3 Discussion of data

The following chapters contain public health information reported by all jurisdictions in accordance with the core public health definitions. Each chapter contains descriptive data that is specific to the jurisdictions, and data on each jurisdiction's public health expenditure.

The data in this report must be interpreted cautiously as this is the first time this method of data collection has been used. Although the definitions used are the same, the scope of the 1998–99 collection is different for the jurisdictions. For example, some State health authorities have responsibilities in the areas of food regulation and environment health regulation, which in other jurisdictions are covered almost entirely by local government authorities. There are also differences between jurisdictions in the methods used to collect the data and the interpretation by each jurisdiction of the inclusions and exclusions under the public health expenditure categories. Therefore it is not valid to make comparisons between the expenditure information contained in the State and Territory chapters.

Public health related expenditure was not included in C*ore public health* expenditure. This information has been included at the end of each jurisdiction's chapter, where it was available and considered important. The 1999–00 collection is likely to allocate to the *Public health related* category significant proportions of expenditure that, in this report, were included in *All other core public health*.

Comparing the data in the previous 1997–98 State of Play Report published by the AIHW with the data in the current NPHE report is not valid. The two sets of data are sourced differently and will therefore only provide information relating to the reporting years they cover. So, for example, they should not be used to calculate growth rates.

3.1 Expenditure components of each category

Expenditure on public health services comprises a number of direct and indirect expenditures. Indirect expenditure includes program-wide expenses and corporate and central office costs. It was optional for jurisdictions to report on indirect expenditure for this report and the methodology used to allocate this expenditure was left to the discretion of the jurisdictions. 'Total expenditure' in this report refers to the sum of direct and indirect expenditure. Because jurisdictions were inconsistent in the expenditure information that they provided in this report, State and Territory comparisons are problematic. Stage 3 of the NPHEP (1999–00 collection) aims to rectify the inconsistencies that were revealed in this report and apply more consistent methodologies for the collection of public health expenditure information.

Each jurisdiction has outlined the methodology they used in the methodology section of their chapter.

Direct expenditure

Direct expenditure may be considered as that which is undertaken by public health expenditure category specific cost centres. Examples include expenditure by the immunisation cost centre or the radiation safety cost centre. This expenditure should include:

- salary costs;
- staff oncosts (for example, employer funded superannuation, long-service leave liability and worker's compensation);
- non-labour staff support costs (for example, office space, electricity and stationery, administration and IT support); and
- program running costs (for example, travel costs, organisation of meetings, conferences, training courses and depreciation).

Indirect expenditure

One of the aims of this project was to identify expenditure on activities that support public health services. Support required for public health activities has, where possible, been reported separately by the jurisdictions. The distinction between expenditure on direct and support activities varies from State to State and within States. Sometimes an administrative worker or epidemiologist doing cross-program work is included in a direct cost centre and sometimes not. As Stage 2 of the project is developmental, the total amount of expenditure has not been included by all jurisdictions.

Program-wide expenditure

Jurisdictions were given the option of including program-wide expenditure for the 1998–99 report. They were also allowed flexibility in the apportioning methodology that was used to allocate program-wide expenditure to each of the core categories.

The program-wide expenditures are defined as those services which support a variety of functions across public health programs, such as:

- information systems, disease surveillance and epidemiology;
- public health policy, program and legislation development;
- public health communication and advocacy;
- public and environmental health laboratory services; and
- public health research and development.

Centralised corporate and executive costs

Jurisdictions were also given the option to allocate head office costs and corporate overheads to each of the core categories. The jurisdictions that were able to collect centralised corporate and executive costs and allocate them to public health categories in this report were Tasmania, the Australian Capital Territory and the Northern Territory.

Examples of centralised corporate and executive costs are:

- centralised corporate services (for example, human resource management, staff development, finance, industrial relations);
- senior executive service costs (for example, executive management and support, Ministerial Advisory Committees);
- head office policy, coordination and strategic development functions (which are not part of the public health division); and
- other centralised functions (for example, complaints unit, legal services unit).

Revenue

Information on revenue has been collected in some areas for this report (see Appendix 2 for revenue figures). Collecting revenue data enables the cost to government of providing a particular activity to be identified. The collection of revenue data provides more scope for a full evaluation of the project and potential policy research.

The results indicate that revenue is a very small component in regard to public health services and in addition, in most jurisdictions, revenue is not returned to health authorities. Nationally, the revenue reported represented 0.66% of the total expenditure on core public health categories. The next collection of the NPHEP—the Stage 3 data collection—will exclude revenue, as the cost of collecting this information was not considered justified in light of the relatively small contribution made by revenue and generally it does not contribute to funding public health.

It should be noted, however, that revenue may be relevant in some areas, for example environmental health, where there is a growing trend towards 'user pays'. The Therapeutic Goods Administration funds a substantial amount of its expenditure through industry levies. Should 'user pays' become more prevalent, revenue may need to be included in future collections.

3.2 Methodology used by jurisdictions

Jurisdictions varied in the methodology they used to collect the public health expenditure information. While most jurisdictions were able to identify the cost centres relating to public health on a centralised accounting system, differences were still found between jurisdictions in whether the reporting system was administratively focused or activity focused. Differences were also found due to the manual component of the collection. Jurisdictions which did not have a completely centralised accounting system had to do a partially manual collection. Table 3.1 summarises the method used by each jurisdiction to collect 1998–99 public health expenditure information.

Table 3.1: Methodology used by each jurisdiction in collecting 1998–99 public health expenditure information

Jurisdictions	Method used to collect public health expenditure information
Commonwealth	The Public Health Division of the Department of Health and Aged Care recorded all expenditure by project. Public health expenditure (as defined by the NPHEP) information was manually extracted and allocated to the appropriate categories. Public health expenditure information outside of this Division was manually collected.
New South Wales	A supplementary survey to the NSW 1998–99 Hospital Cost Data Collection and the Unaudited Annual Return was established to collect public health expenditure information from all Health Services and the Children's Hospital at Westmead. Data was also collected from the NSW Health Department. To achieve this purpose NSW Health developed a customised collection package, including a set of public health sub-programs which map to the national core public health categories and a collection guide in line with the national collection requirements.
Victoria	Oracle Financials was used to download raw figures from the Department's general ledger. The data was then sorted by activity.
Queensland	A central system was used to identify the cost centres containing expenditure on public health activities across all services. A Queensland Collection Guide was distributed to the respective services within Queensland Health requesting that they apportion the cost centre expenditure to the respective public health categories using the Queensland Health Collection Tool.
Western Australia	Financial data was extracted from the Health Department of Western Australia's Oracle financial system from cost centres that are identified in a hierarchical structure under the Public Health Division within the Health Department of Western Australia.
South Australia	Information was initially requested by written correspondence from all State Government departments, the metropolitan and country health units and other related organisations. A total of 97 individual agencies and organisations and seven regional health services were included in the collection. Only 12 organisations did not respond, making the response rate 88%. The bulk of expenditure was within the Department of Human Services, which operated using cost centres and activity based methods.
Tasmania	An administratively focused centralised financial reporting system was used to match Department of Health and Human Services cost centres to public health categories.
Australian Capital Territory	A central accounting function was used. The cost centres within the chart of accounts containing expenditure on public health activities were identified and the core public health definitions were advised to the relevant cost centre managers. These managers were then asked to allocate their costs to each of the public health expenditure categories. This was then combined with the expenditure of the Health**pact** statutory authority to complete the data collection.
Northern Territory	A SAS Expenditure database was used to identify the relevant Public Health cost centres. Public Health Program Managers were provided with the Collection Manual (the collection tool) and were assisted to allocate expenditure to the public health expenditure categories according to the definitions for this collection.

