National Public Health Expenditure Report 1998–99

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Foreword

Australians enjoy one of the best standards of health care in the world. Expectations of the health care system are, moreover, constantly rising and health care budgets rise with those expectations. In Australia's federal system of government, responsibility for the funding, management and regulation of health care rests mostly with the Commonwealth and State and Territory Governments. Who pays, how much, and for what, are topics hotly debated in this context.

Government-funded public health activity is an important part of the Australian health care system. Governments take responsibility for the quality of the water we drink, for the level of immunisation of our population and for campaigns to limit the spread of HIV/AIDS or encourage physical exercise. But what do we know about who pays how much for this activity and how effective it is? How much do governments spend each year on public health? How is this expenditure burden shared between the Commonwealth and State and Territory Governments? Do the outcomes from public health interventions justify the expenditure? And are the needs of the most vulnerable adequately met?

The publication of this report is an important first step in answering these questions. By presenting the information collected in the second stage of the National Public Health Expenditure Project, it identifies the costs associated with public health activities of governments in Australia. It is reported, for example, that the combined amount spent by Commonwealth, State and Territory Governments on core public health activities in 1998–99 was $889m. This expenditure amounted to less than 2% of recurrent health expenditure in Australia in that period.

Unlike the first stage of this Project, which had to rely on estimates from the Commonwealth Grants Commission, in this stage data were collected directly from the Commonwealth, State and Territory departments responsible for public health expenditure—the first collection of its type in Australia. We anticipate that both the publication itself and the protocols developed for extracting and analysing the data will make an important contribution to public health policy making in this country.

Under the guidance of the National Public Health Information Working Group (a Working Group of the National Public Health Partnership), the Project will be reviewed and honed in the light of input from all the jurisdictions involved. As the Project develops and refines its collection methodology it is anticipated that the comprehensiveness of the information will increase. This will increase the value of the collection, and the accumulation of data over time will enable more extensive comparison.

We commend this Report to Australia's health policy makers.

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Executive summary

Public health is characterised by planning and intervening for better health in populations rather than focusing on the health of the individual. These efforts are usually aimed at addressing factors that determine health and the causes of illness rather than its consequences. The aim is to protect and promote health and prevent illness.

This collection of information on 1998–99 public health expenditure marks the first of its type in Australia. The previous National Public Health Expenditure Project (NPHEP) Public Health Expenditure Report commented on the state of play of public health in Australia in 1997–98 and in earlier years, and was based on the public health expenditure estimates produced by the Commonwealth Grants Commission as part of its February 1999 Report. This 1998–99 National Public Health Expenditure Report, however, has collected public health expenditure information from each of the State, Territory and Commonwealth health departments, based on eight distinct public health expenditure categories using a detailed collection manual. The eight public health expenditure categories and the listed inclusions and exclusions under each of these categories were developed by stakeholders at a workshop held in December 1998 and by the Technical Advisory Group of the project, which consists of representatives of each health authority.

The NPHEP aims to develop a complete picture of expenditure on public health activities in Australia by developing clear comprehensive public health definitions that enable expenditure information to be collected in a routine and consistent fashion. It also aims at developing a common agreed process for collecting public health expenditure data in Australia.

Key findings

- This report shows that public health expenditure amounted to less than 2% of recurrent health expenditure in Australia in 1998–99.
- Of this 2%, the Commonwealth funded slightly more than half, providing 52% of all the public health expenditure by Commonwealth, State and Territory Governments—in dollars, $459m.
- This 52% can be divided into two components: 30% was spent by the Commonwealth Health and Aged Care Portfolio ($267m) and 22% was in the form of Commonwealth grants to the States and Territories ($192m).
- The States and Territories funded slightly less than half (48%) of government public health expenditure ($421m).
- State and Territory Governments managed a total expenditure of $613m—that is, ($421m + $192m) on public health services.
- The combined amount spent by Commonwealth, State and Territory Governments on core public health activities in 1998–99 was $880m.

