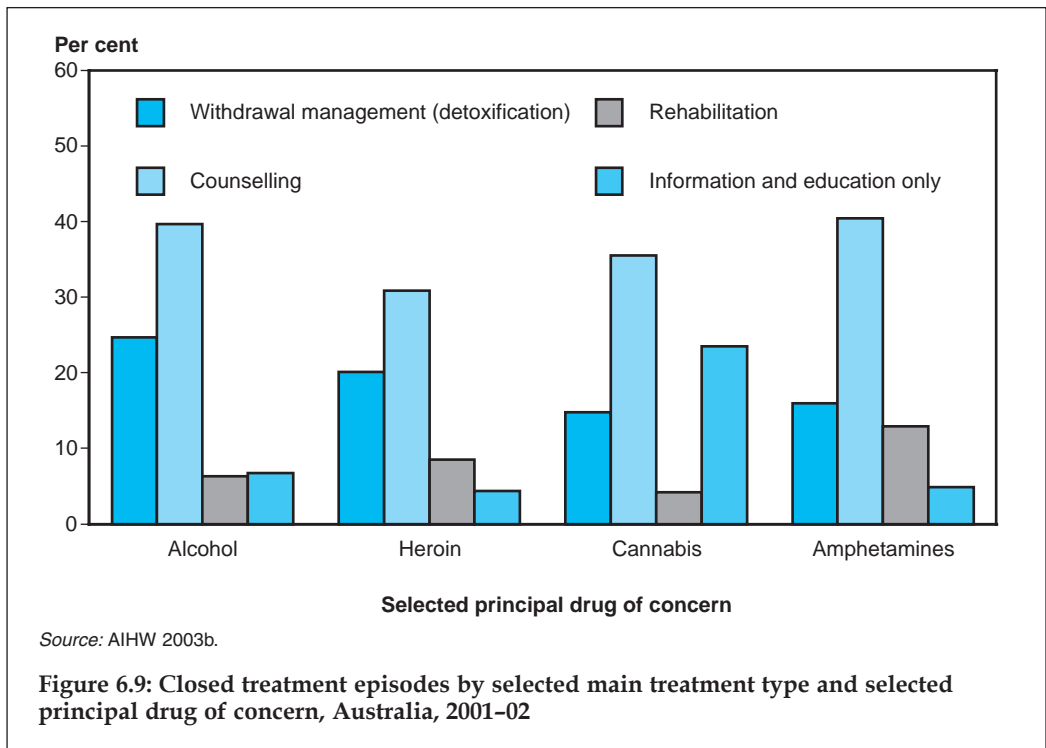


Treatment programs

In 2001–02, counselling was the most common form of main treatment provided (39% of closed treatment episodes), followed by withdrawal management (detoxification) (19%), assessment only (without treatment) (15%), and information and education only (without treatment) (10%) (AIHW 2003a). Rehabilitation was the main treatment in 6% of episodes.

The type of main treatment provided varied depending on the principal drug for which the client sought treatment. Closed treatment episodes where the principal drug was alcohol were more likely to involve withdrawal management (detoxification) (25%) than treatment episodes where the principal drug was cannabis (15%) (Figure 6.9). Treatment episodes for amphetamine use were more likely to include counselling (40%) than treatment episodes for heroin use (31%).



6.7 Primary health care services for Aboriginal and Torres Strait Islander peoples

Section 4.6 of this report provides data on the health status of, hospitalisation rates for and use of GPs by Aboriginal and Torres Strait Islander people, demonstrating that the pattern of use of these mainstream services is different for Indigenous peoples compared with the rest of the Australian population. Health expenditure data (Section 5.2) reinforce this point.

Mainstream services are not always accessible to or the most appropriate provider for Aboriginal and Torres Strait Islander people, due to a mix of geographic, social and cultural reasons. Because of this, and the relatively poor health status of Aboriginal and Torres Strait Islander people, state, territory and Australian governments provide funds for specific health care services to meet the needs of Indigenous people.

The state and territory governments provide funding primarily through hospitals and community clinics. The Australian Government, through the Office for Aboriginal and Torres Strait Islander Health (OATSIH), provides funding for a range of Indigenous-specific health and substance use services, which are largely delivered in community-based settings. In 2002–03, OATSIH funding was provided to 184 Aboriginal and Torres Strait Islander community controlled health organisations that provided or purchased Aboriginal and Torres Strait Islander primary health care services across Australia. These included 66 that provided substance use services, of which 43 were specific substance use services including 30 that provided residential services (DoHA unpublished data).