3.3 Data deficiencies and differences

Cash versus accrual

Jurisdictions varied in the accounting method used to supply data, with four jurisdictions supplying accrual accounting expenditure figures and five jurisdictions supplying cash expenditure figures. Table 3.2 shows which method each jurisdiction used for 1998–99 public health expenditure figures.

This variation in accounting method should be minimised by Stage 3 of the NPHEP, when only the Northern Territory will provide 1999–00 public health expenditure figures based on cash accounting methods. New South Wales calculated that depreciation was 3% of their total public health expenditure for 1998–99. Similar figures are expected for the other jurisdictions using accrual accounting methods. Therefore, the 1998–99 public health

expenditure figures for New South Wales, Victoria, South Australia and the Australian Capital Territory may be about 3% larger than the figures for Queensland, Western Australia, Tasmania and the Northern Territory, due to the difference in the accounting method used. Note that the Commonwealth will be different from other jurisdictions as it largely plays a funding role rather than a provider role. Therefore, the Commonwealth expenditure information would require a smaller cash-accrual adjustment than other jurisdictions.

Table 3.2: Accounting method used by each jurisdiction for the provision of 1998–99 public health expenditure information

Jurisdiction	Cash	Accrual
Commonwealth	√	
New South Wales		√
Victoria		√
Queensland	√	
Western Australia	√	
South Australia		√
Tasmania	√	
Australian Capital Territory		√
Northern Territory	√	

Community health programs and centres

TAG members agreed to include 1998–99 expenditure on public health activities that are run through community based health centres. It was expected that jurisdictions would only include those activities that had a population-wide focus, and that were not focused on delivering services to people with defined illnesses. Jurisdictions will vary in the expenditure reported, since not all jurisdictions have included expenditure by community based health centres and those jurisdictions that have reported this expenditure have not necessarily been able to include only those activities that have a population-wide focus.

Community health programs are often based on promoting holistic lifestyle changes, and can include both public health aspects like mental health promotion and welfare aspects like domestic violence education. No consistent methodology was adopted by jurisdictions when allocating to public health the expenditure from these holistic focused programs.

Table 3.3 outlines those jurisdictions that have included public health expenditure information from community health centres in this report.

Table 3.3: Collection of 1998–99 public health expenditure information from community health centres by each jurisdiction

Jurisdiction	Collection of public health expenditure data from community based health centres
New South Wales	Yes
Victoria	Yes
Queensland	Yes
Western Australia	No
South Australia	Yes
Tasmania	No
Australian Capital Territory	No
Northern Territory	Yes
Commonwealth	Not applicable

Differences in the data collected in the *All other core public health* category

Exact boundaries were not set around the *All other core public health* category. Jurisdictions were advised to include expenditure on public health activities that were not included in the preceding seven categories and were given a list of some of the possible inclusions. The inclusions that each jurisdiction had in this category are listed below.

Commonwealth

The Commonwealth included expenditure on National Drug Strategy Related Initiatives including Treatment Grants to Services Provided by Non-government Organisations (NGOs), Pituitary Hormones Initiatives and Human Quarantine Services.

New South Wales

New South Wales included expenditure on health related aspects of alcohol regulation, tobacco control, illicit drugs/substance control, cost of regulation and enforcement of occupational health and safety, poison registers and poison information systems, product safety and product recalls, cost of regulating pharmaceuticals, therapeutic goods, control of dangerous animals, quarantine and public health orders.

Victoria

Victoria included expenditure on education and training ($3.1m), information and advice ($2.4m), cancer surveillance ($1.7m), other genetic related services ($0.2m), laboratory testing ($5.2m) and licensing and regulation ($1.7m).

Queensland

The expenditure reported against the *All other core public health* category for Queensland in this report consists entirely of alcohol, tobacco and other drug services addressing illicit drugs, the methadone program and other drug related activities not reported under the *Selected health promotion activities* category. Queensland opted to collect only services that were defined in the NPHEP category definitions. Services that may be considered core public health in Queensland, but were not identified in the list of inclusions for the core categories (for example, school dental services), were not collected.

Western Australia

Western Australia included expenditure on occupational safety and health, incentive projects funded separately by the Commonwealth and other small programs.

South Australia

South Australia included expenditure by the Epidemiology Branch within the Department of Human Services. The Branch incorporates the Cancer Registry, injury prevention, population health surveillance and studies, clinical epidemiology, pregnancy and health outcomes, diabetes clearing-house and health statistics. South Australia also included expenditure by The AIDS Council of SA as well as expenditure for processing poisons and pest control licences, dealing with contaminated land issues, the methadone program and the promotion of independent living for psychiatrically disabled people.

Tasmania

Tasmania included expenditure for the administration of compliance measures with regards to regulations governing narcotics and other drugs, education, training and support of people with substance abuse problems, tobacco regulation and breast-feeding support programs.

Australian Capital Territory

The Australian Capital Territory included expenditure on the testing and certification of illicit drugs under various Acts: mainly the *Drugs of Dependence Act 1989*; testing for alcohol and other drugs in drivers under the *Road Transport (Alcohol and Drugs) Act 1977*; urine drug screening for the Alcohol and Drug Service (Methadone program and Detox service); urine drug screening for the Belconnen Remand Centre and Periodic Detention Centre; and the testing of post-mortem tissues for drugs and poisons in coronial matters.

Northern Territory

The Northern Territory included expenditure for pharmaceuticals and therapeutic goods, alcohol regulation, tobacco control, illicit drugs/substances control, occupational health and safety—regulation and health promotion, public health research and non-population health program health promotion.

Reporting of direct expenditure, program-wide expenditure and overheads

Jurisdictions vary in the way public health expenditure is represented for each of the core categories. New South Wales and Tasmania were able to discretely identify program-wide expenditure and have included a program-wide expenditure component for each of the eight public health categories. Western Australia and South Australia have included program-wide expenditure in direct expenditure, and are only able to show a direct expenditure component for each of the eight public health categories. Tasmania, the Australian Capital Territory and the Northern Territory have included an overhead expenditure component which is based on corporate and central office costs, while the overhead component that is used by New South Wales, Victoria and Queensland excludes corporate and central office costs. Table 3.4 shows which components jurisdictions have used to allocate public health expenditure to each of the core categories. Refer to each chapter for further details.

Table 3.4: Expenditure components that jurisdictions have used to allocate public health expenditure to each of the core categories

	Direct expenditure	Program-wide expenditure	Overheads
NSW	√	√	√ Reported for area health services and New Children's Hospital
Vic	√		√
Qld	√		√
WA	√		
SA	√		
Tas	√	√	√ (Centralised corporate and executive)
ACT	√		√ (Centralised corporate and executive)
NT	√		√ (Centralised corporate and executive)

Treatment of program-wide services by each jurisdiction

The program-wide services that were relevant for this collection were set out in the Stage 2 collection manual. Table 3.5 summarises the treatment of these program-wide services by each jurisdiction for this report.