Data deficiencies and differences

Although this report provides the most up-to-date information on public health expenditure in Australia, there are still a number of methodological issues that need to be addressed to achieve a more accurate approach that is consistent across the jurisdictions. Examples of the deficiencies in the data and differences between jurisdictions that obscure the comparability of jurisdictional data include:

- The expenditure data recorded in this report differ between jurisdictions, depending on the practice of accrual or cash accounting. The effect of different accounting methodologies should be minimised by Stage 3 of the project when the Northern Territory will be the only jurisdiction to use cash data. New South Wales calculated that depreciation was 3% of their total public health expenditure and it is expected that other jurisdictions using accrual accounting will have similar results.
- The Project intends to collect expenditure data on all public health activities, regardless of the setting. However, due to difficulties in collecting across all settings, some jurisdictions have limited the collection to services primarily responsible for public health activities. The result is that some jurisdictions have included hospital services, community health and/or primary health centres whilst others have not.
- The scope of activities to be included in the *All other core public health* category was not clearly defined. Jurisdictions were requested to include expenditure on public health activities that were not included in the preceding seven defined core categories and were given a list of some of the possible inclusions.
- Tasmania, the Australian Capital Territory and the Northern Territory are the only jurisdictions that have reported expenditure on centralised corporate and executive overheads in this report. These overheads include activities such as human resource management, finance and information technology.
- Jurisdictions varied in the methodology used to collect the public health expenditure information. While most jurisdictions were able to identify the cost centres that relate to public health on a centralised accounting system, different methodologies were used to extract the information. For example, some jurisdictions asked cost centre managers to verify and to apportion to the categories the cost centre expenditure extracted from the centralised accounting system, whilst other jurisdictions completed the collection from a centralised analysis.
- Public health expenditure information from local governments was not collected in this report due to the changing of the Australian Bureau of Statistics government finance statistics from cash to accrual. Public health expenditure information was not collected from non-health departments or from non-government organisations, although the collection does include expenditure by Commonwealth, State and Territory governments to support these agencies for public health activities.

Preface

The National Public Health Expenditure Project (NPHEP) aims to provide information on the costs of public health activities. To this end a routine national collection of information relating to public health expenditure is being developed.

The Commonwealth Government and the State, Territory and local Governments are all major investors in public health. The information gathered as part of Stage 2 of the NPHEP establishes a baseline for core public health expenditure by Commonwealth, State and Territory health authorities, with further work required to establish the level of public health expenditure by local governments.

The first stage of the NPHEP was the defining of public health categories, and agreement on a collection process. A report was compiled in this first stage discussing the state of play of expenditure on public health in 1997–98 and earlier years.

The second stage of the Project was the collection of expenditure and revenue information across eight distinct public health expenditure categories. The collection of this information marks the first collection of this type in the public health arena in Australia. This report presents the information gathered in the second stage of the NPHEP. It focuses on expenditure provided for public health by Commonwealth, State and Territory health departments. The Stage 2 collection did not capture detailed direct expenditure of local government. Nor did it capture (except for one jurisdiction) expenditure on public health activities undertaken by Commonwealth, State or Territory government departments other than departments of health.

NPHEP administrative arrangements

The National Public Health Expenditure Project is an initiative of the National Public Health Partnership overseen by the National Public Health Information Working Group. Coordination of the project is through the Australian Institute of Health and Welfare (AIHW). The AIHW Project Team reports the progress of the project to the National Public Health Information Working Group, and seeks advice and direction where needed. The Technical Advisory Group (TAG) has the responsibility for the day-to-day oversight of the collection. TAG members also provide advice on the technical aspects of the public health definitions as well as on the future direction of the collection.

National Public Health Expenditure Project categories

Public health expenditure categories were defined in collaboration with health departments from the Commonwealth Government and the State and Territory Governments. Eight major public health expenditure categories were established for the 1998–99 report:

- *Communicable disease control*
- *Selected health promotion activities*
- *Immunisation*
- *Environmental health*
- *Food standards and hygiene*
- *Breast cancer screening*

- *Cervical screening*
- *All other core public health.*

Contributors to public health

The major partners in public health in Australia are the Commonwealth, State and local Governments. The private sector is a minor contributor to the funding of public health activities. They do spend substantial resources in complying with various regulations, which are required to prevent illness and injury and promote and maintain health, but these compliance costs are considered to be outside the scope of this collection. In addition, the household sector also makes a major contribution to preventing injury and illness while promoting healthy environments within the family and the larger community. However, the extent of this contribution is difficult to measure and will not be attempted as a part of the NPHEP. Non-government organisations and community sectors also make contributions to public health in Australia.

Variations between States

There are variations between the States and Territories in the amount reportedly spent on public health services, and in how expenditure is allocated between the different public health categories. There are many reasons for these variations—not least, at this stage of the collection, are the differences in the way the data is collected and classified. Other factors include the higher costs of providing services in smaller jurisdictions and more remote areas, differences in the types and level of public health services provided by local government authorities, and differences in the need for public health services due to age structure and population characteristics—for example, breast cancer screening or communicable disease services.

