3.3	2.6	5.4	*	*	4.2
Total persons aged 2 to 5 years	**316.6**	**234.7**	**155.8**	**74.8**	**86.7**	**27.1**	**11.1**	**16.8**	**923.6**
Per cent	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

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 information 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.

Results of the survey are published in *Handicapped Persons, Australia* (4343.0).

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HISTORY OF HOME NURSING IN AUSTRALIA

(This special article has been contributed by the States and Territories Home Nursing Services)

Introduction

1985 marks the Centenary of the Home Nursing services, historically a vital component of the health care system in the Australian community.

Home nursing began in Australia in 1885 when a group of concerned citizens met in Victoria and formed the Melbourne District Nursing Service with the object of looking after disadvantaged sick people at home. Since those early days the nursing service has spread to every State and Territory and now, 100 years later, there are around 200 active organisations using modern equipment and offering general and specialised nursing care to the people of Australia.

Whilst there are, in 1985, many nurses working in the community providing home care to patients, this article focuses on the first Home Nursing organisations established in each State and Territory.

The majority of the Home Nursing services in Australia commenced as voluntary organisations. Over the hundred years of their existence the nursing services have been challenged constantly by limited finances and growing demand. However the passing of the Commonwealth Home Nursing Subsidy Act in 1956 meant Home Nursing organisations became eligible to receive Commonwealth Government subsidy for the salaries of registered nurses employed, provided the State matched the subsidy. From that time on Home Nursing services rapidly developed and in 1983 there were 193 Home Nursing organisations throughout the six States of Australia receiving a subsidy.

'Prepared for duty'. The bicycle provided a common means of transport for many of the early Home Nurses.

Home Nursing Services of Australia

The following table shows employment in these organisation by State, and the number of nursing visits made over the period 1977-78 to 1981-82.

HOME NURSING ORGANISATIONS—AUSTRALIAN STATES: 1977-78 TO 1981-82

	N.S.W.	*Vic.*	*Qld*	*S.A.*	*W.A.*	*Tas.*	*Total*
Number of home nursing organisations at 30 June—							
1978	89	69	10	1	3	21	193
1979	90	69	10	1	3	21	194
1980	89	69	9	1	3	20	191
1981	89	69	9	1	3	20	191
1982	89	70	10	1	3	20	193
Visits made ('000), year ended 30 June—							
1978	1,195	1,221	1,297	478	820	237	5,248
1979	1,256	1,294	1,302	444	826	205	5,327
1980	1,317	1,389	1,285	441	851	211	5,494
1981	1,375	1,445	1,357	450	868	214	5,709
1982	1,421	1,495	1,445	438	866	231	5,896
Visits made per 1,000 mean population, year ended 30 June—							
1978	240	321	602	372	677	575	379
1979	249	337	597	344	670	494	381
1980	258	359	578	340	679	501	388
1981	264	368	588	343	675	503	395
1982	270	377	606	331	658	538	401
Average number of nurses employed (*a*), year ended 30 June—							
1978	406	513	384	191	233	61	1,788
1979	410	533	410	193	249	62	1,857
1980	425	565	430	190	254	63	1,927
1981	432	598	444	198	260	64	1,996
1982	444	622	472	201	271	74	2,084

(*a*) Federal subsidies in home nursing organisations are based on the number of nurses employed over and above the number employed at 30 September 1956 in the case of organisations existing at that date, and on the total number of nurses employed by home nursing organisations formed after that date. The actual numbers of nurses employed at 30 September 1956 were: New South Wales 43; Victoria 88; Queensland 16; South Australia 38; Western Australia 29; Tasmania 1.

Source: Annual Report of the Director-General of Health 1982-83 p. 191.

Despite financial limitations, the caring concern of the founders of Home Nursing organisations was the catalyst for the development of many innovative programs developed to meet community needs.

The link with district nurses from England is evident in the development of Home Nursing organisations in Australia.

Influence of England's district nursing

Although St Catherine's Royal Hospital was the oldest organisation to provide a visiting nursing service in England, in 1148, it was not until 1848 that there was any mention of nurses being prepared for work districts. In 1859 Mr William Rathborne recognised a need to provide a nurse to work amongst the poor in Liverpool and later established a training school for district nurses at his own expense. These nurses were seen at that time not just as caring for the sick but, due to their direct knowledge and close contact with those for whom they cared, also as social reformers.