The OATSIH-funded Aboriginal and Torres Strait Islander primary health care services (which may also receive funding from other sources such as state and territory governments) are known as Aboriginal Medical Services. They operate in urban, rural and remote locations and offer a wide range of services, including management of acute and chronic health conditions, preventive health measures (such as immunisation and screening) and health promotion activities, transport services, advocacy and assistance in accessing other appropriate community and health services. A small number provide specific programs only, such as dental care, health promotion and counselling.

In 2000–01, approximately 1,340,000 episodes of health care were provided to Indigenous and non-Indigenous clients by 124 Aboriginal and Torres Strait Islander primary health care services (not including specific substance use services) that reported data to OATSIH (DoHA and NACCHO 2003). This compares with approximately 1,200,000 episodes reported by 117 services in 1999–00, 1,060,000 episodes reported by 108 services in 1998–99 and 860,000 episodes reported by 105 services in 1997–98. These services covered an estimated Aboriginal and Torres Strait Islander health service population of 645,000 in 2000–01 compared with 615,000 in 1999–00 (for 115 services), 515,000 in 1998–99 (108 services) and 410,000 in 1997–98 (105 services). Approximately 1,210,000 (90.3%) of the estimated episodes of health care in 2000–01 were provided to Aboriginal and Torres Strait Islander clients. Of these, 60% were provided to female clients.

Respondent Aboriginal and Torres Strait Islander primary health care services employed 2,300 full-time-equivalent staff in 2000–01. Of these, 67% were Aboriginal or Torres Strait Islander staff members. This did not include 200 full-time-equivalent staff who worked at the services but were not paid by the services. Nearly all Aboriginal and Torres Strait Islander health workers and substance use workers were Indigenous people, whereas most nurses and almost all doctors, dentists and specialists were non-Indigenous.

6.8 National Diabetes Services Scheme

The National Diabetes Services Scheme subsidises the supply of insulin syringes, special injection system needles and diagnostic reagents (blood and urine testing strips) to registered persons with diabetes (DoHA 2004). It is funded by the Australian Government and administered through Diabetes Australia, which coordinates the supply of products in all states and territories.

There were 614,727 persons with diabetes registered with the scheme in 2002–03, an increase of 11.8% over the 549,994 in 2001–02 and of 24.5% over the 493,919 in 2000–01 (Table 6.22). At 31 December 2002, persons who did not use insulin comprised the majority (68.5%). In 2002–03, subsidies were provided for 1.6 million supplies of diagnostic reagents and 0.5 million needle and syringe supplies. Australian Government expenditure on the scheme in 2002–03 was \$81.4 million, an increase of 23.6% from the \$65.9 million in 2001–02.

Table 6.22: The National Diabetes Services Scheme, 2000–01 to 2002–03

	Expenditure (\$ million)	Persons registered	Needle and syringe supplies	Diagnostic reagent supplies
2000–01	58.1	493,919	n.a.	n.a.
2001–02	65.9	549,994	440,366	1,425,476
2002–03	81.4	614,727	481,001	1,592,512

n.a. Not available.

Source: DoHA 2004 and unpublished data.

6.9 Hearing services

Public hearing services are provided through the Australian Government's Office of Hearing Services. The Office issues vouchers to eligible clients (persons aged 21 years or more who are Pensioner Concession card holders or their dependants, DVA card holders in certain categories or their dependants, sickness allowance recipients or their dependants, clients referred from CRS Australia (formerly the Commonwealth Rehabilitation Service), and members of the Australian Defence Force). Clients present the voucher to an accredited service provider to obtain services such as hearing assessment; audiological rehabilitation and maintenance; prescription, selection and fitting of hearing devices; and subsidised battery supply and device repair.

In 2002–03, 160,000 clients were issued with a voucher and there were 565,016 voucher hearing services provided (Table 6.23). Most of these were maintenance services (54%), assessment services (25%) and fittings (19%).

Between 1999–00 and 2002–03, the overall number of services increased by 17%, mainly due to increases in maintenance services and assessment services. Although most service types increased, the number of new monaural hearing aid fittings decreased by 17%, from 19,073 to 15,887. The number of return monaural fittings also decreased, but increased relative to 2000–01.