Acknowledgments

Support and funding for this project has come largely from the Commonwealth Department of Health and Aged Care, supported by contributions by the State and Territory jurisdictions. Funding made available thus far has included monies for the project team based at the Australian Institute of Health and Welfare (AIHW) and part funding for the project officers and other staff within each State and Territory health department who have worked on the project.

State and Commonwealth project officers have contributed to this process through participation in the Technical Advisory Group (TAG) workshops and meetings. Project officers contributed to the report through the collection of core public health expenditure data and the provision of descriptive information for inclusion in the final report. VicHealth and Health**pact** made other contributions. A list of project officers and members of TAG is in Appendix 4.

The New South Wales Department of Health would like to acknowledge the support in the collection of public health information of the staff from the Health Services, its hospitals and community health services, the New Children's Hospital at Westmead and the staff within the Department.

Queensland Health would like to acknowledge the support of all staff from the Department who contributed to this report.

The Health Department of Western Australia would like to particularly thank the Development and Support Branch, Public Health Division, for their work on this report, as well as staff in all areas of the health system who contributed.

The South Australian Department of Human Services wishes to acknowledge the support of the major metropolitan hospitals, country health units, community health services, other related health services and a variety of non-government organisations.

The Tasmanian Department of Health and Human Services would like to thank all the staff from the Department who contributed to this report.

Territory Health Services acknowledges the many staff who contributed to, and provided guidance in, the collection, collation and presentation of information in this report. This report is the first edition of the Northern Territory's contribution to the National Public Health Expenditure Project. In many instances data on the provision of public health services in rural and remote communities were not available. In the absence of reliable data, Territory Health Services acknowledges the contribution from staff of long standing who have proven to be a valuable source of information.

The Australian Institute of Health and Welfare thanks the staff of its Health and Welfare Expenditure Unit who have coordinated this project.

Notes

a) Figures in tables and the text have sometimes been rounded. Discrepancies between totals and sums of components are due to rounding.

b) The following abbreviations and symbols are used in tables:

Not applicable	. .
Nil or rounded down to zero	–
Not available	n.a.

1 The National Public Health Expenditure Project

1.1 Introduction to the NPHEP

Interest in public health expenditure was raised as a result of the establishment of the National Public Health Partnership (NPHP) in 1996. The Australian Health Ministers Conference—on advice from the Australian Health Ministers Advisory Council—identified a need to adopt a consistent and coordinated national approach to health policy development, including public health policy development. It established the NPHP to fulfil this role.

One of the strategic directions of the NPHP was to develop and implement a National Public Health Information Development Plan. The Australian Institute of Health and Welfare (AIHW) has the role of lead agency for this particular direction. The National Public Health Information Working Group (NPHIWG) coordinates the work outlined in the Plan.

One of the goals of the Plan is to provide national estimates of public health expenditure. The aim is to identify core public health activities and associate a level of expenditure with categories of public health activity. The NPHIWG oversees the National Public Health Expenditure Project (NPHEP), which has the responsibility for achieving this result. The Technical Advisory Group (TAG) has the responsibility for the strategic development, implementation and review of the Project strategies to achieve the objectives of the NPHIWG. The TAG members represent jurisdictions in providing advice on the technical aspects of the public health definitions as well as on the future direction of the collection.

The NPHEP has a four-stage work program over 1998–2002 and aims to develop a comprehensive picture of expenditure on public health activities in Australia. The first stage of the NPHEP was to define public health categories and reach agreement on a collection process. The State of Play report which was compiled in this first stage discussed the available expenditure information on public health in Australia in 1997–98 and earlier years. The State of Play focused on Commonwealth Grants Commission data and is therefore not comparable to this 1998–99 National Public Health Expenditure Report.

The second stage of the project focused on producing this 1998–99 report, which summarises public health expenditure in Australia by Commonwealth and State and Territory Governments for the financial year 1998–99. The third stage of the project aims to expand the collection to include local government and large non-government organisations (NGOs) that engage in public health activities covered under one of the NPHEP categories. A report will be compiled from Stage 3 that summarises public health expenditure in Australia for the financial year 1999–00.

The final objective of the NPHEP is to have in place a routine, essentially automated system, integrated into existing information systems by 2001–02.

1.2 Description of present study

The study developed measures of public health investment by Australian governments in Australia through the development of a national routine collection of public health activity and expenditure information. It is intended that as the collection evolves further a more complete picture of public health expenditure will be developed, which will enable further insight across the three levels of government and also through NGOs conducting public health interventions.

