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Preface

There are different interpretations as to what may constitute a public health activity. The public health funding and expenditure estimates included in this report and the earlier reports in this series relate only to those activities where the funding is provided or the expenditure incurred by the key health departments and agencies in each jurisdiction. They do not include estimates of funding that is provided for public health activities by 'non-health' government departments and agencies (such as education, veterans' affairs, law enforcement, transport and environment). Nor do they include funding by local government authorities, non-government organisations or households.

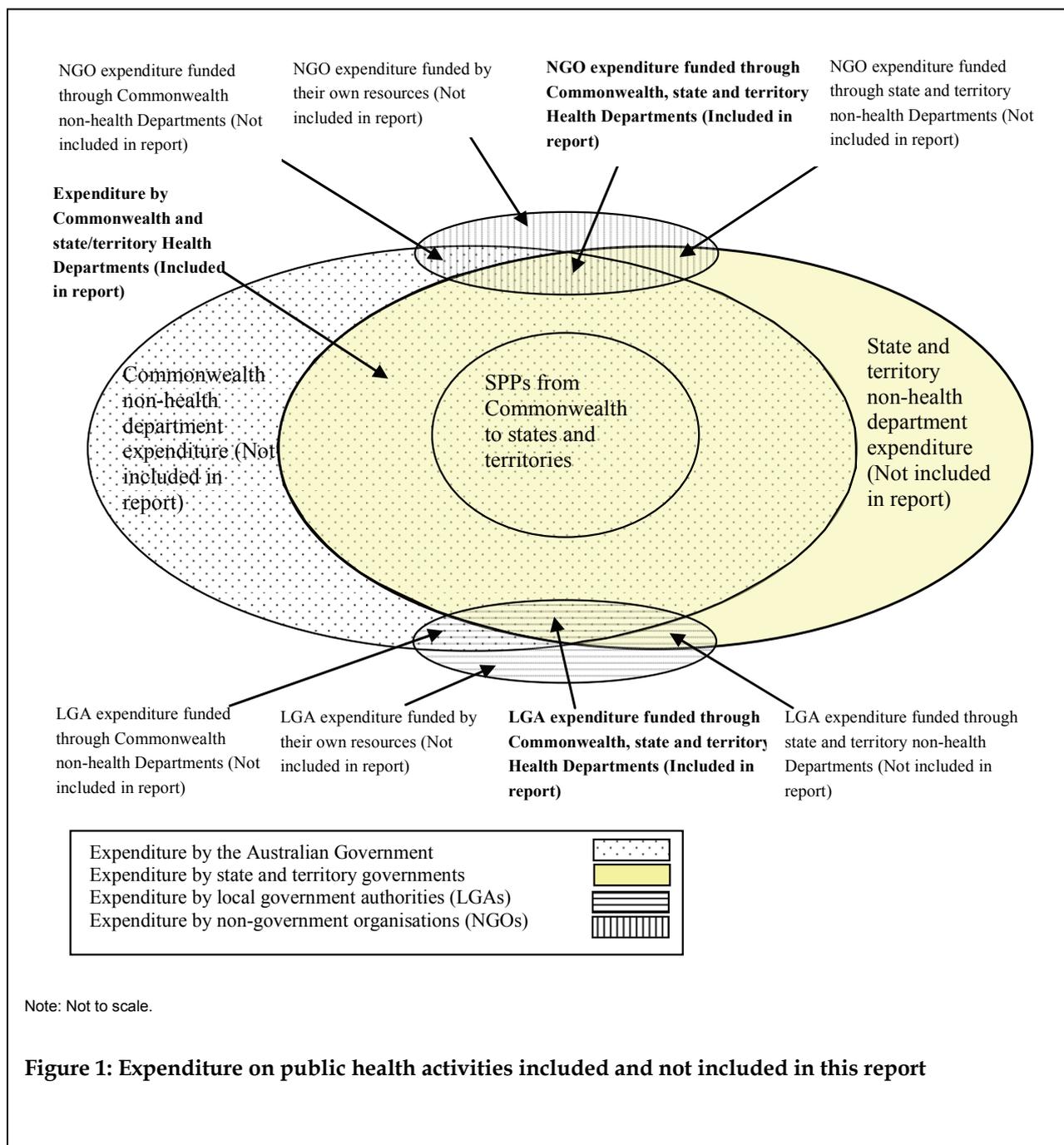
Figure 1 illustrates the portion of the public health expenditure that is captured by this report.

While public health expenditure is an important element of governments' investment in the nation's health, it is not the only such expenditure related to prevention of illness/injury. For example, it does not include the expenditures incurred by individuals to improve their own and their families' existing and future health status and to prevent injury and illness. It also omits expenditures incurred by employers in ensuring that employees have safe workplace in which to work, thereby reducing the risk of injury and illness in the workplace.

With the exception of cervical screenings and immunisations undertaken by general practitioners and other clinicians, expenditure on preventative services delivered in clinical settings has been excluded. This is because the report focuses on the expenditures associated with delivering organised programs on a whole of population basis rather than activities that may be provided by clinicians in other circumstances.

Some of the public health funding provided by the Australian Government to the states and territories through Specific Purpose Payments (SPPs) was through grants under the Public Health Outcome Funding Agreements (PHOFAs) between the Commonwealth and the individual state and territory governments. These agreements provided the states and territories the flexibility to manage priorities within a total pool of funds allocated to them under the agreements. Due to this flexibility, it is not possible to disaggregate total funding under the PHOFAs to individual public health activities. Thus, while this report provides detailed information on public health expenditure, the funding levels are only presented at a higher level.

Finally, the report does not quantify the beneficial outcomes associated with public health activities. Information on the levels of risk factors and other outcomes that are the targets of public health expenditure are included in reports such as *Australia's health 2008* (AIHW 2008).



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Thanks are extended to the Australian, state and territory governments and members of the Technical Advisory Group (TAG) for the National Public Health Expenditure Project. Members of the TAG have worked with the project team in providing these annual public health estimates and the supporting information on public health programs in their jurisdictions. Members of the TAG and additional contributors to this report are listed below.

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Abbreviations and symbols

ABHI	Australian Better Health Initiative
ABS	Australian Bureau of Statistics
AIHW	Australian Institute of Health and Welfare
CDC	Communicable disease control
DoHA	Department of Health and Ageing
EH	Environmental health
FSH	Food standards and hygiene
LGA	Local government authority
NPHP	National Public Health Partnership
OI	Organised immunisation
PHHDU	Prevention of hazardous and harmful drug use
PHOFA	Public Health Outcome Funding Agreement
PHR	Public health research
SHP	Selected health promotion
SP	Screening programs
SPP	Specific Purpose Payment
WHO	World Health Organization
n.a.	not available
n.e.c.	not elsewhere classified
..	not applicable
–	nil or rounded down to zero

Summary

Public health focuses on prevention, promotion and protection rather than on treatment; on populations rather than on individuals; and on the factors and behaviours that cause illness.

The estimates included in the *Public health expenditure in Australia* series relate only to public health activities where the funding was provided or the expenditure incurred by the key health departments and agencies in the various jurisdictions. They are accompanied by descriptions of public health activities undertaken nationally and by states and territories.

Total expenditure on reported public health activities by health departments in Australia during 2007–08 was \$2,158.8 million or \$101.61 per person on average. This was an increase of \$444.0 million on what was spent in 2006–07 which, after adjusting for inflation, represented real growth of 21.5% in 2007–08. Average expenditure per person increased by 19.4%.

Expenditure on public health increased by 77.7%, in real terms, between 1999–00 and 2007–08, averaging 7.4% per year. Total recurrent health expenditure grew at a similar rate over most of this period, maintaining the proportion of public health expenditure at 1.8%–1.9% until 2006–07. The relatively large growth in public health expenditure in 2007–08 meant that public health expenditure as a proportion of total health expenditure increased to 2.2%.

This increase was mainly attributable to a large increase in expenditure on *Organised immunisation*, which increased by \$268.2 million (61.5%), compared to 2006–07. Most of the increase in *Organised immunisation* was due to the implementation and initial catch-up phase of the National Human Papillomavirus (HPV) vaccination program, aimed at reducing the incidence of cervical cancer. The HPV program included \$302.1 million of expenditure for the purchase of the HPV vaccine (an increase in expenditure on the purchase of vaccines of \$235.8 million from 2006–07 levels). This increase in expenditure on HPV vaccine purchases was responsible for 53.1% of the \$444.0 million increase in total public health expenditure.

The Australian Government provided the largest share of the funding for public health activities in 2007–08, contributing \$1,372.7 million, or 63.6%, of the total funding. Of this, \$562.7 million was spent on its own programs and \$810.1 million was provided to state and territory governments through Specific Purpose Payments to fund public health activities. State and territory health departments incurred nearly three quarters (73.9%) of the total public health expenditure with an estimated \$1,596.1 million of expenditure. The \$1,596.1 million comprised \$786.0 million funded from their own resources and \$810.1 million from the Australian Government.

The public health activities recording the highest expenditure in 2007–08 were *Organised immunisation* (\$704.3 million or 32.6% of the total expenditure), *Selected health promotion* (\$366.6 million or 17.0%) and *Screening programs* (\$289.1 million or 13.4%).

1 Introduction

This publication reports estimates of recurrent expenditure (referred to as 'expenditure' throughout the report) on public health activities in Australia that were funded by the Australian Government and state and territory health departments during 2007–08. *Public health expenditure in Australia, 2007–08* continues the Australian Institute of Health and Welfare's (AIHW) series of reports on national public health expenditure, which have been produced since 1999–00.

Detailed time series data are available in online data cubes at <http://www.aihw.gov.au/expenditure/datacubes/index.cfm>

The information on expenditure is accompanied by detailed explanatory information provided by the jurisdictions. The explanatory information provides examples of public health activities and initiatives that were the subject of expenditure in the particular jurisdictions. More information on those particular activities and initiatives can be obtained from the jurisdictional websites listed on page 105.

Much of the analysis undertaken in this report compares growth in expenditure over the period 1999–00 to 2003–04 with growth over 2003–04 to 2007–08 (see Box 2.1). These analysis periods coincide with the periods of the Public Health Outcomes Funding Agreements (PHOFAs). The first PHOFAs covered by this report commenced on 1 July 1999 and ended on 30 June 2004; the second went from 1 July 2004 to 30 June 2009. However, this does not infer that the trends in expenditure growth are necessarily resulting from differences in the PHOFAs themselves. These are merely convenient periods of time in which to examine shorter-term trends in expenditure.

1.1 What is public health?

A widely used definition of public health in Australia is 'the organised response by society to protect and promote health, and to prevent illness, injury and disability; the starting point for identifying public health issues, problems and priorities, and for designing and implementing interventions, is the population as a whole, or population subgroups' (NPHP 1998).

Public health activities can take the form of programs, campaigns, or events. They draw on a large range of methods such as health education, lifestyle advice, infection control, risk factor monitoring, and tax loadings to discourage unhealthy lifestyle choices. They also apply in a multitude of settings (such as schools, homes, workplaces and media outlets), and relate to a broad spectrum of health issues. Public health activities are carried out by the Australian Government, state, territory and local governments instrumentalities; non-government agencies – such as anti-cancer councils and the Heart Foundation; and private health professionals.

In this report, public health activity is reported against the following eight core categories:

- *Communicable disease control*
- *Selected health promotion*
- *Organised immunisation*
- *Environmental health*
- *Food standards and hygiene*
- *Screening programs*
- *Prevention of hazardous and harmful drug use*
- *Public health research*

These categories were derived from the nine categories adopted by the National Public Health Expenditure Project that have been reported in each annual national public health expenditure report since 1999–00. In this publication, two former categories – ‘Breast cancer screening’ and ‘Cervical screening’ – have been subsumed into a new activity category ‘Screening programs’ (see Appendix A).

While jurisdictions were provided with a data collection guide and an associated template to assist with the collection and classification of data according to the above categories, there may be inconsistencies in the manner in which jurisdictions have classified similar programs. For example the Northern Territory’s *No Germs On Me* program may appear to be aimed at the communicable disease control but has been classified by the Northern Territory as an environmental health program.

1.2 Public health funding and expenditure

This report looks at what is spent on public health activities from two perspectives – funding and expenditure. These concepts, while related, are quite distinct and must be borne in mind when discussing particular aspects of public health spending (Box 1.1).

Box 1.1: Defining health funding and expenditure

Health funding

Health funding is reported in terms of who provides the funds used to pay for health expenditure. Thus, although states and territories incur around 70% of the total public health expenditure, they provide less than half the funding from their own revenue fiscal and other sources.

The Australian Government, as well as funding expenditures incurred through its own programs, provides Specific Purpose Payments to states and territories – most notably through the Public Health Outcome Funding Agreements and the Australian Immunisation Agreements – to help fund public health activities undertaken by, or on behalf of each state and territory government.

Health expenditure

Health expenditure is reported in terms of who incurs the expenditure, rather than who ultimately provides the funding for that expenditure. In the case of many vaccination programs for example, the related expenditures are incurred by the states and territories, even though a large proportion of those expenditures are funded by the Australian Government through SPPs.

As well as funding its own public health programs and activities, the Australian Government provides a number of ‘public health’ Specific Purpose Payments (SPPs) to state and territory governments including those under the PHOFAs. Those SPP moneys provided to the states and territories must be spent on agreed public health activities within their jurisdiction or, in the case of the broadbanded PHOFA grants, to achieve agreed public health outcomes. Consequently, the estimates of funding by the Australian Government are higher than its estimated expenditures. On the other hand, the estimates of net funding by individual states and territories have been derived by deducting their estimated receipts of public health SPPs from the reported total expenditure incurred by them on public health programs. Consequently, net funding by states and territories is lower than the expenditures they directly incur.

In some cases the figures in the tables presented in this report may not add to the totals provided due to rounding.

Indirect expenditures included in the estimates

As well as the amounts that each jurisdiction estimated were spent directly on public health activities, the estimates include allocations of corporate overheads and other 'on-costs' incurred by the various health authorities to support those public health activities. These include expenditures on human resources management, legal and industrial relations activities, staff development and finance expenses, development and maintenance of information systems, disease surveillance and epidemiology, and a range of other corporate activities.

Current prices and constant prices

The tables and figures in this report detail expenditure in terms of current and constant prices. The term 'expenditure at current prices' refers to expenditure reported for a particular year, unadjusted for inflation. Expenditure at constant prices, on the other hand, has been 'deflated' to remove the effects of inflation, so that expenditure in one year can be compared with expenditure in other years in a series. This deflation is achieved by using annually re-weighted chain price indexes produced by the Australian Bureau of Statistics (ABS) (see *Deflators* in the Appendix A). These price indexes are referenced to a particular year in the series (the reference year), which is given a value of 100. Because the reference year for the chain price index in this series is 2007-08, the constant price estimates indicate what expenditure would have been had 2007-08 prices applied in all years.

2 National funding and expenditure on public health activities

2.1 Government funding

Total government funding of public health activities during 2007–08 was estimated at \$2,158.8 million (Table 2.1).

Australian Government funding

The Australian Government contributed an estimated \$1,372.7 million (63.6%) of the total funding in 2007–08, compared with \$1,001.2 million or 58.4% in 2006–07. This increase was largely due to increases in funding through SPPs to states and territories, up \$317.3 million (or 64.4%) from 2006–07 levels. Of the total funding by the Australian Government in 2007–08, \$562.7 million was directly spent on its own public health programs.

SPPs to states and territories

Total public health funding to state and territory governments through SPPs in 2007–08 was estimated at \$810.1 million, up from \$492.8 million the previous financial year.

Of the total SPP funding in 2007–08, \$561.8 million (69.3%) was for *Organised immunisation*. This enabled states and territories to purchase essential vaccines listed on the National Immunisation Program Schedule. Nationally, the SPPs for *Organised immunisation* accounted for about 88.6% of the total funding for state and territory governments' expenditures on *Organised immunisation* in 2007–08 (calculated from tables 2.2 and 2.6). On a jurisdictional basis, the proportion of expenditures met by the SPPs ranged from around 18% in the Northern Territory to 61% in New South Wales.

Of the SPP funding, \$167.5 million (20.7%) was for the funding of health programs through the PHOFAs (Table 2.2, Box 2.1).

The increase in SPP funding from 2006–07 to 2007–08 was largely for the purchase of additional essential vaccines. In particular the funding for the purchase of Gardasil, used in the National Human Papillomavirus Vaccination Program, increased substantially.

Funding by state and territory governments

Nationally, the state and territory governments provided an estimated \$786.0 million from their own funding sources to fund public health activities in 2007–08. Of this, almost half was provided by New South Wales and Victoria (Table 2.3). Although the relative share of national funding for these two states declined marginally after 2006–07, this was a reflection of the relatively large increases in funding by other states and territories, rather than a reduction in funding by those two larger states. In particular, Queensland increased funding by almost 30% in that year. Western Australia was the one jurisdiction to have decreased their own funding for public health activities (Table 2.3).

Table 2.1: Total government funding of expenditure on public health activities, current prices, by source of funds and shares of total public health funding/expenditure, 2006–07 and 2007–08

Source of funds	2006–07		2007–08	
	Amount (\$ million)	Share of total (%)	Amount (\$ million)	Share of total (%)
Funding by the Australian Government				
Direct expenditure	508.4	29.6	562.7	26.1
SPPs to states and territories	492.8	28.7	810.1	37.5
<i>Australian Government funding</i>	<i>1,001.2</i>	<i>58.4</i>	<i>1,372.7</i>	<i>63.6</i>
Funding by state and territory governments				
Gross expenditure	1,206.4	70.4	1,596.1	73.9
SPPs from the Australian Government	492.8	28.7	810.1	37.5
<i>Net funding by the states and territories</i>	<i>713.6</i>	<i>41.6</i>	<i>786.0</i>	<i>36.4</i>
Total funding/expenditure	1,714.8	100.0	2,158.8	100.0

Source: AIHW health expenditure database.

Table 2.2: SPPs for public health, current prices, by state and territory, 2007–08 (\$ million)

Category	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
PHOFA funding	52.8	40.6	32.7	15.0	12.8	5.9	3.5	4.1	167.5
Communicable disease control	3.6	2.6	3.1	1.4	1.0	0.4	0.4	0.7	13.3
Selected health promotion	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Food standards and hygiene	0.2	0.1	0.1	0.1	0.1	0.1	0.1	0.0	0.7
Organised immunisation	187.6	139.4	108.0	59.1	37.4	13.9	9.7	6.7	561.8
Prevention of hazardous and harmful drug use	22.8	17.3	9.4	6.9	4.7	2.6	1.4	1.7	66.8
Total payments	267.0	200.1	153.3	82.6	55.9	22.9	15.1	13.2	810.1

Source: AIHW health expenditure database.

Table 2.3: Net state and territory funding for public health activities, by states and territories, current prices, and shares of the total funding, 2006–07 and 2007–08

State/territory	2006–07		2007–08	
	Amount (\$ million)	Share of total (%)	Amount (\$ million)	Share of total (%)
New South Wales	170.1	23.8	174.1	22.1
Victoria	177.8	24.9	186.5	23.7
Queensland	129.6	18.2	168.0	21.4
Western Australia	80.8	11.3	74.1	9.4
South Australia	64.1	9.0	74.1	9.4
Tasmania	19.8	2.8	23.5	3.0
Australian Capital Territory	20.3	2.8	23.8	3.0
Northern Territory	51.2	7.2	62.0	7.9
Total	713.6	100.0	786.0	100.0

Source: AIHW health expenditure database.

Box 2.1: Public Health Outcome Funding Agreements (PHOFAs)

The PHOFAs are funding agreements between the Australian Government and each state and territory government. The first PHOFAs covered by this report commenced on 1 July 1999 and ended on 30 June 2004; the second went from 1 July 2004 to 30 June 2009. The agreements provide funding to achieve outcomes in the following broad areas of public health:

- *communicable diseases*
- *cancer screening*
- *health risk factors – in particular alcohol and tobacco use, women’s health, and sexual and reproductive health.*

Total funding under the PHOFAs is estimated to be \$812 million over the whole period 2004–05 to 2008–09.

Funding provided under these agreements is broadbanded, giving states and territories the flexibility to manage local needs and priorities within the total pool of funds allocated to them (DoHA 2006). As a result, it is not possible to disaggregate total PHOFA funding to individual core public health activities.

In order to show how growth in expenditure has systematically changed over time, some of the expenditure tables in this report show estimates of average annual growth in expenditure during each of the most recent PHOFA periods, to the end of the period being examined (2007–08).

2.2 Government expenditure

Almost three-quarters (73.9%) of the total \$2,158.8 million spent on public health activities in 2007–08, was incurred by the state and territory governments. The balance of \$562.7 million (26.1%) related to programs and activities for which the Australian Government was directly responsible (Table 2.4).

Organised immunisation accounted for \$704.3 million or 32.6% of estimated national expenditure on all public health activities during 2007–08 and was the largest single area of public health expenditure. Other major activities, in terms of their share of total expenditure, were:

- *Selected health promotion* – \$366.6 million (17.0% of total expenditure on public health activities)

- *Screening programs* – \$289.1 million (13.4% of total expenditure on public health activities) (Table 2.5; Figure 2.1).

Table 2.4: Total government expenditure on public health activities, current prices, by activity, 2007–08 (\$ million)

Activity	Australian Government	States and territories	Total
Communicable disease control	37.5	219.2	256.7
Selected health promotion	87.2	279.4	366.6
Organised immunisation	70.5	633.8	704.3
Environmental health	19.6	75.9	95.5
Food standards and hygiene	18.9	19.7	38.6
Screening programs	99.9	189.2	289.1
Prevention of hazardous and harmful drug use	95.1	159.2	254.3
Public health research	134.0	19.6	153.6
Total expenditure	562.7	1,596.1	2,158.8

Source: AIHW health expenditure database.

The proportion of expenditure associated with *Organised immunisation* in 2007–08 was substantially higher than in the previous year, increasing from 25.4% to 32.6%. A large proportion of this increase was an additional \$235.8 million of funding for the purchase of HPV vaccines compared with 2006–07. The relative shares of expenditure on all other public health activities, with the exception of *Selected health promotion*, declined, despite expenditure in all those public health activities having actually increased from 2006–07 levels (Table 2.5).

Table 2.5: Total government expenditure on public health activities, current prices, shares of the total expenditure by activity, 2006–07 and 2007–08 (\$ million)

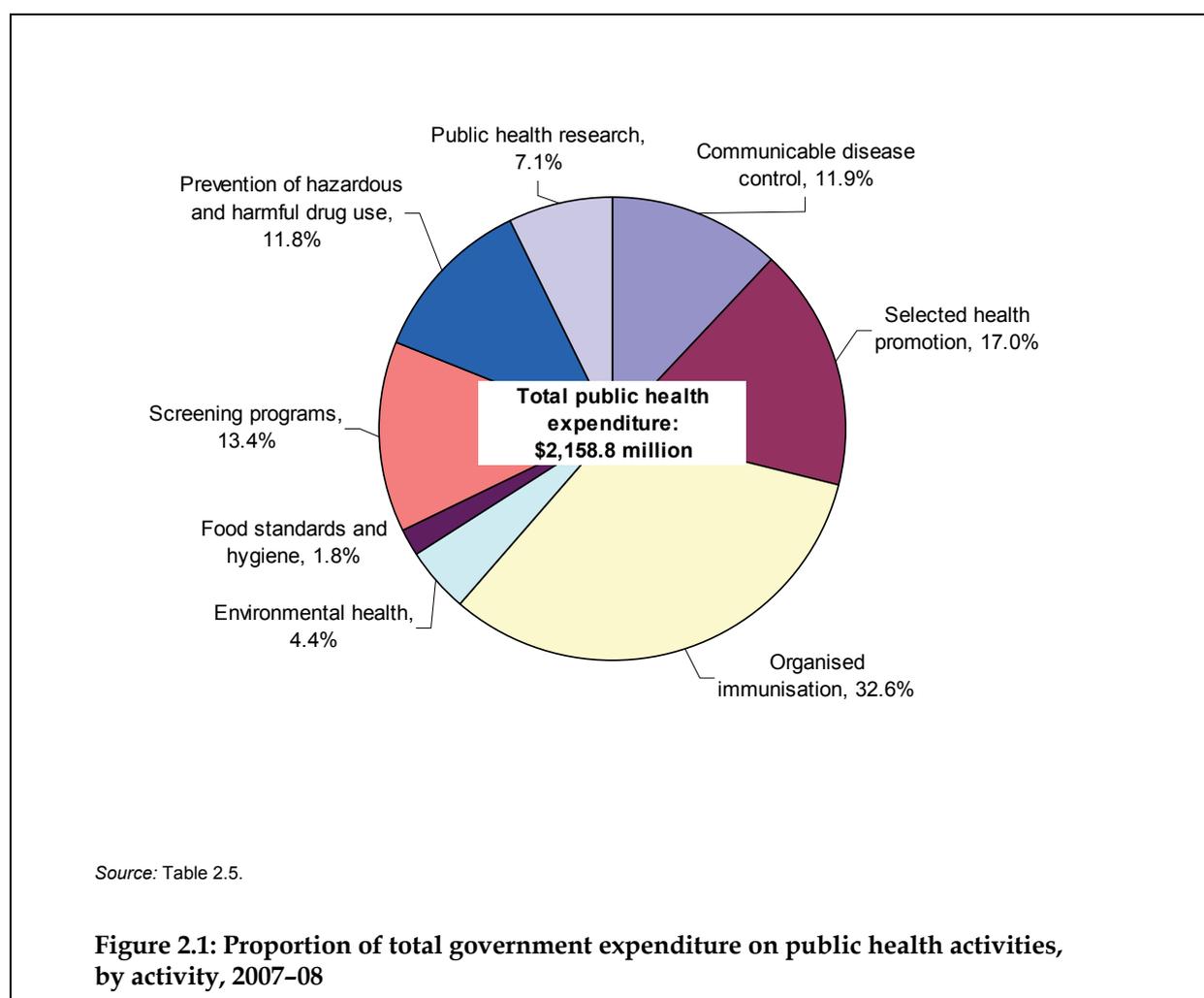
Activity	2006–07		2007–08	
	Amount (\$ million)	Share of total (%)	Amount (\$ million)	Share of total (%)
Communicable disease control	254.2	14.8	256.7	11.9
Selected health promotion	283.5	16.5	366.6	17.0
Organised immunisation	436.1	25.4	704.3	32.6
Environmental health	88.1	5.1	95.5	4.4
Food standards and hygiene	34.5	2.0	38.6	1.8
Screening programs	261.9	15.3	289.1	13.4
Prevention of hazardous and harmful drug use	208.8	12.2	254.3	11.8
Public health research	147.7	8.6	153.6	7.1
Total expenditure	1,714.8	100.0	2,158.8	100.0

Source: AIHW health expenditure database.

Table 2.6: Total state and territory government expenditure on public health activities, current prices, by activity, 2007-08 (\$ million)

Activity	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
Communicable disease control	73.3	40.9	36.1	22.3	16.5	5.4	6.8	17.9	219.2
Selected health promotion	57.5	106.1	45.9	22.8	23.6	6.0	6.7	10.8	279.4
Organised immunisation	199.5	154.2	128.3	59.7	40.9	15.8	12.2	23.1	633.8
Environmental health	17.2	9.0	20.0	10.8	5.3	4.8	3.4	5.4	75.9
Food standards and hygiene	4.9	3.1	2.2	2.9	2.4	0.5	2.8	1.0	19.7
Screening programs	55.1	47.4	43.6	12.2	15.1	6.2	3.2	6.5	189.2
Prevention of hazardous and harmful drug use	30.2	20.3	44.1	22.1	22.8	7.6	3.4	8.7	159.2
Public health research	3.5	5.5	1.1	3.9	3.3	0.2	0.3	1.8	19.6
Total expenditure	441.1	386.6	321.3	156.6	130.0	46.4	38.9	75.2	1,596.1

Source: AIHW health expenditure database.



2.3 Public health expenditure per person

Examining public health expenditure on a per person basis removes from the analyses the influence of changes in population size and allows comparative assessments to be made across different-sized populations.

During 2007–08, estimated government public health expenditure per person was \$101.61 on average, which was \$19.50 more than the average in the previous year. Annual growth in average real per person expenditure between 1999–00 and 2007–08 ranged between –3.8% in 2005–06 to 19.4% in 2007–08 and averaged 6.0% per year over the whole period (Table 2.7).

Average annual growth was substantially higher after 2003–04 (8.5%) than between 1999–00 and 2003–04, when it had averaged 3.6% per year.

Table 2.7: Average public health expenditure per person^(a), current and constant^(b) prices, and annual growth rates, 1999–00 to 2007–08

Year	Amount (\$)		Change from year to year (%)	
	Current	Constant	Current price increase	Real growth
1999–00	48.03	63.74
2000–01	52.56	67.65	9.4	6.1
2001–02	55.85	69.63	6.3	2.9
2002–03	60.75	73.21	8.8	5.1
2003–04	63.09	73.42	3.9	0.3
2004–05	71.09	79.87	12.7	8.8
2005–06	71.37	76.82	0.4	–3.8
2006–07	82.11	85.07	15.0	10.7
2007–08	101.61	101.61	23.8	19.4
	Average expenditure per person		Average annual growth rates (%)	
1999–00 to 2003–04 ^(c)	56.06	69.53	7.1	3.6
2003–04 to 2007–08	77.85	83.36	12.7	8.5
1999–00 to 2007–08	67.38	76.78	9.8	6.0

(a) Based on annual mean resident population for year ended 30 June.

(b) Constant price public health expenditure for 1999–00 to 2007–08 is expressed in terms of 2007–08 prices.

(c) The periods 1990–00 to 2003–04 and 2003–04 to 2007–08 were covered by separate Public Health Outcome Funding Agreements. See Box 2.1 for details.

Source: AIHW health expenditure database.

Average expenditure per person in each state and territory

In order to estimate total government public health expenditure occurring within each state and territory, direct expenditure by the Australian Government has been apportioned across each state and territory (see *Method for allocating direct expenditure by the Australian Government to states and territories* in Appendix A). This means that the following estimates do not just relate to how much each state and territory government spent on public health services for its population—the estimates also include expenditure by the Australian Government that was estimated to have benefited residents of that state or territory. The estimates do not include expenditure by local governments and as the role of local governments (where they exist) vary between jurisdictions.

The expenditure in this report is limited to that undertaken by the key health departments and agencies but some public health funding is provided by the Commonwealth directly to other state and territory public health bodies. Care should be taken in interpreting the figures in this report.

In 2007-08, the highest average expenditure per person occurred in the Northern Territory and the Australian Capital Territory. Their average expenditure was estimated at \$373.23 and \$140.30 per person, respectively, compared with the national average of \$101.61 per person (Table 2.8). In the case of the ACT, while the expenditures are averaged across the Territory's own population, many of the activities covered by those expenditures are also used by, or directed at, the population in the surrounding regions of New South Wales.