In addition, Australian Hearing provides services to persons under the age of 21 and adults with special needs (for example persons with complex hearing rehabilitation needs, eligible Aboriginal and Torres Strait Islander people, and persons living in

remote locations) under its Community Services Obligations program. In 2002–03, services were provided to 28,015 persons under the age of 12 years, and 10,873 adults with complex hearing rehabilitation needs. Of the 38,888 persons provided with services under this program, 1,814 (4.7%) were Aboriginals or Torres Strait Islanders.

Table 6.23: Hearing services provided through the voucher system and community service obligation arrangements, 2002–03

Type of service	1999–00	2000–01	2001–02	2002–03
Assessments				
New	57,867	57,555	63,399	69,540
Return	55,171	53,750	61,061	68,910
<i>Total assessments</i>	<i>113,038</i>	<i>111,305</i>	<i>124,460</i>	<i>138,450</i>
Hearing aid fitted				
New monaural fit	19,073	17,381	16,488	15,887
New binaural fit	30,921	29,277	33,984	39,401
Subsequent binaural	9,636	9,416	10,703	10,960
Return monaural fit	18,018	15,997	16,047	17,066
Return binaural fit	22,291	18,869	18,815	22,272
<i>Total hearing aid fitted</i>	<i>99,939</i>	<i>90,940</i>	<i>96,037</i>	<i>105,586</i>
Replacements	12,969	14,689	16,294	17,642
Maintenance	257,744	262,972	288,271	303,338
Total	483,690	479,906	525,062	565,016

Source: Office of Hearing Services unpublished data.

6.10 Family planning services

A range of clinical, community education and professional training services in sexual and reproductive health are provided by family planning organisations. The clinical services provided to individuals include contraceptive services, counselling and information services, early intervention and health promotion services, and the management of sexual and reproductive health. Family planning organisations provide these services to clients who choose not to use, or do not have access to, mainstream health services, including young people, migrant populations, the homeless and people with disabilities. There are differences among the state and territory family planning organisations in the way service use is defined. Therefore, the data presented here should be interpreted with care.

During 2001–02, 129,879 client visits were made to family planning organisations (excluding those in South Australia) (SH&FPA 2002). When clients visit a family planning organisation they may access a single service or a combination of services; a total of 131,872 services were reported for 2001–02. Clients who were aged less than 25 years received 36% of services and 25% of services were delivered to clients aged 40 years and over. Males made 3% of client visits, although the number of males who attended with their female partners (that is, as couples) is unknown. About 16% of client visits were made by people born outside Australia.

Family planning organisations also provide education and training programs. In 2001–02, about 13,869 people (mainly health and education professionals) attended training sessions, and over 100,000 attended general, community or school education programs.

6.11 Ambulance services and the Royal Flying Doctor Service

Ambulance services are provided by state and territory governments, except in Western Australia and the Northern Territory, where St John's Ambulance Australia is contracted to provide the services.

The role of ambulance services generally includes providing emergency pre-hospital patient care and transport in response to sudden illness and injury, retrieving emergency patients, transporting patients between hospitals, conducting road accident rescues and coordinating patient services in multi-casualty events. Some government ambulance services also provide first aid training courses, as do non-government providers such as St John's Ambulance and Australian Red Cross.

In 2002–03, there were approximately 2.23 million incidents requiring a response from ambulance services in Australia; and 2.56 million responses to incidents. A total of 44.6% were emergency incidents, 20.1% were urgent incidents and 35.3% were non-emergency incidents. In total, there were services provided to about 2.15 million patients. Of those 88.5% were transported and the remainder were treated but not transported. Road distances traveled totaled 43.4 million kilometres and also reported were 12,890 fixed wing flying hours and 7,255 rotary wing flying hours (SCRGSP 2004).

The Royal Flying Doctor Service provides emergency health services, primary health care clinics at remote sites (such as routine health checks and advice, immunisation, child health care, and dental, eye and ear clinics), telehealth consultations via radio, telephone or videoconference, and transfers of patients between rural and remote area hospitals and metropolitan hospitals. In 2001–02 it provided services to 193,943 patients, of whom 55% attended 8,861 health care clinics, 29% received telehealth consultations, 13% were transported by aerial evacuation (including interhospital transfers) and the remaining 3% received immunisations. The number of patients receiving services increased by 27% from 153,012 patients in 1991–92 (RFDS 2002).