Table 3.5: Treatment of program-wide services by each jurisdiction

	Information systems, disease surveillance and epidemiology	Public health policy, program and legislation development	Public health communication and advocacy	Public and environmental health laboratory services	Public health research and development
Cwlth	Allocated to the relevant categories immunisation, communicable diseases, etc.	Allocated across all eight core categories as 'Statistical and other program support'	Allocated to all applicable core categories	. .	Allocated to the research category
NSW	Allocated across all eight core categories as program-wide expenses	Allocated across all eight core categories as program-wide expenses	Allocated across all eight core categories as program-wide expenses	Allocated across all eight core categories as program-wide expenses	Allocated across all eight core categories as program-wide expenses
Vic	Where the costs were separately identified by the type of activity undertaken, the costs have been allocated across the eight core categories	Where the costs were separately identified by the type of activity undertaken, the costs have been allocated across the eight core categories	Where the costs were separately identified by the type of activity undertaken, the costs have been allocated across the eight core categories	Where the costs were separately identified by the type of activity undertaken, the costs have been allocated across the eight core categories	Where the costs were separately identified by the type of activity undertaken, the costs have been allocated across the eight core categories
Qld	Majority allocated within categories, i.e. captured within program cost centres	Majority allocated within categories, i.e. captured within program cost centres	Majority allocated within categories, i.e. captured within program cost centres	Not included (see Queensland chapter for explanation)	Total allocated to core categories
WA	Allocated to all applicable core categories as direct expenses	Allocated to all applicable core categories as direct expenses	Allocated to all applicable core categories as direct expenses	Allocated to all applicable core categories as direct expenses	Allocated to all applicable core categories as direct expenses

(continued)

Table 3.5 (continued): Treatment of program-wide services by each jurisdiction

	Information systems, disease surveillance and epidemiology	Public health policy, program and legislation development	Public health communication and advocacy	Public and environmental health laboratory services	Public health research and development
SA	Allocated across all eight core categories in direct expenditure, where applicable, with the exception of Epidemiology allocated to *All other core public health*	Allocated to all applicable core categories as direct expenditure	Allocated to all applicable core categories as direct expenditure	Allocated to all applicable core categories (except health promotion) as direct expenditure	Allocated to all applicable core categories as direct expenditure
Tas	Allocated across all eight core categories as program-wide expenses	Allocated across all eight core categories as program-wide expenses	Allocated across all eight core categories as program-wide expenses	Allocated across the two categories, *Environmental health* and *Food standards and hygiene*, as program-wide expenses	Allocated across all eight core categories as program-wide expenses
ACT	Information technology included on cost centre basis as direct expense. Disease surveillance and epidemiology allocated to all applicable core categories as direct expenses.	Allocated to all applicable core categories as direct expenses	Allocated to all applicable core categories as direct expenses	Allocated to all applicable core categories as direct expenses	Allocated to all applicable core categories as direct expenses
NT	Apportioned across the categories to reflect actual expenditure	Apportioned across the categories to reflect staffing time, resources and policy/program development. Allocations are estimates only.	Apportioned across the categories to reflect staffing time and resources	An estimate of expenditure for laboratory services was apportioned across the categories to reflect staffing time and resources.	Where applicable, expenditure for public health research and development services was included within the categories.

. . Not applicable

Centralised corporate and executive expenditure

Tasmania, the Australian Capital Territory and the Northern Territory are the only jurisdictions that have allocated and reported centralised corporate and executive costs as a part of the 1998–99 report. Tasmania reported $0.7m as the public health share of centralised corporate services, the Australian Capital Territory reported $0.89m and the Northern Territory reported $3.7m. These relatively high costs reflect the structure for public health policy development and management in these smaller jurisdictions. Their public health policy and management is largely done in their central executive areas. Other States do most of their public health policy development and management in their Public/Population Health Divisions (and these costs have been included in the costs of public health) and very little in their central executive area. Thus when, in the next stage, these centralised corporate and executive costs are added in, it is not expected to add very much expenditure.

Public health expenditure across all sectors

Public health expenditure information from local governments

Public health expenditure information from local governments was not available for 1998–99 due to the changing of the ABS Government Finance Statistics (GFS) from cash to accrual. Local government expenditure was limited for 1997–98, but the available information indicated that local governments spent at least $40m on public health services, which was 5% of total government expenditure on public health in 1997–98. Public health expenditure by local governments should be available from the ABS for 1999–00 and will be included in the 1999–00 National Public Health Expenditure Report.

Public health expenditure information from non-health government departments

Jurisdictions were given the option to collect public health expenditure information from non-health government departments for 1998–99. South Australia was the only jurisdiction to collect this information. Letters were sent out to 28 non-health agencies in South Australia. Relevant data was received from 13 agencies. Only five agencies showed significant expenditure on public health activities. The Department of Education, Training and Employment was the only agency likely to perform significant public health activities that did not provide data to the South Australian Department of Human Services. The amount of public health expenditure that was reported from the non-health sector in South Australia was over $17m. Of this, $10m—16% of South Australia's core public health expenditure—would be considered public health expenditure under the revised public health definitions for the 1999–00 Stage 3 collection. The other $7m of the expenditure would be classified as 'public health related' rather than as 'core public health'.

Some of the concerns raised with the collection of public health expenditure information from non-health government departments were:

- the difficulty in having an automated collection;
- the extra resource requirements needed;
- the varying response rates from departments;
- the quality of the data provided; and
- data inconsistencies.

Jurisdictions have been given the option of collecting this public health expenditure information for the Stage 3 collection.

Public health expenditure information from non-government organisations

Expenditure by NGOs in 1998–99 has been implicitly included where the funding came from State, Territory or Commonwealth Governments. In addition there are many NGO public health activities that are either partly government funded or not funded by government. These NGO public health activities that are not government funded have not been included in this report. The AIHW will be collecting this information from NGOs in the Stage 3 collection of 1999–00 public health expenditure.

3.4 A comparison of public health definitions

NPHEP public health definitions have been developed over the last two to three years. First there was a literature review and then a workshop in December 1998 of all interested parties, and since then meetings of NPHEP's TAG have developed and refined the definitions. These public health definitions were devised to be policy relevant and practical in an Australian context. These definitions are not necessarily consistent with those set out by the OECD, the USA or by the National Public Health Partnership (NPHP), though there is a large degree of overlap. The OECD public health and health related categories, the USA essential public health services and the NPHP core functions are listed below.

The OECD public health and health related categories

- Prevention and public health services
  - Maternal and child health, family planning and counselling;
  - School health services;
  - Prevention of communicable diseases;
  - Prevention of non-communicable diseases;
  - Occupational health care; and
  - All other miscellaneous public health services.
- Health-related functions
  - Capital formation of health care provider institutions;
  - Education and training of health personnel;
  - Research and development in health;
  - Food, hygiene and drinking water control; and
  - Environmental health.
- Administration and provision of social services in kind to assist living with disease and impairment
  - Administration and provision of health-related cash benefits.