At the other end of the scale, the lowest average expenditure per person occurred in New South Wales and Victoria (\$90.30 and \$98.50 per person, respectively) (Table 2.8). Again, the services provided by the ACT to people in surrounding regions of NSW would have an effect, albeit a small one, on the NSW per person average.

While these results indicate that there are some economies of scale in providing public health services to larger populations, it was also true that average expenditure per person was influenced by other non-public health factors such as location; population demographics; and the availability of services provided by other agencies or local governments within a jurisdiction (see *Technical Notes* in Appendix A).

This last point partly explains why expenditure in Victoria, where local governments played a large role in the provision of public health services, is lower than may be expected based purely on population share. For example, nearly half of all childhood vaccinations in Victoria are administered through local government councils and these are not funded by the Victorian Government (AIHW 2006). The opposite will be true in respect of the ACT, where there is no local government and all those functions typically carried out by councils in other jurisdictions are the responsibility of the Territory Government.

In the case of the Northern Territory, expenditure on public health activities was likely to be higher than the national average because of reasons such as the:

- relative isolation of the population; and
- higher proportion of Indigenous people in the population.

Indigenous Australians typically have much poorer average health status than do non-Indigenous Australians (AIHW 2008a).

It is important to consider these qualifications (and others outlined in Appendix A) when comparing estimates across jurisdictions.

Table 2.8: Estimated total government expenditure^{(a)(b)} per person^(c) on public health activities in each state and territory, current prices, 2007–08 (\$)

Activity	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Average ^(d)
Communicable disease control	12.33	9.53	10.28	12.17	12.11	12.64	21.72	83.92	12.08
Selected health promotion	12.38	24.26	14.92	14.77	18.91	16.23	23.62	53.82	17.25
Organised immunisation	32.00	32.54	33.63	31.29	28.90	35.39	38.96	110.75	33.15
Environmental health	3.39	2.64	5.65	5.95	4.27	10.53	10.93	25.70	4.49
Food standards and hygiene	1.60	1.48	1.41	2.22	2.42	1.92	8.99	5.37	1.82
Screening programs	12.98	12.37	15.45	10.83	14.76	18.42	14.53	34.22	13.61
Prevention of hazardous and harmful drug use	8.82	8.34	14.88	14.79	18.78	19.73	14.38	44.68	11.97
Public health research	6.81	7.35	6.57	8.12	8.40	6.72	7.17	14.77	7.23
Total	90.30	98.50	102.77	100.16	108.56	121.58	140.30	373.23	101.61

(a) Includes expenditures incurred by state and territory governments that are wholly or partly funded by the Australian Government through SPPs to states and territories.

(b) Includes estimates of direct expenditure incurred by the Australian Government on its own public health programs which have been apportioned across states and territories (see Appendix A).

(c) Based on the annual mean resident population for the jurisdiction concerned.

(d) Calculated by the average expenditure divided by the total population.

Note: Estimates and comparisons across states and territories need to be interpreted with care. For further information see *Technical notes* in Appendix A.

Source: AIHW health expenditure database.

2.4 Growth in expenditure on public health activities

Between 1999–00 and 2007–08, estimated expenditure in constant price terms grew at an average rate of 7.4% per year. All activities showed real increases in expenditure over the period, with expenditure on *Organised immunisation* (17.0% per annum) and *Public health research* (7.2%) having the highest average growth rates (Table 2.9).

The activities recording the highest real growth between 2006–07 and 2007–08 were *Organised immunisation* (55.9%) and *Selected health promotion* (24.8%) (Table 2.9).

Table 2.9: Total government expenditure on public health activities^(a), constant prices^(b), by activity, 1999–00 to 2007–08 (\$ million)

Year	CDC	SHP	OI	EH	FSH	SP	PHHDU	PHR	PHOFA admin ^(c)	Total
1999–00	201.2	222.6	200.2	76.4	33.2	236.7	156.3	88.2	0.3	1215.3
2000–01	210.5	242.0	217.6	83.7	45.1	237.1	183.4	85.0	0.3	1304.8
2001–02	231.7	274.0	220.8	90.0	41.0	234.4	172.4	96.5	0.3	1361.0
2002–03	241.3	257.5	308.0	89.1	40.8	220.3	184.9	106.6	0.3	1448.8
2003–04	237.3	250.8	312.0	92.8	41.2	229.9	195.3	109.8	0.3	1469.6
2004–05	260.4	259.7	379.8	93.6	36.8	249.4	217.9	119.5	0.3	1617.3
2005–06	266.5	270.1	345.3	91.7	36.9	245.1	189.6	133.3	0.3	1578.7
2006–07	263.4	293.7	451.8	91.3	35.7	271.4	216.3	153.0	—	1776.7
2007–08	256.7	366.6	704.3	95.5	38.6	289.1	254.3	153.6	—	2158.8
Growth rate (%)										
2006–07 to 2007–08	–2.5	24.8	55.9	4.7	8.1	6.5	17.6	0.4	—	21.5
Average annual growth rates (%)^(d)										
1999–00 to 2003–04	4.2	3.0	11.7	5.0	5.5	–0.7	5.7	5.6	–3.2	4.9
2003–04 to 2007–08	2.0	9.9	22.6	0.7	–1.6	5.9	6.8	8.8	—	10.1
1999–00 to 2007–08	3.1	6.4	17.0	2.8	1.9	2.5	6.3	7.2	—	7.4

(a) CDC = Communicable disease control, SHP= Selected health promotion, OI= Organised Immunisation, EH= Environmental health, FSH = Food standards and hygiene, SP = Screening programs, PHHDU = Prevention of hazardous and harmful drug use, PHR = Public health research.

(b) Constant price public health expenditure for 1999–00 to 2007–08 is expressed in terms of 2007–08 prices.

(c) In previous reports, direct expenditure incurred by the Australian Government in administering the PHOFAs was reported separately as it could not be specifically allocated to any of the core public health activity categories. From 2006–07 this expenditure has been treated as corporate overhead expenditure and apportioned across all categories.

(d) The periods 1990–00 to 2003–04 and 2003–04 to 2007–08 were covered by separate Public Health Outcome Funding Agreements. See Box 2.1 for details.

Source: AIHW health expenditure database.

Over the whole period 1999–00 to 2007–08, two states, Queensland (11.7%) and Victoria (8.4%) had annual growth rates that were substantially above the national average (7.4%). Two other jurisdictions, New South Wales (7.3%) and Tasmania (7.3%) had growth rates that were around the national average. The other jurisdictions had growth rates that were below the national average (Table 2.10).

From 2003–04 to 2007–08 national expenditure growth averaged 10.1% per year, compared with 4.9% per year up to 2003–04. Queensland (16.1% per year) had the highest average growth after 2003–04 and the Australian Capital Territory (7.2%), the lowest.

During the last year covered by this report – from 2006–07 to 2007–08 – all jurisdictions, with the exception of the Australian Government, recorded growth rates that were well above their longer-term averages. The Australian Government reported growth in 2007–08 of 6.8%, which was just above their annual average growth over the whole period 1999–00 to 2007–08 of 6.2% per year.

Table 2.10: Total government expenditure on public health activities, constant prices^(a), by jurisdiction, 1999–00 to 2007–08 (\$ million)

Year	Australian Government	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
1999–00	347.8	251.8	202.3	132.2	94.1	78.3	26.4	30.4	51.9	1215.3
2000–01	377.5	257.4	242.8	141.0	99.0	82.7	28.0	28.5	47.8	1304.8
2001–02	390.4	273.7	247.1	153.8	106.3	84.6	29.6	28.2	47.3	1361.0
2002–03	386.0	281.4	284.0	174.7	116.3	98.8	33.6	29.6	44.5	1448.8
2003–04	402.9	303.6	264.6	176.7	117.4	92.1	31.4	29.5	51.4	1469.6
2004–05	529.4	314.7	256.2	186.1	116.3	92.1	29.5	31.7	61.4	1617.3
2005–06	472.7	311.4	261.6	197.6	125.2	89.6	31.3	30.1	59.3	1578.7
2006–07	526.8	347.1	289.5	237.7	134.3	108.8	36.7	31.7	64.2	1776.7
2007–08	562.7	441.1	386.6	321.3	156.6	130.0	46.4	38.9	75.2	2158.8
Growth rate (%)										
2006–07 to 2007–08	6.8	27.1	33.5	35.2	16.7	19.5	26.3	22.5	17.2	21.5
Average annual growth rates (%)										
1999–00 to 2003–04	3.7	4.8	6.9	7.5	5.7	4.1	4.5	–0.7	–0.3	4.9
2003–04 to 2007–08	8.7	9.8	9.9	16.1	7.5	9.0	10.2	7.2	10.0	10.1
1999–00 to 2007–08	6.2	7.3	8.4	11.7	6.6	6.5	7.3	3.1	4.7	7.4

(a) Constant price public health expenditure for 1999–00 to 2007–08 is expressed in terms of 2007–08 prices.

Source: AIHW health expenditure database.

3 Public health expenditure as a proportion of total recurrent health expenditure

Expenditure on public health is an important component of recurrent health expenditure in Australia. It is an investment in the health of the nation, much of the benefit of which will be realised at some future time, in terms of higher average health status and lower demand for expensive curative goods and services. As such, there is interest in knowing what proportion of our total recurrent health funding was directed to this type of investment.

The National Healthcare Agreement (COAG 2009) specifies a number of performance indicators, including 'the allocation of health and aged care expenditure'. The indicator and the detailed specifications for them are yet to be reported. However, the analysis in this chapter may assist in providing related information.

Recurrent health expenditure comprises expenditure on hospitals, medical services, dental services, patient transport services, other health practitioner services, community and public health services, medications, aids and appliances, health research and the administrative systems that support these services (AIHW 2009).

3.1 National and jurisdictional expenditure proportions

From 2006–07 to 2007–08 total government public health expenditure increased from \$1,777 million to \$2,159 million in real terms. The average annual growth rate of public health expenditure from 1999–00 to 2007–08 was 7.4%. This compares to a 5.0% increase in total recurrent health expenditure over these years. The growth in public health expenditure has accelerated in more recent years and recorded average growth of 10.1% over the period 2003–04 to 2007–08 with growth of 21.5% for 2007–08. Total recurrent health expenditure showed growth rates of 5.0% and 6.4% for the same periods (Table 3.1).

Recurrent expenditure on health in 2007–08 was estimated at \$98,017 million. Public health expenditure in the same year was \$2,159 million, or 2.2% of recurrent health expenditure (Figure 3.2).

Table 3.1: Total recurrent health expenditure and public health expenditure, constant prices^{(a)(b)}, 1999–00 to 2007–08 (\$ million)

Year	Total government public health expenditure (\$ million)	Total recurrent health expenditure (\$ million)	
		All funding sources	Government funding
1999–00	1,215	66,092	46,394
2000–01	1,305	70,595	48,743
2001–02	1,361	73,867	50,527
2002–03	1,449	77,656	53,833
2003–04	1,470	80,661	55,433
2004–05	1,617	85,004	58,709
2005–06	1,579	87,169	60,303
2006–07	1,777	92,080	63,624
2007–08	2,159	98,017	68,653
Growth rate (%)			
2006–07 to 2007–08	21.5	6.4	7.9
Average annual growth rates (%)^{(c)(d)}			
1999–00 to 2003–04	4.9	5.1	4.6
2003–04 to 2007–08	10.1	5.0	5.5
1999–00 to 2007–08	7.4	5.0	5.0

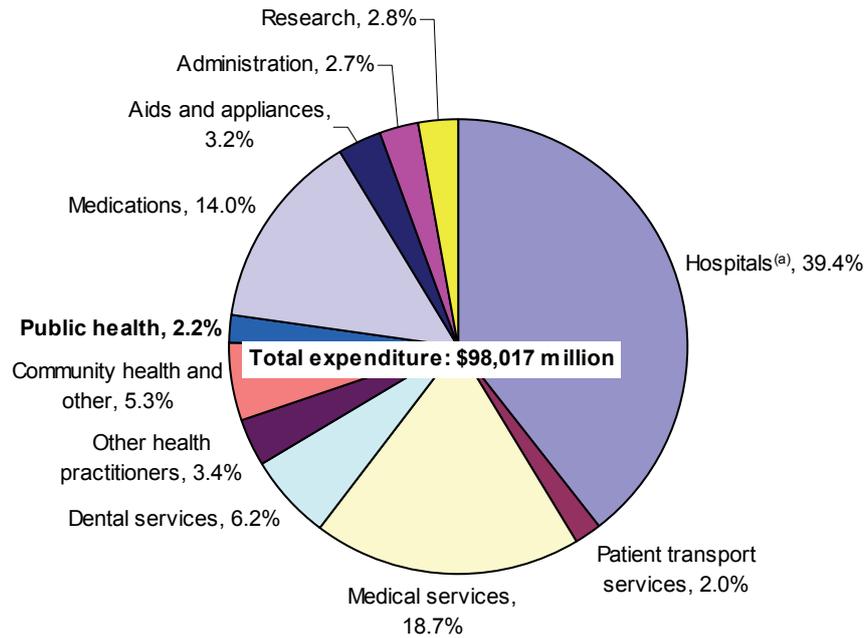
(a) Constant price public health expenditure for 1999–00 to 2007–08 is expressed in terms of 2007–08 prices.

(b) The public health expenditure figures may not reconcile with those used in *Health Expenditure Australia 2007–08* due to timing issues associated with data revisions.

(c) In previous reports, direct expenditure incurred by the Australian Government in administering the PHOFAs was reported separately as it could not be specifically allocated to any of the core public health activity categories. From 2006–07 this expenditure has been treated as corporate overhead expenditure and apportioned across all categories.

(d) The periods 1999–00 to 2003–04 and 2003–04 to 2007–08 were covered by separate Public Health Outcome Funding Agreements. See Box 2.1 for details.

Source: AIHW health expenditure database.



(a) Includes public hospital services and private hospitals. Can include services provided off-site, such as hospital in the home, dialysis or other services.

Source: AIHW health expenditure database.

Figure 3.1: Recurrent expenditure on health goods and services, current prices, by broad area of expenditure, 2007-08

In the 8 years from 1999-00 to 2006-07, the public health share of total recurrent health expenditure fluctuated between 1.8% and 1.9%. In 2007-08, this proportion rose to 2.2% (Tables 3.1 and 3.2).

Table 3.2: Total government expenditure on public health activities and total recurrent health expenditure, current prices, Australia, 1999–00 to 2007–08

Year	Total government public health expenditure (\$ million)	Total recurrent health expenditure (\$ million)		Public health as a proportion of total recurrent expenditure (%)	
		All funding sources	Government funding	All funding sources	Government funding
1999–00	915	49,564	34,799	1.8	2.6
2000–01	1,014	54,978	37,918	1.8	2.7
2001–02	1,091	59,522	40,695	1.8	2.7
2002–03	1,201	64,822	44,931	1.9	2.7
2003–04	1,263	69,901	48,008	1.8	2.6
2004–05	1,440	76,781	52,949	1.9	2.7
2005–06	1,467	81,933	56,609	1.8	2.6
2006–07	1,715	89,449	61,745	1.9	2.8
2007–08	2,159	98,017	68,653	2.2	3.1

Source: AIHW health expenditure database.

In 2007–08 the public health share of total recurrent health expenditure for all jurisdictions was around 2–3% with the exception of the Northern Territory (6.2%). For the two most populous states, New South Wales and Victoria, the proportions were usually marginally lower than the national average in each year, however Victoria’s proportion was equal to the national average in 2006–07 and 2007–08 (Table 3.3).

The share of total recurrent health expenditure directed to public health in the Northern Territory fell from 7.0% to 6.2% over the period 1999–00 to 2007–08. For all other jurisdictions the share of public health expenditure increased over the same period.

Table 3.3: Estimated total government expenditure on public health activities ^{(a)(b)} as a proportion of total recurrent health expenditure for each state and territory, current prices, 1999–00 to 2007–08 (per cent)

Year	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
Proportion of total recurrent health funding (all funding sources) ^(c)									
1999–00	1.7	1.7	1.7	2.1	2.0	2.1	2.6	7.0	1.8
2000–01	1.6	1.8	1.7	2.1	2.1	2.2	2.8	6.1	1.8
2001–02	1.6	1.7	1.7	2.1	2.0	2.0	2.5	5.9	1.8
2002–03	1.6	1.8	1.8	2.1	2.1	2.4	2.5	5.2	1.9
2003–04	1.6	1.7	1.8	2.0	1.9	2.3	2.3	5.5	1.8
2004–05	1.7	1.7	1.9	2.0	1.9	2.2	2.5	6.4	1.9
2005–06	1.6	1.7	1.8	2.0	1.8	2.2	2.2	5.7	1.8
2006–07	1.7	1.9	1.9	2.0	2.1	2.3	2.3	5.9	1.9
2007–08	2.0	2.2	2.3	2.1	2.2	2.6	2.6	6.2	2.2
Proportion of government recurrent health funding									
1999–00	2.4	2.6	2.3	3.0	2.7	3.0	3.4	8.6	2.6
2000–01	2.4	2.8	2.3	3.0	2.9	3.1	3.9	7.7	2.7
2001–02	2.4	2.7	2.5	3.2	2.9	2.8	3.5	7.4	2.7
2002–03	2.3	2.7	2.5	3.0	3.0	3.4	3.4	6.4	2.7
2003–04	2.3	2.7	2.5	2.9	2.7	3.2	3.3	6.7	2.6
2004–05	2.4	2.7	2.7	2.9	2.7	3.1	3.4	7.7	2.7
2005–06	2.3	2.6	2.5	2.9	2.5	3.0	3.1	7.0	2.6
2006–07	2.4	2.9	2.7	3.0	2.8	3.3	3.1	7.2	2.8
2007–08	2.8	3.2	3.2	3.2	3.0	3.6	3.5	7.5	3.1

(a) Total direct expenditure by the Australian Government has been apportioned by state/ territory.

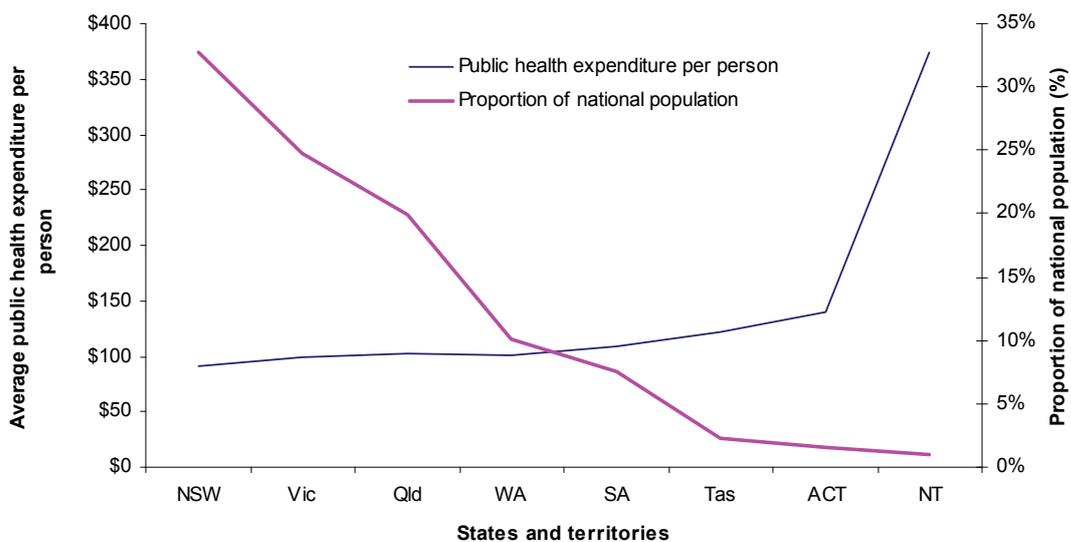
(b) Estimates and comparisons across states and territories need to be interpreted with care. For further information, see Appendix A.

(c) Includes government and non-government sources of funds.

Source: AIHW 2009a and AIHW health expenditure database.

Care must be exercised when comparing estimates of expenditure on public health across jurisdictions. The levels of expenditure on public health activities may vary, because different jurisdictions often need to direct more effort and resources to particular activities to meet needs that are of primary concern to their populations. These are sometimes determined by factors such as their geographic location (see *Technical Notes* in Appendix A).

There may be economies of scale applicable in respect of expenditure on public health. States with larger populations generally have lower per person expenditures (Figure 3.2). In the case of the Northern Territory expenditure, their diseconomies of scale may be exacerbated by other factors, such as the relative isolation of much of the population from the major population centres and the higher proportion of Indigenous people in the population.



Note: Estimates and comparisons across states and jurisdictions need to be interpreted with care. Direct expenditure by the Australian Government has been allocated to states and territories in order to estimate total public health expenditure in each state and territory.

Source: Table 2.8 and AIHW health expenditure database.

Figure 3.2: Average expenditure on public health per person, current prices, and shares of national population, by state and territory, 2007–08

4 Communicable disease control

4.1 Introduction

Control and eradication of communicable diseases remains a significant public health priority both in Australia and internationally. The problems facing Australia today include:

- sexually transmitted diseases
- bloodborne diseases
- foodborne diseases
- vectorborne diseases and
- vaccine preventable diseases.

New and emerging diseases such as bat lyssavirus and bovine spongiform encephalopathy (commonly referred to as mad cow disease) as well as the threat of an intentional release of a biological agent, also pose potential threats to health that require a public health response (DoHA 2008).

The *Communicable disease control* category includes all services associated with the development and implementation of programs to prevent the spread of communicable disease. The activities reported here relate to the following:

- *HIV/AIDS, hepatitis C and sexually transmitted infections*
- *Needle and syringe programs*
- *Other communicable disease control.*

4.2 Expenditure

Governments spent a total of \$256.7 million on *Communicable disease control* in 2007–08, an increase of \$2.5 million on spending in the previous year. This represented 11.9% of all public health expenditure in 2007–08 (Table 2.5, page 7; Table 4.1).

The majority of this expenditure was directed towards prevention of HIV/AIDS, hepatitis C and sexually transmitted infections.

Table 4.1: Government expenditure on *Communicable disease control*, current prices, 2007–08 (\$ million)

Activity	Australian Government	State and territory governments	Total
HIV/AIDS, hepatitis C and sexually transmitted infections	9.5	102.7	112.2
Needle and syringe programs	0.4	33.7	34.1
Other communicable disease control	27.6	82.8	110.4
Total	37.5	219.2	256.7

Source: AIHW health expenditure database.

Nationally, governments spent, on average, \$12.08 per person on *Communicable disease control* in 2007–08. Average expenditure, per person, was highest in the Northern Territory (\$83.92). The Australian Capital Territory's average (\$21.72) was also well above the national average (Table 4.2). Average expenditures per person in the other jurisdictions were generally clustered around the national average.

Table 4.2: Government expenditure^{(a)(b)} per person on *Communicable disease control*, by state and territory, current prices, 2007–08 (\$)

Activity	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Average ^(c)
HIV/AIDS, hepatitis C and sexually transmitted infections	7.67	3.65	2.34	4.43	5.86	3.78	8.58	28.42	5.28
Needle and syringe programs	1.47	1.53	1.07	3.44	0.71	2.88	3.54	0.68	1.60
Other communicable disease control	3.19	4.35	6.87	4.30	5.54	5.98	9.60	54.83	5.20
Total	12.33	9.53	10.28	12.17	12.11	12.64	21.72	83.92	12.08

(a) Includes expenditure incurred by state and territory governments that is partly or wholly funded by Australian Government SPPs to states and territories.

(b) Includes estimates of direct expenditure by the Australian Government on its own *Communicable disease control* programs. This expenditure has been apportioned across states and territories according to relative share of total population.

(c) Weighted by the annual mean resident population share of each jurisdiction.

Source: AIHW health expenditure database.

Real expenditure on *Communicable disease control* decreased by 2.5% between 2006–07 and 2007–08 (Table 4.3). This movement was in contrast to the average increase over the whole period from 1999–00 to 2007–08 (3.1% per annum). Average growth after 2003–04 (2.0% per annum) was much lower than before 2003–04, when it averaged 4.2% per year.

The highest real growth between 2006–07 and 2007–08 were recorded by the Northern Territory (24.5%) and the Australian Capital Territory (2.9%). Data from both Western Australia and South Australia showed substantial real expenditure decreases in the latest year of –14.3% and –14.9% respectively.

Table 4.3: Government expenditure on *Communicable disease control*, by jurisdiction, constant prices^(a), 1999–00 to 2007–08 (\$ million)

Year	Australian Government	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
1999–00	27.7	72.2	31.7	21.3	15.2	15.2	3.1	3.4	11.3	201.2
2000–01	27.4	69.5	40.3	22.3	15.5	16.0	3.2	4.7	11.5	210.5
2001–02	31.1	83.6	40.0	25.1	15.7	17.0	3.2	5.0	11.1	231.7
2002–03	30.3	83.8	41.6	26.5	15.5	18.6	3.9	4.8	16.5	241.3
2003–04	35.4	67.9	47.2	26.8	15.7	17.2	2.8	5.9	18.4	237.3
2004–05	43.4	79.6	47.0	26.0	17.7	17.0	3.3	6.3	20.0	260.4
2005–06	38.6	81.6	49.9	33.0	20.1	16.9	4.2	6.4	15.8	266.5
2006–07	42.2	72.6	41.4	35.7	26.0	19.4	5.3	6.6	14.3	263.4
2007–08	37.5	73.3	40.9	36.1	22.3	16.5	5.4	6.8	17.9	256.7
Annual growth rate (%)										
2006–07 to 2007–08	-11.0	1.1	-1.2	1.3	-14.3	-14.9	2.3	2.9	24.5	-2.5
Average annual growth rates (%)^(b)										
1999–00 to 2003–04	6.3	-1.5	10.4	5.9	0.9	3.1	-3.0	14.7	13.1	4.2
2003–04 to 2007–08	1.5	1.9	-3.5	7.8	9.1	-1.1	18.2	3.6	-0.8	2.0
1999–00 to 2007–08	3.9	0.2	3.2	6.8	4.9	1.0	7.1	9.0	5.9	3.1

(a) Constant price public health expenditure for 1999–00 to 2007–08 is expressed in terms of 2007–08 prices.

(b) The periods 1990–00 to 2003–04 and 2003–04 to 2007–08 were covered by separate Public Health Outcome Funding Agreements. See Box 2.1 for details.

Source: AIHW health expenditure database.

4.3 Programs and activities

HIV/AIDS, hepatitis C and sexually transmitted infections

National HIV/AIDS Strategy 2005–2008

The National HIV/AIDS Strategy 2005 to 2008 identified five priority areas for action to be addressed over the life of the Strategy:

- development of a targeted prevention, education and health promotion program for HIV
- improving the health of people living with HIV/AIDS
- developing an effective response to the changing care and support needs of people living with HIV/AIDS
- review of the National HIV Testing Policy
- provision of a clearer direction for HIV/AIDS research.

The goal of the National HIV/AIDS Strategy is to reduce HIV transmission and to minimise the personal and social impacts of HIV/AIDS infection. In achieving that goal, the strategy pursues the following objectives:

- reducing the number of new HIV/AIDS infections across the nation, through health promotion, harm minimisation, improved education and awareness of transmission
- improving the health and wellbeing of people living with HIV/AIDS through equitable access to treatments and improved continuum of care
- reducing HIV-related discrimination that impacts upon people living with HIV/AIDS and affected communities in Australia
- developing and strengthening links with related national initiatives.

The state and territory governments and the Australian Government Department of Health and Ageing have provided information on the following initiatives.

State and territory HIV/AIDS initiatives

New South Wales

The *NSW HIV/AIDS Strategy 2006-2010* utilises the National HIV/AIDS Strategy priorities in providing a whole of government framework for preventing HIV and reducing the impact of HIV on individuals and communities in NSW.

Goals of the NSW strategy include reducing the number of new HIV infections, improving the health of the people with HIV/AIDS, reducing discrimination and addressing systematic barriers to HIV health promotion. The strategy identifies priorities for program action and resource allocation and provides the structure for assessing the performance of the HIV/AIDS partnership and broader government and health systems in responding to HIV prevention, treatment and care.

The *NSW HIV/AIDS Strategy 2006-2010* establishes the principles, directions, priorities for HIV/AIDS programs and services in NSW. The strategy is intended to be of use to both HIV/AIDS program funded services, and other health and human services with responsibilities for HIV prevention, and improving health outcomes for people living with HIV/AIDS.

The New South Wales Government policies in this area aim to assist people in relationships with HIV positive partners; people in correctional facilities; and people with intellectual disability or mental illness.

Goals of the strategy include reducing the number of new HIV infections, improving the health of people with HIV/AIDS, reducing discrimination and addressing barriers to HIV health promotion. The strategy involves a 'whole-of-government' approach to achieving goals in the fight against HIV/AIDS across the State and is implemented across all the Government's health services.

Victoria

In Victoria, the *HIV/AIDS Strategy Addendum 2005-09* expanded on the existing state HIV/AIDS framework, the *Victorian HIV/AIDS Strategy 2002-2004*. The addendum comprises the text of the HIV/AIDS Strategy 2002-2004 and a number of additional priority issues including:

- improving the records of Indigenous HIV/AIDS status
- encouraging direct involvement of people with HIV in prevention and education strategies
- considering needs of older adults with HIV
- increasing involvement of culturally and linguistically diverse people in policy and program development
- improving HIV services for those in custodial settings
- providing education and service access to rural and regional areas.

Funded activities included surveillance, health promotion, testing, community support, and clinical services that supported the objectives outlined in the state HIV/AIDS strategy.

Queensland

In Queensland, the strategic direction for the HIV/AIDS program is articulated in the *Queensland HIV, Hepatitis C and Sexually Transmissible Infections Strategy 2005-2011*. In addition to the resources provided for clinical services, funding of \$5.1 million was provided to community-based and other non-government organisations. These resources supported HIV prevention initiatives targeting gay men through the Queensland Association for Healthy Communities; peer support, positive prevention, education and advocacy through Queensland Positive People; and a care coordination program through *Spiritus Positive Directions* facilitating access for people living with HIV to a wide range of clinical services.

Western Australia

The Western Australia HIV/AIDS Action Plan 2006–08 proposed actions to address HIV/AIDS education, prevention, treatment and care of people identified as being in priority target groups.

The government provided funding for the WA AIDS Council, which conducted a range of public health activities throughout 2007–08 to provide services for homosexually active men. The council also undertook research into HIV/AIDS issues and promoted public awareness of HIV/AIDS. It also provided counselling, assistance and education to people living with HIV/AIDS.

During 2007–08, the AIDS Council provided:

- anonymous telephone information and counselling
- face-to-face education and counselling at sex on premises venues, clinics and via outreach projects.
- online education and counselling via the CyberReach Program.

A targeted social awareness campaign was conducted with the Australian Federation of AIDS Organisations to provide education on safe sex norms and risk reduction strategies. Printed safe sex education and referral information was developed and distributed. The council also received funding for the STIGMA research project that aims to increase awareness, knowledge and uptake by general practitioners of the STIGMA clinical guidelines on early diagnosis and treatment.