6.12 Other community health services

Government-funded community health services in each state and territory of Australia provide a diverse range of health services, not described elsewhere in this chapter. Statistical information on these services is not developed, with incomplete coverage of services, data systems under development and no agreed basis for measuring volumes across diverse service types, nor for distinguishing between services reported to national data collections and those not reported. Therefore a comprehensive national picture of community health services cannot be provided. However, some information on the nature of the services follows.

Typically, the services include those for particular population groups, such as maternal and child health services, men's health services, women's health services, health services for the aged, health services for those with a severe chronic disease or disability, health services for Aboriginal and Torres Strait Islander peoples, and multiculturally based services.

The types of services provided include health promotion, education and early intervention, primary health care, home nursing, nutrition services, allied health services

such as physiotherapy, post-hospital discharge programs, rehabilitation services, palliative care and sexual health services.

Services are delivered in a number of different settings, such as community health centres, local council buildings, schools and clients' homes.

6.13 Complementary and alternative health services

A range of services complement or provide alternatives to mainstream health care services. Estimates from the 2001 National Health Survey (ABS 2001) were that about 3.5% of the population (661,400) consulted a complementary or alternative health professional in the two weeks before the survey interview, 4.1% of females (388,700) and 2.9% of males (272,700) (Table 6.24). The majority of consultations (423,800) were for persons aged between 25 and 54 years. About 2.0% (387,900) of Australians consulted a chiropractor, 1.0% (129,800) consulted a naturopath and about 177,300 consulted an acupuncturist, herbalist, hypnotherapist or osteopath.

Table 6.24: Persons reporting consultations with complementary and alternative health professionals ('000)^(a), by age group and sex, 2001

	0-4	5-14	15-24	25-34	35-44	45-54	55-64	65-74	75+	Total		
										Males	Females	Persons
Chiropractor	*8.3	29.7	34.6	76.2	84.6	80.9	40.0	21.8	*11.8	188.4	199.4	387.9
Naturopath	**	*9.4	*12.0	25.0	30.0	29.5	*11.1	*3.6	*6.2	32.9	96.8	129.8
Other ^(b)	**	*3.1	16.4	39.6	43.9	36.6	17.2	*10.9	*7.4	61.0	116.3	177.3
Total^(c)	*13.4	40.2	61.2	138.6	148.5	136.7	66.4	34.5	21.9	272.7	388.7	661.4

* Estimate has a relative standard error of between 25% and 50% and should be used with caution.

** Estimate has a relative standard error greater than 50% and is considered too unreliable for general use.

(a) Consultations in the 2 weeks before interview. Excludes consultations in/at hospitals or day clinics.

(b) Includes acupuncturist, herbalist, hypnotherapist and osteopath.

(c) Total will not necessarily be the sum of the rows, as some persons reported consultations with more than one type of professional.

Source: ABS 2001 and unpublished data.

A study in 2000 estimated that 26% of women and 20% of men in South Australia had visited an alternative therapist in the previous year. Chiropractors (16% of males and 17% of females), naturopaths/natural therapists (3% of males and 9% of females) and acupuncturists (3% of males and females) were the most commonly visited. Average expenditure per person per year on alternative therapists was estimated at \$252, or the equivalent of \$616 million for Australia for 2000. This represented an increase of 62% (after adjusting for inflation) over the expenditure estimated for 1993 (\$309 million) (MacLennan et al. 2002).

The extent to which these services have been incorporated into the general healthcare system varies. Only acupuncture performed by a medical practitioner attracts a Medicare rebate; rebates totalled \$13.5 million in 2002-03, for 595,000 acupuncture Medicare items, compared with \$15.2 million and 719,000 Medicare items in 2000-01. Some private health ancillary insurance covers some of these services, such as those provided by naturopaths, osteopaths and chiropractors.

6.14 Public health interventions

Public (or population) health interventions are formally activities defined widely as representing the organised response by society to protect and promote health and to prevent illness, injury and disability. Less formally, they are visible as health awareness and promotion campaigns (such as the *Slip Slop Slap* sun protection advertisements and the *Life. Be in It* promotional activities) and disease prevention services (such as the breast cancer screening program).