The 1998–99 collection of expenditure information across eight public health expenditure categories marks the first collection of this type in Australia. The lessons learnt in this collection will be used to construct a suitable and robust methodology for the routine collection of similar public health information in future years. In addition, at a later stage, the NPHEP intends to promote the link between public health inputs and outputs, so that constructive cost-effective analyses may be undertaken on public health interventions.

Justification of the NPHEP

Public health action is initiated by, and occurs across, a wide range of jurisdictions. The result is either a reduction of risk, or an increase in benefit, which improves health status. Initiating or maintaining a public health action should preferably not happen without information to guide the process. Information on public health expenditure is useful for a number of reasons:

1. It allows for the monitoring of government expenditure and assists in making governments more accountable for their decisions.
2. It assists in the measurement of the cost-effectiveness of public health related programs. Information about the cost of inputs, outputs and future outcomes is needed to evaluate the effectiveness of public health related programs over time. The NPHEP provides an analysis of the costs of public health related programs. It is collected in such a way that it can be related to outputs and outcomes.
3. It creates benchmarks that can be used to improve and monitor performance.
4. It provides a more reliable basis for making comparisons between investment in public health and investments in the rest of the health sector.
5. It enables international comparisons of public health expenditure.

Defining public health expenditure offers an opportunity to explore and focus on costs of public health activities within an Australian setting. This information will be valuable in planning future public health policy and programs.

1.3 Objective of the NPHEP

The objective of the NPHEP is to collect data on public health expenditure on a national basis in a uniform manner. This information establishes a foundation of core public health expenditure information within government health departments from the Commonwealth, State and Territory Governments and NGOs. The information has been gathered according to definitions of core public health activities. The definitions set the parameters for the inclusion or exclusion of activities that best describe public health as the major activity.

The NPHEP is developing measures of public health investment in Australia through the development of a national routine collection of public health activity and expenditure

information. It aims to study public health expenditure in both the government and non-government sectors of the economy, across the three levels of government and non-government organisations conducting public health interventions.

Scope

The 1998–99 expenditure presented in this report was collected according to the eight core public health category definitions that are outlined later in this section. Expenditure information was collected from State, Territory and Commonwealth health departments and includes only expenditure that was funded by government.

The scope of the collection within jurisdictions varied—that is, some jurisdictions collected across all services, whilst other jurisdictions reported expenditure from selected health settings only; for example, community health services are not consistently included in the collection. Consistency in the scope of the collection was somewhat restricted by the absence of information systems to provide appropriate expenditure information across all services.

Included in the expenditure is government funded public health activity that is run through NGOs. It does not contain information on public health activities run through NGOs funded from areas outside of health departments.

The report does not contain information on detailed public health expenditure by local government or (except for one jurisdiction) expenditure on public health activities undertaken by non-health government departments.

1.4 Methodology

A collection manual was created using information gained through the consultative process described earlier. The collection manual defines the eight core public health categories for reporting of expenditure, giving examples of activities to be included and excluded in the reporting of core public health expenditure. In December 1999, a collection instrument was distributed to the participating jurisdictions along with the collection manual.

The data were collected in a variety of ways, which allowed for the particular administration structures within each of the jurisdictions. In some instances the data were collected in a centralised manner, such as mapping the public health activities of the respective health department against the core public health categories. In other instances the data were collected through distribution of the collection instrument with instructions to the public health providers. This variation in method of collection will lead to differences in the data, as the interpretation of definitions varies with each contributor.

The collection manual is a comprehensive document that lists and describes each of the public health expenditure categories. It outlines the expenditure information to be included in the report and provides instructions on completing the collection instrument. The public health expenditure definitions have been included in Appendix 1.

All States forwarded the public health expenditure information for 1998–99 to the AIHW for collation and verification. Further analysis identified the sources of funding for core public health. This information was obtained by deducting Commonwealth Government grants to State and Territory Governments from total public health expenditure.

History of events

The first stage of the NPHEP was the defining of public health categories and agreement on a collection process. A report was compiled in this first stage which discussed the state of play of expenditure on public health in 1997–98 and earlier years.

The second stage was the collection of expenditure and revenue information across eight distinct public health expenditure categories. This report presents the information gathered in the second stage of the NPHEP.

Substantial preparatory work has been conducted to identify a set of definitions for core public health activities. This has been conducted in consultation with Commonwealth, State and Territory health departments. The method used to establish these definitions was to initially collect descriptive data from all jurisdictions on public health activities and programs. This was the first stage of events towards a set of definitions being created.