In 2007–08, the AIDS Council provided support for people living with HIV/AIDS. This included support officers for people living at home or in correctional facilities. The types of support services provided by them included:

- financial and welfare assistance
- medical support
- accommodation
- counselling
- training and facilitating volunteer services
- education and information transference
- life coaching
- assistance with finding employment
- provision of complementary therapies.

The council also provided counselling services for people living with HIV/AIDS.

In 2007–08 Ruah Health Support – a non-profit community services organisation – received financial support from the Western Australia Government. This was provided to assist the operation of a mobile psychosocial support service to people living with AIDS/HIV in metropolitan Perth. Government funding was also provided to the Silver Chain Nursing Service to assist it in coordinating with hospitals to provide home-based clinical care to HIV positive patients.

South Australia

In South Australia, HIV/AIDS expenditure was directed towards health promotion and education programs targeting homosexual and bisexual men.

Funding initiatives included a social marketing campaign consisting of HIV/AIDS preventative messages, an outreach service and community development and education activities focused on HIV awareness. Educational resources addressed new areas for community awareness such as post-exposure prophylaxis. Other projects included implementation of an information service for the general community (including a telephone support line).

Tasmania

Major Tasmanian Government expenditure included collaboration with the Royal Hobart Hospital infectious diseases physicians to provide multidisciplinary services for hospital outpatients diagnosed with HIV. Under the auspices of the Sexual Health Services, \$1.3 million was provided for a state-wide clinical, counselling and educational service, and educational initiatives directed towards supporting best practice, accreditation and education related to pre- and post-HIV test counselling by general practitioners and other health care professionals.

Australian Capital Territory

The strategic plan for addressing sexually transmitted bloodborne disease in the Australian Capital Territory is outlined in the *HIV/AIDS, Hepatitis C Sexually Transmissible Infections: A Strategic Framework for the ACT 2007–12*.

Funding was provided for the development of the Strategic Framework through a consultative process guided by the Ministerial Advisory Council on Sexual Health, HIV/AIDS, Hepatitis C and Related Diseases.

Northern Territory

The Northern Territory Sexual Health Advisory Group was responsible for development of a business plan to address priority needs of all bloodborne virus activities related to sexual health. The business plan links to the national strategy for HIV/AIDS and related national strategies – in particular, the *Aboriginal and Torres Strait Islander Sexual Health and Blood-Borne Virus Strategy*. Northern Territory Government funding in 2007–08 that was in line with that proposed in the business plan and included \$550,000 for the employment of a Sexual Health Physician, two specialist general practitioners (located in Alice Springs and Darwin) and a clinical nurse consultant to provide clinical services to people with HIV and community education and public health support. A further \$140,000 was spent on providing awareness of the risk of contracting HIV/AIDS from unprotected sex when travelling in South-East Asia – this campaign targeted homosexual travellers.

National Hepatitis C Strategy 2005–2008

The *National Hepatitis C Strategy 2005–2008* was developed through a partnership between all levels of government and people with a special interest in the area. This included people affected by hepatitis C as well as medical, scientific and health care professionals involved in treating and studying hepatitis C.

The key priority action areas of the Strategy include:

- enhancing education and prevention efforts related to hepatitis C
- assisting initial and ongoing access to effective treatments for hepatitis C
- improving national hepatitis C surveillance.

State and territory based hepatitis C initiatives

New South Wales

The *NSW Hepatitis C Strategy 2007–2010* provides the principles, directions and priorities for delivery of hepatitis C programs and services. Goals of the strategy include:

- implementing prevention and education strategies to reduce the spread of hepatitis C
- providing equitable access to treatment and support services
- reducing discrimination experienced by people with hepatitis C
- improving the knowledge and skills of health care workers
- increasing the capacity of health services for hepatitis C care and
- improving monitoring, surveillance and research related to hepatitis C.

In 2007–08, \$2.2 million was provided for local activities to increase knowledge and skills for hepatitis C prevention among members of priority populations and for the delivery of treatment and care to individuals with chronic hepatitis C.

Victoria

The Victorian strategic approach to hepatitis C is identified in the *Victorian Hepatitis C Strategy 2002–2004* and *Addendum 2005–2009*. The strategy outlined a ‘whole of government’ response to the issues and guidelines for both public health and acute health care services responses. The addendum comprised of the original text of the second *Victorian Hepatitis C Strategy 2002–2004* and identified five key priority areas:

- prevention and control of hepatitis C transmission
- preventing discrimination and reducing stigma and isolation
- health maintenance, care and support
- research and surveillance
- pharmaceutical treatments.

These were the fields in which the State Government invested funding related to hepatitis C during 2007–08.

Funded activities specifically focused on health promotion, testing, community support and clinical services.

Queensland

The Queensland Government provided over \$1.6 million for the provision of additional resources in the ten liver clinics throughout the state as part of its Hepatitis C Shared Care Initiative. Additional resources were also provided during 2007–08 to fund an independent evaluation of this initiative.

Funds provided support to community-based organisations such as the Hepatitis Council of Queensland and other non-government organisations such as the Ethnic Communities Council of Queensland to support the Queensland Government in the delivery of health promotion, prevention and education initiatives across the state.

Western Australia

WA Hepatitis C Action Plan 2006-2008 provides a framework to reduce transmission and minimise the personal and social impact of hepatitis C within Western Australia. The WA action plan is aligned with the national hepatitis C strategies and the WA Government has funded programs to:

- Reduce transmission of the hepatitis C virus through education, improved awareness of risks and access to harm reduction strategies.
- Maximise the health and well being of people with hepatitis C by providing equitable access to appropriate testing, treatments, information and support services.
- Improve surveillance within the WA community to provide prevalence and incidence data to better identify and monitor hepatitis C prevention and control strategies.
- Reduce the discrimination, isolation and stigma experienced by people with hepatitis C through raising community awareness of hepatitis C and its consequences.
- Support research which informs evidenced based prevention, treatment and support services.

South Australia

In South Australia, major expenditure in the area of HIV/AIDS, hepatitis C and sexually transmitted infections takes place through NGO grant funding program for education and prevention, health promotion, community support and for workforce development. An example of such an educational activity was the development and distribution of a pocket brochure titled *You can have hep C treatment* under the South Australian Government's hepatitis C initiatives.

Australian Capital Territory

In September 2007 the ACT Government released *HIV/AIDS, Hepatitis C Sexually Transmissible Infections: A Strategic Framework*. The framework was developed through a consultative process guided by the Ministerial Advisory Council on Sexual Health, HIV/AIDS, Hepatitis C and Related Diseases and identified local priorities to improve outcomes on these health priorities. Under the framework the Australian Capital Territory Government provided \$98,881 in funding to support the ACT Hepatitis C Council in promoting community awareness of hepatitis C treatments.

Tasmania

The Tasmanian Government provided \$177,000 for two major initiatives. The first was to develop and deliver workshops, focused on hepatitis C, for young adults, non-government organisations and people from culturally and linguistic diverse backgrounds. The second was to produce and provide educational and promotional materials for health care providers.

Northern Territory

The Northern Territory Government provided more than \$1 million to fund the operations of the Northern Territory AIDS and Hepatitis Council. About \$200,000 was spent to employ two clinical nurse consultants and to provide support services with outreach capacity to the Darwin, Alice Springs, Katherine and Tennant Creek communities.

National Sexually Transmissible Infections Strategy 2005–08

The National Sexually Transmissible Infections (STIs) Strategy documented by the Department of Health and Ageing was the first of its kind in Australia.

STIs can result in significant morbidity and can indicate an increase in the risk of HIV transmission. STIs disproportionately affect specific groups of people and these are the focus of the National Strategy. The three specific priority targets of the strategy are:

- STIs in Aboriginal and Torres Strait Islander communities
- STIs in gay and other homosexually active men
- chlamydia control and prevention.

The objectives of the national STIs strategy are to:

- improve government, medical and community awareness of STIs, in particular their economic, social and personal effects.
- establish national coordination on STIs
- increase access to diagnosis, treatment and care of STIs
- minimise the transmission and morbidity of STIs in priority target groups
- improve surveillance and research in order to guide development and implementation of prevention initiatives.

State and territory-based STIs programs

New South Wales

The *NSW Sexually Transmissible Infections Strategy 2006–2009* outlines goals and objectives for the prevention, diagnosis, treatment and management of STIs.

In 2007–08 the State Government provided \$400,000 to the Aboriginal Health and Medical Research Council to undertake a large-scale preventative campaign focused on STIs and HIV. The campaign targeted young Aboriginal people aged between 16 and 30 years. The campaign goals were to increase knowledge about STIs and HIV, to promote condom usage and to increase awareness of and access to STI testing.

Victoria

The Victorian Government released its first *Victorian Sexually Transmissible Infections Strategy 2006–2009* during 2007–08. Its aims are to improve the overall sexual health and wellbeing of all Victorians and to reduce the incidence of STIs in Victoria. The STIs reported to be of particular concern in the state are chlamydia, gonorrhoea and syphilis. These diseases are therefore the primary focus of the strategy.

Population groups at increased risk of STIs and/or who carry a higher burden related to STIs are identified as young people, men who have sex with men, Aboriginal and Torres Strait Islander

people, sex workers and people living with HIV/AIDS. The strategy gives priority to sexual health promotion activities, including testing and treatment for these groups.

The State Government provided funding for surveillance, health promotion, testing, community support and clinical services during 2007–08.

Queensland

In 2007–08 the Queensland Government provided \$3.9 million for clinical services and programs addressing health promotion, prevention, education, research and workforce development initiatives. These initiatives were supported with funded programs delivered through community-based and other non-government organisations targeting groups most at risk of STIs. This funding was in addition to resources provided for sixteen public sexual health clinics.

Western Australia

The goal of the Western Australian *Sexually Transmitted Infections Action Plan 2006–2008* is to reduce the transmission of STIs in WA, with particular reference to STIs other than HIV, through improved awareness and access to appropriate health services.

Using a practical and committed partnership approach, the WA Government provided funding to improve the awareness of STIs, in particular their economic, social and personal impacts, within the government, medical and community sectors. This approach was also used to increase access to diagnosis, treatment and care of STIs, minimise the transmission and morbidity of STIs in identified priority groups and to provide surveillance and research activities in order to guide the development and implementation of prevention initiatives.

In recognition of the burden of STIs within the Aboriginal population, the WA Department of Health has worked toward implementation of the WA Aboriginal Sexual Health Strategy 2005–2008. The strategy aims to improve the sexual health of Aboriginal people living in WA, including through reducing the transmission of STIs and HIV, and increasing the involvement of Aboriginal people in the design and implementation of sexual health services.

South Australia

The South Australian State Government provided funding for an assessment and review of existing sexual health programs in Aboriginal Community Controlled Health Services (ACCHSs) at Port Lincoln, Port Augusta, Yalata, Oak Valley and Ceduna, with the aim of recommending strategies for improving STI management in these Indigenous communities. In 2007–08 the South Australia Government also funded a health promotion and education program targeting sex workers, including sex workers from culturally and linguistically diverse backgrounds.

Australian Capital Territory

ACT Health, through community forums, provided education about the chlamydia profile of the ACT and promoted the work of agencies tackling chlamydia in the ACT. As a result a range of initiatives have been developed to improve chlamydia outcomes in the ACT.

Tasmania

The Tasmanian State Government undertook qualitative research with the nationally identified priority group, young people, to assess knowledge of chlamydia infections. From this, health promotion materials were developed under the theme of 'don't be a fool wrap your tool'. These resources are directed towards 15 – 19 year olds, especially males and encourage safer sex practices and screening for chlamydia. In response to a cluster of syphilis cases collaboration with

NGOs, local government, private enterprise and State government has targeted high risk behaviours in men who have sex with men. The outcomes are to improve knowledge, screening and safer sex practices.

Northern Territory

In 2007–08 the Northern Territory Government provided \$532,000 for the implementation of comprehensive sexual health programs. This funding was provided through grants to Aboriginal Community Controlled Organisations for services in Alice Springs and across the Katherine region. Government funding for the Alice Springs Sexual Health Unit was increased to enable it to provide support for remote STI service delivery (based on the comprehensive '8-ways model') and to support its annual STI/HIV Screen. The Government also provided \$40,000 to fund the Central Australia STI Risk Factor Study. This 8 month project looked at the contribution of a number of behavioural risk factors to the prevalence of STIs in the Indigenous community in central Australia. Findings from the study will inform the development of future treatment policies and guidelines.

Needle and syringe programs

NSPs aim to reduce the transmission of infections – particularly HIV and hepatitis C – that can arise from the shared use of drug injecting equipment. The services offered to injecting drug users include provision of free or affordable sterile injecting equipment and disposal facilities, education and information on reducing drug-related harm, referral to drug treatment, medical care, and legal and other social services.

Such programs operate in all states and territories of Australia, although their nature varies in terms of their:

- being run by government or non-government organisations
- operating as primary outlets (specifically established as stand-alone NSPs) or operating as secondary outlets (incorporated into other health services such as community health centres)
- operating as mobile or outreach services, or making needles and syringes available through vending machines. Needles and syringes may also be available through pharmacies, either on a commercial basis or through a government-funded scheme.

An estimated 32 million needles were distributed in Australia in 1999–2000 through NSPs (DoHA 2002).

Funding for certain NSPs has been provided under the Council of Australian Governments (COAG) Illicit Drug Diversion Initiative.

State and territory NSPs

The aim of state and territory NSPs is to reduce the incidence of bloodborne viruses, other diseases and injury related to drug injecting behaviours. Objectives of the programs include:

- improving access of intravenous drug users to sterile injecting equipment
- facilitating safe disposal of used equipment
- providing intravenous drug users with access and referral to health care and drug treatment programs
- providing confidential access to education and resources.

New South Wales

The New South Wales Government allocated in excess of \$12 million to support the State's NSP during 2007–08. Operating since 1986, the NSW NSP is an evidenced-based public health program that aims to protect the community from the spread of infections such as HIV and hepatitis C among people who inject drugs. The public NSP is coordinated by Area Health Services while the NSW Pharmacy Guild co-ordinates the NSW Pharmacy Fitpack Scheme. As well as performing needle and syringe distribution and disposal services, the educators and counsellors working in the NSP provide education, health promotion and brief interventions, including referrals to drug treatment and other health and welfare agencies, for people who inject drugs.

Victoria

In Victoria, over 250 registered NSPs are operated by state-funded non-government organisations. Services are classified as primary NSPs, which are stand-alone services, or enhanced secondary NSPs that operate within existing organisations such as community health services or hospitals.

NSPs in Victoria have a primary function of providing sterile injecting equipment, such as syringes, needles and alcohol swabs, as well as providing equipment for safe sex (for example condoms and lubricant).

NSPs provide safe disposal equipment; make health care and drug treatment program referrals; liaise with local government authorities, police and welfare agencies; and provide health education.

Primary NSPs are responsible for establishing and maintaining networks of intravenous drug users and pharmacy-based NSPs. Victorian NSPs also provide mobile services, a disposal Hotline, Outreach and Outreach Foot Patrol.

Queensland

The Queensland Government introduced NSPs in 1988 with a primary focus of developing partnerships with the community to respond to its concerns about the inappropriate disposal of used injecting equipment. The NSPs also supply sterile injecting equipment and safe disposal resources.

Queensland NSPs can be classified as either primary programs that are dedicated to the service of intravenous drug users and employ staff whose primary role is the provision of NSP services; secondary programs provided as an adjunct to existing health services; or community pharmacies which provide access to sterile injecting equipment on a commercial basis.

Funding is provided through the Alcohol, Tobacco and Other Drug Branch of Queensland Health to the Health Service Districts within Queensland. In addition, two non-government providers – Youthlink (Cairns) and Youth and Family Services Inc. (Logan) – receive funding from the Queensland Government to support their NSPs.

Western Australia

NSPs in Western Australia are conducted through pharmacies, hospitals and other health services. They operate under the *Guidelines for the Establishment and Operation of a Needle and Syringe Program*.

The WA AIDS Council received state funding to provide NSPs in the Perth metropolitan area while outer metropolitan area NSPs were funded through Commonwealth/State funding arrangements agreed through COAG.

As well as providing safe injecting facilities and equipment, NSPs provided information and education about HIV and other bloodborne viruses to people who inject drugs. This is provided through peer education, outreach, and written information and resources.

In 2007–08 the Western Australian Government funded a review of NSPs. This involved service providers, consumers and other stakeholders and included focus group discussions with NSP workers. Recommendations emanating from this review included:

- expanding the existing training and education programs for staff at secondary NSP sites
- expanding existing guidelines
- developing a new primary NSP site and additional secondary sites
- developing strategies to increase the range of injecting equipment made available to injecting drug users.

The Western Australia Substance Users' Association also received government funding during 2007–08. This is a peer-based service that provides support, counselling and referral services to intravenous drug users and members of the community at high risk of commencing drug injection. The association provides drug education, safe sex education and a fixed site needle exchange service.

South Australia

The South Australian Government provided \$1 million in funding to Drug and Alcohol Services SA for coordination of the state-wide Clean Needle Program (CNP). The CNP provided sterile injecting equipment at no cost to injecting drug users. This aimed to reduce the risk of drug users contracting bloodborne disease and transmission to the broader community. Coordination of the program includes providing equipment, organising syringe disposal, conducting hepatitis C awareness training, providing resources and support to all CNP sites and identifying new sites for CNP services.

Northern Territory

In 2007–08 the Northern Territory Government funded NSPs at a variety of locations. Three primary services were funded at Northern Territory AIDS and Hepatitis C Council and ten secondary NSPs were provided at other government locations including Clinic 34, Northern Territory Emergency Departments and the Ayers Rock Royal Flying Doctor Service. An additional thirteen NSPs were run through commercial businesses, primarily NT pharmacies.

Tasmania

Tasmanian NSPs can be classified as either stand-alone primary programs; secondary programs – within existing organisations; or community pharmacy-based programs. The Tasmanian Government provided more than \$1 million in 2007–08 to support NSPs.

In 2007–08, Tasmania had seven primary NSPs, one of which was operated by the Department of Health and Human Services (funded with Australian and Tasmanian State Government funding). The remaining six were provided through non-government organisations. Sixteen secondary NSPs were conducted in a variety of facilities – including

- hospitals
- community health centres
- community houses
- multi-purpose centres

- alcohol and drug service centres and
- Aboriginal centres.

In addition, two syringe vending machines were introduced in major metropolitan centres.

The State Government's funding for NSPs was in the form of:

- staff salaries
- operational and on-costs
- the purchase, distribution and disposal of injecting equipment.

While most services are provided to intravenous drug users at no cost, NSPs in pharmacies generally charge fees.

Other communicable disease control

National initiatives

Activities under this category mainly related to disease surveillance, biosecurity and pandemic preparedness, and provision of information and referral services. Examples of specific programs funded in 2007–08 were:

- management of the Biosecurity Surveillance System and Syndromic Surveillance System to improve the detection and response to national communicable disease outbreaks
- a major simulation exercise involving all jurisdictions for responding to a pandemic
- continued maintenance of the National Emergency Medicines Stockpile which includes essential vaccines, antibiotics and antiviral drugs to ensure supplies do not run low in response to a bioterrorism incident.

The National Notifiable Disease Surveillance System was established in 1990 under the auspices of the Communicable Diseases Network Australia (CDNA).

The system coordinates the national surveillance of more than 60 communicable diseases or disease groups endorsed by the CDNA. Medical practices and laboratories are required to notify the relevant state/territory health authority when they observe the existence of a notifiable disease. These health authorities then provide reports to DoHA for national collation.

State and territory expenditure

Some jurisdictions identified public health expenditure specific to other communicable diseases including

- pandemic planning
- public education on disease transmission
- research on the spread of other communicable diseases
- screening programs.

In some jurisdictions spending on other communicable diseases does not receive specific funding and is subsumed within spending on activities (for example public health research, sexual health clinics) that is reported under other funded categories.

In Victoria, the State Government funded activities related to a range of other notifiable diseases that would be classified as 'other communicable diseases'. These activities were primarily for the

prevention, surveillance and control of diseases, including tuberculosis and influenza. Funds were made available for the provision of free first and second line treatment medication for people with tuberculosis, as well as for improving public health laboratory testing capabilities and investigation into vaccine-preventable diseases. A key project in 2007–08 was planning and preparedness for pandemic influenza.

The South Australia Government funded to increase the awareness of and compliance with basic hand and respiratory hygiene. SA Health was responsible for the development of educational resource materials titled *Wash, Wipe, Cover: don't infect another!* Funding was also provided for the surveillance of communicable diseases and investigation and management of outbreaks.

The Tasmanian Government spent \$80,000 on the development of a pandemic influenza Local Community Epidemic Protection Plan.

In January 2008 the ACT Government provided funding to support a move to universal leucodepletion of blood supplies. Leucodepletion is the removal of white blood cells from blood component in donated blood supplies. This process reduces the incidence of adverse response to blood transfusion and the risk of transfer of a number of bloodborne diseases. Funding was also provided for a permanent haemovigilance/transfusion nurse to be responsible for providing coordination and leadership in the safe and high quality use of blood and blood products.

The ACT Government also completed and released the *ACT Health Management Plan for Pandemic Influenza* (2007). It outlined the Territory's capacity and planning to respond to pandemic influenza events including standard operating procedures and specific response activities to initiate during an officially declared pandemic. The ACT Government also introduced a *Pandemic Planning Framework* (2007).

Funding for 'other communicable disease' programs in the Northern Territory included some \$550,000 for the Rheumatic Heart Disease Program. This aims to decrease the incidence of rheumatic fever in the Northern Territory by working closely with people diagnosed with the disease. Its goals include providing education and training to community members and health care staff regarding rheumatic disease management.

The Government also spent \$150,000 on a Trachoma Program that provides trachoma control activities in endemic communities throughout the Northern Territory. Significant activity under the program includes training for health care providers in detecting and managing trachoma as well as support for screening activities, particularly in remote Aboriginal communities.

The Northern Territory Government also provides funding to support the Australian Government's illegal fisherpersons project. This supports the tuberculosis screening of illegal fisherpersons (a population identified as having a high incidence of tuberculosis) in the Northern Territory Detention Centre via a chest x-ray and General Practitioner review.

5 Selected health promotion

5.1 Introduction

This activity includes the promotion of population-wide initiatives that foster healthy lifestyles and a healthy social environment, and other initiatives that target health risk factors such as sun exposure, poor nutrition and physical inactivity.

Overall, health promotion is a process that enables individuals and communities to increase control over the determinants of health. This, in turn, can lead to improvement in the overall health of the communities and the health of the individuals that make up those communities. Health promotion strategies can include:

- skill development
- community and organisational development
- mutual support
- environmental change
- legislation and
- public policy advocacy, information, education and social action.

To separate 'health promotion' as a unique category would be inappropriate as health promotion is a core function for all public health. Therefore, this category has been titled *Selected health promotion* to more accurately reflect a collection of organised programs that address targeted health matters.

The following types of health promotion programs are examples of *Selected health promotion* activities:

- healthy settings (for example municipal health planning)
- encouraging healthy weight through nutrition and physical activity
- personal hygiene
- mental health awareness
- sun exposure and protection
- injury prevention (including suicide prevention and prevention of female genital mutilation).

5.2 Expenditure

Governments spent a total of \$366.6 million on *Selected health promotion* in 2007–08 (Table 5.1). This was an increase of \$83.1 million from 2006–07 and resulted in a 24.8% growth for the year.

Expenditure on *Selected health promotion* represented 17.0% of all public health expenditure in 2007–08 (see Table 2.5, page 7).

Table 5.1: Government expenditure on Selected health promotion, current prices, 2007–08 (\$ million)

Activity	Australian Government	State and territory governments	Total
<i>Selected health promotion</i>	87.2	279.4	366.6
Total	87.2	279.4	366.6

Source: AIHW health expenditure database.

Total government expenditure on *Selected health promotion* in 2007–08, nationally, averaged about \$17.26 per person. The Northern Territory, at \$53.82, had the highest of all the state and territory averages. Victoria (\$24.26) and South Australia (\$18.91) were also above the national average. New South Wales (\$12.38) had the lowest average expenditure per person (Table 5.2).

Table 5.2: Government expenditure^{(a)(b)} per person on Selected health promotion, by state and territory, current prices, 2007–08 (\$)

Activity	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Average ^(c)
<i>Selected health promotion</i>	12.38	24.26	14.92	14.77	18.91	16.23	23.62	53.82	17.26
Total	12.38	24.26	14.92	14.77	18.91	16.23	23.62	53.82	17.26

(a) Includes expenditure incurred by state and territory governments that is partly or wholly funded by Australian Government SPPs to states and territories.

(b) Includes estimates of direct expenditure by the Australian Government on its own *Selected health promotion* programs. This expenditure has been apportioned across states and territories according to relative share of total population.

(c) Weighted by the annual mean resident population share of each jurisdiction.

Source: AIHW health expenditure database.

Expenditure on *Selected health promotion* grew at an average of 6.4% per year between 1999–00 and 2007–08. Growth between 1999–00 and 2003–04 was much lower (3.0% per annum) than after 2003–04, when it averaged 9.9% per year (Table 5.3).

Caution should be exercised when drawing inferences from these data. The growth patterns shown seem to indicate there may be quality issues with some of the data – particularly where small levels of expenditure are being examined and compared from year-to-year. For example, the Northern Territory shows a very large drop in expenditure, from \$11.1 million in 2001–02 to \$2.2 million in the following year. This is followed by steady growth each year to \$3.5 million in 2004–05. Expenditure then more than doubled between 2004–05 and 2005–06.

Growth in the latest year examined (that is to say between 2006–07 and 2007–08) averaged 24.8%, nationally. This fluctuated widely from jurisdiction-to-jurisdiction. Expenditure by the Australian Government increased by 77.1% in that year; expenditure by the Western Australian Government, at the other end of the scale, decreased by -11.8% in the year.

Table 5.3: Government expenditure on *Selected health promotion*, by jurisdiction, constant prices^(a), 1999–00 to 2007–08 (\$ million)

Year	Australian Government	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
1999–00	26.2	38.2	78.1	22.6	19.8	12.9	5.2	6.6	13.0	222.6
2000–01	39.8	46.5	77.9	22.8	20.1	12.6	5.7	4.3	12.2	242.0
2001–02	57.6	44.2	82.2	31.1	20.3	15.5	8.4	3.6	11.1	274.0
2002–03	54.5	42.3	79.6	30.5	20.9	15.8	7.7	4.0	2.2	257.5
2003–04	51.6	43.3	75.0	28.2	21.8	16.5	7.1	4.6	2.8	250.8
2004–05	45.4	48.4	76.7	31.5	27.0	15.6	4.4	7.1	3.5	259.7
2005–06	44.8	46.4	79.6	36.6	26.6	15.3	5.0	7.8	8.1	270.1
2006–07	49.2	49.0	90.8	39.7	25.9	16.3	5.5	6.6	10.8	293.7
2007–08	87.2	57.5	106.1	45.9	22.8	23.6	6.0	6.7	10.8	366.6
Annual growth rate (%)										
2006–07 to 2007–08	77.1	17.4	16.9	15.6	-11.8	45.1	9.6	2.0	-0.3	24.8
Average annual growth rates (%)										
1999–00 to 2003–04	18.5	3.2	-1.0	5.7	2.4	6.3	7.9	-8.4	-31.9	3.0
2003–04 to 2007–08	14.0	7.3	9.1	12.9	1.2	9.4	-4.1	9.7	40.2	9.9
1999–00 to 2007–08	16.2	5.2	3.9	9.2	1.8	7.8	1.7	0.2	-2.3	6.4

(a) Constant price public health expenditure for 1999–00 to 2007–08 is expressed in terms of 2007–08 prices.

Source: AIHW health expenditure database.

5.3 Programs and activities

These explanatory notes were provided by the jurisdictional health departments and provide examples of some of their initiatives.

National programs and activities

The Australian Government has a grants program to encourage schools and community groups to conduct healthy eating and physical activity projects. The *Healthy Active Australia* program awards grants to community organisations and schools to conduct healthy eating and physical activity projects in local areas. On 12 October 2007, the Australian Government announced grants for the 320 organisations under the Healthy Active Australia program.

The *National Suicide Prevention Strategy* commenced in 1999 and for the period 2006–07 to 2011–12 it included \$127.1 million in funding. Projects under the strategy target the whole of the population as well as groups identified as being at greater risk of suicide, such as Aboriginal and Torres Strait Islander people, men aged between 20 and 54, people with a mental illness and people living in rural and remote areas. The program also targets those bereaved by suicide who are known to be at higher risk of suicide themselves.

Beyondblue: the national depression initiative is a collaborative initiative funded by the Australian, state and territory governments. It was launched in 2000 and aims to address issues associated

with depression, anxiety and related disorders. It has a key goal of raising community awareness about depression and reducing stigma associated with the illness.

Injury is a major cause of preventable death and disability in Australia. The National Injury Prevention Program aims to reduce the incidence, morbidity and mortality associated with injury across all age groups. The *National Injury Prevention and Safety Promotion Plan (2004–14)* provides a strategic framework for injury prevention and safety promotion with key objectives of the plan including promotion of a positive safety culture and safe public environment in Australia. Priority areas for action under the plan include children, youth and young people, adults, older persons, Aboriginal and Torres Strait Islander people, rural and remote populations and alcohol related injuries. Two other plans exist in conjunction with this plan. The aim of *National Falls Prevention for Older People Plan: 2004* is to work strategically and collectively to reduce the burden and impact of falls and fall related injury among older people. The *National Aboriginal and Torres Strait Islander Safety Promotion Strategy* has been developed to provide a broad strategic framework for preventing injury in Aboriginal and Torres Strait Islander peoples.

State and territory programs and activities

State and territory funding in this category was directed towards a wide range of initiatives. Whilst some funding supported national programs, other funding was provided by individual states and territories for their own initiatives. Healthy eating and exercise/physical activity programs were substantial recipients of state and territory funding in this category. Many projects were targeted towards specific populations such as children.

Children's healthy eating and exercise programs

As they need to meet both their daily activity requirements and their special needs for growth and development, children have unique nutritional requirements. Eating healthy food in the younger years not only assists in meeting these needs but also establishes good habits for life-long healthy eating. As such, many of the states and territories invest in educational and other programs to promote healthy eating and physical activity in children.

New South Wales

In 2007–08 the New South Wales Government invested in a number of initiatives focused on nutrition and physical activity in children and young people. NSW committed \$6.5 million (over 2006–07 to 2010–11) for *Live Life Well @ School* and the *Munch and Move* programs. *Live Life Well @ School* is administered by the NSW Department of Health and the NSW Department of Education and Training. The program provides professional learning opportunities for government primary school teachers so that quality nutrition and physical education programs can be delivered as part of the curriculum.