In 1887, Queen Victoria's Jubilee year, part of the money collected for her gift was granted by the Queen for the establishment of the Queen Victoria Jubilee Institute for Nurses. When Queen Mary succeeded as patron of the Institute, in 1925, the name was changed to Queen's Institute of District Nursing. For many years the Institute was responsible for both the training and the employment of district nurses throughout England and quite a number of district nurses in Australia today have undertaken this training program.

Information about district nursing services was brought to Australia from England and Scotland by Dr Caffyn and Rev. C. Strong who were instrumental in setting up the first Home Nursing organisation in Australia—the Melbourne District Nursing Society.

DEVELOPMENT OF DISTRICT NURSING IN AUSTRALIA

Victoria was the first State to introduce a district nursing service in 1885. This was followed by South Australia (1894), Tasmania (1896), New South Wales (1900), Queensland (1904) and Western Australia (1905). The Northern Territory introduced an infant health and home service in 1929 to cater for the needs of Darwin while the first service in the A.C.T. started in 1946. A record of the development of district nursing in Australia is given below.

Victoria (1885)

The poor health and living conditions of disadvantaged sick persons in Melbourne prompted a group of concerned citizens to meet on the 17th February, 1885. Dr Caffyn and Reverend Charles Strong, two of the participants, were familiar with the working of the district nurses in Scotland. They briefed the meeting on their work, and the outcome of the meeting was the formation of the Melbourne District Nursing Society, to look after the sick poor persons at home to prevent unnecessary hospitalisation.

The nursing link with England was strengthened in 1892 with the appointment of Mrs L. Smith, the first fully trained nurse to be employed and a graduate from the Florence Nightingale training school. Quality of care was a concern of the Society even in those early days and was supported by members such as Mrs Caffyn who was known as a strong advocate for lifting nursing from the stereotype of Sarah Gamp—the drunken nurse in Dickens—to a 'scientific profession for gentlewomen'.

In 1898, the Society was incorporated under the Hospital and Charity Act. The need for a convalescent nursing home for the Society's patients prompted the building of an 'After Care Hospital' in 1925. Subsequently, in 1957, at the request of the Hospitals and Charities Commission, separate Boards of Management for the After Care Hospital and the District Nursing Society were developed. Each was incorporated as a separate entity and the name of Melbourne District Nursing Society was changed to Melbourne District Nursing Service. The 'Royal' prefix was granted to the Service by charter in 1966.

As a result of close contact that nurses had with the sick at home, in the context of their families and the community, nurses developed an awareness of community needs. This understanding prompted district nurses to pioneer a number of innovative programs over the years. Some of these were:

- 1894—The Service established a popular lecture series on hygiene.
- 1917—The Service helped in the establishment of welfare baby clinics.
- 1934—The Melbourne District Nursing Society Women's Welfare Clinic commenced offering advice on family planning and birth control.
- 1948—It was recorded that the Melbourne District Nursing Society Ante-Natal Clinic (established in 1931) was one of the first to institute routine weighing and blood pressure taking of pregnant women which resulted in the early detection and effective treatment of toxaemia of pregnancy.
- 1975—Two R.D.N.S. staff worked as outreach workers from the North Richmond Community Health Centre to residents in Housing Commission dwellings, focusing on case finding.

Currently the Service provides care which includes both general and specialist nursing care. This includes nursing treatments such as catheterization, stoma care and injections, rehabilitation nursing care, assessment of people at home regarding aids to daily living, psycho-social supportive care to patients and their relatives who may be under stress or grieving, health teaching in all aspects of health maintenance and self care.

In the area of mothers and babies, specialist staff provide ante-natal care and prescribed post-natal care following early discharge from hospital. This post-natal care includes general supervision and health teaching, nursing treatments for mother and baby and family planning advice. The service is provided to bridge the period between hospital discharge and the time mother and baby are able to attend the local Infant Welfare Centre.