A joint meeting was held at NSW Health on Friday 3 July 1998 to propose a work program for the NPHEP. The meeting was attended by representatives of all jurisdictions—including the Commonwealth—and provided an opportunity to resolve the concerns of jurisdictions. In-principle agreement was reached on the following proposals:

- Collecting descriptive information on public health activity in the government sector (the 'mud-map'). This would cover the collection and description of information from health and non-health agencies thereby providing a picture of public health activity across government agencies.
- Undertaking a pilot collection of public health activity expenditure data across a number of organisational units within health and non-health agencies. This exercise would aim to expose the difficulties and inconsistencies associated with the collection of public health expenditure data.
- Defining the type of public health activity for which expenditure data may be collected and streamlining the proposed classification schedule of public health activity to reflect activities relevant to health policy and public health policy.
- Organising a Public Health Expenditure Workshop to consider the information to be collected, promote work on definitions of public health, and establish the framework for routine collection of public health expenditure. It was held in Canberra during early December 1998.

Establishment of the Technical Advisory Group

Due to the scope of the project, each State allocated a coordinator for the NPHEP, thereby providing the project with consistent input from all jurisdictions. These coordinators, together with AIHW project staff, formed the Technical Advisory Group (TAG). The Commonwealth Department of Health and Aged Care provided partial funding for the contribution of the States and Territories to the NPHEP. The TAG has met regularly to establish the core definitions and to coordinate the collection, analysis and reporting of data for the project (refer to Appendix 4 for TAG membership list). Funding for the TAG has come from Commonwealth, State and Territory Governments.

Definition of public health

The NPHP defines public health as

> …the organised response by society to protect and promote health, and to prevent illness, injury and disability. The starting point for identifying public health issues, problems and priorities, and for designing and implementing interventions, is the population as a whole, or population subgroups. (NPHP 1998b)

Public health is characterised by planning and intervening for better health in populations rather than focusing on the health of the individual. These efforts are usually aimed at addressing factors that determine health, and the causes of illness rather than its consequences, with the aim of protecting or promoting health or preventing illness.

The NPHEP has examined a wide range of definitions of public health activities and has refined these to define public health expenditure categories. Information from the Organisation for Economic Cooperation and Development (OECD), the World Health Organization (WHO), the National Public Health Partnership Core Public Health Functions Project, State health authorities and academics has been considered. The public health definitions were devised and refined by all interested parties at a workshop in December 1998, and also by the TAG.

National Public Health Expenditure Project core categories

These categories were determined after the collection of descriptive information from health and non-health agencies. This information was then used by the jurisdictions to create a picture of public health activity across government agencies. Each jurisdiction then conducted a pilot collection of data on public health activity expenditure across a number of organisational units within health and non-health agencies. This exercise exposed difficulties and inconsistencies associated with the collection of public health expenditure data. The proposed classification schedule of public health activity was streamlined to reflect activities relevant to health policy and public health policy. Three major categories of activities/programs relevant to public health were identified:

1. *Core public health activities*
2. *Public health related activities*
3. *Other government activities with a public health impact*.

The 1998–99 collection focused on core public health activities, but where information on public health related expenditure was available, jurisdictions have included this information at the end of their chapter.

Investments in areas such as information systems, epidemiological analysis, public health legislation, policy and program development, public health communication and advice, public health workforce development and public health research and development all play a fundamental role in the business of public health and have been reported by all jurisdictions. However, the appropriate allocation of these expenditures to the core public health activity categories is still under development, and this leads to some differences between the States and Territories which are due to methodological issues, not to real differences in spending.

The eight major core public health expenditure categories decided for the 1998–99 report were:

1. Communicable disease control

All jurisdictions maintain surveillance, notification and control systems, which deal with prevention of communicable diseases and management of disease outbreaks. The national collaborative approach to communicable disease control is represented by the Communicable Diseases Network Australia New Zealand.

2. Selected health promotion activities

Health promotion interventions range from those delivered to specific target groups or populations to those administered at the local level or in a community health setting. These include programs on healthy settings, nutrition, physical activity, injury prevention, anti-smoking and safe alcohol consumption. Health foundations such as VicHealth also contribute large resources to health promotion. NGOs, such as the cancer foundations, are also major health promotion players in most jurisdictions. Government funding of NGOs has been included in the 1998–99 expenditure figures, but funding from NGOs' own sources has not.

The Stage 2 collection includes only government funded health promotion activities aimed at populations, not individual or 'opportunistic' health promotion activities. Stage 3 of the project aims to collect information on non-government funded public health activities that are undertaken by NGOs either partly government funded or reliant solely on fundraising activities.