The *Munch and Move* program is a joint initiative of the NSW Department of Health and the NSW Department of Community Services. It seeks to promote the healthy development of young children by promoting physical activity, healthy eating and reduced small screen recreation (TV, DVD and computer usage). The program offers training for childcare staff, contact with local health promotion professionals, informative resources and practical assistance in incorporating healthy eating activities and active play into day-to-day practice.

Victoria

The Victorian Government provided funding for a program entitled *Kids – Go For Your Life*, designed to reduce the risk of overweight and obesity in children aged 0-12 through the promotion of healthy eating and physical activity. The program is managed by Diabetes Australia and the Cancer Council Victoria. The project is directed at Victorian primary schools and early childhood settings. Schools/services become members of Kids – ‘Go for your life’ and work progressively towards achieving the Kids – ‘Go for your life’ Award. The award program supports and recognises the adoption of policy and practice within children's settings to support physical activity and healthy eating. Key messages of the initiative included to:

- drink water every day
- provide fruit and vegetables in school lunches
- limit ‘sometimes foods’
- engage in daily active play including walking and riding to school and
- turn off the television, electronic games and computers.

The Victorian Government provided financial support for the *Go for your Life* community demonstration program that focuses on healthy eating, obesity reduction and promotion of physical activity. The program includes six community-based projects, four of which have a primary target of children or adolescents.

Queensland

In Queensland, over 100 cross-agency initiatives have been supported under the *Eat Well Be Active – healthy kids for life action plan 2005-2008*. Highlights include:

- *Smart Choices - Healthy Food and Drink Supply Strategy for Queensland Schools* which is mandatory in all situations where foods and drinks are supplied in Queensland schools.
- *Smart Moves - Physical Activity Programs in Queensland State Schools* aims to increase student participation in physical activity and to improve the quality of that activity. Primary school students will participate in at least 30 minutes of daily physical activity and lower secondary school students will participate in at least two hours of physical activity each school week.
- *Physical Activity and Nutrition Outside School Hours (PANOSH)* program assists Outside School Hours Care facilities to promote healthy eating and physical activity. The PANOSH program includes the provision of documents on physical activity and nutrition, culture food and physical activity, food safety and communicating with families.
- *Healthy Kids Queensland survey*. Anthropometry, dietary and physical activity behaviours were measured in a total of 3,691 children aged 5-17 in years 1, 5 and 10 of school with results are used to target a range of intervention programs.

Western Australia

The Western Australian Government provided funding for a range of healthy eating programs for children, including the school-based *Crunch&Sip* program, the Parental Guidance Recommended program to boost parents knowledge and skills to get children eating well and physically active (both delivered by the Cancer Council WA) and a combined healthy school breakfast program and associated nutrition education activities in among children in disadvantaged and regional schools (delivered by Foodbank).

South Australia

The South Australian *Eat Well Be Active Healthy Weight Strategy 2006–10* provides the framework for programs promoting healthy eating and physical activity for children including:

- The *Premier's Be Active Challenge*, a 10-week program in which students (to year 9) accumulate at least 60 minutes of moderate to vigorous activity on at least five days a week.
- The *Start Right Eat Right* award program which recognises long-day child care centres that provide and promote healthy food. At 30 June 2008, of SA's eligible 262 centres, 185 have been trained and 138 have received the award.
- The *Right Bite Healthy Food and Drinks Supply* strategy which aims to ensure government schools and preschools provide and promote healthy food in school canteens.
- *Be Active Playtime* which promotes the development of fundamental movement skills required to support ongoing participation in physical activity across the lifespan through a series of parent child interactive play sessions.

Tasmania

The Tasmanian Government's public health expenditure included support for two children's nutrition programs – the *Move Well, Eat Well* program, run jointly by the Departments of Health and Human Services and Education, and the *Family Food Patch* program. The *Move Well, Eat Well* program is based on the Victorian *Kids – Go For Your Life* initiative, with primary schools registering for participation and achieving certificates, awards and external signage on meeting key criteria related to healthy eating and physical activity. By the end of 2008, around 29% of Tasmanian schools had registered for participation. The *Family Food Patch* program is designed to transfer knowledge of child and infant nutrition and activity requirements to parents. It commenced in 2001 and operates in 25 local Tasmanian communities. It involves training of volunteers, such as parents, community health workers and teachers, to provide community-based education.

Australian Capital Territory

In 2007–08 the Australian Capital Territory Government funded the Kids at Play Active Play and Eating Well project. Delivered through a partnership between ACT Health, ACT Sport and Recreation Services and the Heart Foundation ACT, the project targets children aged birth to 5 years, early childhood sector staff and families of children utilising these services. The project's aims are to:

- create supportive environments in ACT Early Childhood services to promote active play and healthy eating, and to promote these activities to families of children aged birth to 5 years in the ACT
- promote active play and healthy eating through five messages: active play; fruit and vegetables consumption; drinking water; managing screen time; and the benefits of breast feeding.

The ACT Health Promoting Schools Funding Round funded 20 projects in schools and early childhood centres to encourage children and young people to adopt a healthy lifestyle through the development of a supportive school environment. Priority was given to projects which integrated healthy eating and physical activity into teaching and learning programs and school community activities.

Other healthy eating and exercise programs

Victoria

The Victorian Government provided financial support for the *Go for your Life* community demonstration program that focuses on healthy eating, obesity reduction and promotion of physical activity. The program includes six community-based projects, each focusing on different demographics, including one project for working adults and one project conducted in the Indigenous community. Additional funding was ear-marked for the *Life! Diabetes Prevention* program. This is a lifestyle modification program for people at high risk of Type 2 diabetes targeting adults over aged 50, and Aboriginal Victorians of all ages, that includes a telephone support line and an online risk test.

Queensland

The Queensland Government's investment primary prevention supports 148 positions in nutrition, physical activity and Indigenous health across the State to deliver services such as the *Go for 2&5* fruit and vegetable promotion campaign, the *Lighten Up to a Healthy Lifestyle* and other group-based behaviour modification programs, *10,000 Steps* programs and specific programs for Aboriginal and Torres Strait Islanders. Other initiatives supported include the *Eat Well Be Active* social marketing campaign and local level activities, community capacity building funding programs and the development of supportive physical and social environments for healthy eating and physical activity.

Western Australia

The Western Australian Government funded two social marketing campaigns directed at adults. The *Go for 2&5* campaign, managed by the Cancer Council WA, aimed to increase fruit and vegetable consumption. The *Find Thirty* campaign, managed by the Heart Foundation WA, aimed to increase levels of physical activity.

South Australia

The South Australian Government supported a number of initiatives focused on nutrition and physical activity including the *Go For 2&5* Campaign, Healthy Weight Coordinators and *Eat Well Be Active* community programs. The *Go For 2&5* Campaign was supported through \$700,000 in funding and aimed to increase adults' awareness of the need to eat more fruit and vegetables through television, point of sale and radio advertising and promotions; community education material and merchandise; and online resources. Ten Healthy Weight Coordinator positions to implement and evaluate regional Healthy Weight Action plans based on the *Eat Well Be Active Healthy Weight Strategy for SA* were funded at a cost of \$879,500. A further \$480,000 was spent supporting two community programs on in Murray Bridge and one in Morphett Vale. These two linked community projects aimed to build research on effectiveness of multi-strategy community-based healthy eating interventions and to increase healthy eating, physical activity and healthy body image.

The South Australian Government provided financial support (\$311,000) through the Office for Recreation & Sport for three *Be Active* programs - *Be Active Workplace*, *Be Active Play Time* and the *Be Active Campaign*.

Tasmania

The Tasmanian Government provided over \$1 million for Regional and District Health Promotion Coordinators and a further \$544,000 to support community-based nationally-funded ABHI projects promoting healthy lifestyle and supporting lifestyle and risk modification.

Australian Capital Territory

The ACT Government provided \$117,000 in 2007–08 to commence the promotion of the *Find Thirty. It's not a big exercise* social marketing campaign. The aim of the campaign is to encourage adults to find the time for 30 minutes of moderate-intensity physical activity on most days, in order to achieve a health benefit. The ACT Government also continued its commitment to the Go for 2&5 Campaign.

A partnership between the ACT Departments of Education and Health commenced the production of the *Take a Tour of the Markets School Manual*. This resource is linked to the curriculum framework and encourages teachers to take their primary school students on a tour of our local markets to see fresh produce first hand.

The ACT Chronic Disease Strategy provided the opportunity to support the ABHI Measure Up Campaign. Locally initiated strategies supported the national social marketing campaign through direct mail recruitment to 23,000, 45 to 49 year olds in the ACT. This mail out delivered information directly to the campaign's target group and encouraged people at risk to seek advice from their General Practitioner.

Northern Territory

The Northern Territory Government provided \$60,000 in funding to improve participation in physical activity throughout its community through the *GO NT* campaign and \$35,000 to support the national *Go For 2&5* Campaign.

Breastfeeding programs

Queensland

The Queensland Government funded a social marketing campaign to increase breastfeeding duration. Campaign messages have been distributed through a range of mediums including bus shelters, child health clinics, maternity hospitals, Australian Breastfeeding Association networks and a pack received by expectant mothers at their 18 week scan or antenatal visit. The current campaign message is '12+ months on the breast-normal, natural, healthy'. The campaign is supported by a wide range of local level activities and services throughout the state including the *Child health information: Your guide to the first 12 months* booklet which is provided to every new mother in Queensland and *Growing Strong: Feeding You and Your Baby* resources and training for Aboriginal and Torres Strait Islander families.

South Australia

In 2007–08 the South Australia Government provided \$300,000 to the Children, Youth and Women's Health Service to develop and implement a Breastfeeding Communication Strategy. The campaign included development and distribution of promotional material for health and community agencies; support to achieve Baby Friendly Health Initiative (BFHI) accreditation, in

those birthing hospitals and community services which support women post-birth; monitoring of breastfeeding rates; and web-based education for health care professionals to assist BFHI accreditation. The campaign also targeted disadvantaged groups, including Aboriginal and Torres Strait Islander women.

Tasmania

The Tasmanian Government provided financial support to the Tasmanian Breastfeeding Coalition that consists of 19 organisations that work together to promote breastfeeding within Tasmania. Purposes of the coalition include providing supportive breastfeeding environments, engaging key stakeholders in the shared responsibility to promote breastfeeding, promotion of the World Health Organization's International Code of Marketing of Breast-milk Substitutes, and achieving strategic investment in the protection and promotion of breastfeeding.

Australian Capital Territory

The ACT Government committed funds in 2007-08 for the development of a social marketing message and associated resources to promote breastfeeding. This message "Breastfeeding - Good for Baby, Good for Mum" was developed as part of the Kids at Play - Active Play and Eating Well Early Childhood Project. The message aims to inform mothers, mothers-to-be and early childhood staff of the benefits of breastfeeding for mother and baby as well as the long term benefits gained from longer durations of breastfeeding.

Injury prevention projects

Victoria

In Victoria, there are numerous state government funded injury prevention initiatives. Expenditure included funding for Whole of Community projects that enable *Primary Care Partnerships* to work with partners across multiple settings in acute and sub-acute, and public sector residential aged care services. Other funded projects included group exercise and nutrition projects for people aged over 65 years and at risk of falls, home-based exercise and nutrition projects for isolated people over 80 years at risk of falls and staging of the Third National Falls Prevention Conference in Melbourne in 2008. In childhood injury prevention, the *Safestart* program funded and evaluated injury prevention activity through local government.

Queensland

In Queensland, funding of \$1 million per annum for 4 years (2007-11) was committed for the support of research conducted by the Queensland Injury Prevention Council. The council was established in 2007 to act as an authoritative body on injury prevention in Queensland. Additional injury prevention programs funded by the Queensland Government were primarily focused on child injury prevention, falls prevention and poisoning prevention.

Australian Capital Territory

The ACT Government provided funding towards preventing injuries through the *Stay on Your Feet* Falls Prevention Funding Round. This funding allowed residential aged care facilities in the ACT and/or community organisations working with older people to use funds to reduce the incidence and severity of falls and fall injuries among older people within the ACT.

Sun exposure and protection

In 2007–08, the Australian Government provided funding for the National Skin Cancer Awareness Campaign. The campaign was designed to capture the attention of young Australians, and increase their awareness of both their susceptibility to skin cancer through sun exposure and the seriousness of developing skin cancer. The campaign was also designed to increase the acceptability of sun protection behaviours and perceptions that sun protection is normal, socially accepted/endorsed behaviour. The campaign targeted teenagers 13–17 years of age and young adults 18–24 years of age with television, print and radio commercials.

In 2007–08 the Queensland Government provided \$1 million of funding for prevention of skin cancer. Projects supported under this funding included development of a strategic plan of action, a radio-based social marketing campaign and enhancement of a sun safety website. The strategic plan provides a framework for achieving outcomes in the four priority areas:

- research
- development of supportive environments and infrastructure
- communication of skin cancer prevention messages and
- identification of populations most at risk of high levels of ultraviolet radiation exposure.

The ACT Government, through the Health Promotion Grants Program committed \$123,040 in funding to individual projects and through sponsorships of arts and cultural organisations to promote sun protective behaviours and policies. Health Promotion Sponsorships aim to create healthy environments through the use of branding with health promotion messages and encouraging the development of health promoting organisations. The ACT Government supports the Cancer Council's Sun Smart Program which promotes a range of sun protective behaviours including the promotion and provision of shade, the promotion of sun protective clothing, the promotion and provision of sunscreen and the provision of information regarding UV index.

Mental health awareness and promotion

Initiatives in the Indigenous community

The Northern Territory Government provided of \$105,930 for Aboriginal Mental Health Worker Programs. This included funding for Social and Emotional Wellbeing training in regions by the Central Australian Aboriginal Congress Incorporated and for the Ltyentye Apurte Community Aboriginal Mental Health Worker.

New South Wales

Funding was assigned to early identification of mental health issues experienced by women. Screening initiatives are being introduced through maternity, child and family services to promote early identification of mental health problems.

Expenditure also included over \$26 million over 5 years for a 24-hour mental health support telephone access line. The state-wide support line provides telephone advice, triage and referral service staffed by mental health clinicians.

Victoria

The Victorian Government has an agreement with VicHealth for the funding of mental health promotion to create and share knowledge about the social, economic and environmental determinants of community wellbeing and mental health. Among other things, the VicHealth Mental Health and Wellbeing program provided funding for the development and delivery of mental health promotion initiatives and the prevention of mental health problems and disorders. Additional funding was provided to the nationally-funded *Beyondblue* organisation.

Queensland

Expenditure on mental health promotion in Queensland is predominantly focused on the early years, social connectedness and inclusion. One example is the *Social and Emotional Early Development Strategy* project under which a mental health promotion framework for the early childhood education sector and care sector (children, staff, parents and the community) was developed.

The Queensland Government also invested in the mental health promotion campaign, *Be Kind to Your Mind*. In 2007–08 the 2 year pilot phase of this campaign was completed. The program, which involved radio and newspaper advertising to promote the messages of connectedness, help-seeking and work life balance, was conducted in North Queensland with additional support provided by community activities in Townsville, Mount Isa, Moranbah and Innisfail.

South Australia

The South Australian Government provided funding to *Beyondblue*, to work in partnership on a range of activities aimed at assisting to reduce the discrimination associated with depression and anxiety, including promoting the mental health of young people, assisting drought affected communities, engaging various sporting codes to support the prevention of depression and the development of the national post natal depression prevention initiative.

The South Australia Government also provided funding for the annual Mental Health Week that aims to improve community awareness of mental health issues and promote knowledge of mental health support services. Activities included announcement of the annual mental health Dr Margaret Tobin Awards, provision of health literacy resources, seminars and arts and community-based activities.

The *Headroom* project addresses the mental health and wellbeing of young people aged 6-18 years. The program is delivered by Children, Youth and Women's Health Service and aims to develop and implement strategies that contribute to an increase in the mental health literacy of children and young people. *Headroom* includes a comprehensive website with age specific mental health information and resources on issues of concern, details of support services available, as well as looking at skills to address issues commonly experienced by particular age groups. For example, resources for 6 to 12 year olds focus on topics such as bullying, problem-solving, friendship and feelings. Information for young people (12 to 18 years) relates to exams, being different, sexual issues, social and community pressure, body image, loss and grief, chronic health problems and peer pressure. The website also provides resources and education for parents, families and health professionals.

Northern Territory

In the Northern Territory, Government funding focused on suicide prevention included \$100,000 for a Suicide Prevention Co-ordinator and \$80,000 for an Aboriginal Life Promotion Officer. Some \$400,000 was provided for training in suicide prevention for mental health professionals, non-government organisations, police and remote health staff and \$50,000 was provided to support the *Lifeline* suicide prevention telephone support service.

The Life Promotion program that had been operating in central Australia received \$80,000 in funding to expand into Tennant Creek. This program is a suicide prevention program that applies the principles of the LIFE framework defined under the *National Suicide Prevention Strategy*. The life promotion program uses a lifespan framework and in a variety of settings it uses a community-based approach to provide mental health support using existing resources and collaborations.

The Northern Territory Government provided \$150,000 to Anglicare for provision of suicide intervention and awareness training to government, non-government, the general public and targeted communities across the NT. The training program delivered by Anglicare include a two day skills base program (*Applied Suicide Interventions Skills Training*) and a half day Suicide Awareness session, both developed using standardised evidence-based materials and used throughout the world. The programs aim to improve capacity for intervention within the community when someone is displaying suicidal behaviour.

Australian Capital Territory

The ACT Government allocated \$12.6 million for mental health services over four years from 2007–08 in response to identified mental health needs in the ACT community including supported accommodation services, enhanced access to services, additional staff and increased capacity in hospitals.

Mental health promotion activity in the ACT continues to be guided by the *ACT Action Plan for Mental Health Promotion, Prevention and Early Intervention 2006-2008*. The plan's principle message is that mental health promotion is everybody's business and the responsibility of the whole community. A range of new and existing programs operate to enhance the mental health and wellbeing of the whole population, including specific programs for young people, families, women and workplaces.

Funding from the ACT Government enabled the development of the *Beyondblue Workplace Mental Health Promotion Program*. The program is being delivered in nine workplaces across the ACT and is part of a three year research project with the University of Melbourne. ACT Health, in conjunction with VYNE (part of the OzHelp foundation) undertook training to deliver a new training module called Understanding Mental Health and Wellbeing, which was developed by Australian Network for Promotion, Prevention and Early Intervention for Mental Health. This training will be offered to a broad range of people to increase their understanding of mental health promotion.

The ACT Government continues to fund the award winning organisation, Mental Illness Education ACT to deliver education to schools and community groups. The program has been found to be effective in meeting its aims of increasing mental health literacy in young people and reducing negative attitudes towards people with mental health difficulties. This funding enables the ACT community to hold a series of events during National Mental Health Week in an effort to increase the public's understanding of mental illness, encourage the reduction of stigma and discrimination against people living with mental illness, and promote positive mental health.

6 Organised immunisation

6.1 Introduction

Immunisation can protect people against harmful infections that can cause serious complications or even death. Immunisation uses the body's natural defence mechanism, the immune response, to build resistance to specific infections. Immunisation is generally regarded as a highly cost-effective means of reducing morbidity and mortality rates for vaccine-preventable diseases.

In December 2008 the Australian Childhood Immunisation Register coverage reports showed that the proportion of children vaccinated at the highest level appropriate for their age group was above 90% for diphtheria, poliomyelitis, *Haemophilus influenzae* type b, hepatitis B, tetanus, pertussis, pneumococcal disease, measles, mumps and rubella. Nationally, 91.7% of children aged 12 to 15 months and 92.5% of children aged 24 to 27 months were fully immunised by December 2008, compared to fully-immunised rates of 84% and 68%, respectively, in these age groups in December 1998.

The *Organised immunisation* category includes all services associated with the promotion, distribution, provision and administration of vaccines.

Organised immunisation activities are reported here for each of the following categories:

- *Organised childhood immunisation* as defined under the Australian Government's National Immunisation Program (NIP) Schedule
- *Organised pneumococcal and influenza immunisation*
- *All other organised immunisation* programs.

Ad hoc or opportunistic immunisation is not included.

6.2 Expenditure

Governments spent a total of \$704.3 million on *Organised immunisation* in 2007–08 (Table 6.1), an increase of \$268.2 million over the level of spending in 2006–07. Expenditure on *Organised immunisation* was 32.6% of all public health expenditure in 2007–08 (see Table 2.5, page 7).

The total \$268.2 million increase in expenditure on *Organised immunisation* from 2006–07 was largely due to a \$235.8 million increase in SPP funding from 2006–07 levels for the purchase of Human Papillomavirus (HPV) vaccines for the National HPV Vaccination Program. Additionally this increase in funding for the HPV vaccine was responsible for 53.1% of the total \$444.0 million increase in total public health expenditure.

The large increase in expenditure from 2006–07 was due to the national HPV program only commencing in late 2006–07, so 2007–08 was the first full financial year for this program. The expenditure for this program resulted in a substantial increase in expenditure on both organised childhood immunisation and other organised immunisation (Table 6.2).

Table 6.1: Government expenditure on *Organised immunisation*, current prices, 2007–08 (\$ million)

Activity	Australian Government	State and territory governments	Total
Organised childhood immunisation	51.0	434.0	485.0
Organised pneumococcal and influenza immunisation	0.0	47.7	47.7
Other organised immunisation	19.5	152.1	171.6
Total	70.5	633.8	704.3

Source: AIHW health expenditure database.

Table 6.2: Government expenditure on *Organised immunisation*, constant prices^(a), 1999–00 to 2007–08 (\$ million)

Year	Organised childhood immunisation	Organised pneumococcal and influenza immunisation	Other organised immunisation	Total
1999–00	142.3	40.8	17.1	200.2
2000–01	151.8	36.9	28.9	217.6
2001–02	151.9	40.8	28.1	220.8
2002–03	224.0	40.1	43.8	308.0
2003–04	224.6	39.3	48.1	312.0
2004–05	272.0	63.6	44.2	379.8
2005–06	272.5	34.3	38.5	345.3
2006–07	286.2	65.7	99.9	451.8
2007–08	485.0	47.7	171.6	704.3
Annual growth (%)				
2006–07 to 2007–08	69.4	–27.4	71.8	55.9
Average annual growth rates (%)				
1999–00 to 2003–04	12.1	–0.9	29.5	11.7
2003–04 to 2007–08	21.2	5.0	37.4	22.6
1999–00 to 2007–08	16.6	2.0	33.4	17.0

(a) Constant price public health expenditure for 1999–00 to 2007–08 is expressed in terms of 2007–08 prices.

Source: AIHW health expenditure database.

Government expenditure on *Organised immunisation* in 2007–08 averaged \$33.15 per person, nationally. The average for the Northern Territory (\$109.63) was over three times the national average. This was largely due to spending on other organised immunisation (\$62.97 per person, compared with a national average of \$8.08) and, to a lesser extent organised childhood immunisation (\$37.68 compared to \$22.83 nationally). The averages for other states and territories were generally around the national average, ranging from \$28.99 in South Australia to \$38.96 for the Australian Capital Territory (Table 6.3).

Table 6.3: Government expenditure^{(a)(b)} per person on *Organised immunisation*, by state and territory, current prices, 2007–08 (\$)

Activity	NSW	Vic	Qld	WA	SA	Tas	ACT ^(c)	NT	Average ^(d)
Organised childhood immunisation	15.51	28.78	30.19	20.57	20.39	13.79	17.71	37.68	22.83
Organised pneumococcal and influenza immunisation	2.94	0.46	1.14	5.70	2.38	2.76	1.95	8.98	2.25
Other organised immunisation	13.60	3.36	2.22	4.95	6.23	18.67	19.30	62.97	8.08
Total	32.05	32.60	33.56	31.22	28.99	35.23	38.96	109.63	33.15

(a) Includes expenditure incurred by state and territory governments that is partly or wholly funded by Australian Government SPPs to states and territories.

(b) Includes estimates of direct expenditure by the Australian Government on its own *Organised immunisation* programs. This expenditure has been apportioned across states and territories according to relative share of total population.

(c) ACT expenditure includes expenditures for NSW residents not included in the denominator.

(d) Weighted by the annual mean resident population share of each jurisdiction.

Source: AIHW health expenditure database.

Expenditure on *Organised immunisation* increased from \$451.8 million in 2006–07 (2007–08 prices) to \$704.3 million in 2007–08. This represented a real growth in expenditure of 55.9% in that year (Table 6.4).

On a jurisdictional basis, growth in expenditure between 2006–07 and 2007–08 ranged from a fall of 43.0% for the Australian Government to a rise of 152.4% for Victoria. However, the Australian Government expenditure of \$70.5 million does not include the \$561.8 million in SPP funding that the Australian Government provided for *Organised immunisation* activities in 2007–08 (Table 2.2).

While the national HPV vaccination program resulted in substantial increases in expenditure for 2007–08, the timing of the expenses relating to this program varied between jurisdictions. As some jurisdictions progressed further with the three dose vaccination course than others in 2006–07, jurisdictional growth rates from 2006–07 to 2007–08 varied considerably.

Over the whole period 1999–00 to 2007–08, growth in expenditure had averaged 17.0% per year. Much of this growth occurred after 2003–04. In the period from 1999–00 to 2003–04, growth in expenditure, nationally, averaged 11.7% per year, compared with an average growth rate of 22.6% after 2003–04.

Growth in expenditure after 2003–04 was higher than in the previous period for all jurisdictions, except New South Wales.

Table 6.4: Government expenditure on *Organised immunisation*, by jurisdiction, constant prices^(a), 1999–00 to 2007–08 (\$ million)

Year	Australian Government	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
1999–00	65.1	42.7	31.3	21.5	11.5	11.5	4.0	4.3	8.2	200.2
2000–01	65.5	49.0	35.0	24.3	13.1	11.7	4.6	5.2	9.1	217.6
2001–02	65.5	51.3	35.4	21.9	16.3	12.1	3.2	4.6	10.6	220.8
2002–03	63.9	68.2	71.2	39.4	24.7	20.9	5.7	5.2	8.6	308.0
2003–04	57.6	98.5	51.1	43.8	23.8	16.3	5.0	6.4	9.4	312.0
2004–05	153.0	88.9	42.3	40.2	17.4	15.1	5.5	5.8	11.6	379.8
2005–06	142.6	69.8	40.7	34.1	20.8	13.1	6.2	4.7	13.2	345.3
2006–07	123.6	114.0	61.1	63.4	30.4	27.7	8.8	6.3	16.6	451.8
2007–08	70.5	199.5	154.2	128.3	59.7	40.9	15.8	12.2	23.1	704.3
Annual growth rate (%)										
2006–07 to 2007–08	–43.0	75.0	152.4	102.3	96.6	47.6	80.2	95.1	39.4	55.9
Average annual growth rates (%)										
1999–00 to 2003–04	–3.0	23.3	13.0	19.4	19.9	9.3	5.7	10.0	3.6	11.7
2003–04 to 2007–08	5.2	19.3	31.8	30.8	25.8	25.8	33.0	17.7	25.2	22.6
1999–00 to 2007–08	1.0	21.3	22.1	25.0	22.8	17.3	18.6	13.8	13.8	17.0

(a) Constant price public health expenditure for 1999–00 to 2007–08 is expressed in terms of 2007–08 prices.

Source: AIHW health expenditure database.

6.3 Programs and activities

These explanatory notes were provided by the jurisdictional health departments and provide examples of some of their initiatives.

National programs and activities

The Immunise Australia Program (IAP) aims to reduce the incidence of vaccine-preventable diseases and their associated mortality and morbidity by maintaining and increasing high immunisation coverage in Australia. The program is a joint initiative of the Australian Government and state and territory governments, with the involvement of immunisation providers.

The Australian Government provides funding for state and territory governments to obtain vaccines listed on the National Immunisation Program (NIP); monitoring of immunisation uptake conducted through the Australian Childhood Immunisation Register; promotion of immunisation in general practice through the General Practice Immunisation Incentive (GPII) Scheme; immunisation-specific research; and production of immunisation education resources (for example clinical guidelines) for health professionals and consumers.

Organised childhood immunisation

The NIP Schedule, details nationally funded and organised childhood immunisations. The Australian Government's major role is to provide funding to state and territory governments for the purchase of essential vaccines through the Australian Immunisation Agreements. Under the NIP, the Australian Government funds childhood immunisation against diphtheria, tetanus, pertussis, poliomyelitis, pneumococcal disease, measles, mumps, rubella, meningococcal C disease, varicella zoster virus (chickenpox), hepatitis B, *Haemophilus influenzae* type b, rotavirus and human papillomavirus in all Australian children.

Organised immunisation for older Australians

People aged 65 years and older are at high risk from influenza and pneumococcal disease and the complications of these diseases, with a higher rate of death from these conditions occurring in older age groups compared to younger adults and children. Since 2005, the Australian Government has funded free vaccination against influenza and pneumococcal disease for all Australian adults aged over 65 years and Aboriginal and Torres Strait Islander people aged over 50 years.

Organised immunisation for Aboriginal and Torres Strait Islander people

Aboriginal and Torres Strait Islander people aged 50 years and over are at high risk from influenza and pneumococcal disease and the complications of these diseases. Respiratory diseases are major causes of preventable sickness and death in Aboriginal and Torres Strait Islander communities, with some Aboriginal communities having the highest incidence of invasive pneumococcal disease in the world.

Immunisation programs for Aboriginal and Torres Strait Islander people are administered through the NIP and the National Indigenous Pneumococcal and Influenza Immunisation Program. This provides free pneumococcal and influenza vaccines, administered through Aboriginal community controlled health services, state and territory immunisation clinics and general practitioner clinics, for Indigenous people aged over 50 years of age and also those aged between 15 and 48 years who are considered to be at high risk.

In Queensland, Western Australia, South Australia and the Northern Territory an additional booster dose of the pneumococcal vaccine is included in the NIP for Indigenous children aged between 18 and 24 months. This is because Aboriginal and Torres Strait Islander children living in these areas remain at risk of pneumococcal disease for a longer period than other children.

Hepatitis A is also more common among Indigenous children than it is among other children. The NIP schedule in Queensland, Western Australia, South Australia and the Northern Territory includes two doses of vaccine against hepatitis A (administered between 12 and 24 months of age) for all Aboriginal and Torres Strait Islander children.

New national immunisation initiatives in 2007–08

National Human Papillomavirus vaccination program

The HPV vaccine, Gardasil, can prevent infection with four HPV types. Two types cause 7 out of 10 cervical cancers. The other two types cause 9 out of 10 cases of genital warts (DoHA 2007).

In 2007 the Australian Government commenced funding a National HPV vaccination program and 2007–08 was the first full financial year that the program has run. In 2007–08 this program included ongoing funding for the provision of HPV vaccine through school-based immunisation

programs for 12 to 13 year old females. A course of three doses of vaccine is given, usually over a 6 month period. The HPV vaccination program also included catch-up programs for women aged between 12 and 18 who had not completed their vaccination course at school and for females aged between 18 and 26 years, conducted through general practice and community-based programs. In June 2009, the catch-up component of this initiative ceased, however eligible females who had commence their vaccination course have until 31 December 2009 to receive their second and third dose. Activity under the national HPV vaccination program included establishment of the national HPV Vaccination Register, which records HPV vaccinations (not HPV test results) for ongoing monitoring and evaluation.