Staff working in the specialist area of oncology nursing, work closely with the major referring hospitals to keep up-to-date with current treatment plans of patients and thus maintain continuity of care into the home. In addition they provide a domiciliary pathology service for patients who require frequent ongoing blood tests, thus helping to reduce the considerable stress on patients associated with frequent visits to hospitals. There are Royal District Nursing Service Liaison Nurses working in major teaching hospitals and some private hospitals to participate in discharge planning and ensure continuity of care.

The Service has an education department providing in-service education and post basic courses available to all district nurses in Victoria. In addition, all Royal District Nursing Service staff have access to and receive support from consultative staff such as the psycho-geriatric, mental health, breast prosthesis, stomal therapist nurses, physiotherapists and social workers.

A centralised administration and regionalised management model has been developed to ensure efficient and effective service delivery as the service expands. A quality assurance program has also been implemented to ensure care given is of excellent standard.

In 1984, there were seven organisations providing a Home Nursing service in the Melbourne metropolitan area and over eighty in country areas. The size of service varies, from a part time district nurse to the largest service, the Royal District Nursing Service with a staff of 377.

At the end of June 1982, it was recorded that 639 district nurses provided care for 43,600 patients and made 525,900 visits within Victoria.

South Australia (1894)

The Royal District Nursing Society of South Australia, initially the District Trained Nursing Society (D.T.N.S.), was inaugurated on 12th July, 1894 following 12 months work by a trained nurse in the Adelaide suburb of Bowden. This experiment, which was financed by the philanthropic Barr Smith and Elder families, had convinced founders, Dr. Allan Campbell, M.L.C., Rev. B. C. Stephenson and Nightingale nurse Matron Edith Noble, of the local demand for a district nursing service. Meanwhile, the financial viability of such a venture was being demonstrated by the Pirie Street Nursing Sisters' Association, which was organised by the inner-city Pirie Street Wesleyan Methodist Church but supported by public donations. Founder Rev. Joseph Berry was on the inaugural committee of the D.T.N.S., although his Pirie Street Nursing Sisters' Association remained independent until 1898. Subsequently, in 1937, the D.T.N.S. was re-named the District and Bush Nursing Society of S.A. Inc.; in 1965 the 'Royal' prefix was granted and in 1973 'Bush' was removed from the title. R.D.N.S. has been South Australia's sole district nursing service operating, with the aid of local committees and over 70 branches, throughout the State, including several cottage hospitals. The existence of country as well as metropolitan branches was recognised in the transitional title 'District and Bush Nursing Society'.

The objects of the Society have changed little over the years. They include:

- 'On the basis of need, provide skilled nursing care to the sick and disabled in their own homes.
- Assist in education and field experience programmes for nursing, medical and paramedical personnel in domiciliary nursing care.'

The promulgation of the *Home Nursing Subsidy Act 1956* assured the Society of both State and Federal Government grants, but the organisation has still maintained community funding of approximately 20 percent of its total budget.

The Society promotes a concept of 'family-centred care' offering and providing nursing care, promoting health and educating and encouraging families towards maximum independence, co-ordinating that care in the complex multi-disciplinary health care setting.

As staffing numbers increased and hospitals began to discharge patients earlier to home care services, R.D.N.S. regionalised its services, and now operates with 5 metropolitan and 2 country regions. Each regional supervisor is responsible for 25-30 field staff, and, particularly in country areas, covers a large geographical area.

To enhance the co-ordination of care between hospital and home based services, R.D.N.S. established the position of liaison sister in each metropolitan teaching hospital. This service facilitates discharge planning and the provision of increasingly complex nursing care in the home care setting.

Continuing nursing education is promoted through in-service programs and tertiary studies. Education programs enhance the skills of nursing staff and enable them to appreciate the social, cultural and ecological factors influencing health care. Specialist resource staff further support nurses as trends in community care change.

A recent major review of R.D.N.S. identified the need for a change to some financial, administrative and professional aspects and the development of a computerised data and recording system to assist the society to work more effectively in the regionally based multi-disciplinary health care setting.

The trend in South Australia for some country hospitals to provide 'outreach' nursing services has prompted the South Australian Health Commission to request the use of R.D.N.S. education and administrative support for these services and the utilisation of their problem oriented recording system. There is, therefore, a move to the utilisation of a common data base in domiciliary nursing in this State.