Health promotion strategies that are integral to other public health categories, for example communicable diseases, are not included in this category. Public health activity that is undertaken in community health centres was included in the definitions under this category. The inclusions should relate to those programs that have a population-wide focus and are not defined by illness. Jurisdictions will vary in the expenditure reported in this category as not all jurisdictions have included expenditure by community based health centres, and those jurisdictions that have reported this expenditure have not necessarily included only those programs that have a population-wide focus.

3. Immunisation

All States and Territories undertake immunisation programs. The priorities in this area include childhood disease, pneumococcal and influenza immunisation. State and local government agencies generally deliver these programs, while the Commonwealth provides funds for vaccine purchase and maintenance of a national register, and performs an advisory role to the State and Territories. In addition, general practitioners have a major role in some jurisdictions.

4. Environmental health

Intervention in this area includes protection of the community from environmental dangers arising from air, land or water, vectors, radiation and other hazardous substances. Examples of these interventions are:

- radiation safety
- vector and rodent control
- chemical regulation
- water quality including water fluoridation and water environment

- contaminated land, waste and hazardous materials management
- public health disaster management.

While States and Territories take the lead in legislative and policy development, the responsibility is often shared with local government and other government departments in regulating, controlling activity, surveillance and compliance measures.

5. Food standards and hygiene

State health agencies and local government predominantly administer food standards and hygiene regulation. State health agencies generally have the legislative, educative and advocacy roles. Local governments in some jurisdictions administer monitoring and surveillance activities, and regulatory enforcement, while in other jurisdictions it is a joint health authority role. State and Commonwealth jurisdictions jointly set food standards and food hygiene standards through the Australian New Zealand Food Authority, which is funded by the Commonwealth.

6. ***Breast cancer screening***

Breast cancer screening is supported by all jurisdictions. Funding and delivery of screening is nationally coordinated.

7. Cervical screening

Cervical screening is supported by State health agencies through recruitment activities such as education of general practitioners on cervical screening, and in some States much of the screening is undertaken by State agencies.

8. ***All other core public health***

This category is designed to capture other core public health activities that have not been captured in the preceding seven core public health categories. Some of the inclusions within this category are pharmaceutical and therapeutic goods regulation, alcohol regulation, tobacco and illicit drug control, human remains regulation, air and noise pollution control and the control of dangerous animals and licensing of pets.

Refinement of categories for the 1999–00 Report

The TAG has refined the public health expenditure definitions for the 1999–00 collection of public health expenditure information to include two new categories, *Hazardous and harmful drug use* and *Research.*

The core public health categories that are being used for the 1999–00 National Public Health Expenditure Report are:

1. *Communicable disease control*
2. *Selected health promotion*
3. *Organised immunisation*
4. *Environmental health*
5. *Food standards and hygiene*
6. *Breast cancer screening*
7. *Cervical screening*
8. *Hazardous and harmful drug use*
9. *Research.*

There will also be a category called *Public health related activities*. This category will allow jurisdictions to include expenditure on those activities that are related to public health and which are important to the work done within each jurisdiction. The expenditure in this category will be reported separately and will not be included in the aggregate public health expenditure figures.

The *Hazardous and harmful drug use* category will include expenditure that relates to health promotional activities. These activities were included in the *Selected health promotion* category for the 1998–99 report by most jurisdictions because there was not a separate drug category.

The *All other core public health* category will not be included in the 1999–00 National Public Health Expenditure Report. Expenditure from this category will now be included under the *Hazardous and harmful drug use* category, the *Environmental health* category or the *Public health related activities* category.

Program-wide functions

In all jurisdictions there is substantial investment in generic-type public health activities, such as information systems, epidemiological analysis, public health legislation, policy and program development, public health communication and advice, public health workforce development and public health research and development. These investments play a fundamental role in the business of public health across all jurisdictions and are included in core public health expenditure.

Public health related interventions

There are also a number of public health related interventions carried out within jurisdictions. While they are not 'core' public health activities, they make an important contribution to the health and wellbeing of all Australians. These activities include sanitation and sewage treatment, maternal and child health (including family planning), domestic violence prevention and control, urban planning and transport safety. As with other interventions, these activities are administered across all levels of government in Australia.

2 Review of previous work

During the latter half of 1998 during Stage 1 of the NPHEP, an exercise was undertaken by Commonwealth, State and Territory departments of health, to describe the range of public health interventions delivered in their respective jurisdictions.

It was evident from this that public health effort in Australia is widespread. Public health interventions are undertaken by many sectors of the economy, and by a range of organisations. While many interventions are undertaken by divisions of public health at Commonwealth and State level, a large number are delivered by community health services, local governments, general practitioners and NGOs. Academic institutions also play an important role in public health research.