Rotavirus vaccination program

In Australia, there are about 10,000 hospitalisations due to rotavirus in children less than 5 years of age each year. In addition, an estimated 115,000 children under 5 years of age visit a general practitioner, and 22,000 children require an emergency department visit. On average, there is one death due to rotavirus each year in Australia. In July 2007 rotavirus vaccination was added to the national immunisation program schedule for children born on or after 1 May 2007 and aged between 2 and 6 months.

State and territory programs and activities

Although the purchase of vaccines on the NIP Schedule is funded by the Australian Government under the IAP, state and territory governments are generally responsible for managing the service delivery of this program, including the acquisition and distribution of vaccines for national organised immunisation programs.

Immunisation activities

In 2007–08 the NSW Government spent \$2 million on extending and supporting the NIP through the NSW Immunisation Program. Additional funding was targeted towards maximising protection against vaccine-preventable disease in higher risk groups including infants, adolescents, health care workers and older adults. The initiative has a focus on raising community awareness of, and participation in, immunisation coverage programs. NSW also spent \$1 million in maintaining and improving vaccine distribution. This initiative included provision of resources for general practice to promote cold chain maintenance as well as ongoing monitoring of cold chain practice, the transportation and storage activities conducted within a given temperature range, throughout the state.

In 2007–08 the NSW Government provided \$350,000 in funding to the National Centre for Immunisation Research and Surveillance. The centre was contracted by the NSW Government to undertake state-specific research to identify population groups with sub-optimal immunisation coverage, determine barriers to immunisation uptake within NSW, and identify specific risks associated with poor immunisation coverage.

Health care worker immunisation schemes

In 2007–08 New South Wales, Victoria, Queensland and South Australia Governments all funded schemes to vaccinate health care personnel. Such schemes generally cover clinical personnel in acute hospitals, particularly those in contact with persons at high risk, such as pregnant women and babies. In some states the schemes also provided cover against vaccine-preventable diseases for aged care workers.

In 2007–08 the NSW scheme provided protection for health care workers against pertussis, measles, mumps, rubella, varicella, hepatitis B and influenza. In comparison, the schemes funded by the Victorian and South Australian governments were limited to provision of influenza vaccines. The Queensland scheme covered health care workers in the public system.

Refugee immunisation programs

In 2007–08 the New South Wales, Queensland and South Australian Governments provided funding to promote a coordinated approach to the assessment and delivery of immunisation services for newly arrived refugees. Programs in these states aimed to increase accessibility to resources, including administrative support, interpreter services and purchase of vaccines.

Surveillance and related activities

In 2007–08 the Victorian Government established and funded the *Surveillance of Adverse Events Following Vaccination in the Community* service. This is a specialist service with a role in promotion of immunisation, development of education resources and provision of clinical support to health providers. The service includes clinics for children and adults with a history of significant adverse events following immunisation. A primary goal of this initiative is to monitor and analyse adverse events following immunisation in order to increase understanding about the factors leading to such adverse events, to prevent adverse events and to increase consumer confidence in the efficacy and safety of immunisation.

The New South Wales Immunisation Program conducts annual population-based surveys (for example assessment of the over-65's influenza and pneumococcal program); state-wide surveillance and reporting of adverse effects following immunisation; and development of strategies to minimise wastage of vaccines.

7 Environmental health

7.1 Introduction

The National Environmental Health Strategy embraces the World Health Organization (WHO) definition of environmental health. According to WHO, '*Environmental health addresses all the physical, chemical, and biological factors external to a person, and all the related factors impacting behaviours. It encompasses the assessment and control of those environmental factors that can potentially affect health. It is targeted towards preventing disease and creating health-supportive environments.*' (WHO 2009)

The above definition, used in this report, excludes behaviour related to the social and cultural environment, and genetics.

Improvements environmental health such as those in sanitation, drinking water quality, food safety, disease control and housing conditions have been central to many improvements in quality of life and longevity experienced over the last hundred years.

7.2 Expenditure

Governments spent a total of \$95.5 million on *Environmental health* in 2007–08 (Table 7.1), an increase of \$7.4 million compared with the previous year. This represented 4.4% of all public health expenditure in 2007–08 (see Table 2.5, page 7).

Table 7.1: Government expenditure on *Environmental health*, current prices, 2007–08 (\$ million)

Activity	Australian Government	State and territory governments	Total
<i>Environmental health</i>	19.6	75.9	95.5
Total	19.6	75.9	95.5

Source: AIHW health expenditure database.

Total expenditure in 2007–08 equated to about \$4.50 per person on average. Per person expenditure was highest in those jurisdictions with the smallest populations – the Northern Territory (\$25.70 per person), the Australian Capital Territory (\$10.93) and Tasmania (\$10.53). The states with the lowest per person expenditures were those with the largest populations (New South Wales (\$3.39 per person) and Victoria (\$2.64)) (Table 7.2).

Table 7.2: Government expenditure^{(a)(b)} per person on *Environmental health*, by state and territory, current prices, 2007–08 (\$)

Activity	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Average^(c)
<i>Environmental health</i>	3.39	2.64	5.65	5.95	4.27	10.53	10.93	25.70	4.50
Total	3.39	2.64	5.65	5.95	4.27	10.53	10.93	25.70	4.50

(a) Includes expenditure incurred by state and territory governments that is partly or wholly funded by Australian Government SPPs to states and territories.

(b) Includes estimates of direct expenditure by the Australian Government on its own *Environmental health* programs. This expenditure has been apportioned across states and territories according to relative share of total population.

(c) Weighted by the annual mean resident population share of each jurisdiction.

Source: AIHW health expenditure database.

Real expenditure on *Environmental health* increased by 4.7% between 2006–07 and 2007–08. This was generally in line with average growth over the period from 1999–00 to 2003–04 (5.0% per year). Average growth after 2003–04 was lower at 0.7% per year (Table 7.3).

In all jurisdictions, other than Victoria and Queensland, average annual growth in expenditure was lower after 2003–04 than it had been up to 2003–04.

Two jurisdictions had negative growth over the final year – Northern Territory (–8.3%); and Victoria (–3.5%). The highest annual growth rates from 2006–07 to 2007–08 were recorded by Tasmania (18.3%) and Queensland (13.1%).

Table 7.3: Government expenditure on *Environmental health*, by jurisdiction, constant prices^(a), 1999–00 to 2007–08 (\$ million)

Year	Australian Government	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
1999–00	18.6	9.7	3.9	13.1	13.6	7.4	3.4	1.9	4.8	76.4
2000–01	18.7	13.9	4.1	14.9	14.0	7.7	3.3	2.5	4.6	83.7
2001–02	18.8	18.8	4.4	14.4	14.9	8.0	3.6	2.6	4.5	90.0
2002–03	16.0	17.7	5.3	15.7	14.6	7.9	3.7	2.9	5.3	89.1
2003–04	22.3	14.3	5.7	15.4	14.3	6.8	4.6	3.3	6.1	92.8
2004–05	19.1	16.2	6.2	16.0	12.9	6.8	5.4	3.1	8.0	93.6
2005–06	16.2	18.4	9.2	17.0	11.9	6.5	3.6	2.9	5.9	91.7
2006–07	19.5	16.0	9.4	17.7	10.7	4.9	4.0	3.2	5.9	91.3
2007–08	19.6	17.2	9.0	20.0	10.8	5.3	4.8	3.4	5.4	95.5
Annual growth rate (%)										
2006–07 to 2007–08	0.3	7.0	–3.5	13.1	0.7	9.2	18.3	8.7	–8.3	4.7
Average annual growth rates (%)										
1999–00 to 2003–04	4.6	10.1	9.6	4.2	1.2	–2.0	8.2	14.2	6.3	5.0
2003–04 to 2007–08	–3.2	4.6	12.2	6.7	–6.8	–5.8	0.8	1.0	–3.0	0.7
1999–00 to 2007–08	0.6	7.3	10.9	5.5	–2.9	–3.9	4.4	7.4	1.5	2.8

(a) Constant price public health expenditure for 1999–00 to 2007–08 is expressed in terms of 2007–08 prices.

Source: AIHW health expenditure database.

7.3 Programs and activities

These explanatory notes were provided by the jurisdictional health departments and provide examples of some of their initiatives.

National programs and activities

The Australian Government provides funding for the Australian Radiation Protection and Nuclear Safety Agency (ARPANSA) and the Therapeutic Goods Administration (TGA). ARPANSA has responsibilities protect the health and safety of people, and the environment, from the harmful effects of ionising and non ionising radiation while the TGA carries out a range of assessment and monitoring activities to ensure therapeutic goods available in Australia are of an acceptable standard respectively.

The *National Environmental Health Strategy 2007–12* was approved by the Australian Health Ministers' Advisory Council's Australian Health Protection Committee (AHPC) in October 2007. The strategy provides direction for environmental health management across Australia and identifies the Australian environmental health sector's role in developing and supporting infrastructure for health protection.

The key environmental health risks in Australia to be addressed by the *National Environmental Health Strategy 2007–12* include:

- Emergencies and disasters

- Climate change
- Increasing pressure on drinking water supplies
- The intensity of urban development
- The lack of effective environmental health infrastructure in Aboriginal and Torres Strait Islander communities.

Responsibility for implementing this strategy rests with the Environmental Health Committee (enHealth) of the AHPC.

State and territory programs and activities

State and territory governments had varied priorities for environmental health programs and activities in 2007–08. Major state/territory expenditure in this category included funding related to climate change (for example research on heatwaves and heat-related illness and death), water fluoridation, radiation protection and development and implementation of environmental monitoring schemes, such as water quality testing and monitoring of contaminated sites. There was a wide range of other environmental public health initiatives, including:

- malaria control strategies and education
- shellfish quality assurance
- training of environmental health officers
- Indigenous environmental health projects
- legislation review, including stakeholder consultation
- lead level monitoring.

Climate change

The Victorian Government provided funding for research into the health-related impact of climate change. Because climate change is expected to increase the frequency and intensity of heatwaves in Victoria, which are likely to increase the incidence of heat-related illness and death, environmental health expenditure in 2007–08 included support of the *Victorian Heatwave Strategy*. The strategy objectives included conducting research on heatwaves and their impact, assisting local councils to develop heatwave plans, and raising community awareness. Research on the impact of heatwaves on specific populations (for example the elderly and homeless persons) and health professional awareness was conducted. A trial heat alert system was developed, and throughout 2008 a total of thirteen pilot programs were undertaken with the aim of developing and incorporating programs into existing local government processes. The South Australian Government funded a similar project related to heatwaves that included research on the impact of air pollution in heat-related stress.

Water fluoridation

Water fluoridation is the most effective means of achieving community-wide exposure to fluoride for the prevention of dental cavities. More than 80% of Australians have optimally fluoridated water. In 2004 all Australian health ministers endorsed Australia's *National Oral Health Plan 2004–13* that included recommendations on the extension of water fluoridation throughout Australia.

In Victoria, more than 75% of the population drink fluoridated water. Over 2007–08 state expenditure contributed to the introduction of water fluoridation in some rural and regional areas, as well as distribution of educational material to the public in these regions.

In December 2007, the Queensland Government announced its intention to invest \$35 million over 5 years to introduce water fluoridation to address the high levels of tooth decay identified in Queensland children and adults. Public health expenditure for 2008 was \$1.5 million and was directed towards a multi-media public information campaign to inform the Queensland public of the benefits associated with water fluoridation and consultation with key stakeholders regarding the rollout of water fluoridation. Additional funding for managing recycled and drinking water quality was directed towards improving operational and laboratory capabilities and introducing new regulatory requirements, including water quality standards.

In Tasmania, \$1 million was expended on fluoridation of water in 2007–08. As a result, in 2008, 83% of the Tasmanian population had access to fluoridated water.

Indigenous environmental health programs

In 2007, Queensland Government expenditure on environmental health included \$2 million on Animal Management Programs for Aboriginal and Torres Strait Islander communities. The main components of the community based program include: employment of local animal management workers; control of domestic and feral animals; and a Certificate II training course specifically tailored to the needs of Aboriginal and Torres Strait Islander local governments facilitated by the Queensland Rural Industry Training Council.

This was an initiative from '*Supporting Animal Management by Aboriginal Local Governments and Torres Strait Island Councils - The Queensland Government Action Plan 2005-2009*'.

The South Australian Government spent \$200,000 on a range of environmental health projects conducted in remote Aboriginal communities which are not incorporated into local council areas. A large amount of this funding was directed towards the *Fixing Houses for Better Health* program. The Australian Capital Territory Government provides similar funding to promote availability of appropriate and safe housing for Indigenous communities within the jurisdiction.

In the Northern Territory, Government environment health expenditure included the *No Germs On Me* campaign. Infectious diseases are the leading cause of hospitalisation for Aboriginal and Torres Strait Islander children and create a substantial health burden within Indigenous Northern Territory communities. Rates of infection are many times higher than in the non-Indigenous population. The aim of the *No Germs On Me* campaign is to determine the most appropriate interventions to reduce the transmission of organisms associated with diarrhoea, skin sores and respiratory diseases in Northern Territory Indigenous communities and develop strategies to implement these interventions. Throughout 2007 and 2008 components of the program have focused on community development and implementation of social marketing strategies to promote the benefits of routine hand washing and safe disposal of children's faeces.

Public education

In Queensland, environmental health expenditure included \$265,000 towards an Asbestos Awareness Campaign that coincided with the introduction in June 2007 of legislative changes relating to the removal, disposal and cleaning of asbestos. The 3-month awareness campaign communicated the risk of asbestos and the new laws via television, radio, print media and a website. Public resources included a 1300 telephone information line and an information

booklet available on the website or in print that detailed information on asbestos and responsibilities in its handling.

Expenditure by the South Australian Government on environmental health included the development of education resources on a range of relevant topics. In response to an increase in reports of *Cryptosporidiosis* infections in public swimming facilities, material on the management of water quality in swimming pools was developed. A *Drought Response* package was developed to facilitate safe and hygienic water reuse, including guidelines on transport of recycled water, purposes for which grey water can safely be used and safety consideration for storage of recycled water. Funding continued for the state's seasonal arbovirus prevention program that includes a media awareness campaign as well as printed and digital educational resources.

Lead level monitoring

Due to long term smelting activities in the region, the Port Pirie community is exposed to high levels of lead. In partnership with the Port Pirie Regional Council, Environment Protection Agency and Nyrstar Smelter, South Australia Department of Health is focused on reducing lead exposure and raising public awareness about the risks associated with lead exposure. Government expenditure on this project was directed towards analysis of blood lead level data and lead levels in air, as well as ongoing research into the impact of meteorology and resident location relative to the smelter on children's blood lead levels and lead levels in the air.

The Queensland Government commenced a study of Mount Isa children between one and four years old in order to determine blood lead levels in this age group. This study was conducted due to increasing interest in lead levels from the general Mount Isa community. The main aims of the study were to identify children who had elevated blood lead levels, to work with the families of these children to reduce their blood lead level, and provide key data to drive further community action.

Shellfish quality assurance

In 2007-08 the Tasmania Government spent \$325,000 on the *Shellfish Quality Assurance Program*. Consumption of bivalve shellfish (for example oysters, scallops and mussels) poses a public health risk if they are harvested from polluted waters. Since its implementation in the 1980s the Tasmanian *Shellfish Quality Assurance Program* has ensured that shellfish are only harvested from unpolluted waters. The program requires annual sanitation surveys, ongoing bacteriological and biotoxin monitoring, continuous environmental monitoring, chemical residue testing and development and implementation of an annual plan to manage commercial shellfish environments.

Pollen counting

In ACT, one of the major initiatives in 2007-08 under the environmental health category has been the establishment of a pollen-counting and warning program. Expenditure included the procuring and instalment of pollen-counting equipment and training staff in the counting of pollens.

8 Food standards and hygiene

8.1 Introduction

The food standards and hygiene category includes all activities relating to the development, review and implementation of food standards, regulations and legislation as well as the testing of food by regulatory agencies.

8.2 Expenditure

Governments spent a total of \$38.6 million on *Food standards and hygiene* in 2007–08 (Table 8.1), an increase of \$4.1 million compared with the previous year. This represented 1.8% of all public health expenditure in 2007–08 (see Table 2.5, page 7).

Table 8.1: Government expenditure on *Food standards and hygiene*, current prices, 2007–08 (\$ million)

Activity	Australian Government	State and territory governments	Total
<i>Food standards and hygiene</i>	18.9	19.7	38.6
Total	18.9	19.7	38.6

Source: AIHW health expenditure database.

Total government expenditure on *Food standards and hygiene* in 2007–08 equated to \$1.82 per person on average. Government expenditure per person was the highest in the Australian Capital Territory (\$8.99), followed by the Northern Territory (\$5.37) with per person expenditure in the other jurisdictions ranging from \$1.41 (Queensland) to \$2.42 (South Australia) (Table 8.2).

Table 8.2: Government expenditure^{(a)(b)} per person on *Food standards and hygiene*, by state and territory, current prices, 2007–08 (\$)

Activity	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Average ^(c)
<i>Food standards and hygiene</i>	1.60	1.48	1.41	2.22	2.42	1.92	8.99	5.37	1.82
Total	1.60	1.48	1.41	2.22	2.42	1.92	8.99	5.37	1.82

(a) Includes expenditure incurred by state and territory governments that is partly or wholly funded by Australian Government SPPs to states and territories.

(b) Includes estimates of direct expenditure by the Australian Government on its own *Food standards and hygiene* programs. This expenditure has been apportioned across states and territories according to relative share of total population.

(c) Weighted by the annual mean resident population share of each jurisdiction.

Source: AIHW health expenditure database.

Expenditure on *Food standards and hygiene* grew by 8.1% between 2006–07 and 2007–08. Annual growth in expenditure on *Food standards and hygiene* averaged 1.9% over the period 1999–00 to 2007–08. The jurisdictions with the highest expenditure growth from 2006–07 to 2007–08 were Tasmania (54.6%), Western Australia (25.3%) and the Northern Territory (16.9%) (Table 8.3).

Table 8.3: Government expenditure on Food standards and hygiene, by jurisdiction, constant prices^(a), 1999–00 to 2007–08 (\$ million)

Year	Australian Government	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
1999–00	14.8	5.9	3.1	2.0	2.2	1.6	0.1	2.2	1.3	33.2
2000–01	21.4	9.4	4.0	2.4	2.2	1.9	0.2	2.3	1.3	45.1
2001–02	18.9	8.9	3.0	2.5	2.4	1.5	0.3	2.4	1.0	41.0
2002–03	16.1	9.3	3.4	3.5	2.4	2.1	0.3	2.7	0.9	40.8
2003–04	17.0	8.8	3.8	3.6	2.5	1.6	0.2	2.8	0.9	41.2
2004–05	15.8	5.5	3.4	4.2	2.5	1.5	0.3	2.7	1.0	36.8
2005–06	16.2	7.6	2.2	4.1	2.1	1.3	0.3	2.4	0.7	36.9
2006–07	17.2	5.4	2.7	2.2	2.3	2.2	0.3	2.6	0.8	35.7
2007–08	18.9	4.9	3.1	2.2	2.9	2.4	0.5	2.8	1.0	38.6
Annual growth rate (%)										
2006–07 to 2007–08	10.1	-8.4	13.3	-0.5	25.3	8.6	54.6	6.7	16.9	8.1
Average annual growth rates (%)										
1999–00 to 2003–04	3.6	10.5	5.1	15.1	3.2	1.0	17.3	6.9	-10.0	5.5
2003–04 to 2007–08	2.7	-13.6	-4.9	-11.6	3.8	10.2	30.5	-0.4	2.8	-1.6
1999–00 to 2007–08	3.1	-2.3	0.0	0.9	3.5	5.5	23.7	3.2	-3.8	1.9

(a) Constant price public health expenditure for 1999–00 to 2007–08 is expressed in terms of 2007–08 prices.

Source: AIHW health expenditure database.

8.3 Programs and activities

These explanatory notes were provided by the jurisdictional health departments and provide examples of some of their initiatives.

National programs and activities

Food Standards Australia New Zealand (FSANZ, formally the Australia and New Zealand Food Authority) is the government body responsible for developing food standards for Australia and New Zealand.

FSANZ develops food standards after consulting with other government agencies and stakeholders. The recommendations made by the body are open and accountable, and based upon a rigorous scientific assessment of risk to public health and safety. The ultimate goal of FSANZ is a safe food supply and well-informed consumers.

OzFoodNet

The Australian Government established OzFoodNet in 2000 as a collaborative initiative with state and territory health authorities to provide better understanding of the causes and incidence of foodborne disease in the community and to provide an evidence base for policy formulation. It is overseen by the Communicable Diseases Network Australia, and is supported by technical

assistance from the National Centre for Epidemiology and Population Health at the Australian National University, FSANZ and the Public Health Laboratory Network.

OzFoodNet analyses data on foodborne diseases in Australia. These analyses enable the network to identify outbreaks linked to particular infections, and to help health departments to detect problems with food or water safety.

State and territory programs

Administration of food safety and hygiene varies between the states and territories and therefore is not reported under government public health expenditure for all jurisdictions. For example, in NSW the Department of Health has no role in the food safety and hygiene administration and implementation activities of the state. In the Northern Territory, only a small component of food safety is administered by the Department of Health and Families. In other jurisdictions food safety is a responsibility of health departments.

The South Australian Government also incurred expenditure in implementing systems for a new food safety standard for food services provided to vulnerable populations. New food standards required development and implementation of a food safety auditor training, approval and management system; introduction of food auditing programs in public hospitals and mobile meal delivery organisations; and providing education and advice to food businesses and local governments.

Victoria

Expenditure by the Victorian Government on food safety and hygiene was directed towards development, review and implementation of food standards, regulations and legislation. Activities funded by the Victorian Government in 2007–08 included enforcement of food labelling requirements; testing of food samples in disease outbreaks and product recalls; and providing education to businesses and consumers on food safety. The Victorian Government also provided funding for a state food safety advice hotline that receives about 4,000 enquiries per year.

Western Australia

Expenditure on food safety and hygiene by the Western Australian Government increased from 2006–07 primarily as a consequence of the introduction of new piece of legislation to regulate food production. The new food regulatory model represents a shift to the management of food safety in Western Australia. Guidance and support was provided to local governments, food industry and key stakeholders to assist with the transition to the outcome based approach.

In addition, Western Australian expenditure on food safety and hygiene included the continued auditing of primary food production for food standards compliance, the management of the *Seafood Quality Assurance Program*, the coordination of a number of state-wide food sampling surveys and continued support of the Local Health Authorities Analytical Committee food sampling scheme. Two food monitoring surveys were also undertaken in this period: the poultry baseline survey and the fruit and vegetable survey, which resulted in expenditure in excess of \$400,000.

South Australia

The South Australian Government expenditure on food safety and hygiene included confirmation of compliance surveys. Surveys of food standards compliance were conducted to ensure the safe preparation, handling and labelling of various foods considered to be of particular concern to

public health. In 2007–08 South Australia completed major surveys on food handling; microbial quality of soft serve ice cream, fresh chicken, eggs and uncooked fermented meat.

Tasmania

The Tasmanian Government food safety and hygiene expenditure included \$128,000 for nutritional status testing and sampling. This expenditure was related to the state's *Iodine Supplementation Program*, in which iodised salt is used for bread production to address iodine deficiency in the Tasmanian population. The Tasmanian Government provided \$40,000 for a review of Department of Health and Human Services-funded food safety programs in facilities providing food to vulnerable people. An additional \$20,000 was also provided for training of food service staff within these facilities.

Northern Territory

The Northern Territory *Food Safety Program* includes the *Food Sampling Program*. A key role of the food sampling program is administering and implementing a comprehensive food monitoring and surveillance program that includes compliance checking and food-sampling. Activities of the program include detection of illegal food colouring, flavouring and preservatives and monitoring the safe preparation and distribution of food. The program also administers territory involvement in national food sampling programs.

Queensland

In Queensland, changes to the legislation governing food businesses required the introduction of new food safety personnel and programs in 2007–08. New requirements included introduction of a food safety supervisor in all food businesses covered by the *Food Act (2006)*, Queensland Health approved food auditors and food safety programs and guidelines for high risk food handling activities. The Queensland Government provided funding for training courses; maintenance of a register of approved food safety auditors; and to assisted food businesses and local governments in meeting new legislative requirements.

Australian Capital Territory

Also following legislation changes, food businesses in the ACT defined as being of high risk to public health safety (for example providing food to vulnerable people) were required to introduce food safety programs. These programs require systematic identification of risks and hazards in handling food, and the implementation of controls for, and ongoing monitoring of, these risks. The ACT Government provided financial support throughout 2007–08 to assist businesses to comply with new requirements.

9 Screening programs

9.1 Introduction

Screening is a strategy used in a population to detect a disease in individuals without signs or symptoms of that disease. Unlike most medicine, in screening, tests are performed on those without any clinical indication of disease.

The intention of screening is to identify disease early, thus enabling earlier intervention and management to reduce mortality and morbidity.

The screening categories included in this chapter are:

- *Breast cancer screening*
- *Cervical screening*
- *Bowel cancer screening*

9.2 Expenditure

Governments spent a total of \$289.1 million on *Screening programs* in 2007–08 (Table 9.1). This was up by \$27.2 million on spending in 2006–07, resulting in a 10.4% growth in expenditure. Of note, expenditure on bowel cancer screening increased from \$11.2 million in 2006–07 to \$26.3 million in 2007–08.

Spending on screening programs represented 13.4% of all public health expenditure in 2007–08 (see Table 2.5, page 7).

Table 9.1: Government expenditure on *Screening programs*, current prices, 2007–08 (\$ million)

Activity	Australian Government	State and territory governments	Total
Breast cancer screening	1.3	148.3	149.6
Cervical screening	79.3	33.9	113.2
Bowel cancer screening	19.3	7.0	26.3
Total	99.9	189.2	289.1

Source: AIHW health expenditure database.

Total government expenditure on *Screening programs* in 2007–08 equated to \$13.61 per person. Government expenditure per person was the highest in the Northern Territory (\$34.61), followed by Tasmania (\$17.19) with per person expenditure in other jurisdictions ranging from \$10.39 (Western Australia) to \$14.98 (Queensland) (Table 9.2).

Table 9.2: Government expenditure^{(a)(b)} per person on *Screening programs*, by state and territory, current prices, 2007–08 (\$)

Activity	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Average ^(c)
Breast cancer screening	7.61	6.50	7.88	4.62	6.20	10.27	7.66	7.25	7.04
Cervical screening	4.12	6.29	5.06	4.56	6.36	5.16	5.58	26.08	5.33
Bowel cancer screening	0.91	0.91	2.04	1.21	1.59	1.76	0.91	1.28	1.24
Total	12.64	13.70	14.98	10.39	14.15	17.19	14.14	34.61	13.61

(a) Includes expenditure incurred by state and territory governments that is partly or wholly funded by Australian Government SPPs to states and territories

(b) Includes estimates of direct expenditure by the Australian Government on its own *Screening programs*. This expenditure has been apportioned across states and territories according to relative share of total population.

(c) Weighted by the annual mean resident population share of each jurisdiction.

Source: AIHW health expenditure database.

Real growth in expenditure on *Screening programs* between 2006–07 and 2007–08 was 6.5%. This continued the steady rise in expenditure since 2002–03. Expenditure on *Screening programs* grew in real terms at an average of 2.5% per year over the period 1999–00 to 2007–08. The highest growth rates between 2006–07 and 2007–08 were recorded by the Northern Territory (21.9%), Queensland (18.8%) and South Australia (15.1%) (Table 9.3).

Growth was generally higher after 2003–04 than in the previous period – 1999–00 to 2003–04. This was the same for all jurisdictions, other than Western Australia. Its expenditure averaged 4.3% per year between 1999–00 and 2003–04 and fell to an average of –2.1% per year after 2003–04.

Table 9.3: Government expenditure on *Screening programs*, by jurisdiction, constant prices^(a), 1999–00 to 2007–08 (\$ million)

Year	Australian Government	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
1999–00	81.7	54.2	35.3	29.3	11.2	13.1	4.3	3.4	4.3	236.7
2000–01	83.9	46.2	39.4	29.8	11.5	14.1	4.9	3.4	3.8	237.1
2001–02	85.5	47.5	36.9	30.1	12.6	11.7	4.0	2.5	3.6	234.4
2002–03	77.6	40.3	38.1	29.3	12.8	11.7	5.1	2.3	3.1	220.3
2003–04	78.3	45.5	40.3	29.7	13.3	11.9	4.9	2.3	3.7	229.9
2004–05	88.9	52.3	40.6	30.2	12.8	12.4	5.3	2.3	4.7	249.4
2005–06	84.8	50.6	40.1	32.3	12.0	12.7	5.3	2.5	4.7	245.1
2006–07	97.0	54.5	45.6	36.7	10.9	13.1	5.4	3.0	5.3	271.4
2007–08	99.9	55.1	47.4	43.6	12.2	15.1	6.2	3.2	6.5	289.1
Annual growth rate (%)										
2006–07 to 2007–08	3.1	1.1	3.9	18.8	12.2	15.1	14.3	8.5	21.9	6.5
Average annual growth rate (%)										
1999–00 to 2003–04	-1.0	-4.3	3.3	0.4	4.3	-2.3	3.4	-9.8	-3.3	-0.7
2003–04 to 2007–08	6.3	4.9	4.2	10.0	-2.1	6.1	5.8	9.3	14.9	5.9
1999–00 to 2007–08	2.6	0.2	3.7	5.1	1.0	1.8	4.6	-0.7	5.4	2.5

(a) Constant price public health expenditure for 1999–00 to 2007–08 is expressed in terms of 2007–08 prices.

Source: AIHW health expenditure database.

9.3 Programs and activities

For breast, cervical and bowel cancers, there are national population screening programs in Australia. Their goals are to reduce morbidity and mortality from these cancers through early detection of cancer and pre-cancerous abnormalities and effective follow up treatment.

These explanatory notes were provided by the jurisdictional health departments and provide examples of some of their initiatives.

National programs and activities

The major national programs are:

- BreastScreen Australia, using mammography for screening
- The National Cervical Screening Program, using Pap tests
- The National Bowel Cancer Screening Program, using faecal occult blood tests (FOBT)

BreastScreen Australia

The BreastScreen Australia program is jointly funded by the Australian Government and state and territory governments. It aims to reduce mortality and morbidity from breast cancer by actively recruiting and screening females without symptoms in the target age group 50 to 69 years. The program comprises a network of dedicated screening and assessment services throughout

metropolitan, rural and remote areas of all Australian states and territories. Services are available through both fixed and mobile centres. They provide free 2-yearly mammographic screening and follow-up of any abnormal results identified at screening, to the point of either diagnosis of breast cancer or confirmation of the absence of the cancer. As well as those from the target age group, females aged 40 to 49 years and 70 years and over may use the screening service. Attendance at the service does not require a doctor's referral.