The Royal District Nursing Society of South Australia is committed to uphold a standard of excellence in its nursing practice and a quality assurance program, with documentation of standards for practice as the major, professional undertaking of the present and the future.

R.D.N.S. employs 210 full time equivalent registered nursing staff and has an additional 100 registered nurses available for casual employment. These nursing staff visited 15,000 patients making 427,000 visits and travelled 2,150,000 kilometres in the 1983-84 financial year.

Tasmania (1896)

In the same year that South Australia initiated its first district nursing organisation, some key women of the local Hobart Young Women's Christian Association came together with the aim of helping the aged, the incapacitated and the chronically ill. They called themselves the 'Amateur Nursing Band' and set themselves to learn about simple home-nursing, bed-making, cooking for invalids and home maintenance generally. The wife of the Governor of Tasmania became their president and in 1896 the 'Band' changed its name to the Hobart District Nursing Association. Today the Association employs the equivalent of 14 nursing staff and about 20 home help staff to complement the nursing care they provide. In the year ending June 1984 the Association made 32,500 visits.

New South Wales (1900)

For some fourteen to fifteen years prior to the founding of the District Nursing Association in Sydney, there were a few women devoted to the work of tending the sick poor in their own homes.

The formation of the District Nursing Association was largely the work of a Church of England Association, the Christian Social Union, which took up the work because it was considered that care of the sick poor was part of the social work of the Church.

From this strong Church of England base, the issue as to whether the District Nursing Association should be non-denominational was settled in 1906 when the rules of the Association were changed so that members of all religious bodies could work together.

The activities of the District Nursing Association were increased from year to year as funds became available for additional staff. By 1935, the association was incorporated as a second schedule hospital and was thenceforth governed by a board of directors appointed by the Government.

With the passing of the Home Nursing Subsidy Act in 1956, a number of local government authorities developed home nursing services and some country hospitals provided nurses for home nursing.

After 1956, the District Nursing Association rapidly expanded and in 1967–68, decentralisation became necessary. Branches were located at some hospitals, the first being located at Hornsby hospital. The name was changed to the Sydney Home Nursing Service.

The next significant growth period in community nursing was heralded by the introduction of the community health program in 1974. Some district nurses were seconded to multi-disciplinary teams working from community health centres. Today there are more than 250 community health centres in operation in New South Wales varying in size from the large polyclinic type of centre to the single community nurse based in outback areas.

The preferred delivery model of community nursing in the western metropolitan health region was the school based community nurse. The selection of this model was made after a pilot project was conducted in 1974 and was determined to be the best model to meet the needs of the population to be served. The school based nurse in the western metropolitan health region provides home nursing as well as the screening of school children and school health programmes.

The Sydney Home Nursing Service continues to be the largest single organisation delivering community nursing care and currently employs 200 registered nurses, 50 seconded registered nurses and 10 enrolled nurses. The Service operates from ten centres located at various public hospitals throughout Sydney's metropolitan area and one centre operating from Auburn community health centre. Thirty-eight of its nurses are seconded to community health centres.

Queensland (1904)

On Ash Wednesday 1904, the Mother's Union of the Anglican Church at Milton conducted a mission to assist poor, sick and needy parishioners.

The members of the Mother's Union decided to make-up 'Maternity Packs' to assist in a confinement, as most children were born at home. However, much of their good work was in vain as most people did not know what to do with a maternity pack! It was then decided to employ a nurse on a six month trial basis, to show the women how to use the packs. Thus began the first domiciliary nursing service in Queensland.

As the work increased, it was found necessary to appoint a committee of management and in 1910 the Mother's Union District Nursing Association was formed with most of its work in midwifery care. Payment for visits was 'whatever the patient could afford'. In 1937 the Mother's Union was dropped from the title and the service became known as the District Nursing Association. By 1965, the committee of management considered that a larger and more permanent body was required for the

future growth of the association and the Brisbane diocese of the Church of England was asked to assume responsibility of the Association. The name 'St Luke's Nursing Service' was adopted in 1968. By 1984 the Service had branches at Cleveland, Milton and Zillmere and employed 37 full time staff.