Public health activities may focus on populations or population groups or they may focus on the environment (for example, maintaining water and air quality). Some initiatives are carried out by non-health organisations (such as transport departments) while others are undertaken in the health arena. Some work through the treatment system (including hospitals and medical practitioners); however, most are aimed at people who are not ill, but have the potential to become ill due to their biological characteristics (such as age, in relation to falls) or their behaviours (such as smoking, in relation to cancer).

Some examples of the range of public health interventions are:

- cancer screening and sun protection awareness campaigns
- immunisation programs and campaigns (recently for meningococcal disease)
- illicit drug awareness campaigns and safe drug-injecting facilities
- anti-smoking campaigns and support groups
- exercise programs for schools and the elderly.

Public health activities of particular interest in recent years were the work planning responses to bioterrorism threats (such as anthrax) and to the outbreak of the SARS virus, and managing the risks around international events such as the Rugby World Cup and natural events such as the Canberra bushfires. In these instances, specific emergency response training was implemented, emergency department rapid data capture systems were put in place to monitor any outbreaks of diseases and symptoms, management protocols were designed as new information came to light about potential diseases, and potentially harmful sources of infection were minimised.

Three key public health interventions are described below – cancer screening, childhood immunisation, and needle and syringe programs.

Cancer screening

For breast, cervical and bowel cancers, there is evidence that illness and death can be reduced through population-based screening and effective follow-up treatment. National screening programs for breast cancer (via mammography) and cervical cancer (via Pap smears) have been implemented in Australia with the aim of achieving this reduction. These programs are called BreastScreen Australia and the National Cervical Screening Program. Pilot tests for a population-based screening program for bowel cancer are currently being undertaken.

BreastScreen Australia

The BreastScreen Australia Program is jointly funded by the Australian Government and state and territory governments. It consists of a network of dedicated screening and assessment services throughout metropolitan, rural and remote areas of all Australian states and territories. These services can be fixed or mobile and provide free two-yearly mammographic screening and follow-up of any suspicious lesions identified at screening to the point of diagnosis of breast cancer. The program is aimed specifically at women aged 50–69 years of age without symptoms, although women aged 40–49 years and 70 years and older may attend for screening. Women may attend without a doctor's referral.

In addition, recruitment and reminder systems are used to promote screening and rescreening among women in the target group once every two years.

A comprehensive system of accreditation is used to ensure that all BreastScreen Australia services operate under a common set of standards. Each service is assessed regularly by an independent team to ensure that the service provided complies with national standards.

The proportion of women in the target age group who were screened under the BreastScreen Australia program in a two-year period rose from 52.3% in the two-year period 1996–1997 to 57.1% in 2001–2002 (Table 6.25). Age-standardised participation rates for women in the target age group in major cities (55.6%) and very remote areas (47.9%) were lower than the national rate of 57.1%. Higher than the national rate were inner regional areas at 59.7%, outer regional areas at 60.7% and remote areas at 60.9% (Figure 6.10). Women in the target age group with the highest socioeconomic status had the lowest age-standardised participation rate (53.7%) in 2001–2002. In contrast, women with the lowest socioeconomic status had the highest participation rate (63.9%) (Figure 6.11).