2.1 State of play of expenditure on public health by Australian governments: A survey of data available on public health expenditure in Australia for 1997–98 and for earlier years

The State of Play Report was the first document to be published for the NPHEP and was drafted with assistance from the Commonwealth, State and Territory health departments. It discussed the public health expenditure data that was available, its deficiencies and strategies to improve the quality of the data. The main source of the data contained in the report was the Commonwealth Grants Commission (CGC) Report on General Revenue Grant Relativities 1999, and unpublished data provided by the Commission. The CGC's public health data was the most comprehensive data available for 1997–98.

The 1997–98 report on public health expenditure is based on data from the CGC public health category 4395. CGC 4395 includes four Government Purpose Classification (GPC) categories: Public health services (GPC 2550), Pharmaceuticals, Aids and Appliances (GPC 2560), other Health Research (GPC 2579) and Health Administration not elsewhere classified (GPC 2590).

Although GPC 2550 is quite similar to the NPHEP core public health categories, not all of the information is compatible. The NPHEP 1998–99 numbers will therefore not totally reconcile with GPC 2550 numbers. The 1997–98 GPC 2550 definition appears below.

ABS Government Purpose Classification category of 'public health services' (2550)

The Australian Bureau of Statistics (ABS) Government Purpose Classification (GPC) defines 'public health services' for the purposes of Government Finance Statistics (GFS). Data is collected from governments by the ABS under the GFS framework and is published by the ABS at an aggregate level in various publications.

Agreed in 1997, the ABS definition of 'public health services' is: 'Outlays on public health services consisting of population health service programs and preventive health service programs'.

Population health service programs are defined as those programs which aim to protect, promote and/or restore the collective health of whole or specific populations (as distinct from activities directed to the care of individuals). This includes:

- health promotion campaigns
- occupational health and safety programs
- food standards regulation
- environmental health
- nutrition services
- communicable disease surveillance and control
- epidemiology.

Preventive health service programs are those programs that have the aim of preventing disease. These include:

- Immunisation programs
- Breast cancer and cervical screening
- Screening for childhood diseases.

2.2 Summary of the 1997–98 State of Play Report

Key findings

The level of investment in core public health activities that took place in Australia in 1997–98 was about 2% of total recurrent health expenditure. Total public health expenditure from the Commonwealth, States, Territories and local government in 1997–98 was $776m. State and Territory Governments funded $479m of public health expenditure, which was 62% of all government funding of public health in 1997–98. The Commonwealth Government funded $258m of public health services, which was 33% of total public health expenditure, and local government expenditure (as sourced from the ABS public finance database for 1997–98) was reported as $40m or 5% of public health expenditure.

Data deficiencies

Notwithstanding the key findings outlined above, the State of Play Report indicated that the accuracy and scope of current public health expenditure data was inadequate for the purpose of informing public health policy. It showed that more information was required on expenditure on the components of public health, in order to provide a more accurate understanding of public health. Obtaining this information, the report found, required clear definitions of core public health functions, and that public health expenditure be reported according to these definitions. Problems highlighted by the report included:

- inconsistencies in the way then current definitions were applied from State to State
- confusion over the classification of activities on the borderline of public and community health
- collection of reliable data from local governments
- collection of reliable data from non-health government departments
- an unknown overlap between public health research expenditure and other public health expenditure data
- exclusion of NGO funded and household sector expenditure
- comparability across time.

The NPHEP has addressed some of these deficiencies in this 1998–99 report, by collecting public health expenditure data in a more uniform manner according to an agreed set of definitions of public health functions.

2.3 Differentiating between the data in the 1997–98 State of Play Report and the 1998–99 Public Health Expenditure Report

The differences between the two reports are mostly the result of different methodologies for the collection of public health expenditure data and different definitions for inclusions and exclusions. The 1998–99 NPHEP collection process is quite different from the 1997–98 ABS GPC collection process. The 1998–99 NPHEP collects data through the project coordinators working in each of the health authorities according to a detailed collection manual, which carefully defines the inclusions and exclusions for each of the core public health categories. The ABS data are compiled mostly by Treasuries, who have only a macro understanding of the data they are compiling. The categorisation of the ABS data is also highly influenced in most jurisdictions by the administrative organisation of the expenditure information and not by the type of service or activity provided. These data are published by the ABS at a high level of aggregation, which results in significant amounts of expenditure incorrectly reported as public health, and other expenditure not reported as public health that should be. The data are then passed on to the CGC for some modifications before being published in its annual reports.