The Blue Nursing Service. In early 1953 the Rev. Arthur Preston, superintendent minister of the West End Methodist Mission, responded to a request for a home nursing service. He initiated a meeting between Mr Norman Brandon, Mission Treasurer, Mrs Anderson, Registered Nurse and Rev. McKibbin, Newtown Methodist Mission.

They agreed that since there was a shortage of hospital beds and existing home nursing bodies were unable to cope with the demands of a growing population it seemed there was a great need for the establishment of a home nursing service. Financial support to the equivalent of $60, a commitment by the mission, enabled the venture to become a reality.

Generous assistance given by the press and media and members of the newly formed committee resulted in donations of money and offers of assistance.

Miss Olive Crombie was employed as the first registered nurse to work with this newly formed home nursing service, named the Blue Nursing Service after the blue uniforms chosen by the registered nurse. Blue was selected not only because it was more practical than white but because the color is associated with acts of care and mercy which was considered the emphasis of the Service.

The Blue Nursing Service like other home nursing services in Queensland has remained an outreach of the church. However, these services would not have survived or grown without the financial support of State and Commonwealth Governments.

By the end of 1956 the vision of a State wide community nursing service was becoming a reality with the setting up of regional centres. It also become apparent that a co-ordinating body was essential to provide guidance and direction, to negotiate with governments and to disburse funds provided by the State and Commonwealth Governments. This led to the development of the Blue Nursing Service Council in March 1957.

The Blue Nursing Service now has 59 centres from Mossman in the north to Coolangatta in the south and as far as Cunnamulla and Mount Isa in the west.

Each centre has a committee of 15 persons—9 appointed by parish council of the Uniting Church, 1 director—a member of the Uniting Church, and appointed by the parish council of the Uniting Church, and 5 elected by the community.

Early in 1974 a state nursing executive officer was appointed to become the official representative on all nursing matters. The Blue Nursing Service was successful in receiving monies for education through the community health program and by 1976 a nurse educator was appointed to co-ordinate education programs for the 47 centres throughout Queensland.

The education thrust commenced at that time has continued and the Blue Nursing Service council now employs 3 staff development officers and the role of state nursing executive officer has been incorporated into the position of director of nursing services.

The service also has 13 hostels, 10 nursing homes, 4 day therapy centres, 10 day care centres and employs 422 registered nurses.

Western Australia (1905)

The *Silver Chain Nursing Association* was formed originally to care for the sick and disadvantaged children of Perth. In fact, the original funding of the Association was by children themselves, each child sending a silver coin to become a 'link' in the 'Silver Chain'. As the years progressed, and with the improvement of child care services in Western Australia, the function of the Association changed from nursing children to nursing the elderly. 1985 finds the Association concerned with the health of *all* people in the community, no matter what their age or economic position.

The main object of the Silver Chain service is to offer people the opportunity of being cared for in their own homes, rather than being institutionalised when they are ill and to provide all the services necessary to enable them to do so with dignity, for as long as it is feasible. The services provided include home help, domiciliary physiotherapists for those patients who can't afford to obtain this service privately, also equipment for loan. There is also a hospital liaison service to facilitate continuity of care between hospital and home.

Silver Chain services are available in all major country towns in Western Australia. In towns where there is no resident doctor, or hospital facilities, Bush Nursing Medical Centres have been established. The sister at the Centre works in conjunction with the nearest doctor, sometimes by radio, in other instances, medical care is provided by a visiting doctor.

Early in the history of Silver Chain, it was recognised that not only was it desirable to care for people in their own homes, but also that accommodation should be available for people who are unable to be maintained safely at home. One metropolitan and two country residences for the frail aged have been provided as well as two sixty-one bed hospitals for the long term sick.

The services provided by Silver Chain are expanding year by year. The most recent innovation is a Hospice Palliative Care service which enables the terminally ill to remain in their own homes for as long as possible, free from pain and distress, rather than be admitted to hospital as soon as intensive nursing and medical care becomes necessary.

The Association works in close liaison with the State Government, public and private hospitals, and medical practitioners. It forms an integral part of the overall health care system within Western Australia.