Performance indicators were developed and endorsed for the BreastScreen Australia program by the former National Screening Information Advisory Group and by state and territory BreastScreen programs. The performance indicators cover the areas of participation, cancer detection, sensitivity, ductal carcinoma in situ (DCIS) detection (the most common type of non-invasive breast cancer), recall to assessment and rescreening, as well as incidence of breast cancer and DCIS and mortality from breast cancer in Australia.

National cervical screening program

Screening to detect abnormalities of the cervix has been available for Australian females since the 1960s. However, until the early 1990s this screening was not organised, with no national agreement on either the screening target group or the best interval between screens. In 1991, the Organised Approach to Preventing Cancer of the Cervix was established as a joint initiative of the Australian and state and territory governments. In 1995 it was renamed the *National Cervical Screening Program*. The major goals of this program are to reduce the incidence and mortality of cervical cancer. Cervical screening through Pap tests detects abnormalities of the cervix at an early stage and medical intervention can avert the possible progression to cervical cancer.

The Australian recommendation is that women who have ever been sexually active, whether vaccinated or unvaccinated, should start having Pap tests between the ages of 18 and 20 years, or 1 or 2 years after first having sexual intercourse, whichever is later. Screening may cease at the age of 70 for females who have had two normal Pap tests within the previous 5 years. Females over 70 years who have never had a Pap test or who request one are also screened. For reporting purposes the target group is taken to be all females aged 20–69 years who have not had a hysterectomy.

The number of women in the target group who participated in cervical screening in Australia increased from 2,563,107 in the 2 years 1996 and 1997, to 3,549,524 in 2006 and 2007. The 2-year participation rate in 2006 and 2007 was 61.5% (AIHW 2009).

Unlike breast screening, cervical screening in Australia does not operate through a separate dedicated screening and assessment service. Instead, screening services are provided as part of mainstream health services, with the great majority of Pap tests performed by general practitioners. Patients can claim reimbursement for Pap tests and any subsequent diagnostic follow-up services through Medicare rebates while Pap tests carried out in the public sector (such as sexual health clinics or women's health clinics) are often provided free of charge.

The *National Cervical Screening Program* has both national and state and territory components. Policy is usually decided at a national level in consultation with states and territories, with coordination of screening activity conducted at a state and territory level.

Cervical cytology registries operate in all states and territories. The major functions of the registries are to:

- remind women to attend for screening
- ensure the follow-up of women with abnormal Pap tests
- provide cervical screening histories to laboratories and clinicians to aid reporting and management

- monitor the effects of initiatives to improve participation by women in screening.

National bowel cancer screening program

The National Health and Medical Research Council recommends that organised faecal occult blood test (FOBT) screening of average risk people should commence at 50 years of age, the age after which the risk of developing bowel cancer rises significantly. The Australian Government introduced the *National Bowel Cancer Screening Program* (NBCSP), aimed at reducing the incidence and mortality of bowel cancer through screening to enable early detection of colon and/or rectal abnormalities. Early detection of non-cancerous abnormalities can prompt medical intervention to avert the possible progression to bowel cancer. Where bowel cancer has developed, detection at an early stage makes treatment more effective.

Following a successful pilot program, the NBCSP began in Queensland in August 2006 and was rolled out to other states and territories over a period of 7 months. The program was phased in gradually to ensure that health services, such as colonoscopy and treatment services, were able to meet increased demand. Phase one of the program offered screening to people turning 55 or 65 between 1 May 2006 to 30 June 2008 as well as re-screening of pilot participants. The second phase of the program, which commenced in July 2008, now includes screening for people turning 50, 55 and 65 years of age between 1 January 2008 and 31 December 2010.

Eligible people are invited to participate in the program. The NBCSP *Register* sends invitation packs, including a FOBT kit, directly to eligible Australians. Those who elect to participate in the screening program are asked to post their completed FOBT to the program's pathology laboratory for analysis. Results are sent to the participant, the participant's nominated general practitioner and the register. Participants with a positive result are advised to consult their general practitioner to discuss further assessment.

The NBCSP is coordinated at the national level by the Australian Government Department of Health and Ageing in partnership with the states and territories. The register is maintained by Medicare Australia. The major functions of the register are to:

- invite eligible people to participate in the screening program
- ensure follow-up of those with positive FOBT results
- provide monitoring data to aid reporting and management.

State and territory screening programs

State and territory expenditure in this category is generally to support the implementation of national screening programs, and to promote community awareness of such programs. Funding reported by state and territory governments in this category ranged from grants for the carrying out of screening activities to administrative support for such programs. Government expenditure included the following projects, some of which are outlined in greater detail below:

- The New South Wales Government provided \$32.2 million to Area Health Services to conduct breast screening and assessment; over \$4 million for digital upgrades of breast screening technology; \$2 million in support of cervical screening projects and \$220,000 to support national bowel cancer screening initiatives.
- The Victorian Government funded baseline studies into bowel cancer awareness, attitudes and behaviours. It also provided funding for research and tailored strategies to increase participation of Aboriginal and Torres Strait Islander women and hard to reach women in cervical screening.

- The Queensland Government provided almost \$3 million in funding for the cervical screening programs and over \$4 million providing infrastructure, clinicians and a co-ordinating unit to support the national bowel cancer screening program.
- The Western Australian Government provided support for the Indigenous Women's Reference Group that promotes cervical screening for Aboriginal and Torres Strait Islander women.
- The South Australian Government provided funding for health professionals to support the national bowel cancer screening program and for social awareness campaigns focused on cervical and bowel cancer screening.
- The Tasmanian Government provided \$163,000 to support national bowel cancer screening, as well as funding for mass media promotions of cervical screening services and an awareness-raising art exhibition.
- The Australian Capital Territory Government provides funding to support the jurisdictional Pap screening register.

Breast cancer screening initiatives

Throughout 2007–08 the NSW Government funded digital technology upgrades for the Cancer Institute of NSW at a cost of over \$4 million. The upgrades included digital mammography technology for both fixed and mobile services. Digital upgrades also enable electronic transmission from screening centres to radiologists at central reading rooms.

In addition the NSW Government contributed \$3.3 million of funding towards the upgrade of administration, management and clinical resources of state-based breast screening services. A change in the structure of the NSW Screening and Assessment Services, in which jurisdiction boundaries were aligned with Area Health Services, also required funding for re-accreditation of a number of breast screen services.

The Queensland Government commenced its digital implementation project during 2007–08. Queensland also spent \$437,000 on the BreastScreen Queensland Social Marketing Campaign which incorporated television advertising across the state. Monitoring of the BreastScreen Queensland data showed that following the airing of the campaign during 2007–08, the number of women who made a booking at a BreastScreen Queensland Service across the state increased by 27%.

Cervical cancer screening initiatives

Pap test registers (PTRs)

All state and territory governments provided support for national cervical screening initiatives through funding and administration of state/territory PTRs.

In 2007, the NSW Government contributed funding to trial a special reminder letter initiative. In addition to the regular reminder letters generated by the state PTR, special reminders were sent to 500,000 women in NSW who had not had a Pap test for 4 years or more. The program had a moderate success rate, with a 3.5% overall response rate (uptake of cervical screening within 3 months of receiving the special reminder letter).

The Queensland Government contributed almost \$1 million towards maintenance of its state PTR, and the South Australian Government's funding enabled redevelopment and modernisation of its PTR.

The Western Australian Government spent over \$1 million in 2007–08 to operate and maintain the Cervical Cytology Registry.

Cervical cancer screening social awareness campaigns

The NSW Government spent \$1 million in 2007–08 implementing a modified version of a Victorian media campaign, *Don't Just Sit There*. The modified campaign was run in NSW over 2 months in 2007 and from February to June 2008. There was a substantial increase in the number of daily Pap tests conducted during the campaign months.

In Victoria the Government supported the *Don't Just Sit There* media campaign, which included public awareness messages about the HPV vaccine. The primary aim of the program was to encourage women in the 18 to 69 years age range to have regular, 2-yearly Pap tests. This major campaign was funded for five weeks over a 3-month period and included television and radio promotion of cervical screening services. Success of the program was demonstrated by a 13% increase in daily Pap tests conducted in Victoria during the campaign period.

Tasmania ran major media campaigns involving television, radio and newspaper advertising encouraging cervical screening during 2007 and conducted Pap Smear Awareness Weeks in 2008.

In Western Australia almost half a million dollars was spent for the health promotion and recruitment component of the Cervical Cancer Prevention program. This included coordinated Pap test month campaigns in the Pilbara, the Great Southern and the South West of Western Australia in 2007. Staff also participated in conferences and training aimed at improving participation in cervical screening.

In South Australia a major social marketing campaign, incorporating Pap Smear Awareness Week, was conducted in May 2008, reminding women of the importance of regular screening, including those who have received the HPV vaccine. The main target groups were women from low socioeconomic status for Areas (SEIFA) index communities, culturally and linguistically diverse women and Aboriginal women.

In Queensland \$440,000 was spent on the Queensland Cervical Screening Program Social Marketing Campaign which incorporated television and magazine advertising across the state. This campaign resulted in a significant increase in the Queensland cervical screening participation rate with an 11.2% increase in the number of women who had a Pap smear in 2007 compared to the average number of women screened per year in the previous five years.

Mobile cervical screening services

During 2007–08 the Queensland Government funded the Mobile Women's Health Service, a network of 15 mobile women's health nurses and two Aboriginal and Torres Strait Islander health workers, at a cost of over \$1.8 million. The main aim of this service is the provision of cervical screening for women who are geographically isolated.

As well as cervical screening, free and confidential preventative health care services were provided through this service for women in over 200 rural and remote communities including Aboriginal and Torres Strait Islander women and women from culturally and linguistically diverse backgrounds.

Bowel cancer screening initiatives

The Western Australian Government provided \$651,603 in 2007–08 to support the implementation of the NBCSP via a staggered roll out of programs across the state. Funded activities included the support of a Bowel Cancer Screening Implementation Team (established within the WA Cancer

and Palliative Care Network); education activities targeted towards health professionals and delivered in partnership with Cancer Council WA; and upgrade of colonoscopy equipment in Western Australia regional hospitals to meet increased colonoscopy demand as a result of NBCSP implementation.

In 2007-08 the Queensland Government provided \$900,000 of funding for the establishment of a State Coordination Unit for bowel cancer screening initiatives. This unit is responsible for program management and planning and time-limited projects in the area of policy development, quality management, health promotion, monitoring and evaluation and training. The Queensland Government also provided \$500,000 to upgrade colonoscopy equipment in regional areas of the state.

The Queensland Government provided additional funding to continue developing the Endoscopy Services Information System Solution (ESISS) project during 2007-08. The implementation of ESISS will significantly enhance the ability of Queensland to monitor clinical colonoscopy quality and report against standards for the future accreditation of facilities, the certification and recertification of proceduralists and reporting to the NBCSP Register.

Awareness campaigns

In 2007-08, state and territory governments provided additional funding to support and promote the NBCSP to health professionals and the community through a range of marketing and educational strategies.

The Victorian Government funded community and health professional communication, education and support – as well as a study of bowel cancer awareness, attitudes and behaviours – through the Cancer Council Victoria.

In Queensland, eleven Health Promotion Officers were funded to undertake community and health professional education and promotion of bowel cancer screening and healthy lifestyles.

In South Australia, community promotion of the NBCSP was funded by the Government and conducted by the Cancer Council SA, with health professional education programs delivered in conjunction with the SA Divisions of General Practice.

The Tasmanian Government also provided funding for the promotion and marketing of bowel cancer screening services, including regular face-to-face community health promotion activities.

Screening program nurse coordinators

In 2007-08 the Queensland and South Australian governments provided additional funding for the establishment and maintenance of nurse co-ordinators to support the NBSCP.

The Queensland Government provided \$2.5 million to support twelve Gastroenterology Nurse Coordinator positions. These coordinators provide individualised service and care coordination for patients who return positive FOBTs and require further follow-up. This included enabling access to follow-up care and referral, assistance throughout the colonoscopy process and support during rescreening and/or treatment phase of the bowel cancer program.

Similarly, the South Australian Government provided funding for the employment and training of four Nurse Pathway Coordinators specific to the NBCSP. The aim of these coordinators is to minimise the impact of bowel screening procedures on hospital outpatient clinics. They conduct health assessments for patients referred for colonoscopy under the NBCSP and provide education about the procedure, risks, preparation and alternatives. The coordinators also provide ongoing support for patients who require rescreening or treatment and complete paperwork required for the national register.

Screening programs for Aboriginal and Torres Strait Islander people

Cervical cancer screening

Aboriginal and Torres Strait Islander women are twice as likely to develop cervical cancer (AIHW 2008b). One of the main reasons for the increased rate of cervical cancer is that Indigenous women are less likely to have regular Pap tests.

In 2007–08, the Cancer Council Victoria received state government funding to support an initiative titled *Protecting Our Mob*. The program included public education resources for Indigenous Victorian women on cervical screening services, as well as a comprehensive guide for Aboriginal health providers on cervical cancer prevention. The resource was developed in consultation with Aboriginal health workers, and included Aboriginal artwork that promoted a theme of everyone being involved in the health of the community.

In Queensland, the state government through the Indigenous Health Package expanded the Healthy Women's Initiative in 2007–08. The focus of this initiative is improving Aboriginal and Torres Strait Islander women's participation in cervical screening through a range of strategies including community education and health promotion activities, enhancing service integration in remote communities, developing culturally appropriate resources and developing a specialised workforce of designated Indigenous women's health workers.

In Western Australia, government funding in 2007–08 supported the Indigenous Women's Reference Group. This group consists of Aboriginal health workers and health promotion officers from each health region in Western Australian. It provides advice on women's health issues, informs the development of promotional materials and helps improve awareness of cervical and breast cancer screening within Western Australian Aboriginal and Torres Strait Islander communities.

The Western Australia Government also funded an Indigenous Program Officer to develop health promotion activities and help to establish culturally appropriate Pap test campaigns throughout the state. In 2007–08 twelve workshops were conducted for Aboriginal women in rural regions. These generally coincided with Pap test awareness campaigns.

Also in Western Australia, the State Government provided funding for educational strategies related to cervical screening in the Indigenous community. A partnership was formed with Marr Mooditj Aboriginal Health College to provide ongoing support for student placements and education related to cervical screening. Two cervical screening education sessions were developed for Aboriginal health professionals.

In South Australia health promotion and education activities were conducted in partnership with female Aboriginal Health Workers and community women. Key activities included projects with Aboriginal health services to provide culturally competent screening services; production and distribution of culturally appropriate information resources for community women and women's health workers; and professional education for Aboriginal women's health workers, medical practitioners and practice nurses.

Bowel cancer screening

The Queensland Government implemented an alternative bowel screening program for Aboriginal and Torres Strait Islander communities. In 2007–08 the Queensland Government received funding from the Commonwealth Government for a pilot project offering bowel cancer screening for Aboriginal and Torres Strait Islanders aged 50 to 74 years in specific remote Queensland communities. A trial delivery method, whereby FOBTs were delivered directly to individuals through community health services rather than through the mail, was implemented in thirteen

Aboriginal and Torres Strait Islander communities. To increase uptake of screening services by Indigenous Queenslanders, specific educational resources were developed in consultation with health workers and community members to improve knowledge of bowel cancer risk factors, screening and assessment services.

10 Prevention of hazardous and harmful drug use

10.1 Introduction

The National Drug Strategy is a cooperative venture between Australian, state and territory governments and the non-government sector. It is aimed at preventing the uptake of harmful drug use and reducing the harmful effects of licit and illicit drugs.

Health education campaigns are the main activities conducted under the strategy to increase the public's awareness of the health impacts of drug use.

Emphasis is on increasing the public's understanding of drug-related harm and the wider impacts of drug use on individuals, families and communities. This includes increasing understanding and acceptance of the broad range of prevention, treatment and harm-reduction programs and services and of evidence-based approaches to new treatment options.

This category includes activities targeted at the general population with the aim of reducing the overuse or abuse of:

- Alcohol
- Tobacco
- Illicit and other drugs of dependence
- Mixed drugs.

10.2 Expenditure

Governments spent a total of \$254.3 million on *Prevention of hazardous and harmful drug use* in 2007–08, an increase of \$45.5 million from 2006–07. This represented an annual growth of 21.8%. *Prevention of hazardous and harmful drug use* made up 11.8% of all public health expenditure in 2007–08 (see Table 2.5, page 7).

Table 10.1: Government expenditure on *Prevention of hazardous and harmful drug use*, current prices, 2007–08 (\$ million)

Activity	Australian Government	State and territory governments	Total
Alcohol	0.6	20.2	20.8
Tobacco	3.4	43.9	47.3
Illicit drugs	29.0	39.3	68.3
Mixed drugs	62.1	55.8	117.9
Total	95.1	159.2	254.3

Source: AIHW health expenditure database.

Total government expenditure on *Prevention of hazardous and harmful drug use* in 2007–08 equated to \$11.97 per person. Government expenditure per person was the highest in the Northern

Territory (\$44.68), followed by Tasmania (\$19.73) with per person expenditure in other jurisdictions ranging from \$8.34 (Victoria) to \$18.78 (South Australia) (Table 10.2).

Table 10.2: Government expenditure^{(a)(b)} per person on *Prevention of hazardous and harmful drug use*, by state and territory, current prices, 2007–08 (\$)

Activity	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Average ^(c)
Alcohol	0.49	0.21	2.21	1.84	0.60	1.22	0.49	5.52	0.98
Tobacco	2.76	1.03	1.49	3.60	3.63	2.18	1.34	6.31	2.23
Illicit drugs	1.88	1.84	4.26	4.35	7.97	4.21	4.12	8.83	3.21
Mixed drugs	3.68	5.26	6.92	5.00	6.59	12.12	8.42	24.03	5.55
Total	8.82	8.34	14.88	14.79	18.78	19.73	14.38	44.68	11.97

(a) Includes expenditure incurred by state and territory governments that is partly or wholly funded by Australian Government SPPs to states and territories.

(b) Includes estimates of direct expenditure by the Australian Government on its own *Prevention of hazardous and harmful drug use* programs. This expenditure has been apportioned across states and territories according to relative share of total population.

(c) Weighted by the annual mean resident population share of each jurisdiction.

Source: AIHW health expenditure database.

Real expenditure on *Prevention of hazardous and harmful drug use* increased by 17.6% between 2006–07 and 2007–08 (Table 10.3). This increase was almost three times the average over the whole period 1999–00 to 2007–08. It was largely due to a 96.3% growth in expenditure by the Australian Government in that year.

The data indicate substantial fluctuations in expenditure from year-to-year for a number of jurisdictions between 1999–00 and 2007–08. For example, expenditure by the Australian Government fell substantially in 2 years – between 2000–01 and 2001–02 (–23.2%) and between 2004–05 and 2005–06 (–61.3%); and these falls in expenditure were followed by substantial increases of 20.4% and 63.5%, respectively. Despite these fluctuations from year-to-year, growth in expenditure by the Australian Government averaged 12.4% per year over the whole period and 12.9% and 12.0% in each of the shorter term periods presented in this report.

Table 10.3: Government expenditure on *Prevention of hazardous and harmful drug use*, by jurisdiction, constant prices^(a), 1999–00 to 2007–08 (\$ million)

Year	Australian Government	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
1999–00	37.3	25.7	15.9	20.4	18.3	15.9	5.8	8.5	8.5	156.3
2000–01	53.0	22.2	32.9	23.0	18.4	17.8	5.6	5.9	4.6	183.4
2001–02	40.7	17.3	32.1	27.7	19.9	16.0	6.7	7.5	4.6	172.4
2002–03	49.0	17.1	30.9	28.3	20.6	17.4	6.9	7.5	7.2	184.9
2003–04	60.5	22.9	26.9	27.4	20.9	17.0	6.4	3.9	9.3	195.3
2004–05	76.4	16.5	27.7	35.7	21.4	19.3	5.0	4.2	11.7	217.9
2005–06	29.6	24.2	30.4	38.6	27.6	20.1	6.5	3.1	9.5	189.6
2006–07	48.4	32.4	29.1	41.3	24.1	21.8	7.1	3.3	8.8	216.3
2007–08	95.1	30.2	20.3	44.1	22.1	22.8	7.6	3.4	8.7	254.3
Annual growth rate (%)										
2006–07 to 2007–08	96.3	–7.0	–30.0	6.7	–8.3	4.7	5.9	3.9	–0.3	17.6
Average annual growth rates (%)										
1999–00 to 2003–04	12.9	–2.8	14.0	7.7	3.4	1.7	2.6	–17.7	2.3	5.7
2003–04 to 2007–08	12.0	7.2	–6.7	12.6	1.3	7.6	4.1	–3.4	–1.7	6.8
1999–00 to 2007–08	12.4	2.0	3.1	10.1	2.4	4.6	3.3	–10.8	0.3	6.3

(a) Constant price public health expenditure for 1999–00 to 2007–08 is expressed in terms of 2007–08 prices.

Source: AIHW health expenditure database.

10.3 Programs and activities

These explanatory notes were provided by the jurisdictional health departments and provide examples of some of their initiatives.

National hazardous and harmful alcohol use prevention programs and activities

Alcohol Strategy

The *National Alcohol Strategy 2006–2009* was developed to address patterns of high risk alcohol consumption that are prevalent in Australia. The strategy was endorsed by the Ministerial Council on Drug Strategy in May 2006 after development through collaboration between all levels of government, non-government organisations and the broader community. The strategy highlights four priority areas for coordinated action to address harmful alcohol use over 2006–2009. The nominated priority areas for this national initiative are intoxication, public safety and amenity, health impacts, and cultural place and availability. The responsibility for implementing the recommendations contained within the National Alcohol Strategy is spread across jurisdictions and across portfolios and stakeholder groups.

The National Binge Drinking Strategy

The National Binge Drinking Strategy which was announced in March 2008 provides \$53.5 million over 4 years to address the problem of alcohol misuse among young Australians, including:

- \$14.4 million to invest in community level initiatives to confront the culture of binge drinking, particularly in sporting organisations
- \$2 million is being invested in Club Champions – two members from each major sporting club competing in the national competitions for Australian Rules football, rugby union, rugby league, cricket, netball and football – to help foster leaders in responsible drinking at the elite level
- \$5.2 million will be invested in a significant expansion of the Good Sports initiative of the Australian Drug Foundation – to support local sporting clubs to build a culture of responsible drinking at the grassroots level
- \$7.2 million for a community based grants round, which will provide an avenue to establish sustainable partnerships between non government organisations, local government, sporting groups, police and interested parties to work together to develop local solutions to address youth binge drinking within their own community
- \$19.1 million to intervene earlier to assist young people and ensure that they assume personal responsibility for their binge drinking
- \$20 million to fund advertising that confronts young people with the costs and consequences of binge drinking. The media campaign was designed to promote a more responsible drinking culture following the review of the Australian Alcohol Guidelines by the National Health and Medical Research Council.

State and territory programs and activities

State and territory expenditure on prevention of hazardous and harmful alcohol use covered a broad range of initiatives. Funding was provided for the development and support of state and territory alcohol management strategies and social market campaigns, and a wide range of harm-reduction programs aimed at preventing the hazardous and harmful use of alcohol. In addition to those projects outlined below, most jurisdictions provided some funding for legislative amendments, alcohol and drug treatment centres, training for health professionals working in rehabilitative skills, and the development of alcohol-specific education resources.

Alcohol management strategies

In 2007–08 the Queensland, Western Australia, Australian Capital Territory and Northern Territory Governments developed jurisdictional alcohol action strategies. In Victoria, the *Restoring the Balance* alcohol management plan was released in May 2008. The *Queensland Drug Strategy* outlines alcohol management plans for their jurisdiction for 2006–10. In 2007–08 the Western Australian Government outlined alcohol-related community initiatives in three key policy documents: the *Western Australian Drug and Alcohol Strategy 2005–2009*, the *Western Australian Alcohol Plan 2006–2009* and the *Strong Spirit Strong Mind—WA Aboriginal Alcohol and Other Drugs Plan 2005–2009*. The ACT Government's *Alcohol, Tobacco and other Drug Strategy* documented the ACT's alcohol management plan for 2004–2008. South Australia developed the *South Australian Alcohol Action Plan 2009–2012* for public consultation.

Victoria, Queensland, Western Australia and the Australian Capital Territory have short, medium and long term strategies designed to reduce the impact and consequences of irresponsible and

risky drinking patterns on their communities. The alcohol management plans in these states and territory are developed by panels including government and non-government experts and aim to achieve reduction in harms associated with alcohol through community-wide, coordinated plans. In general these strategic plans document education, health care and legal and law enforcement strategies to promote the safe and responsible sale and consumption of alcohol. Examples of initiatives included in jurisdictional alcohol management strategies include school-based education initiatives; development of detoxification services; review of liquor licensing arrangements; and strategies specific to at risk populations including women, young adults, Aboriginal and Torres Strait Islander populations and people from culturally and linguistically diverse backgrounds.

In the Northern Territory, alcohol action strategies are specific to towns and/or local communities. Known as *Alcohol Management Plans*, the strategies are developed and overseen by local government representatives, key service providers and relevant Northern Territory agencies such as police, health and justice representatives. *Alcohol Management Plans* document a range of alcohol control strategies including supply restrictions, sale permit systems and agreements between suppliers and the community regarding provision of community detoxification services.

Alcohol social marketing campaigns

Major state and territory funded social marketing campaigns operated in New South Wales, Queensland, South Australia and Tasmania in 2007–08. Social marketing campaigns use the systematic application of marketing concepts and techniques to achieve behavioural goals relevant to the social good. Alcohol-related campaigns aim to maximise societal awareness and decrease the acceptance of excessive alcohol consumption and socially inappropriate behaviour that frequently accompanies drunkenness. Campaigns generally target specific problems, such as binge drinking and public drunkenness, in specific demographic groups (for example young adults and women) to achieve success in behavioural change. The following are examples of social marketing campaigns that were funded by state or territory governments in 2007–08.

***Be Part Of It, Not Out Of It* campaign**

In NSW, the *Be Part Of It, Not Out Of It* responsible drinking campaign targeted adolescents in four target geographical locations — Orange, Lake Macquarie, Sydney Central and Sydney eastern beaches. The campaign primarily involved a series of poster advertisements focused on reduction of excessive drinking and anti-social behaviour associated with public drunkenness.

***Which Way Our Way* campaign**

The *Which Way Our Way* program targeted Indigenous Australians in 17 specific Aboriginal communities in Northern Queensland. The program used media and community channels to promote strong, culturally sensitive messages supporting the reduction in local alcohol demand.

***Young Women and Alcohol* program**

The Queensland Government funded the *Young Women and Alcohol* campaign to reduce harmful alcohol consumption in women aged 18 to 22 years. The campaign commenced in 2004 as a result of research indicating that young women in Queensland were more prone to risky alcohol consumption than other Australians. In 2007–08 the program included advertising in cinemas, television, magazines, venues and outdoors promoting the empowerment of young women to reject excessive alcohol consumption.

***Drink Too Much It Gets Ugly* campaign**

The South Australian Government funded the *Drink Too Much It Gets Ugly* program targeted towards males aged between 18 and 39 years who drink alcohol at least weekly. The campaign focused on reducing the acceptance of public drunkenness, highlighting the negative impact of binge drinking (particularly on relationships with family and friends), building awareness of the costs and harms associated with alcohol intoxication, and reducing the desire to engage in risky drinking activity. The campaign included television commercials, bathroom posters and urinal stickers.

***Just Like That* campaign**

In Tasmania the *Just Like That* program was conducted by the Road Traffic Task Force and focused on reducing the incidence of alcohol-related harms associated with driving. The campaign primarily used print and electronic media to promote the campaign message within the general community.

Rethink Drink

The *Rethink Drink* alcohol campaign is the community education and marketing component of the Western Australian effort to reduce the impact that risky alcohol use has on the community. It aims to reduce the level of alcohol-related harm that results from drunkenness by changing the drinking culture in Western Australia to support safer drinking environments and practices.

Other alcohol harm reduction initiatives

In 2007–08 there was a wide range of state and territory government funded alcohol-related initiatives, generally aimed at encouraging socially responsible alcohol provision and use within the community, and directed towards health care programs related to alcohol misuse and/or addiction. Some examples of state and territory funded initiatives are detailed below.

***Good Sports* program**

The Good Sports program is an initiative of the Australian Drug Foundation to support local sporting clubs to build a culture of responsible drinking at the grassroots level. This program received \$5.2 million in funding from the Australian Government and the South Australian Government also provides state funding for operation of the program within its jurisdiction.

The *Good Sports* program is designed to assist sporting clubs to responsibly manage the sale and consumption of alcohol on their premises. The program goals include reducing problems associated with irresponsible and excessive consumption of alcohol, promotion of family-friendly atmospheres at local sporting facilities, reducing the risk of litigation for sporting clubs, assisting clubs in the development of alternative revenue raising sources, and improving relationships between sporting clubs and other local community organisations (for example local councils).

NSW Community Drug Action Teams

In NSW, Community Drug Action Teams receive government funding to provide a range of alcohol-related harm prevention, reduction and uptake projects within the community. Initiatives include facilitating community forums and seminars, conducting skill building and social support workshops and programs for at risk younger people, and hosting drug and alcohol free events for families and young adults. In 2007–08 education was conducted for over 1,000 school-age NSW North Coast students on alcohol and driving.

NSW Controlled Drinking Program

Operated by the Australian Centre for Addiction Research, the Controlled Drinking program received funding from the NSW Government in 2007–08. The program offered to members of the community to assist in the reduction of problematic alcohol consumption. The program offers individualised assistance to manage high-risk situations such as social situations, cravings, binge drinking and mood-related consumption, as well as education on lifestyle change and prevention of relapse. Its goal is to encourage problematic high risk drinkers to control their drinking habits before alcohol use becomes a significant problem.

Western Australian Alcohol Pharmacotherapies Call-back Service

In 2007–08 the Western Australian Government funded the Alcohol Pharmacotherapies Call-back Service. This is a support program for people prescribed alcohol pharmacotherapy – medication used to assist people to cease alcohol consumption. Access to the service is through GP referral. The call-back service provides counselling and support to people attempting to stop drinking alcohol and provides information and feedback to GPs about their patients' progress.

Places of Safety in Tasmania

In 2007–08 the Tasmanian Government provided funding to community sector organisations for the provision of services for detoxification. Three facilities operate within the state providing safe places for people found intoxicated by alcohol or illicit drugs to sober up. The facilities also provide follow-up counselling and assistance in accessing detoxification support programs.