Table 6.25: Women screened in each two-year period, 1996–1997 to 2001–2002

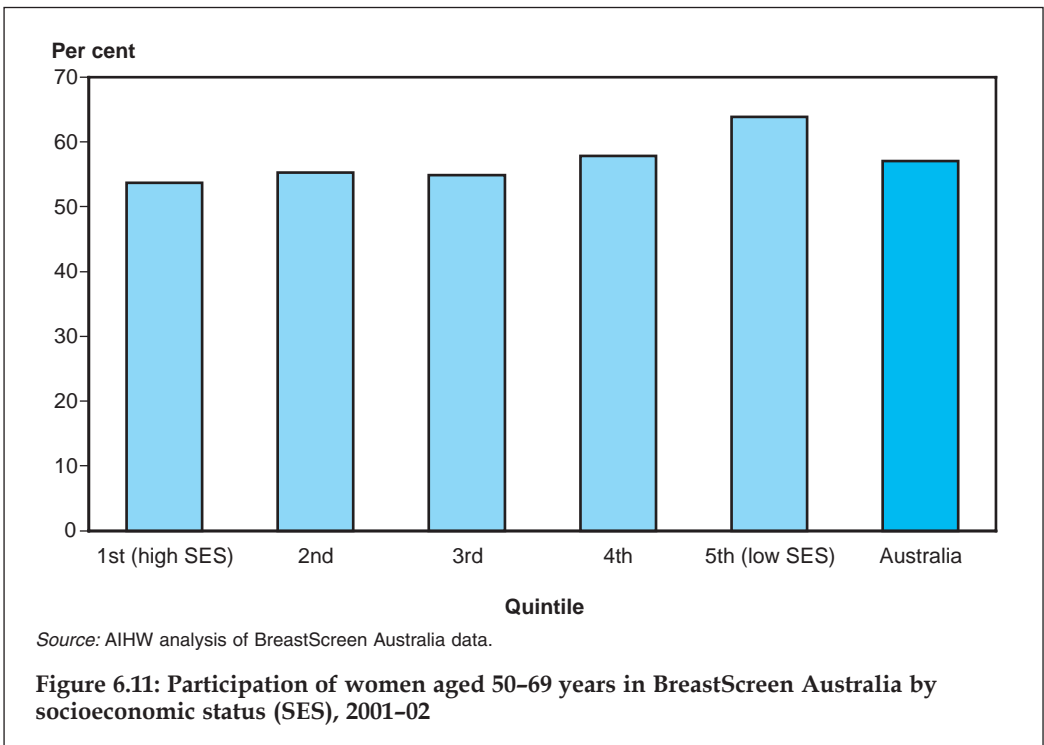
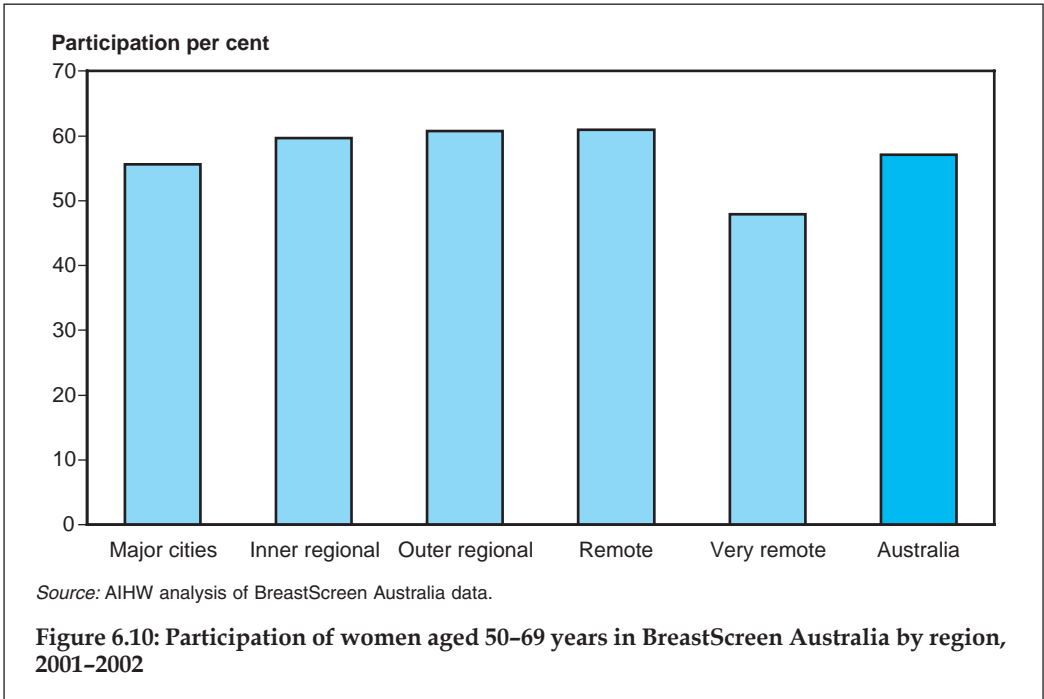
	1996–1997	1997–1998	1998–1999	1999–2000	2000–2001	2001–2002
BreastScreen Australia						
All ages 40 years and over	1,240,885	1,367,759	1,452,263	1,496,417	1,567,544	1,611,262
Target population (ages 50–69)	844,607	921,283	975,258	1,011,394	1,063,479	1,102,227
Participation rate for target population (%) ^(a)	52.3	54.3	55.6	55.9	56.9	57.1
National Cervical Screening Program^(b)						
All ages 20 years and over	2,630,235	2,721,650	2,777,324	3,314,787	3,331,408	331,013
Target population (ages 20–69)	2,563,107	2,653,504	2,716,364	3,244,329	3,262,931	3,262,574
Participation rate for target population (%) ^(a)	60.8	62.4	63.4	61.3	61.0	61.0

(a) Participation rates are age-standardised to the 2001 total Australian population.