Northern Territory (1929)

In 1929 Sister Constance Stone was appointed to provide an Infant Health and Home Nursing service to the people of Darwin. As far as is known, the service continued in this way until 1942 when Darwin was evacuated during World War 2. Immediately post-war, Sister Roslyn Gordon was employed by the Department of Works to provide health care to their employees, this later, extended to include their families. This appears to have been the only nursing activity at that time, outside the hospital sphere.

Around 1950 Sister Gordon was transferred to the Department of Health and, together with another nurse, established infant health and some home nursing care in Darwin.

Home nursing, allied with infant and school health work, was also carried out by a number of rural health nurses. Due to the vast distances, lack of transport and medical staff, these nurses were often the only source of health care.

Around 1960 a separate Home Nursing section within the Department of Health was established, together with sections for Infant and School Health.

A similar arrangement was made in Alice Springs with two nurses sharing infant health and home nursing duties.

In 1974 integration of Home Nursing, Infant and School Health sections took place and the generalist nurse concept was incorporated within the community health system. This concept embraces aspects of health education together with primary care within the context of the individual, the family and the wider community.

Within the major urban areas, it is estimated that bedside care in the home comprises between 35-40 per cent of the community health nurses work.

Until relatively recently the percentage of older people within Northern Territory communities has been small in comparison with other States, but as the population is becoming more stable this percentage is increasing. Adding to this cost constraints of long term hospital care, and earlier discharge patterns which are being established, it is reasonable to assume that the need for home nursing services will increase in the years to come.

Australian Capital Territory (1946)

The National Council of Women, which was composed of representatives from a number of women's organisations, initially supported the introduction of a Domiciliary Nursing Service in the A.C.T. in 1946.

Two Sisters founded this service, working for the Commonwealth Department of Health. They were taken on their rounds by Commonwealth Transport Department drivers until cars were provided for their use. Although the original nurses were conscious that there was a general belief that the Domiciliary Nursing Service was unlikely to continue, demand forced recruitment of more staff. These nurses held double certificates to enable them to cope with home deliveries (which in fact did not eventuate) but the demand for personal care, dressings, medication and injections grew—the latter was often the 'new drug, Penicillin'. The nurses worked under difficult conditions, for example, up to 19-21 days at a time.

Domiciliary nursing services were structurally changed after 1975, with the introduction of a general community health nursing model of service delivery, which was introduced to provide holistic nursing care within defined geographical areas. Community nurses provide domiciliary nursing care, and infant and child health services. Additionally, community nurses undertake preventative health maintenance programs, and offer counselling and information services to the public.

Changes in the focus of services in response to community needs

From the above it becomes apparent that all Home Nursing organisations developed because of identified health care needs in the community. The focus at the beginning was on the sick, poor and the disadvantaged. However, services were later made accessible to all people within the community as agencies began to receive increased Government subsidy.

Currently Home Nursing organisations function with various structures and operate under different auspices such as hospitals, voluntary bodies and local government. Nurses working in these organisations are unified in their shared concern and commitment to providing quality care in the community.

Rapid development in medical and technological services has placed new demands on nurses working in the community. Over recent years people are being discharged from hospital earlier and at a more acute stage of illness and nurses have to undertake further in-service, post-basic, and/or post graduate education in order to continue to provide quality care.

With increasing mobility of nuclear families and increasing numbers of women entering the work force, more and more elderly persons are living alone without families to care for them. This has presented a challege for nurses in the community as to how best to meet the needs of the elderly and the chronically ill given finite resources. This challenge has prompted Home Nursing organisations to develop a role for auxiliary health workers to meet these needs. These new workers include health service aides in N.S.W., paramedical aides in S.A., home care aides in Western Australia and home health aides in Victoria. New and innovative ways of responding to identified needs in local communities, whilst at the same time maintaining accountability for standards of care, will present challenges for the future of Home Nursing organisations in Australia.

This brief outline of Home Nursing in Australia is a record of achievement. Recognition of the extended roles of nurses, based on their knowledge, expertise and experience, is paramount as is the recognition of their educational needs if these services are to continue to be effective.