Northern Territory Night Patrol Services

Operating in the Northern Territory since 2004 and primarily funded by the Northern Territory Government, Night Patrol Services provide assistance to people at risk of coming into adverse contact with the justice system, primarily as a result of excessive alcohol use. Night patrols circulate in local community areas at night and have a core function of providing safe transportation to detoxification venues, intervening to prevent disorder within the community and diverting people from committing crime. They also provide information to clients and follow-up of clients to ensure they receive appropriate support services. In June 2007 the Night Patrol Services received a commitment from the Australian Government to provide national funding to enable the expansion of services to an additional 73 Indigenous communities.

National hazardous and harmful tobacco use prevention programs

National Tobacco Campaign

The National Tobacco Campaign is a collaborative quit-smoking health initiative between federal, state and territory governments and non-government organisations to improve health and to reduce the social costs caused by tobacco.

The campaign targets 18 to 40 year – old smokers and consists of a combination of 'hard-hitting' advertising through national media promotions and a dedicated website, and nationally coordinated state and territory run Quitline services. The campaign is designed to deliver messages such as 'every cigarette is doing you damage' and 'smoking damages your arteries, lungs and eyesight'.

In November 2007, the Department of Health and Ageing commissioned an evaluation of the graphic health warnings on tobacco product packaging. The purpose of the evaluation was to

provide information on the health warnings' impact on smoking behaviour, attitudes, knowledge and intentions. The published results of the evaluation (DoHA 2009) show that the health warnings had increased consumer knowledge of the health effects relating to smoking, encouraged the cessation of smoking and discouraged smoking uptake or relapse. The evaluation also noted that in 2008 there was a strong perception that a number of issues were having a significant effect on smokers, in particular, legislative changes and anti-smoking advertising, including the graphic health warnings.

Quitline

The nationally coordinated initiative Quitline provides evidence-based smoking cessation interventions, including non-judgemental telephone support to members of the public requiring assistance to monitor and maintain their tobacco use cessation. Members of the Quitline also maintain a call-back system, actively contacting registered users on a regular basis to assist in quitting smoking. State and territory governments provide additional funding to support various Quitline services and research.

Following the introduction of smokefree bars and clubs in Victoria, the number of people calling Quitline for advice on how to quit smoking increased by 27% on the month prior to the ban.

State and territory hazardous and harmful tobacco use prevention programs

The majority of expenditure by jurisdictions included in the tobacco category related to achieving the goals of the National Tobacco Strategy, in particular:

- Regulation of promotion, place of sale, tobacco tax, pace of use, packaging and tobacco products
- Increased promotion of Quit and Smokefree messages,
- More useful support to parents and educators.

All the states and territories have legislation and/or regulations in place that relate to smoking in public places, including smoking in workplaces. During 2007–08, the interior of New South Wales, South Australian and Victorian pubs, clubs and other licensed premises became smokefree and the South Australian Government banned the sale of tobacco products by mail, telephone and electronic communication.

Tobacco social marketing campaigns

State/territory-funded social marketing campaigns operated in New South Wales, Victoria, Queensland, South Australia, Tasmania and the Northern Territory in 2007–08. Media campaigns aimed to maintain a continuing presence of the anti-smoking message to promote smoking cessation. Campaigns were targeted at specific demographic groups, such as young adults or women, and focused on health issues and particular behaviours that present a barrier to smoking cessation.

Victorian social marketing campaigns

Funding from the Victorian Government supported social marketing campaigns including: *Smokefree Homes and Cars*, which highlighted the dangers of secondhand tobacco smoke, especially for children; the *Voice Within*, focusing on how smoking can lead to stroke; *Sponge*, which informed

people about the serious impacts of smoking on their health; *Bubblewrap*, which looked at the risks of emphysema; *Bronchoscopy*, focusing on lung cancer; and the highly emotive campaign titled *Zita*, which featured Zita Roberts, a 37-year-old mother of three children in the final stages of dying from lung cancer caused by smoking.

Queensland *Echo Excuses* campaign

In 2007–08 Queensland Government funded the implementation and evaluation of the Quit media campaign and promotion of Quitline including a specific social marketing campaign, *Echo Excuses*. This aimed to promote smoking cessation in the 18 to 39 years age group and involved television and radio advertising directed at self-exempting beliefs in smokers, including excuses for delaying quitting. The campaign also included an SMS response option which allowed users to text the Quitline to receive a mail-out of Quit resources.

Young Women and Smoking '*Feeling Good*' campaign

In Queensland, significant funding was assigned to the *Young Women and Smoking 'Feeling Good'* campaign. The program targets smoking behaviour of Queensland women aged 18 to 29 years. Research conducted in late 2007 explored the target population's life values, smoking behaviour and new creative concepts that could extend the campaign. Research was also conducted amongst focus groups of young Queensland males, with a goal of extending the next phase of the campaign to non-gender specific concepts.

South Australian social marketing campaign

Funding from the South Australian Government supported social marketing campaigns directed towards young adults (18 to 39 years) from low socioeconomic backgrounds. The campaign included television advertisements and other resources, including an SMS response initiative.

Tasmania and New South Wales *Sponge* campaign

In early 2008 both the Tasmanian and New South Wales Government funded the *Sponge* campaign. Originally airing 25 years ago and graphically demonstrating the dangers of smoking, the television advertising campaign was resurrected to target the younger generation of smokers who had not had previous exposure to this successful social marketing campaign.

Northern Territory *I'm Smarter than Smoking* campaign

This social marketing campaign was directed towards youth smoking and run in conjunction with nationally-funded smoking cessation campaigns. Commenced in rural NT communities, the campaign consisted of television advertising, posters and other resources including promotion by the Australian rapper Jessica Mauboy.

Initiatives for tobacco use reduction

In 2007–08 there was a wide range of state and territory government funded initiatives to promote tobacco use reduction and for tobacco-related health care. Some examples of state and territory funded initiatives are detailed below.

NSW Smoke Check project

In 2007, the NSW commenced funding for the *Smoke Check* project. The initiative provides evidence-based training programs on smoking cessation for Aboriginal health workers and other health professionals working in Indigenous communities. The goals of the program are to

maximise the smoking cessation support provided by health workers in order to reduce smoking amongst the Aboriginal population.

ACT Smoking Cessation in Pregnancy program

In May 2008 the ACT Government-funded *Smoking Cessation in Pregnancy* program commenced. The 1 year program, co-ordinated through the Canberra Hospital, focuses on educating midwives involved in antenatal care and providing support and resources to assist women to cease or decrease smoking during pregnancy.

Top End Tobacco Project in the Northern Territory

The Top End Tobacco and Tobacco Monitoring Projects were funded by Northern Territory Government throughout 2007–08. The initiatives provided coordinated approaches to the promotion of smoking cessation in five remote Northern Territory communities. The project included education courses, smoke-free policies and targeted health advice.

National hazardous and harmful illicit drug use prevention programs

National Drugs Campaign

The *National Drugs Campaign* (NDC) aims to reduce young Australians' motivation to use illicit drugs by increasing their knowledge about the potential negative consequences of drug use and encouraging parents to talk with their children about drugs by providing them with practical and up-to-date information about illicit drugs.

The campaign included four television commercials highlighting the negative consequences of ice, marijuana, speed and ecstasy. A booklet for parents reflecting the most current information about drugs and tips to help them openly discuss drugs with their children was distributed to all households in September 2007.

The National Drugs Campaign 2007 (DoHA 2008a) was evaluated in 2008 and the key findings were that:

- Two in three parents (67%) indicated that the NDC had made it easier to talk to their children about drugs, with 47 percent claiming to have discussed drugs with their child as a result of seeing the campaign. Compared to September 2000, prior to the inception of the NDC, the Phase Three NDC evaluation found that more parents indicated that 'no drug taking is ok', more indicated they were 'very confident' about their ability to prevent their child using illegal drugs, and more had discussed illegal drugs with their child 'in the last 2 months'.
- 78% of 13–24 year olds said the campaign had influenced what they did or thought about illegal drugs, including resolving to think more about illegal drugs and the consequences of their use, to avoid their use or to receive confirmation of a pre-existing negative view of drugs or a choice not to use them. More than half (59%) said the campaign had made it easier to talk with their parents about illegal drugs.
- The evaluation found that, compared with September 2004 fewer 13–24 year olds exhibited positive perceptions of marijuana, ecstasy and speed and more associate these drugs with mental health problems such as aggression, depression and paranoia. There was also a decrease in the proportion of 13–24 year olds 'at risk' of accepting a friend's offer of marijuana, ecstasy or speed during this time.

State and territory hazardous and harmful illicit drug use prevention programs

Funding for illicit and mixed drug initiatives was combined with alcohol or tobacco use reduction programs in most jurisdictions; therefore there was little reporting of specific illicit drug prevention activities. Initiatives funded by state and territory governments to address illicit and mixed drug use included community awareness campaigns, research, resource development and clinical support, generally conducted in conjunction with either alcohol or tobacco use schemes.

Victorian and South Australian government funding in this category was generally focused on providing support to Australian Government funded programs, including the *Illicit Drug Diversion Initiative*. The Victorian Drug and Alcohol Prevention Council was established to address issues associated with alcohol and drug use. In South Australia, training and support was provided for thirteen educators from African communities for the delivery of alcohol, HIV and hepatitis health education programs, which included components related to illicit drug use. The New South Wales Government provided funding for a number of campaigns to raise awareness of illicit and mixed drug issues to address illicit drug use as an issue within the Aboriginal community. The Northern Territory Government provided funding for a number of specific activities in this category.

Some of the more substantial state and territory government funded initiatives in this category are detailed below.

New South Wales

NSW Community Drug Action Teams

Community Drug Action Teams operate throughout the NSW community with NSW Government support. Teams operate with a goal of raising community awareness about illicit drug use and assisting local communities to develop responses to local drug issues. There are sixty teams operating across the state, and each team aims to undertake two major projects each year. Projects are practical initiatives, reflecting the specific needs and culture of the local community in which they are conducted.

NSW Social awareness campaigns

Numerous NSW social marketing campaigns focused raising awareness of illicit and mixed drugs use within the community. Some examples of campaigns funded throughout 2007-08 include:

- *Club Drugs* – targeted towards 19 to 25 year olds attending night clubs, dance events and music festivals, this campaign was conducted through posters, advertisements and websites promoted in street press, gay and lesbian media and clubs and venues.
- *Family Matters Multicultural Drug Education* – targeted families from culturally and linguistically diverse backgrounds, the campaign included the production of educational resources in 15 languages and was promoted in print and radio advertising in ethnic media outlets.
- *Drug Information at Your Library* – targeted towards ensuring that accurate alcohol and drug information is available throughout NSW public libraries, the campaign involves the provision of informative books and pamphlets.

Queensland

Ice Breaker' Crystal Methamphetamine Education Campaign

In 2007-08 the Queensland Government provided \$100,000 for the Ice Breaker Crystal Methamphetamine Education Campaign. The campaign aims to raise awareness within the target market of the harmful consequences of the use of crystal methamphetamine ('ice') and other stimulants and to provide information and assistance with regard to the use of these stimulants (in the first instance via the website and telephone service).

The primary target audience are people aged 18 – 29 years who are:

- at risk of methamphetamine use (particularly 'ice')
- experimenting or using methamphetamine or other stimulants occasionally socially or recreationally
- current 'regular' users of methamphetamine.

Western Australia

Drug Aware Amphetamine Education Campaign

The Amphetamine Prevention Campaign was developed in response to an increase of amphetamine-related harm being experienced by people across Western Australia. The project is a joint initiative of the Drug and Alcohol Office and West Australian Network of Alcohol and Drug Agencies. It aims to prevent and delay use, reduce the harms associated with amphetamine use and increase access to support services at an early stage.

Night Venues and Entertainment Events Project (NVEEP)

NVEEP is a collaborative initiative of the Drug and Alcohol Office, Police, State Government departments and gaming, liquor and events industry representatives and associations. It targets people attending night venues and/or entertainment events, youth entertainment industry and young people at risk of alcohol and drug-related harm.

Northern Territory

Volatile substance sniffing

Communities throughout the Northern Territory have had an ongoing concern regarding morbidity, mortality and anti-social behaviour associated with illicit drug use, particularly petrol and paint sniffing. In 2006 there was an estimated 600 Aboriginal people in the Central Desert region regularly sniffing. Local community initiatives funded by the NT Government, and legislative changes enabling the seizure of volatile substances have made an impact. A July 2007 study identified 244 regular sniffers in the same region and a similar study in July 2008 estimated only 85 regular sniffers.

The Northern Territory Government funds the development and support of local community management plans. Management plans are developed by communities to address local issues through legislation and community support. For example, community management plans have been introduced to ban petrol sniffing, the introduction of fines for bringing intoxicating fuel within community borders and replacing local fuel supplies with a non-aromatic fuel option that does not give a 'high' when sniffed (Opal fuel). In 2007-08 there were 15 management plans in place covering six community areas.

The Northern Territory Government also provides funding for support personnel working to decrease the use of illicit and mixed drugs within the community. There were 14 funded Community Support Officers to provide advice, planning and general support to remote communities. In 2007–08 funding was provided for 40 people to undertake Authorised Officer training to support the implementation of community management plans.

Control of prescription and over-the-counter drug use

The Drug Monitoring System database provides a secure internet interface in order for prescription monitoring and registration of prescribed Schedule 8 substances. Funding of the system enables pharmacies to document Schedule 8 prescriptions and to review relevant information from Poisons Control.

Project STOP is an initiative that mandates recording of personal details for the retail supply of pseudoephedrine. The project is funded by the Territory Government and operates in conjunction with relevant organisations including the Pharmacy Guild and the Northern Territory Police.

11 Public health research

11.1 Introduction

The definition of research and development (R and D) applied to the data collected for this report is as follows:

'R and D' is defined according to the OECD standard as comprising creative work undertaken on a systematic basis in order to increase the stock of knowledge, including knowledge of man, culture and society, and the use of this stock of knowledge to devise new applications.

An 'R and D' activity is characterised by originality. It has investigation as a primary objective, the outcome of which is new knowledge, with or without a specific application, or new or improved materials, product, devices, processes or services. 'R and D' ends when work is no longer primarily investigative (ABS 2008).

Thus, a basic criterion applied in this report in distinguishing research from other public health activities is the presence of an appreciable element of novelty and resolution of scientific and/or technical uncertainty. For example, assessment of a pilot for a proposed screening program, such as the bowel cancer screening pilot study, or an assessment of the likely impact of implementing or modifying a program, would be considered to be research activities. The on-going program monitoring and evaluation of public health activities are not regarded as research in this report.

11.2 Expenditure

Governments spent a total of \$153.6 million on *Public health research* in 2007–08, an increase of \$5.9 million from 2006–07. Expenditure on *Public health research* represented 7.1% of all public health expenditure in 2007–08 (see Table 2.5, page 7).

Real growth in expenditure between 2006–07 and 2007–08 was less than half a percentage point (0.4%) (Table 11.3). This was much lower than the longer term growth rate from 1999–00 to 2007–08 of 7.2% per year.

Table 11.1: Government expenditure on *Public health research*, current prices, 2007–08 (\$ million)

Activity	Australian Government	State and territory governments	Total
<i>Public health research</i>	134.0	19.6	153.6
Total	134.0	19.6	153.6

Source: AIHW health expenditure database.

Average expenditure per person by governments on *Public health research* in 2007–08 was \$7.23. The Northern Territory's per person expenditure was more than double the national average at (\$14.77). For the other states and territories, their average per person expenditures were generally clustered around the national average (Table 11.2).

Table 11.2: Government expenditure^{(a)(b)} per person on *Public health research*, by state and territory, current prices, 2007–08 (\$)

Activity	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Average^(c)
<i>Public health research</i>	6.81	7.35	6.57	8.12	8.40	6.72	7.17	14.77	7.23
Total	6.81	7.35	6.57	8.12	8.40	6.72	7.17	14.77	7.23

(a) Includes expenditure incurred by state and territory governments that is partly or wholly funded by Australian Government SPPs to states and territories.

(b) Includes estimates of direct expenditure by the Australian Government on its own *Public health research* programs. This expenditure has been apportioned across states and territories according to relative share of total population.

(c) Weighted by the annual mean resident population share of each jurisdiction.

Source: AIHW health expenditure database.

Expenditure on *Public health research* grew by 0.4% between 2006–07 and 2007–08. This growth was much lower than the longer term trends. Growth had averaged 5.6% per year between 1990–00 and 2007–08 and 8.8% over the period 2003–04 to 2007–08. The much lower growth after 2006–07 was largely the result of a 42.3% decrease in expenditure in Victoria. There had been a high growth in expenditure by the Australian Government in 2006–07 (30.1%) that was not sustained in the following year when it grew by 3.3%.

The highest annual growth rates from 2006–07 to 2007–08 were recorded by the Australian Capital Territory (17.4%), Queensland (15.5%) and New South Wales (7.2%) (Table 11.3).

Table 11.3: Government expenditure on *Public health research*, by jurisdiction, constant prices^(a), and annual growth^(b), 1999–00 to 2007–08

Year	Australian Government	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
	\$ million									
1999–00	76.1	3.2	2.9	1.9	2.2	0.8	0.4	—	0.6	88.2
2000–01	67.5	0.8	9.1	1.4	4.1	0.9	0.5	0.1	0.7	85.0
2001–02	72.0	2.2	13.1	1.0	4.1	2.9	0.3	0.1	0.7	96.5
2002–03	78.3	2.7	13.9	1.4	4.9	4.4	0.3	0.2	0.6	106.6
2003–04	79.8	2.4	14.8	1.7	5.1	4.7	0.4	0.3	0.7	109.8
2004–05	87.1	7.4	12.3	2.4	4.6	4.3	0.3	0.1	1.0	119.5
2005–06	99.7	12.8	9.6	1.7	4.1	3.6	0.3	0.1	1.3	133.3
2006–07	129.7	3.2	9.5	0.9	4.1	3.4	0.3	0.3	1.6	153.0
2007–08	134.0	3.5	5.5	1.1	3.9	3.3	0.2	0.3	1.8	153.6
	Annual growth rate (%)									
2006–07 to 2007–08	3.3	7.2	–42.3	15.5	–4.5	–1.9	–37.3	17.4	12.6	0.4
	Average annual growth rates (%)									
1999–00 to 2003–04	1.2	–7.1	49.7	–3.2	23.1	56.6	–1.2	69.6	5.4	5.6
2003–04 to 2007–08	13.8	9.5	–22.0	–10.0	–6.8	–8.0	–14.4	1.2	28.0	8.8
1999–00 to 2007–08	7.3	0.9	8.0	–6.7	7.1	20.0	–8.0	31.0	16.1	7.2

(a) Constant price public health expenditure for 1999–00 to 2007–08 is expressed in terms of 2007–08 prices.

(b) Growth rates have been calculated using unrounded expenditure estimates.

Source: AIHW health expenditure database.

11.3 Programs and activities

These explanatory notes were provided by the jurisdictional health departments and provide examples of some of their initiatives.

National research programs and activities

The Australian Government's main contribution to public health research programs was through funding. It provided grants of more than \$100 million through the National Health and Medical Research Council (NHMRC) for public health research during 2007–08.

The NHMRC is Australia's peak body for supporting health and medical research; for developing health advice for the Australian community, health professionals and governments; and for providing advice on ethical behaviour in health care and in the conduct of health and medical research. NHMRC supports all research relevant to health—including biomedical, clinical, public health and health services research.

In March 2008, the NHMRC established a Public Health Research Advisory Committee to review the ways in which NHMRC could marshal its funding to most effectively contribute to improved public health in Australia.

State and territory public health research programs and activities

New South Wales

In 2007–08, New South Wales government public health research expenditure was directed towards the *Capacity Building Infrastructure Grants* program, which builds capacity in, and strengthens public health, primary health care and health services research throughout the state. Funding also provided core support for the Sax Institute for building and supporting policy-relevant population health and health services research.

Victoria

The Victorian Government expenditure in this category for 2007–08 included commissioned research project funding into public health issues related to Department of Human Services.

Queensland

In Queensland, public health research was co-funded by the Queensland Injury Prevention Council (QIPC) and Health Promotion Queensland (HPQ).

The QIPC provided funding for injury prevention projects to investigate behaviour and events that increase the risk of injury. Particular behaviours and injuries investigated were risky driving; burn injuries; cyclist, motorcycle and moped injuries; and the impact of prescription drugs on vehicle and machinery operation. QIPC also directed funding to the Queensland University of Technology to undertake research to identify the scope of injury in Queensland and to provide recommendations on strategic approaches and investment opportunity to reduce injury in the state.

Support was provided through HPQ for the following projects:

- research into development of an Injury Prevention and Safety Promotion Framework conducted in the Indigenous community of Cherbourg
- a research project to develop a Sexual Health Communications campaign in Aboriginal and Torres Strait Islander communities in North Queensland and the Torres Strait Islands
- A project to develop a framework that defines social, emotional, cultural and spiritual wellbeing amongst Aboriginal and Torres Strait Islander peoples
- comprehensive research investigating potential stakeholders, opportunities and key entry points for increasing physical activity participation in rural communities.

Western Australia

The Western Australian Government funded a number of research projects that had relevance to public health. These included:

- A project involving Indigenous communities to develop culturally inclusive approaches to prevention and management of complex wounds
- Building community capacity and improving efficiencies for identifying rural and remote patients with eating disorders.

South Australia

Public health research in South Australia is largely funded through the *Strategic Health Research Program (SHRP)*.

In 2007–08 the SHRP conducted epidemiological and qualitative research studies into bowel cancer. These included studies into the equity of bowel screening; the psychosocial, demographic and program variables associated with bowel cancer screening; and an investigation into the system and patient outcomes associated with the *National Bowel Cancer Screening Program*.

The SHRP also conducted two separate studies related to tobacco smoking. One explored the relationship between smoking and coping/resilience and the barriers to quitting smoking in populations identified as being at-risk (young people, those with mental health issues and Aboriginal people). The second, which had commenced in 2006, focused on smoking in the Indigenous community. More than 50% of Indigenous adults are classified as regular smokers, and smoking is a highly accepted behaviour within rural and urban Indigenous communities. This project aimed to provide a systematic investigation into evidence-based prevention and smoking cessation strategies for Aboriginal and Torres Strait Islanders.

The State Government funded a number of other public health research projects, including investigations into:

- the impact of asthma within the community and the impact of risk
- protective factors related to health and physical activity.

Research undertaken by the South Australian health department into asthma, which has been identified as a priority under the national health priority areas, was widely disseminated through presentations and publications on demographics and epidemiology related to this chronic respiratory condition.

The South Australian component of NDARC's two national annual surveys on illicit drug use, namely the:

- Illicit Drug Reporting System (IDRS) and
- Ecstasy and Related Drugs Reporting System (EDRS)

was completed during the year.

These surveys monitor emerging trends in drug use and drug-related harm in Australia, and specifically monitor the price, purity, availability and patterns of use of illicit drugs in each state and territory.

Information for the IDRS was compiled through reviews of existing databases (for example customs, overdose and seizures databases and the National Household Surveys of Drug Use) and through interviews with regular drug users and experts working in drug-related fields such as syringe and needle program workers.

The EDRS is an ongoing project that monitors the use and market for ecstasy, methamphetamine and ketamine across Australia with the intention of providing policy-makers with strategic advance information regarding future health implication of illicit use of these drugs. Along with the national funding provided by the Australian Government, the South Australia components of the surveys received funding from the South Australian Government.

Tasmania

Tasmanian Government research expenditure for 2007–08 consisted of epidemiological research conducted by the Menzies Research Institute. This included a project to improve knowledge of

lifestyle and environmental factors – including physical activity, diet, alcohol intake, exposure to tobacco smoke and level of sunlight exposure related to problems of obesity and overweight. The project also investigated the influence of these lifestyle and environment factors on chronic diseases, in particular cardiovascular disease, diabetes, musculoskeletal conditions and respiratory disease.

Northern Territory

In 2007–08 the Northern Territory Government contributed funding to help maintain the partnership between the Menzies School of Health Research (MSHR) and the Departments of Health and Families, and Justice. During the reporting period the MSHR established a dedicated research unit for substance misuse, which completed a projects investigating drug and alcohol issues abuse in the Territory. This included qualitative research into Aboriginal perspectives of smoking behaviour and the general acceptance of smoking within the Indigenous community. The research verified the existence of complex relationships between social, psychological and historical factors that influence smoking behaviour and this will inform policy development and smoking cessation programs in the Territory. The Northern Territory Government also provided funding for the Co-operative Research Centre for Aboriginal Health that included funding for the ‘capacity building in Indigenous policy-relevant health Research’ project.

Appendix A: Technical notes

Public health activity definitions

Table A1: Definitions of core public health activities used to compile *Public health expenditure in Australia, 2007–08*

Public health activity category	Definition
Communicable disease control	<p>This category includes all activities associated with the development and implementation of programs to prevent the spread of communicable diseases.</p> <p>Expenditure on <i>Communicable disease control</i> is recorded using three subcategories:</p> <ul style="list-style-type: none"> • HIV/AIDS, hepatitis C and sexually transmitted infections • NSPs • Other communicable disease control. <p>The public health component of the HIV/AIDS, hepatitis C and sexually transmitted infections strategies includes all activities associated with the development and implementation of prevention and education programs to prevent the spread of HIV/AIDS, hepatitis C and sexually transmitted infections.</p>
Selected health promotion	<p>This category includes activities that are delivered on a population-wide basis that foster healthy lifestyle and a healthy social environment, and health promotion activities that address health risk factors such as sun exposure, poor nutrition and physical inactivity. The underlying criterion for the inclusion of health promotion programs within this category is that they are population health programs promoting health and wellbeing.</p> <p>The following health promotion programs delineate the boundaries for <i>Selected health promotion</i>:</p> <ul style="list-style-type: none"> • healthy settings (such as municipal health planning) • encouraging healthy weight through nutrition and physical activity • personal hygiene • mental health awareness • sun exposure and protection • injury prevention (including suicide prevention and prevention of female genital mutilation) • organised population health screening of heart disease risk factors.
Organised immunisation	<p>This category includes immunisation clinics, school immunisation programs, immunisation education, public awareness, immunisation databases and information systems.</p> <p>Expenditure on <i>Organised immunisation</i> is reported for each of the following three subcategories:</p> <ul style="list-style-type: none"> • Organised childhood immunisation as defined under the Australian Government's National Immunisation Program (see <www.immunise.health.gov.au/internet/immunise/publishing.nsf/content/nips>) • Organised pneumococcal and influenza immunisation • All other organised immunisation programs (excluding ad hoc or opportunistic immunisation).

(continued)

Table A1 (continued): Definition of core public health activities used to compile *Public health expenditure in Australia, 2007–08*

Public health activity category	Definition
Environmental health	This category relates to health protection education (for example safe chemical storage and water pollutants), expert advice on specific issues, development of standards, risk management and public health aspects of environmental health protection. The costs of monitoring and regulating are to be included where costs are borne by a regulatory agency and principally have a public health focus (for example, radiation safety, and pharmaceutical regulation and safety).
Food standards and hygiene	This category includes all activities relating to the development, review and implementation of food standards, regulations and legislation, as well as the testing of food by regulatory agencies.
Screening programs	This category includes all related activities for the three national population based screening programs including BreastScreen Australia, the National Cervical Screening Program and the National Bowel Cancer Screening Program
Prevention of hazardous and harmful drug use	<p>This category includes activities targeted at the general population to reduce and prevent the overuse or abuse of alcohol, tobacco, illicit and other drugs of dependence.</p> <p>Expenditure is reported for each of the following subcategories:</p> <ul style="list-style-type: none"> • Alcohol • Tobacco • Illicit and other drugs of dependence • Mixed.
Public health research	<p>The definition of research and development (R and D) is as follows (ABS 2008):</p> <p>‘R and D’ is defined according to the OECD standard as comprising creative work undertaken on a systematic basis in order to increase the stock of knowledge, including knowledge of man, culture and society, and the use of this stock of knowledge to devise new applications.</p> <p>An ‘R and D’ activity is characterised by originality. It has investigation as a primary objective, the outcome of which is new knowledge, with or without a specific application, or new or improved materials, product, devices, processes or services. ‘R and D’ ends when work is no longer primarily investigative.</p> <p>Thus the basic criterion for distinguishing ‘R and D’ from other public health activities is the presence of an appreciable element of novelty and resolution of scientific and/or technical uncertainty.</p> <p>Expenditure on general ‘R and D’ work relating to the running of ongoing public health programs is included under the other relevant public health activities.</p>

Jurisdictions' technical notes

Care must be exercised when comparing estimates of expenditure on public health across jurisdictions because different jurisdictions often need to direct more effort and resources to particular activities to meet needs that are of primary concern to their populations. These are sometimes determined by factors outside their control, such as their geographic location in relation to known or perceived risks to public health.

In addition, the relevance and levels of expenditure on public health activities by individual states and territories are also influenced by 'non-public health' factors, such as:

- location and population demographics (for example, age–sex structure and geographic distribution)
- relative economies of scale in the delivery of particular activities
- the need to cater for some populations who are residents of other states and territories
- the roles assigned to other agencies, such as local government authorities (LGAs), within jurisdictions.

Furthermore, while every effort has been taken to minimise differences in the methods used to estimate expenditure, there remain some methodological differences that render comparisons across jurisdictions a little problematic. These include:

- some differences arising from the different data collection processes across jurisdictions
- differences in the treatment of some overheads in the health expenditure estimates.

Role of Local Government Authorities within each jurisdiction

As stated elsewhere in this report, funding for public health activities provided by local governments is outside the scope of this project. However, the type and number of public health services funded by local governments within each jurisdiction will affect the need for similar services to be funded by higher levels of government.

For example, councils provide near half of all preschool childhood immunisations in Victoria.

While local government involvement in public health activities varies greatly between states and territories (Table A2), it is possible to recognise some functions that are common to the majority of local governments in Australia. These include waste and sanitation management, food safety, water quality control, prevention of *Legionella* disease and vector-borne disease control (NPHP 2002).

Table A2: Level of local government involvement^(a) in provision of public health activities, by jurisdiction^(b)

	NSW	Vic	Qld	WA	SA	Tas	NT
Communicable disease control	1	1	2	1	1	2	1
Selected health promotion	2	1	1	1	2	2	1
Organised immunisation	2	3	3	2	3	3	2
Environmental health	3	3	3	3	3	3	3
Food standards and hygiene	3	3	2	2	2	3	2
Screening programs	1	1	1	1	1	1	1
Prevention of hazardous and harmful drug use	2	3	2	1	1	1	1
Public health research	1	1	1	1	1	1	1
Other activities related to public health	3	3	3	3	3	3	3

(a) The level of local government involvement is denoted by a number where '1' represents little or no involvement, '2' represents minor involvement, and '3' represents major involvement.

(b) The Australian Capital Territory is a self-governing territory without local government. Traditional local government services are provided by the Territory government.

Sources: NPHP 2002, LGSA 2005, Municipal Association of Victoria 2007, Queensland Government Department of Local Government, Planning, Sport and Recreation 2007, Western Australian Local Government Association 2007, Local Government Association of South Australia 2008, Local Government Association of Tasmania 2007, Local Government Association of the Northern Territory 2008.