(b) The Queensland Health Pap Smear registry began in February 1999, so the cervical screening data presented here exclude Queensland.

n.a. Not available.

Source: AIHW analysis of state and territory Cervical Cytology Registry data and BreastScreen Australia data.



National Cervical Screening Program

Screening to detect abnormalities of the cervix has been available for Australian women since the 1960s. Until the early 1990s this screening was largely unstructured, with no agreement on the screening target group or the best interval between screens. Since then it has become progressively more organised and in 1995 the program became known as the National Cervical Screening Program.

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 approximately 80% of Pap smears performed by GPs. Cervical screening is funded mainly by Medicare (61%) with the remainder funded by Australian government contributions through special purpose payments to state and territory governments (23%) and these governments' own revenue sources (16%).

The National Cervical Screening Program has both national and state and territory components. Although policy is usually decided at a national level, coordination of screening activity mainly happens 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 smears
- 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.

The Australian recommendation is for all women who have been sexually active at any stage in their lives to have a Pap smear every two years until they reach the age of 70 years. Screening may cease at the age of 70 for women who have had two normal Pap smears within the last five years. Women over 70 years who have never had a Pap smear or who request a Pap smear are also screened. However, for reporting purposes the target group is taken to be all women aged between 20 and 69 years who have not had a hysterectomy.

The proportion of women in the target age group who were screened under the National Cervical Cancer Screening Program in a two-year period rose from 60.8% in the period 1996–1997 to 63.4% in 1998–1999 before falling to 61.0% in 2001–2002 (Table 6.25).

Childhood immunisation

The Australian Standard Vaccination Schedule is recommended by the National Health and Medical Research Council. The purchase of most vaccines is funded by the Australian government (with pneumococcal vaccine, funded only for Aboriginal and Torres Strait Islander children and some other groups and inactivated polio vaccine and varicella vaccine not funded). Delivery of vaccines and program implementation are the responsibility of the states and territories. The Australian Standard Vaccination Schedule includes vaccines recommended for children against diseases such as measles, rubella, diphtheria, tetanus, pertussis, meningococcal disease and hepatitis B (see Chapter 3).

The national childhood vaccination activities include the Australian Childhood Immunisation Register (ACIR), which is administered by the Health Insurance Commission. It records details of vaccinations given to children under the age of 7 years who live in Australia, based on reports of each completed schedule milestone, for which providers are paid a reporting fee.

Nationally, GPs are the major childhood vaccine providers but there is considerable variation among jurisdictions in the proportion of vaccines delivered in the private and public sectors. In 2002–03, there were over 4 million vaccinations recorded by the ACIR (Table 6.26). The majority (71.2%) were provided by GPs, although this varied from state to state. Local government councils (16.1%) and community health centres (9.1%) administered a substantial proportion of vaccinations, particularly in Victoria for the former, and in the Australian Capital Territory and the Northern Territory for the latter.

Table 6.26: Immunisation episodes by state and territory and provider type^(a), 2002–03

Provider type	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Australia
Episodes									
Local government council	73,857	443,039	55,375	22,368	43,595	11,249	0	0	649,483
State/territory health department	0	0	93	20,978	271	0	130	205	21,677
Royal Flying Doctor Service	419	0	2,737	0	473	0	0	0	3,629
General practice	1,105,645	561,753	668,084	241,921	190,486	77,776	20,122	2,940	2,868,727
Public hospital	17,918	5,036	27,915	23,641	3,552	209	248	4,999	83,878
Private hospital	6	3	128	0	0	105	0	533	775
Aboriginal health service or worker	8,285	3,169	13,260	2,841	1,532	0	0	6,040	33,127
Community health centre	108,652	9,680	55,071	62,754	39,833	887	37,169	52,483	366,663
Total	1,312,782	1,002,704	822,666	374,503	279,742	90,226	57,706	67,213	4,028,036
Per cent									
Local government council	5.6	43.3	6.7	6.0	15.6	12.5	0	0	16.1
State/territory health department	0	0	0	5.6	0.1	0	0.2	0.3	0.5
Royal Flying Doctor Service	0	0	0.3	0	0.2	0	0	0	0.1
General practice	84.2	54.9	81.2	64.6	68.1	86.2	34.9	4.4	71.2
Public hospital	1.4	0.5	3.4	6.3	1.3	0.2	0.4	7.4	2.1
Private hospital	0	0	0	0	0	0.1	0	0.8	0
Aboriginal health service or worker	0.5	0.3	1.6	0.7	0.6	0	0	9.0	0.8
Community health centre	8.3	1.0	6.7	16.8	14.2	1.0	64.4	78.1	9.1
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