The USA essential public health services

- Monitor health status to identify and solve community health problems;
- Diagnose and investigate health problems and health hazards in the community;
- Inform, educate and empower people about health issues;
- Mobilise community partnerships and action to identify and solve health problems;
- Develop policies and plans that support individual and community health efforts;
- Enforce laws and regulations that protect health and ensure safety;
- Link people to needed personal health services and assure the provision of health care when otherwise unavailable;
- Assure a competent public health and personal health care workforce;

- Evaluate effectiveness, accessibility, and quality of personal and population based health services; and
- Research for new insights and innovative solutions to health problems.

National Public Health Partnership core functions

1. Assess, analyse and communicate population health needs and community expectations;
2. Prevent and control communicable and non-communicable diseases and injuries through risk factor reduction, education, screening, immunisation and other interventions;
3. Promote and support healthy lifestyles and behaviours through action with individuals, families, communities and wider society;
4. Promote, develop and support healthy public policy, including legislation, regulation and fiscal measures;
5. Plan, fund, manage and evaluate health gain and capacity building programs designed to achieve measurable improvements in health status and to strengthen skills, competencies, systems and infrastructure;
6. Strengthen communities and build social capital through consultation, participation and empowerment;
7. Promote, develop, support and initiate actions which ensure safe and healthy environments;
8. Promote, develop and support healthy growth and development throughout all life stages; and
9. Promote, develop and support actions to improve the health status of Aboriginal and Torres Strait Islander people and other vulnerable groups.

The National Public Health Expenditure Project definitions differ from those of the OECD because the NPHEP's definitions do not include any expenditure on maternal and child health, as these are seen as community health services in Australia. They also differ because the NPHEP has public health categories for *Environmental health* and *Food standards and hygiene*, which are listed under the OECD section of health-related functions. The NPHEP also has separate public health categories for *Selected health promotion*, *Immunisation*, *Breast cancer screening* and *Cervical screening* that are not mentioned discretely or at all in the OECD definitions.

The NPHEP definitions differ from those of the NPHP or the USA, in that they target specific areas of public health on which jurisdictions will be able to collect public health expenditure information, via specific cost centres, in a consistent and routine manner.

4 Public health expenditure by the Commonwealth Health and Aged Care Portfolio

4.1 Introduction

The Commonwealth Health and Aged Care Portfolio encompasses a wide range of agencies and program areas which seek to address the health and aged care needs of the Australian community. In 1998–99 the Portfolio administered appropriations of over $23 billion, with most spending being within the Health Care Access Program (predominantly Medicare benefits, pharmaceutical benefits and grants to the States and Territories for acute area), and the Aged and Community Care Program.[1]

Public health spending was predominantly within the Department of Health and Aged Care's Public Health Program (through the Population Health Division and the Therapeutic Goods Administration), the Health Care and Access Program (through the Health Access and Financing Division) and the Aboriginal and Torres Strait Islander Program (through the Office for Aboriginal and Torres Strait Islander Health), and by the following portfolio agencies: the Australia New Zealand Food Authority, the Australian Radiation Protection Nuclear Safety Authority, the Nuclear Safety Bureau and the Australian Institute of Health and Welfare.

4.2 Overview of expenditure

Total Commonwealth funding for public health activities in 1998–99 amounted to $459.1m and is summarised in Table 4.1. This includes public health funding of $192.4m provided to States and Territories and total direct and overhead expenditure of $266.7m by the Commonwealth. Public Health Outcome Funding Agreement (PHOFA) grants, other public health grants and demonstration projects are shown separately at the bottom of the table, as this funding cannot be allocated according to the public health expenditure categories.

[1] The former Department of Health and Family Services was subject to an Administrative Arrangements Order in October 1998 that transferred Family and Children's Services and Disability Programs to the Department of Family and Community Services.

Table 4.1: Total core public health funding, including payments made to States and Territories, by the Commonwealth Department of Health and Aged Care, 1998–99 ($)

Category	Total direct and overhead expenditure[(a)]	Payments to States and Territories	Total funding	% of core public health expenditure
Communicable disease control	24,193,170	4,230,593	28,423,763	6.2
Selected health promotion	40,128,117	3,069, 500	43,197,617	9.4
Immunisation	72,493,136	65,009,832	137,502,968	29.9
Environmental health	31,670,639		31,670,639	6.9
Food standards and hygiene	9,006,112		9,006,112	2.0
Breast cancer screening	5,133,327		5,133,327	1.1
Cervical screening	59,652,592		59,652,592	13.0
Research	16,993,750		16,993,750	3.7
All other core public health	6,602,095		6,602,095	1.4
PHOFA base (including demonstration projects), and other public health grants	840,156	120,139,900	120,980,056	26.3
Total core public health	**266,713,095**	**192,449,825**	**459,162,920**	**100.0**

(a) Total direct and overhead expenditure is made up of direct project expenditure, statistical and other program support, population health non-grant program costs and running costs. A breakdown of this expenditure is reported in Table 4.3.

(b) This figure represents the overheads associated with administering the grants to States and Territories by the Commonwealth Department of Health and Aged Care. It is made up of $498,300 in Population Health Division Running Costs, and $341,856 in non-grant program costs.

Commonwealth grants to States and Territories for public health

The Commonwealth Department of Health and Aged Care provides funding to States and Territories under various arrangements, including the Public Health Outcome Funding Agreements, the Indigenous Sexual Health Strategy, and the National Youth Suicide Prevention Strategy. The Commonwealth and the States and Territories have given formal and public expression to their shared interest in improving the health and wellbeing of Australians in the PHOFAs. These are bilateral agreements that were initially for the two financial years 1997–98 and 1998–99. A second round is currently in operation for the five years 1999–00 to 2003–04.

Under the PHOFAs, all jurisdictions have committed themselves to working cooperatively towards the achievement of an agreed set of goals and targets through a range of national public health policies and strategies. The Agreements formally acknowledge the contributions made by each jurisdiction to public health, and their individual and mutual obligations in the promotion of designated population health outcomes.

The Commonwealth contributes to the national public health effort through the provision of designated assistance to the States and Territories throughout the life of each Agreement. The base funding allocations in the PHOFAs resulted from the broadbanding of Commonwealth funding to States and Territories for the following public health programs:

- National Drug Strategy
- National HIV/AIDS Strategy
- National Immunisation Program
- BreastScreen Australia

- National Cervical Screening Program
- National Women's Health Program
- National Education Program on Female Genital Mutilation
- Alternative Birthing Services.

States and Territories have the flexibility to use the base component of the Commonwealth assistance according to local needs and priorities. Therefore, it is not possible to disaggregate this Commonwealth assistance to States and Territories by type of activity.

The PHOFAs do not replace any of these national initiatives. Rather they have been designed to promote administrative consistency and efficiency across public health initiatives through a single funding and reporting process. The programs in the PHOFAs generally have their own national strategies, each of which, in turn, has a range of performance indicators and evaluation processes in place.