Method for allocating Australian Government expenditure by state/territory

In order to estimate the overall levels of public health expenditure in each state and territory, it is necessary to allocate the Australian Government funding in supporting public health programs on a state and territory basis. The Australian Government funds expenditure on public health activities through:

- the provision of SPPs to states and territories
- its own direct expenditure in supporting public health programs.

The Australian Government's SPPs can readily be allocated on a state and territory basis. Because its direct expenditures are generally not available on this basis, other methods need to be used to allocate these expenditures.

Except for the purchases of essential vaccines by the Australian Government on behalf of the state and territory governments, direct expenditure by the Australian Government has been apportioned across state and territories using population measures that directly relate to the recipients or the people that are direct beneficiaries of the expenditure. For example, direct expenditure on breast cancer screening has been split according to the relative share of specific target populations in each state and territory – in this case women aged 50–69 years. Alternatively, where the specific populations are not readily identifiable, then the total populations for each state and territory have been used (Table A3).

Table A3: Population groups used in apportioning direct expenditure by the Australia Government across state and territories

Public health activity categories	Population groups
Communicable disease control	
HIV/AIDS, hepatitis C and STIs	Total state/territory population numbers
NSPs	Total state/territory population numbers
Other communicable disease control	Total state/territory population numbers
Selected health promotion	Total state/territory population numbers
Organised immunisation	
Organised childhood immunisation	
General Practice Immunisation Incentives (GPII)	Children aged 0–9 years by state/territory
Other	Children and adolescents aged 0–19 years by state/territory
Organised pneumococcal and influenza immunisation	Adult population aged 65 and over by state/territory
All other organised immunisation	Total state/territory population numbers
Environmental health	Total state/territory population numbers
Foods standards and hygiene	Total state/territory population numbers
Screening programs	
Breast cancer screening	Females aged 50–69 years by state/territory
Cervical screening	
Medicare benefit payments	Recipients by state of location
Other expenditure	Females aged 20–69 years by state/territory
Bowel cancer screening	Adult population aged 55–64 years by state/territory
Prevention of hazardous and harmful drug use	
Alcohol	Total state/territory population numbers
Tobacco	Total state/territory population numbers
Illicit and other drugs of dependence	Total state/territory population numbers
Mixed	Total state/territory population numbers
Public health research	Total state/territory population numbers

Deflators

The real value of money is diminished over time by rises in prices (inflation). In order to measure real changes in expenditure on public health activities, it is necessary to adjust the estimates of expenditure to remove the effects of inflation. In this report, this is achieved by expressing the estimates of expenditure for all periods in terms of the purchasing power of money in 2007–08. This is referred to throughout the report as ‘expenditure as constant prices’. This has been achieved by deflating or inflating the current price expenditure estimates for all periods using the chain price indexes for government final consumption expenditure on hospitals and nursing home services derived by the ABS (Table A4).

The index used is an annually re-weighted Laspeyres chain price index and is calculated at such a detailed level that the ABS considers it equivalent to measures of pure price change. Although the index used relates primarily to consumption of hospital and nursing home services, it is heavily weighted towards health staff costs. As such it is also considered to be a reasonable indicator of price movements in relation to public health activities.

Table A4: Government final consumption expenditure on 'Hospital and nursing home services' – chain price index referenced to 2007–08

State and local hospital and nursing home services	1999–00	2000–01	2001–02	2002–03	2003–04	2004–05	2005–06	2006–07	2007–08
New South Wales	75.18	77.66	80.11	82.85	85.86	89.03	92.85	96.51	100.00
Victoria	74.56	76.99	79.49	82.29	85.53	88.94	92.77	96.38	100.00
Queensland	75.27	77.78	80.36	83.07	86.04	89.17	92.84	96.60	100.00
Western Australia	76.05	78.54	81.12	83.86	86.66	89.47	93.28	96.69	100.00
South Australia	75.39	77.86	80.18	82.85	85.81	89.00	92.95	96.43	100.00
Tasmania	75.39	78.01	80.17	83.03	85.87	88.92	92.90	96.48	100.00
Australian Capital Territory	75.24	77.76	80.24	83.38	86.58	89.59	93.11	96.73	100.00
Northern Territory	76.22	78.64	80.96	83.52	86.26	89.15	93.01	96.62	100.00
Australia	75.35	77.70	80.20	82.98	85.94	89.01	92.90	96.52	100.00

Note: These are annually re-weighted Laspeyres chain price indexes.

Source: Unpublished ABS data.

Appendix B: Other activities related to public health

Introduction

While this report focuses on expenditure and funding within eight core public health categories adopted by the National Public Health Expenditure Project there are programs and activities that either fall wholly outside the scope of this report, or have only a portion of the overall program classified as within scope for this report. But these activities and/or programs are important in understanding the context of public health activities in Australia.

In the case of the latter group of activities, only that part of the overall expenditure that has been classified as public health has been reported in the relevant chapter(s) of this report. For the former, none of the associated expenditure and funding has been included in the estimates of expenditure on public health.

These programs and activities are referred to as *other activities related to public health*. A selection is described here to provide some additional contextual information regarding expenditure on public health in Australia. They are:

- *Cervical screening*
- *Innovative Health Services for Homeless Youth*
- *Non-Government Organisation Treatment Grants Program*
- *The 45–49 year old health check program.*

Programs partially excluded from public health expenditure

Cervical screening

Chapter eight presented estimates of public health expenditure through the *National Cervical Screening Program* (see page 67). Such expenditure relates to Pap tests undertaken in respect of asymptomatic women to enable early detection of possible abnormalities in the cervix so that early medical intervention can avert the possible progression to cervical cancer.

Many of these Pap tests occur during the course of routine GP consultations or specialist consultations related to other health issues. The duration of the consultations during which the Pap tests are conducted vary, and the Pap tests themselves, on average, account for only an estimated 63% of the consultation. Therefore, only 63% of the Medicare benefits paid in respect of consultations that involve a Pap test are included in the estimates of expenditure on public health in this report. The remaining 37% of the Medicare benefits are assumed to relate to the 'non-Pap test' portion of these consultations and this is excluded from the public health expenditure estimates. That excluded portion was estimated to be \$19.8 million in 2007–08.

Innovative Health Services for Homeless Youth

The *Innovative Health Services for Homeless Youth Program* is jointly funded between the Australian Government and the state and territory governments. The aim of the program is to improve the health outcomes of homeless and otherwise at-risk youth aged 12–24 years, and their dependants, through the provision of specialised health services and improved access to mainstream health services.

The program provides funding for innovative health-related services for homeless and otherwise at-risk young people and their dependants. These include community and youth health services, services for homeless youth, health promotion, detox services, Aboriginal health services, a sexual assault centre, and a young parent's program.

While the program plays an important role in facilitating access to health services for marginalised young people, only half of the expenditure on the program was categorised as core public health and included in the estimates of expenditure on *Prevention of hazardous and harmful drug use*. The remaining half, \$1.3 million, was considered to be treatment costs and as such has not been included in the estimates of expenditure on public health activities.

Non-Government Organisation Treatment Grants Program

Under the *Non-Government Organisation (NGO) Treatment Grants Program*, the Australian Government provided \$34.2 million during 2007–08 to a range of NGOs to deliver tailored services to assist people with their drug addictions. These services include flexible family therapies and detoxification arrangements for individuals and their families who are trying to fight drug addiction. The program is also designed to meet the particular needs of young people in drug and alcohol treatment by providing additional treatment and residential places for them.

While the *NGO Treatment Grants Program* plays an important role in facilitating access to health services by marginalised young people, only half of the expenditure related to this program is categorised as core public health and is included in the expenditure for *Prevention of hazardous and harmful drug use*. The remaining half, \$17.6 million is considered to be treatment costs and as such has not been included in the estimates of expenditure on public health activities.

Programs wholly excluded from public health expenditure

The 45–49 year-old health check

The 45–49 year-old health check is part of the Australian Better Health Initiative (ABHI) announced by the COAG in February 2006. It aims to enhance the capacity of the health system to promote good health and reduce the burden of chronic disease.

A health check for individuals aged between 45 and 49 can assist these individuals to make the necessary lifestyle changes to prevent or delay the onset of chronic disease.

Eligible patients must be aged 45 to 49 years (inclusive) and at risk of developing chronic disease(s). At least one risk factor for developing a chronic disease must be identified. These include, but are not limited to:

- Lifestyle risk factors such as smoking, physical inactivity, poor nutrition or alcohol misuse
- Biomedical risk factors such as high cholesterol, high blood pressure, impaired glucose metabolism or excess weight
- Family history of a chronic disease.

The health check includes taking a patient's history and undertaking relevant examinations, making an overall assessment of the patient's health, before initiating interventions and providing advice and information to the patient – including strategies to achieve lifestyle and behaviour changes.

Appendix C: Developments in public health funding

There are developments within Australia that are relevant to the discussion of public health funding, but which fall outside of the 2007–08 timeframe on which this report focuses. For example, the new federal financial relations that began on 1 January 2009 changed the manner in which funding for government services are to be provided, including in relation to public health services.

Intergovernmental Agreement (IGA) on Federal Financial Relations

In December 2008, a new financial framework was agreed by the Council of Australian Governments. The changes in Australia's federal financial relations are aimed at improving the quality and effectiveness of government services by reducing Commonwealth prescriptions on service delivery by the states and territories, providing them with increased flexibility in the way they deliver services (COAG 2009a). The new framework, which is embodied in a single *Intergovernmental Agreement on Federal Financial Relations* between the Commonwealth and all the state and territory governments, reduced the number of payments to the states and territories from the Australian Government to five new national SPPs covering:

- Healthcare
- Schools
- Skills & Workforce Development
- Disability Services
- Affordable Housing.

The National Healthcare Agreement, which is part of the Intergovernmental Agreement, replaced the eight 2003–08 Australian Health Care Agreements between the Commonwealth and each of the state and territory governments. It affirmed that Australia's health system should:

- be shaped around the health needs of individual patients, their families and communities
- focus on the prevention of disease and injury and the maintenance of health, not simply the treatment of illness
- support an integrated approach to the promotion of healthy lifestyles, prevention of illness and injury, and diagnosis and treatment of illness across the continuum of care
- provide all Australians with timely access to quality health services based on their needs, not ability to pay, regardless of where they live in the country.

The National Healthcare Agreement specified a number of performance indicators covering the responsibilities of the Commonwealth and the state and territory governments in relation to health. These include:

- immunisation rates
- cancer screening rates
- access to GPs

- the number of mental health services
- waiting times for services
- the number of aged care assessments conducted and
- the allocation of health and aged care expenditure.

The National Healthcare Agreement indicators and the detailed specifications for them are yet to be reported. However, the analysis in chapter three may be relevant to the last indicator in the above list.

The new financial arrangements also included a new form of payment - National Partnership (NP) payments - to fund specific projects and to facilitate and/or reward states and territories that deliver on nationally-significant reforms. A NP agreement on preventative health has been established through which jurisdictions will commit to:

- support all Australians in reducing their risk of chronic disease by embedding healthy behaviours in the settings of their pre-schools, schools, workplaces and communities
- work with the food supply and the food service sectors towards offering healthy choices and minimising choices high in fat, sugar or salt, and with the sport, recreation and commercial fitness sectors in efforts towards increasing physical activity in the community
- support behavioural change with public education by placing on a sustained and adequately resourced footing the national *MeasureUP* or other agreed social marketing campaigns that will be initiated until 2010 under the ABHI, and administering this from a dedicated national preventive health agency
- similarly supporting behavioural change with a national anti-smoking campaign
- invest in the evidence base necessary for effective prevention by instituting national programs in chronic disease risk factor surveillance, translational research, evaluation, a national collaboration in eating disorders, and a workforce audit, and establishing a national preventive health agency to inform best practice.

The financial arrangements of this NP will include facilitation and incentive payments to reward performance which may total up to \$642.94 million - with the actual incentive payment funding to be decided at a later date (COAG 2009a).

Appendix D: International definitions for Public health expenditure reporting

There are international discussions currently taking place in relation to the definition of public health. The outcomes of these discussions may influence the definition of public health that future reports in this series will use.

In 2000, the OECD approved the release of its first manual outlining the standard framework to be adopted by member countries for producing comprehensive, consistent and internationally comparable accounts. The SHA manual includes guidelines to aid in classifying expenditure on prevention and public health services. These are activities that are designed to enhance the health status of the broader population, as distinct from those activities that provide curative services to individuals. An example of an activity that would be classified as 'prevention and public health services' is a measles vaccination campaign.

At the time of its release, there were a number of activities that appear to have a specific public health focus, but which could not be agreed on for inclusion in the SHA. These included expenditure on some activities with a public health focus, such as:

- monitoring the environment and of environmental control
- inspection and regulation of some industries, such as water supply.

These expenditures are reported as 'health related' activities, but are not included in the national estimates of expenditure on health.

The release of the SHA manual has led to considerable improvement in the comparability of international health accounts – particularly within the OECD member states. The SHA has also been adopted by the WHO and is gradually being implemented in reporting expenditure on health in developing economies – particularly in the Asia/Pacific region.

There is currently a proposal by the WHO to revise the SHA including making changes to the definition of 'public health and prevention'. The proposed definition covers a wider range of activities such as promoting health through environmental sanitation and the development of the social machinery to ensure standards of living that are adequate for the maintenance of good health.

Such a broadening of the definition of 'public health and prevention' may mean that, in the future, Australia could consider similarly broadening the scope used for public health expenditure reporting to include other activities that are outside the eight core public health activities used in this report but also have an impact on the health of populations.

Appendix E: Information on jurisdictional public health activities

Chapters 4-11 include selected summary information on state and territory public health activities. More detail is available in the following websites.

Communicable disease control

HIV/AIDS, hepatitis C, sexually transmitted infections

Campaign – AHMRC (NSW)

<www.health.nsw.gov.au/policies/pd/2006/PD2006_072.html>

Peer education (NSW)

<www.health.nsw.gov.au/policies/pd/2007/PD2007_093.html>

Prevention effectiveness (NSW)

<www.health.nsw.gov.au/resources/publichealth/sexualhealth/impactstatement_pdf.asp>

HIV/AIDS (VIC)

<www.health.vic.gov.au/ideas/diseases/hiv_strategy>

Hepatitis C (VIC)

<www.health.vic.gov.au/ideas/diseases/hepc_strategy>

STIs (VIC)

<www.health.vic.gov.au/ideas/home/sti-strategy>

Other (VIC)

<www.health.vic.gov.au/ideas/diseases/something_borrowed>

State Action Plan (WA)

<www.public.health.wa.gov.au/3/466/3/reports_and_pub.pm>

The Sexual Health and Blood-borne Virus Program (WA)

<www.public.health.wa.gov.au>

HIV/AIDS (SA)

<www.acsa.org.au/gmh_resources.html>

Hepatitis C (NT)

<www.health.nt.gov.au/Centre_for_Disease_Control>

STIs (NT)

<www.safesexnoregrets.nt.gov.au/>

Other (NT)

<www.ntahc.org.au/>

Needle and syringe programs

NSP (VIC)

<www.health.vic.gov.au/drugservices/services/needle.htm>

NSP (QLD)

<www.health.qld.gov.au/qnsp/pdf/QNSP_Policy.pdf> >

NSP (NT)

<www.health.nt.gov.au/Centre_for_Disease_Control>

<www.NTAHC.org.au>

Other communicable disease control

Range of notifiable infections (VIC)

<www.health.vic.gov.au/ideas>

Other communicable disease control (SA)

<www.dh.sa.gov.au/pehs/notifiable-diseases-summary/introduction-to-summary.htm>

<www.health.sa.gov.au/INFECTIONCONTROL/Default.aspx?tabid=175>

Rheumatic Heart Disease Program (NT)

<www.health.nt.gov.au/Rheumatic_Heart_Disease/index.aspx>

Illegal Fisherpersons (screening for tuberculosis) (NT)

<http://www.health.nt.gov.au/Publications/Corporate_Publications/Annual_Report_2007-2008/index.aspx>

Selected health promotion

Selected Health Promotion – Aged Care (VIC)

<www.health.vic.gov.au/agedcare/maintaining/wellforlife.htm>

<www.health.vic.gov.au/agedcare/publications/wellforlife_eval.htm>

<www.health.vic.gov.au/agedcare/maintaining/wellforlife_ph.htm>

<www.health.vic.gov.au/agedcare/downloads/wellforlife_ph_evaluation.pdf>

<www.health.vic.gov.au/agedcare/downloads/wellforlife_ph_collection_stories.pdf>

Falls Prevention (VIC)

<www.health.vic.gov.au/agedcare/maintaining/falls/index.htm>

VicHealth (VIC)

<www.vichealth.vic.gov.au/>

Kids – ‘Go for your life’ (VIC)

<www.goforyourlife.vic.gov.au/hav/articles.nsf/pracpages/Kids_Go_for_your_life?open>

VicHealth Mental Health and Wellbeing promotion. (VIC)

<www.vichealth.vic.gov.au/~media/About%20Us/Annual%20Report/Attachments/AnnualReport_WEB.ashx>

Skin cancer prevention (QLD)

<www.health.qld.gov.au/qphf/documents/qld_sun_strat_plan.pdf>

<www.health.qld.gov.au/sunsafety/campaigns/radio.asp>

<www.health.qld.gov.au/sunsafety>

Injury prevention (QLD)

<www.health.qld.gov.au/chipp>

<www.health.qld.gov.au/stayonyourfeet>

<www.health.qld.gov.au/PoisonsInformationCentre/default.asp>

Go for 2&5® (WA)

<www.gofor2and5.com.au/>

Crunch&Sip® (WA)

<www.crunchandsip.com.au>

Parental Guidance Recommended (WA)

<www.cancerwa.asn.au/prevention/nutrition/pgr>

Find Thirty® (WA)

<www.findthirtyeveryday.com.au>

Mental health promotion (QLD)

<www.health.qld.gov.au/bekindtoyourmind>

NAPMH (SA)

<www.Headroom.net.au>

Mental Health Week (NT)

<<http://www.ntcoss.org.au/gallery/mental-health-week>>

Go for 2 and 5 – campaign (NT)

<www.health.nt.gov.au/Nutrition_and_Physical_Activity/Publications/index.aspx>

GoNT (NT)

<www.health.nt.gov.au/Nutrition_and_Physical_Activity/Publications/index.aspx>

Suicide prevention (NT)

<http://www.lifeline.org.au/learn_more/media_centre/media_releases/2007/nt_government_funding_supports_lifelines_role_in_central_australia>

<www.anglicare-nt.org.au/pages/Top-End-Suicide-Intervention-%26amp%3B-Awareness-Training-Project.html>

MHACA (Life Promotion activities in Central Australia. Expansion to Tennant Creek) (NT)

<www.mhaca.org.au/programsLPP.html>

Organised immunisation

Immunisation strategy (NSW)

<www.health.nsw.gov.au/pubs/2008/pdf/immun_strategy2008.pdf>

Health care worker vaccination (NSW)

<www.health.nsw.gov.au/publichealth/immunisation/ohs/>

State Vaccination Program (VIC)

<www.health.vic.gov.au/immunisation/>

Statewide School Based Vaccination Program (QLD)

<www.health.qld.gov.au/school_vaccination/>

New Arrival Refugee Immunisation program (SA)

<www.dh.sa.gov.au/pehs/publications/NARI-Immunisation-A4-Poster-2008.pdf>

Health Care Worker Immunisation program (SA)

<www.dh.sa.gov.au/pehs/Immunisation/09-P6-access-fluvacc-dh.pdf>

Environmental health

Environmental Health (NSW)

<www.health.nsw.gov.au/publichealth/environment/index.asp>

Water Fluoridation (VIC)

<www.health.vic.gov.au/environment/climate/index.htm>

Climate Change (VIC)

<www.health.vic.gov.au/environment/climate/index.htm>

Asbestos Awareness Campaign (QLD)

<www.health.qld.gov.au/asbestos/>

No Germs on Me (NT)

<www.health.nt.gov.au/Environmental_Health/No_Germs_on_Me_Campaign/index.aspx>

Food standards and hygiene

Food Safety & Hygiene (VIC)

<www.health.vic.gov.au/foodsafety/>

Introduction of the food safety supervisor requirement (QLD)

<www.health.qld.gov.au/ph/documents/ehu/33147.pdf>

<www.health.qld.gov.au/ph/documents/ehu/33262.pdf>

<www.health.qld.gov.au/ph/documents/ehu/fs_guideline.pdf>

<www.health.qld.gov.au/ph/documents/ehu/qhfss_crtransmatrix.pdf>

Requirement for high risk food handling activities and food safety programs (QLD)

<www.health.qld.gov.au/ph/documents/ehu/food_safety_programs.pdf>

<www.health.qld.gov.au/ph/documents/ehu/30373.pdf>

<www.health.qld.gov.au/ph/documents/ehu/33320.pdf>

<www.health.qld.gov.au/ph/documents/ehu/child_care_fsp.pdf>

Queensland Health approval of auditors from Population Health Units, Local Governments and industry to undertake the auditing of food safety programs (QLD)

<www.health.qld.gov.au/ph/ehu/auditors.asp>

<www.health.qld.gov.au/ph/documents/ehu/food_auditor_fs.pdf>

<www.health.qld.gov.au/ph/documents/ehu/food_codeconduct.pdf>

Food standards compliance surveys (SA)

<www.health.sa.gov.au/pehs>

Food Sampling (NT)

<www.health.nt.gov.au/Environmental_Health/Food_Safety/index.aspx>

Screening programs

Breast cancer screening

<www.cancerscreening.gov.au/>

Breast screening (VIC)

<www.breastscreen.org.au/>

Cervical screening

Campaign (NSW)

<www.cancerinstitute.org.au/cancer_inst/publications/pdfs/ir-2008-01_annualreport2008.pdf>

Victorian Cytology Services (VIC)

<www.vcs.org.au/>

<vccr.org/>

PapScreen Victoria (VIC)

<www.papscreen.org.au/>

<www.papscreen.org.au/browse.asp?ContainerID=d2>

Mobile Women's Health Service (QLD)

<www.health.qld.gov.au/cervicalscreening/women/mobile.asp>

Queensland Cervical Screening Program (QCSP) (QLD)

<www.health.qld.gov.au/cervicalscreening/women/register.asp>

Cervical screening (WA)

<www.health.wa.gov.au/cervical>

Cervical screening (SA)

<www.health.sa.gov.au/pehs/cervix-screening-index.htm>

Cervical screening (NT)

<www.health.nt.gov.au/Womens_Health/index.aspx>

Prevention of hazardous and harmful drug use

Alcohol

Community Drug Action Teams (NSW)

<www.communitybuilders.nsw.gov.au/drugs_action/>

Controlled Drinking Program (NSW)

<www.acar.net.au/mail01.html>

Alcohol -related action plan (VIC)

<www.health.vic.gov.au/drugservices/pubs/action_plan.htm>

Alcohol -related action plan, Queensland Drug Strategy> (QLD)

<www.health.qld.gov.au/atods/documents/pdu/phstratdir_chronic.pdf>

WA Alcohol Plan 2006-2009 (WA)

<www.dao.health.wa.gov.au/SiteList/PolicyDiscussionPapers/tabid/178/Default.aspx>

Rethink Drink Alcohol Education Program (WA)

<www.rethinkdrink.com.au>

Good Sports (SA)

<www.goodsports.com.au>

Community Sector Organisations funding (TAS)

<www.den.org.au/>

Liquor Licensing Act 1990 (TAS)

<www.thelaw.tas.gov.au/tocview/index.w3p;cond=;doc_id=44%2B%2B1990%2BAT%40EN%2B20090320100000;histon=;prompt=;rec=;term>

Just like that media campaign (TAS)

<www.rstf.tas.gov.au/>

Alcohol Management Plans under the Department of Justice (NT)

<www.asb.nt.gov.au/alcohol.html>

<www.nt.gov.au/justice/alcohol.shtml>

Tobacco

Tobacco Campaign (NSW)

Tobacco Campaign (NSW)

<www.cancerinstitute.org.au/cancer_inst/publications/pdfs/ir-2008-01_annualreport2008.pdf>

Tobacco Social Marketing and Cessation Services (VIC)

<www.quit.org.au/browse.asp?ContainerID=1640>

Tobacco -related programs (WA)

<www.cancerwa.asn.au/prevention/tobacco/makesmokinghistory>

<www.smokefreebaby.org.au/>

Tobacco Control (SA)

<www.quitsa.org.au>

<www.tobaccolaws.sa.gov.au>

Media campaigns (TAS)

<www.quittas.org.au/campaigns/sponge/>

Illicit and mixed drugs programs

Community Drug Action Teams (NSW)

<www.communitybuilders.nsw.gov.au/drugs_action/>

Play Now Act Now (NSW)

<www.pnan.com.au/>

Drug Aware Amphetamine Education Campaign (WA)

<www.amphets.com.au>

Night Venues and Entertainment Events Project (NVEEP) (WA)

<www.dao.health.wa.gov.au>

Public health research

Public health research programs

Capacity Building Infrastructure Grants program (NSW)

<www.health.nsw.gov.au/ethics/research/cbigp.asp>

Core funding for Sax Institute (NSW)

<www.saxinstitute.org.au/aboutus/Ourorganisation.cfm?objid=123>

Strategic Health Research Program (SA)

Equity of bowel screening, an epidemiological and qualitative study: (SA)

<www.health.sa.gov.au/SHRP/Portals/0/SHRP%20HLE-11612%20Ward.pdf>

Psychosocial, demographic and program variables associated with bowel cancer screening (SA)

<www.health.sa.gov.au/SHRP/Portals/0/SHRP%20HLE-11632%20Cole.pdf>

Managing System and Patient Sequelae to the National Bowel Screening Program (SA)

<www.health.sa.gov.au/SHRP/Portals/0/SHRP%20HSR-11635%20Young.pdf>

Exploring resilience and coping in relation to smoking 'at risk' populations (SA)

<www.health.sa.gov.au/SHRP/Portals/0/SHRP%20ST1-9869%20Tsourtos.pdf>

Indigenous Smoking Scoping Study (SA)

<www.health.sa.gov.au/SHRP/Portals/0/Urban%20report%20Oct%202008.pdf>

Population Health Research – Chronic Disease (SA)

<www.health.sa.gov.au/pros/Default.aspx?tabid=76>

Population Health Research – Risk Factors (SA)

<www.health.sa.gov.au/pros/Default.aspx?tabid=68>

IDRS/EDRS (Illicit Drug Reporting System (IDRS) and the Ecstasy and Related Drugs Reporting System (EDRS)) (SA)

<ndarc.med.unsw.edu.au/NDARCWeb.nsf/page/Drug%20Trends>

Public health research programs (NT)

<www.health.nt.gov.au/Publications/Corporate_Publications/Annual_Report_2007-2008/index.aspx>

Menzies School of Health Research Funding (NT)

<www.menzies.edu.au>

Menzies School of Health Research also has partnerships with DHF programs funded separately. (NT)

<www.health.nt.gov.au/Publications/Corporate_Publications/Annual_Report_2007-2008/index.aspx>

References

- ABS (Australian Bureau of Statistics) 2008. Australian and New Zealand Standard Research Classification (ANZSRC). ABS cat. No. 1297.0. Canberra: ABS.
- AIHW (Australian Institute of Health and Welfare) 2006. Australia's health 2006. Cat. no. AUS 73. Canberra: AIHW.
- AIHW 2008. Australia's health 2008. Cat. no. AUS 99. Canberra: AIHW.
- AIHW 2008a. Expenditures of health for Aboriginal and Torres Strait Islander peoples 2004–05. Cat. no. HWE 30. Canberra: AIHW.
- AIHW 2008b. The health and welfare of Australia's Aboriginal and Torres Strait Islander peoples 2008. Cat. No. IHW 21. Canberra AIHW.
- AIHW 2009. Public health expenditure in Australia, 2006–07. Cat. no. HWE 41. Canberra: AIHW.
- AIHW 2009a. Health expenditure Australia 2007–08. Cat. no. HWE 46. Canberra: AIHW.
- AIHW 2009b. Cervical screening in Australia 2006–2007. Cat. no. CAN 43. Canberra: AIHW.
- Council of Australian Governments (COAG) 2009. Viewed 17 October 2009, <http://www.coag.gov.au/intergov_agreements/federal_financial_relations/index.cfm>.
- COAG 2009a. Viewed 5 August 2009, <www.coag.gov.au>.
- DoHA (Department of Health and Ageing) 2002. Return on investment in needle and syringe programs in Australia. Canberra: Commonwealth.
- DoHA 2006. Canberra: Commonwealth Department of Health and Ageing. Viewed 11 March 2008, <<http://www.health.gov.au/internet/wcms/publishing.nsf/Content/health-pubhlth-about-phofa-phofa.htm>>.
- DoHA 2007. Protecting your daughter from cervical cancer. Canberra: Commonwealth Department of Health and Ageing. Viewed 24 August 2009 <www.immunise.health.gov.au>.
- DoHA 2008. Communicable diseases information. Canberra: Commonwealth Department of Health and Ageing. Viewed 24 August 2009 <www.health.gov.au>.
- DoHA 2008a. National Drugs Campaign 2007. Canberra: Commonwealth Department of Health and Ageing. Viewed 27 August 2009 <www.drugs.health.gov.au>.
- DoHA 2009. Evaluation of the Effectiveness of Graphic Health Warnings on Tobacco Product Packaging 2008. Canberra: Commonwealth Department of Health and Ageing. Viewed 24 August 2009 <www.health.gov.au>.
- Local Government Association of South Australia 2008. Adelaide: Local Government Association of South Australia. Viewed 27 February 2008, <www.lga.sa.gov.au>.
- Local Government Association of Tasmania 2007. Hobart: Local Government Association of Tasmania. Viewed 27 February 2008, <www.lgat.tas.gov.au>.
- Local Government Association of the Northern Territory 2008. Parap: Local Government Association of Northern Territory. Viewed 27 February 2008, <www.lgant.nt.gov.au>.
- Local Government and Shires Associations of NSW 2005. Public health in NSW local governments: summary results of Local Government Public Health Survey. Sydney: LGSA.
- Municipal Association of Victoria 2007. Melbourne: Municipal Association of Victoria. Viewed 27 February 2008, <www.mav.asn.au>.

NPHP (National Public Health Partnership) 2002. *The Role of Local Government in Public Health Regulation*. Melbourne: NPHP.

NPHP 1998. *Public health in Australia: the public health landscape: person, society, environment*. Melbourne: NPHP.

Queensland Government Department of Local Government, Planning, Sport and Recreation. 2007. Brisbane: Queensland Government Department of Local Government, Planning, Sport and Recreation. Viewed 27 February 2008, <www.localgovernment.qld.gov.au>.

Western Australian Local Government Association 2007. West Perth: Western Australian Local Government Association. Viewed 27 February 2008, <www.walga.asn.au>.

WHO (World Health Organization) 2009. Viewed 1 September 2009, <<http://www.who.int>>.

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