(a) Other and unknown provider types are included in the column totals. Unknown state or territory is included in the row totals.

Source: Australian Childhood Immunisation Register, HIC 2004.

The national immunisation program has introduced a range of funding arrangements and financial incentives to increase the proportion of children immunised. The level of immunisation (which rose initially and has now plateaued; see Chapter 3) has been regularly monitored using ACIR data, and modifications have been made to the program and payments.

The incentives for increased immunisation and reporting have included the General Practice Immunisation Incentives Scheme, which was introduced by the Australian Government in 1998. The scheme includes service incentive payments, which are paid on the completion of each immunisation schedule in accordance with the approved Australian Standard Vaccination Schedule. In addition, outcomes payments are paid quarterly to general practices that achieve target levels of immunisation for children who attend the practice. In 2001-02, \$19.4 million was paid in service incentive payments (4.9% increase over the \$18.5 million in 1999-00), and \$16.3 million in outcome payments (22.6% increase over the \$13.3 million in 1999-00).

Two incentives for parents were introduced in 2000. The means-tested Maternity Immunisation Allowance is payable for children from 18 months of age either when all immunisations due by that age have been recorded on the ACIR, or when there is a documented medical contraindication (reason against use) or conscientious objection to immunisation. The Child Care Benefit, which is available to partially reimburse expenditure on approved or registered child care, is also available only with evidence of either up-to-date immunisation on the ACIR, or contraindication or conscientious objection.

Needle and syringe programs

Needle and syringe programs operate in all states and territories of Australia, funded as a public health measure to reduce the spread of bloodborne viral infections such as HIV and hepatitis C among injecting drug users (Health Outcomes International et al. 2002). They provide a range of services that include provision of 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. The aim of providing injecting equipment is to prevent its shared use, which can lead to the transmission of infection.

The nature of needle and syringe programs varies among the states and territories. Some are government-run and others are run by non-government organisations. Some operate as primary outlets, specifically established as stand-alone needle and syringe programs. Others operate as secondary outlets, incorporated into other health services, such as emergency departments. Others operate as mobile or outreach services, or make needles and syringes available through vending machines. Needles and syringes are also available through pharmacies, commercially and, in New South Wales, through a government-sponsored scheme.

In 1999-00, an estimated 31,848,000 needles were distributed by needle and syringe programs in Australia. Estimated expenditure on them was \$22.7 million, \$19.7 million by governments, and \$3.0 million by consumers (Health Outcomes International et al. 2002).

Box 6.6: The Sydney medically supervised injecting centre

The Sydney medically supervised injecting centre (MSIC), located at Kings Cross, opened for client services in May 2001. It provides on-site medical consultations and assessments, health education, and testing for bloodborne viruses and sexually transmissible diseases as well as needle and syringe programs. Referrals for drug and alcohol detoxification and rehabilitation services are also provided. The main aim of the MSIC is to reduce harm associated with illicit drug use by supervising injecting episodes that might otherwise occur in less safe circumstances, such as public places or alone (Sydney MSIC 2004).

An evaluation report of the trial operating period to October 2003 found that the MSIC positively contributed to the management of drug overdoses (within the MSIC), improved client injecting-related health and decreased the number of syringe counts in the local area (MSIC Evaluation Committee 2003). During the 18-month trial, 3,810 individuals registered to use the MSIC; 73% were male and their average age was 31 years. Clients made 56,861 visits to the MSIC with an average of 15 visits per client, and a range of 1 to 646 visits. Heroin was the drug most frequently injected (61% of visits) followed by cocaine (30% of visits). A total of 409 drug-overdose incidents requiring clinical management occurred at the MSIC, a rate of 7.2 incidents per 1,000 visits; 80% were heroin-related overdoses.

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