The first round of PHOFAs included incentive funding in excess of $14.0m to contribute towards the development of local public health infrastructure that would assist States and Territories to meet agreed targets and give them as much flexibility as possible to meet local public health priorities. In 1998–99, $7.66m of this funding was spent. These allocations were in addition to the broadbanded funding and the provision for vaccine purchases.

Table 4.2 summarises all the payments that were made to State and Territory Governments in the financial year 1998–99. These payments include $65.0m on Immunisation, $4.2m on an Indigenous Sexual Health Strategy, $3.0m on the National Youth Suicide Prevention Strategy, $117.4m through the PHOFAs and $2.7m on other public health grants. Total public health payments to State and Territory Governments in 1998–99 were $192.4m.

Table 4.2: Specific purpose and other payments to States and Territories for public health by the Commonwealth Department of Health and Aged Care, 1998–99 ($'000)

Category	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
Essential vaccine purchases	11,634.0	8,604.0	5,971.1	3,289.0	2,955.0	998.0	504.1	431.0	34,386.2
Measles Control Campaign	2,080.6	1,599.8	1,347.9	784.6	700.5	266.5	225.3	202.8	7,208.2
Influenza 65+ vaccine purchases	5,364.0	5,170.0	3,602.0	2,003.0	1,865.0	550.0	213.0	60.0	18,827.0
National Indigenous Pneumococcal & Influenza Immunisation Program	1,396.7	289.0	1,300.4	674.3	289.0	192.6	48.2	398.4	4,588.5
Total immunisation	*20,475.4*	*15,662.8*	*12,221.4*	*6,750.9*	*5,809.5*	*2,007.2*	*990.6*	*1092.2*	*65,009.8*
Indigenous Sexual Health Strategy	1,688.9	37.0	1,070.0	1,021.5	347.0	—	—	66.2	4,230.6

(continued)

Table 4.2 (continued): Specific purpose and other payments to States and Territories for public health by the Commonwealth Department of Health and Aged Care, 1998–99 ($'000)

Category	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
National Youth Suicide Prevention Strategy	845.0	684.0	765.0	254.5	197.0	178.0	60.0	86.0	3,069.5
PHOFA base	40,929.0	25,964.0	18,095.0	11,280.0	9,909.0	5,043.0	3,090.0	3,090.0	117,400.0
Other public health grants	252.9	844.5	181.8	268.3	558.5	175.0	283.9	175.0	2,739.9
Total public health grants	**64,191.2**	**43,192.3**	**32,333.2**	**19,575.1**	**16,821.0**	**7,403.2**	**4,424.5**	**4,509.4**	**192,449.8**

Commonwealth direct public health expenditure and overheads

The Commonwealth Health and Aged Care Portfolio direct expenditure on public health other than to States and Territories, as well as overheads, was $266.7m in 1998–99.

Table 4.3 summarises the direct and indirect public health expenditure by the Commonwealth in 1998–99. Indirect expenditure refers to statistical and other program support, population health non-grant program costs and running costs for each of the core categories. The Commonwealth also incurred costs in administering the grants to States and Territories. This expenditure is represented at the bottom of Table 4.3 and consists of a proportion of total population health non-grant program costs and running costs.

Administrative expenditure associated with supporting core public health programs and activities

Table 4.3 also includes the level of expenditure associated with administrative functions. Items such as salaries and administration costs of the Department are described as running costs in the annual report. The Commonwealth Health and Aged Care Portfolio identified running costs for the core public health categories developed under this project as $29.393m. Of these running costs, $15,151,798 were associated with the Population Health Division, $1,743,990 with the Health Services Division, $7,081,894 with the Therapeutic Goods Administration, $529,700 with the Office of Aboriginal and Torres Strait Islander Health, $212,018 with the National Health and Medical Research Council, $4,265,778 with the Australian Radiation Protection and Nuclear Safety Authority and $407,327 with the Nuclear Safety Bureau.

The running costs for the Population Health Division of $15,151,798 were identified in the Department's annual report and represent the running costs for the entire Population Health Division. Thus the running cost values presented in Table 4.3 are likely to over-estimate the administrative costs associated with the core public health categories identified for this project, as the Division also undertakes work outside the scope of these categories.

The Population Health Division also reported expenditure of $10,394,814 for extra expenses—such as fees and travel for committee members, function centre rental and freight costs—as non-grant program costs. Expenditure reported by the Population Health Division as non-grant program costs was allocated to each category in accordance with the proportion of running costs allocated to each category. Non-grant program costs were not allocated to the *HIV/AIDS, hepatitis C and sexually transmitted infections*, and *Needle and*

syringe programs sub-categories of *Communicable disease control*, as the specific nature of these categories made it possible to accurately identify all the expenses for these activities. The Office of Aboriginal and Torres Strait Islander Health (OATSIH) reported running costs for public health expenditure activities at 5% of total OATSIH overheads. This expenditure was allocated on a pro rata basis to the appropriate categories of OATSIH expenditure on core public health programs.

Australian Institute of Health and Welfare

The AIHW identifies and meets the information needs of governments and the community to enable them to make informed decisions to improve the health and welfare of Australians. The primary function of the AIHW is to collect and produce information and statistics relating to health and welfare in Australia (*AIHW Annual Report 1998–99*).

That proportion of expenditure by the AIHW which is dedicated to public health and which is funded from its government appropriation is included in the 'Statistical and other program support' column of Table 4.3.

Table 4.3: Direct project expenditure by the Commonwealth Health and Aged Care Portfolio on the core public health categories and administrative expenditure on both the core public health categories and payments to States and Territories, 1998–99 ($)

Category	Direct project expenditure	Statistical and other program support	Population health non-grant program	Running costs	Total direct and overhead expenditure	% of direct and overhead core public health expenditure
Communicable disease control	18,825,714	114,424	2,021,985	3,231,047	24,193,170	9.1
Selected health promotion	29,600,878	179,917	3,515,331	6,831,991	40,128,117	15.0
Immunisation	69,413,822	421,903	995,714	1,661,697	72,493,136	27.2
Environmental health	18,118,916	110,128	686,269	12,755,326	31,670,639	11.9
Food standards & hygiene	8,231,903	50,034	294,664	429,511	9,006,112	3.4
Breast cancer screening	2,925,980	17,784	876,318	1,313,245	5,133,327	1.9
Cervical screening	57,350,980	348,584	780,073	1,172,955	59,652,592	22.4
Research	15,740,162	95,670	384,883	773,035	16,993,750	6.4
All other core public health	5,346,382	32,496	497,722	725,495	6,602,095	2.5
Grants to States and Territories	. .	. .	341,856	498,300	840,156	0.3
Total	**225,554,737**	**1,370,941**	**10,394,815**	**29,392,502**	**266,713,095**	**100.0**

(a) This figure represents the overheads associated with administering the grants to States and Territories by the Commonwealth Department of Health and Aged Care. It is made up of $498,300 in Population Health Division Running Costs, and $341,856 in non-grant program costs.

. . Not applicable

4.3 Public health expenditure by categories

Communicable disease control [2]

Total expenditure by the Commonwealth Health and Aged Care Portfolio for the *Communicable disease control* category in 1998–99 was $24.2m (see Table 4.4).

HIV/AIDS, hepatitis C and sexually transmitted infections

Through successive HIV/AIDS strategies and the National Hepatitis C Action Plan, the Commonwealth has provided funding to peak community and professional bodies for a wide range of research, health promotion programs and policy developments addressing HIV/AIDS, hepatitis C and related diseases. Research is undertaken by the National Centre in HIV Social Research, the National Centre in HIV Epidemiology and Clinical Research and the National Centre in HIV Virology.

The target populations identified include gay men, other men engaging in active homosexual behaviour, people living with HIV/AIDS, people living with hepatitis C, Aboriginal and Torres Strait Islander peoples, sex workers, young people, prisoners and people who inject drugs. Activities in this area included a best practice manual—*STD control in remote Aboriginal communities*—commissioned, published and distributed through OATSIH.

Needle and syringe programs

The States and Territories are responsible for the operation and resourcing of needle and syringe programs (NSPs) in their respective jurisdictions. From time to time, however, the Australian National Council on AIDS, Hepatitis C and Related Diseases (ANCAHRD) will provide advice to government on the efficacy and public health policy aspects of NSPs. HIV/AIDS and hepatitis C research at the national level also incorporates data generated by NSPs operating across Australia. The Commonwealth does not provide funding for needle and syringe programs.

Other communicable disease control

This category includes expenditure by the Population Health Division on disease surveillance systems, and by OATSIH on the National Indigenous Australians' Sexual Health Strategy. A total of $6,239,000 was spent on the Strategy in 1998–99. This expenditure comprised $4,230,593 in grants to selected States and Territories for priority projects consistent with the strategy, and $2,008,407 direct project expenditure. A breakdown of the payments made to States and Territories for the Indigenous Sexual Health Strategy is presented in Table 4.5.

[2] Excluding immunisation expenditure, which is reported later in the chapter.

Table 4.4: Expenditure for *Communicable disease control* by the Commonwealth Department of Health and Aged Care, 1998–99 ($)

Expenditure	HIV/AIDS and hepatitis C[(a)]	Other communicable disease control	Total communicable disease control
Population Health Division (PHD)	16,321,240	496,067	16,817,307
Office of Aboriginal and Torres Strait Islander Health	—	2,008,407	2,008,407
Direct expenditure by the Commonwealth	*16,321,240*	*2,504,474*	*18,825,714*
Overheads[(b)]			
PHD salaries and administration	2,860,368	86,938	2,947,306
PHD non-grant program costs	1,962,342	59,643	2,021,985
Statistical and other program support	99,202	15,222	114,424
Office of Aboriginal and Torres Strait Islander Health	—	283,741	283,741
Total direct and overhead expenditure	**21,243,151**	**2,950,019**	**24,193,170**

(a) Included in this category is $51,000 for the production of a Needle and Syringe Information Kit, published by ANCAHRD, which comprises a review of the evidence of the efficacy of these programs and a summary booklet of frequently asked questions. This expenditure does not include funding for program operations or the purchase of equipment. The States and Territories are responsible for the operation and resourcing of NSPs in their respective jurisdictions.

(b) Running costs, non-grant program costs and statistical and other program support costs have been allocated to each of the two communicable disease sub-categories based on the amount of public health expenditure in each category. Therefore these figures do not reflect the actual cost of overheads associated with each sub-category, but are instead an estimate of overhead expenditure within each category. These data do not include those funds provided by the Commonwealth through the PHOFAs and used by State and Territory Governments for communicable disease control activities.

Table 4.5: Payments to selected States and Territories to implement the Indigenous Sexual Health Strategy, 1998–99 ($)

State	Payments to States and Territories
New South Wales	1,688,900
Victoria	37,014
Queensland	1,070,021
Western Australia	1,021,458
South Australia	347,000
Northern Territory	66,200
Total	**4,230,593**

Selected health promotion activities

Total expenditure by the Commonwealth Department of Health and Aged Care in 1998–99 for *Selected health promotion activities* was $40,571,611 (see Table 4.6).

This category includes expenditure to coordinate and maintain the Health Education and Promotion System Database and the National Diabetes Strategy, the latter in part through the Vision Impairment Prevention Program. The Population Health Division also financed a consultancy for the development of a comprehensive system for food and nutrition monitoring research in Australia.

Table 4.6: Expenditure for *Selected health promotion activities* by the Commonwealth Department of Health and Aged Care, 1998–99 ($)

	Selected health promotion activities
Expenditure	
Population Health Division (PHD)	19,661,084
Office of Aboriginal and Torres Strait Islander Health	532,767
Health Services Division (HSD)	9,407,027
Direct expenditure by the Commonwealth	*29,600,878*
Overheads	
PHD salaries and administration	5,124,053
PHD non-grant program costs	3,515,331
HSD running costs	1,672,193
Office of Aboriginal and Torres Strait Islander Health	35,745
Statistical and other program support	179,917
Total direct and overhead expenditure	**40,128,117**

Note: These data do not include those funds provided by the Commonwealth through the PHOFAs and other grants and used by State and Territory Governments for *Selected health promotion activities*.

Youth Suicide Prevention Strategy

A major component of expenditure reported in this category was to support the National Youth Suicide Prevention Strategy.

This national strategy aims to reduce deaths and injury from suicidal and self-destructive behaviour, and to increase protective factors such as resilience, respect and positive socialisation among young people, by improving links between young people and service providers. The strategy includes evaluation of existing programs and research into youth suicide, and education and training about depression and prevention of suicide issues for the community and professionals.

In 1998–99 the Commonwealth also provided funds to State and Territory mental health services as part of the Strategy to support counselling in rural and remote areas. Priority was given to interventions focused on rural males (particularly those with high risk factors such as mental illness), small communities, areas with significant Aboriginal populations without alternative access to counselling, and provision of post-suicide community counselling. A total of $2,625,000 was provided to States and Territory health authorities for these services.

In addition to these rural counselling payments, an additional allocation to the States and Territories of $444,500 was made for youth suicide prevention initiatives.

A breakdown of these expenditures is presented in Table 4.7.

Table 4.7: Commonwealth payments to States and Territories under the National Youth Suicide Prevention Strategy, 1998–99 ($)

State/Territory	Payments to States and Territories
New South Wales	845,000
Victoria	684,000
Queensland	765,000
Western Australia	254,500
South Australia	197,000
Tasmania	178,000
Australian Capital Territory	60,000
Northern Territory	86,000
Total	**3,069,500**

Immunisation

Total expenditure for *Immunisation* by the Commonwealth Department of Health and Aged Care in 1998–99 was $72.5m (see Table 4.8). This expenditure excludes immunisation grants to States and Territories which totalled $65.0m (see Table 4.9).

The Immunise Australia Program

The Immunise Australia Program aims to reduce the incidence of vaccine-preventable diseases and their associated mortality and morbidity by increasing and maintaining high immunisation coverage in Australia. The Program is a joint initiative between the Commonwealth Government and State and Territory Governments, with the involvement of immunisation providers.

The Commonwealth's role is to provide national leadership and policy direction for the Program. Its major funding role is to provide funds to States and Territories to purchase essential vaccines in accordance with the NHMRC Australian Standard Vaccination Schedule. State and Territory Governments are responsible for the service delivery components of the program, including the purchase and distribution of vaccines to immunisation providers.

Some of the initiatives introduced under the Immunise Australia Program have included:

- The Measles Control Campaign, a national one-off school based campaign, which offered a second dose of measles, mumps and rubella vaccine to all primary school age children. By the end of the Campaign (conducted between August and November 1998) around 1.7m or 96% of school children aged 5–12 years had been vaccinated against measles, mumps and rubella.
- The free provision of influenza vaccine for all Australians aged 65 years and over.
- Funding for States and Territories to purchase diphtheria, tetanus and pertussis acellular vaccine for the primary childhood course of vaccinations.

Indigenous Pneumococcal and Influenza Immunisation Program

The National Indigenous Pneumococcal and Influenza Immunisation Program, managed through OATSIH, made free influenza and pneumococcal vaccines available to Aboriginal and Torres Strait Islander adults and younger people in high risk groups in 1999 through bilateral arrangements with the State and Territory Governments.

General Practice Immunisation Incentive Scheme

The Department of Health and Aged Care implemented the General Practice Immunisation Incentive (GPII) Scheme in July 1998. The scheme provides financial incentives to general practitioners who monitor, promote and provide age-appropriate immunisation services to children under the age of seven years.

In addition to GPII payments, providers also receive a $3 notification payment upon notifying the Australian Childhood Immunisation Register (ACIR) that they have administered a vaccination (not necessarily completing a schedule). These payments are to compensate general practitioners for the administrative costs associated with providing information to the ACIR and cost a total of $9,568,677 in 1998–99. All jurisdictions make a contribution in this area but administrative and financing arrangements vary from State to State.

The GPII is made up of three components: a service incentive payment (SIP), an outcome payment, and funding to the Divisions of General Practice.

Service incentive payments

The SIP is a payment of $18.50 to general practitioners notifying the ACIR of an immunisation event that completes one of the six immunisation schedules for children under the age of seven. Payments commenced from 1 July 1998 and a total of $16,133,110 was distributed in 1998–99.

Outcomes payments

This payment assists general practices to meet infrastructure costs associated with immunisation (reminder recall systems, computer software, etc).

The outcome payment is made to practices that achieve a 70%, 80%, and 90% proportion of age appropriate immunisation in the first year of the scheme (1998–99), and 80% and 90% in the second year (1999–00). This tiered system provides an incentive for practices to improve coverage over time. A total of $9.6m was provided to practices under the outcome payment component of the GPII scheme in 1998–99.

Immunisation infrastructure funding

This funding aims to help Divisions of General Practice in their role as promoters of quality service. Divisions are provided with immunisation statements, reporting the proportion of age appropriate immunisation of children who reside in postcodes covered by their Divisions. In return they are asked to list child immunisation as a core activity in their strategic/business plans. This funding also supports State based organisations undertaking immunisation activities. Indicators for measuring progress are to be negotiated as part of the Divisions' business planning processes. A total of $1.3m was provided to Divisions in 1998–99.

Health Insurance Commission administration payment

The Health Insurance Commission was paid $1.3m to administer the GPII scheme.

Table 4.8: Expenditure for *Immunisation* by the Commonwealth Department of Health and Aged Care, 1998–99 ($)

	Childhood immunisation	Pneumococcal and influenza immunisation	All other immunisation	Total immunisation
Expenditure				
Population Health Division (PHD)	33,247,120	—	5,633,592	38,880,712
General Practice Immunisation Incentive	30,533,110	—	—	30,533,110
Direct expenditure by the Commonwealth	63,780,120	—	5,633,592	69,413,822
Overheads				
PHD salaries and administration	1,325,252	—	126,131	1,451,383
PHD non-grant program costs	909,182	—	86,532	995,714
Office of Aboriginal and Torres Strait Islander Health	—	210,314	—	210,314
Statistical and other program support	359,773	27,889	34,241	421,903
Total direct and overhead expenditure	**66,374,437**	**238,203**	**5,880,496**	**72,493,136**

Note: These data do not include those funds provided by the Commonwealth through the PHOFAs and used by State and Territory Governments for *Immunisation*. Running costs, non-grant program costs and statistical and other program support costs have been allocated to each of the three immunisation sub-categories based on the amount of public health expenditure in each category. Therefore these figures do not reflect the actual cost of overheads associated with each sub-category, but are instead an estimate of overhead expenditure within each category.

Table 4.9: Commonwealth payments to the States and Territories for the purchase of vaccines, 1998–99 ($)

	Payments to States and Territories
Category	
Essential vaccines	34,386,200
Measles	7,208,163
Influenza 65+	18,827,000
National Indigenous Pneumo. & Influenza Immunisation Program	4,588,469
Total immunisation grants	**65,009,832**

Environmental health

This section reports expenditure by the Department of Health and Aged Care, the Australian Radiation Protection and Nuclear Safety Agency (ARPANSA) and the Nuclear Safety Bureau (NSB). Total expenditure for *Environmental health* by the Commonwealth Health and Aged Care Portfolio in 1998–99 was $31.7m (see Table 4.10).

ARPANSA was established with the proclamation of the *Australian Radiation Protection and Nuclear Safety Act 1998*, and is responsible for the regulation of all radiation and nuclear activities undertaken by Commonwealth entities.

Expenditure by the Department of Health and Aged Care on *Environmental health* included the regulatory functions of the Therapeutic Goods Administration (TGA), the development and finalisation of the National Environmental Health Strategy, and policy development on

health impact assessment, health risk assessment, water quality and environmental health information and workforce development.

Regulation of therapeutic goods

Most of the functions of the TGA relate to public health. They include, for example, regulatory functions with regard to laboratory licences, handling of blood products and the authorisation of vaccines used for vaccination programs. Checking and affirming the safety of therapeutic products prevent injury and so are also preventive functions. It is difficult at this stage to separate expenditure on these public health functions from total expenditure by the TGA.

The TGA expenditure of $17.7m shown in Table 4.10 includes only the funding provided by the Commonwealth Department of Health and Aged Care. In addition, in 1998–99 $49.1m of TGA expenses were funded from revenue and a reduction in assets. Most of the revenue was from companies paying fees to list their products on the National Therapeutic Goods Register. The expenditure funded by this revenue is considered to be a compliance cost, and therefore is not included as public health expenditure.

Table 4.10: Expenditure for *Environmental health* by the Commonwealth Health and Aged Care Portfolio, 1998–99 ($)

Expenditure	Environmental health
Population Health Division (PHD)	471,724
Aust. Radiation Protection & Nuclear Safety Authority (ARPANSA)	6,404,000
Nuclear Safety Bureau (NSB)	611,500
Therapeutic Goods Administration (TGA)	10,631,692
Direct expenditure by the Commonwealth	*18,118,916*
Overheads	
PHD salaries and administration	1,000,326
PHD non-grant program costs	686,269
Overheads for ARPANSA and NSB	4,673,106
TGA	7,081,894
Statistical and other program support	110,128
Total direct and overhead expenditure	**31,670,639**

Food standards and hygiene

Total expenditure for *Food standards and hygiene* by the Commonwealth Health and Aged Care Portfolio in 1998–99 was $9.0m (see Table 4.11).

The Australia New Zealand Food Authority is a Commonwealth statutory authority established under the *Australia New Zealand Food Authority Act 1991*. It provides a focus for cooperation between governments, industry and the community to ensure a safe and nutritious food supply.

Under a 1991 agreement between the Commonwealth of Australia and States and Territories, the States and Territories adopt, without variation, food standards which the Food Authority has recommended and which the Australia New Zealand Food Safety Council, representing all jurisdictions, has approved. The purpose of the 1991 agreement

was to consolidate responsibility for developing food standards in one specialist agency and to ensure the uniformity of food standards in the States and Territories, which continue to have primary responsibility for administering food laws (ANZFA 1998–99 annual report page 1).

Table 4.11: Expenditure for *Food standards and hygiene* by the Commonwealth Health and Aged Care Portfolio, 1998–99 ($)

Expenditure	Food standards and hygiene
Expenditure by the Population Health Division (PHD)	137,903
Australia NZ Food Authority	8,094,000
Direct expenditure by the Commonwealth	*8,231,903*
Overheads	
PHD salaries and administration	429,511
PHD non-grant program costs	294,664
Statistical and other program support	50,034
Total direct and overhead expenditure	**9,006,112**

Breast cancer screening

In 1998–99 the Commonwealth Department of Health and Aged Care spent $5.1m on activities related to *Breast cancer screening* (see Table 4.12). This excludes PHOFA grants to the States, part of which is used to fund breast cancer screening activities. Most of the expenditure reported in this section was for the BreastScreen Australia program.

BreastScreen Australia Program

The BreastScreen Australia Program aims to provide mammography screening to 70% of women aged 50–69. During 1997 and 1998, 54.3% of the target group attended a screening service.

There was a fall in mortality rates from breast cancer from 1994 to 1996, which may have been partly due to screening, which enables breast cancers to be found earlier. The earlier and smaller the cancer, the more treatment options are available to the patient.

Medicare funding for radiographic breast examinations has been excluded from this report because it is suspected that the majority of examinations performed were for patients showing possible symptoms of breast malignancy and so would not be considered to be public health. Medicare funding for radiographic examinations consists of item numbers 59300 and 59303. Expenditure for these two items includes both the GP consultation and the radiographic examination. In 1998–99 Medicare funding was provided in respect of 347,736 radiographic examinations with a total cost of $30,222,109. These examinations are undertaken when the patient is referred with a specific request for this procedure and there is reason to expect the presence of malignancy in the breast because of:

(i) the past occurrence of breast malignancy in the patient or members of the patient's family; or

(ii) symptoms or indicators of a malignancy found on an examination of the patient by a medical practitioner.

Examinations are regarded as being a public health intervention if the patient does not have a family history of breast malignancy or where the patient does not have symptoms. Examinations undertaken when the patient is showing signs of breast malignancy or where the patient has had a past incidence of breast malignancy are not considered to be public health. Medicare expenditure for breast screening could not be broken down into its public health and non-public health components, and therefore the total amount has been excluded from this 1998–99 report. An estimate of the public health component will be provided in subsequent reports.

Table 4.12: Expenditure for *Breast cancer screening*, by the Commonwealth Department of Health and Aged Care, 1998–99 ($)

	Breast cancer screening
Expenditure	
Population Health Division (PHD)	2,865,980
National Cancer Control Initiative	60,000
Overheads	
PHD salaries and administration	1,277,348
Health Services Division running costs	35,897
PHD non-grant program costs	876,318
Statistical and other program support	17,784
Total direct and overhead expenditure	**5,133,327**

Note: These data do not include the contributions made by the Commonwealth to State and Territory Governments through the PHOFAs for breast cancer screening.

Cervical screening

Total expenditure by the Commonwealth Department of Health and Aged Care for *Cervical screening*, including pathology, in 1998–99 was $59.7m (see Table 4.13).

The National Cervical Screening Program aims to increase the participation of women aged 20–69 years in cervical screening. In 1997 and 1998 63.9% of the target group were screened.

Medicare expenditure accounted for $54.7m (92%) of the direct expenditure on *Cervical screening* by the Department of Health and Aged Care. This was made up of $26.3m relating to the general practitioner consultations, $7.4m relating to the collection of Pap smears and $21m relating to the testing of the Pap smears. The Pap smears that are included in these public health expenditure figures are for those women showing no symptoms, signs or recent history suggestive of cervical neoplasia. Data from the Bettering the Evaluation and Care of Health study were used to apportion the cost of the general practitioner consultations between the Pap smear and other activities occurring during the consultation.

Table 4.13: Expenditure for *Cervical screening*, by the Commonwealth Department of Health and Aged Care, 1998–99 ($)

Expenditure	Cervical screening
Population Health Division	2,691,172
Medicare	54,705,758
Overheads	
PHD salaries and administration	1,137,058
Medicare running costs	35,897
PHD non-grant program costs	780,073
Statistical and other program support	348,584
Total direct and overhead expenditure	**59,652,592**

Note: These data do not include those funds provided by the Commonwealth through the PHOFAs and used by State and Territory Governments for cervical screening activities.

Public health research

Total expenditure for public health research was $17.0m (see Table 4.14). In this report, public health research has been included as a separate category of core public health expenditure for the Commonwealth only. Research will be a category for all jurisdictions in the future, with the Commonwealth serving as a pilot in 1998–99. Only research which is funded by the Population Health Division and the National Health and Medical Research Council (NHMRC) is included here.

Public health research funded by the Population Health Division was conducted largely in the area of assessment into the effect that investment in public health activity has on society—for example, the analysis of the effect of changes in government support on the health status of low-income groups and a paper on the benefits and implications of a population health perspective. Other expenditure in this area was on the Public Health Education and Research Program and quality assurance programs in public health systems.

Table 4.14: Expenditure for public health research, by the Commonwealth Department of Health and Aged Care, 1998–99 ($)

Expenditure	Research
Population Health Division (PHD)	10,960,936
NHMRC	4,779,226
Direct expenditure by the Commonwealth	*15,740,162*
Overheads	
PHD salaries and administration	561,018
PHD non-grant program costs	384,883
Statistical and other program support	95,670
NHMRC	212,017
Total direct and overhead expenditure	**16,993,750**

All other core public health expenditure

Total expenditure by the Commonwealth for *All other core public health* activities in 1998–99 was $6.6m (see Table 4.15).

The Commonwealth Department of Health and Aged Care identified expenditure in this category for the following activities:

- pituitary hormones initiatives
- human quarantine services
- National Drug Strategy initiatives, including grants for services provided by NGOs. (Some of these grants were predominantly for treatment, and some predominantly of a preventive nature. The proportion which was of a preventive nature was not clear, so 50% of these grants were allocated as public health.)

Table 4.15: Expenditure for *All other core public health*, by the Commonwealth Department of Health and Aged Care, 1998–99 ($)

Expenditure	All other core public health
Population Health Division (PHD)	5,346,382
Overheads	
PHD salaries and administration	725,495
PHD non-grant program costs	497,722
Statistical and other program support	32,496
Total direct and overhead expenditure	**6,602,095**

Note: These data do not include those funds provided by the Commonwealth through the PHOFAs and used by State and Territory Governments for *All other core public health* activities.