The ABS data is normally compiled by adding up program categories. For example, in the public health area the whole of the expenditure of the Population Health Program would be included. The 1998–99 report uses, where possible, a more detailed activity approach. Some jurisdictions have identified and reported on public health activity expenditure that is delivered by community health programs. Under the ABS collection process this expenditure would usually be recorded against the Community Health GPC category.

It should also be noted that the 1998–99 NPHEP report will not be comparable with the CGC public health category 4395 published in the annual CGC reports because 4395 includes GPC categories apart from the Public Health Services GPC category 2550. It also includes the following GPC categories: Pharmaceuticals, Aids and Appliances (GPC 2560), other Health Research (GPC 2579) and Health Administration not elsewhere classified (GPC 2590).

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.

5 Public health expenditure by New South Wales Department of Health

5.1 Introduction

New South Wales Department of Health overall structure

The NSW Department of Health, through health services and other stakeholders, is responsible for providing the people of New South Wales with better health and good health care. It provides advice and leadership on health issues while being responsive to the health concerns of the community and fulfilling its overarching responsibilities for the performance of NSW Health. Accordingly, the Department has major state-wide responsibilities for policy development, system-wide planning and performance monitoring and management of health issues.

The *Health Services Act July 1997* describes the 'public health organisations' collectively making up the New South Wales Public Health System. These include:

- seventeen Area Health Services (AHSs), covering the whole of New South Wales;
- Ambulance Service;
- Corrections Health Service; and
- The New Children's Hospital.

A number of affiliated health organisations run by religious or charitable bodies also provide services and facilities that are formally recognised under the *Health Services Act July 1997* as part of the New South Wales Public Health System.

AHSs operate within specific geographic areas of the State. They each play major roles in planning, delivering and coordinating local services, managing resources, and setting and maintaining the balance between treatment and preventive services within their geographic area. They are responsible for providing services such as public health, community health, public hospitals, psychiatric hospitals and nursing homes, community support services, domiciliary nursing and other outreach programs. The distribution of funding to the AHSs is aimed at enabling residents in all areas to have comparable and comprehensive access to services that are necessary to meet their health needs. At the same time it is recognised that some high-cost and specialised services can only be provided efficiently and effectively in a limited number of locations and that some people may need to travel in order to have access to these services. Therefore, some AHSs also have state-wide roles in provision of special services.

The Department uses a planning tool known as the resource distribution formula (RDF) to guide the allocation of funding to AHSs. That same tool is used to monitor progress towards the achievement of fairness in health funding. At its core, the RDF attempts to quantify the health needs of the resident population of each of the AHSs.

However, the annual funding allocation to AHSs takes into account a range of other factors as well as the population based funding needs indicated by the RDF. These include the

recurrent requirements of new facilities as they come into operation and changes in funding arrangements between the Commonwealth and State Governments.

New South Wales public health system

Legislated responsibility for public health in New South Wales rests with the NSW Department of Health, with AHSs and with local councils. However, the public health system in New South Wales extends beyond the sphere of activity of NSW Health and local government. The public health roles and responsibilities of the NSW Department of Health, the AHSs and local government are detailed below.

NSW Department of Health

The Department's primary responsibilities in public health are to:

- provide timely information about health status and health risks in New South Wales;
- establish public health priorities and develop policies to address these;
- allocate resources for public health;
- develop and administer public health legislation;
- develop and disseminate information about the evidence base for public health action, including funding research into public health problems as appropriate;
- provide guidance to AHSs about the implementation of public health programs;
- monitor the performance of public health programs and services against agreed indicators;
- ensure that the public health workforce is adequately trained and has opportunities for continuous learning; and
- integrate and coordinate the public health effort across government and non-government agencies.

Area Health Services

Under the *Health Services Act July 1997*, AHSs have a general responsibility 'to promote, protect and maintain the health of the community'. More specifically, AHSs are required to:

- investigate and assess health needs in the area;
- plan the future development of health services in the area;
- establish and maintain an appropriate balance in the provision and use of resources for health protection, health promotion, health education and treatment services;
- provide training and education relevant to the provision of health services;
- undertake research and development relevant to the provision of health services; and
- make available to the public information and advice concerning public health and the health services available within the area.

Most AHSs have established Divisions of Population Health to draw together a range of activities that reflect a comprehensive approach to the protection and promotion of health and to the planning and delivery of health services. Divisions of Population Health are variously structured but all include Public Health Units and Health Promotion Units, and most have a health services planning and development role.

Public Health Units

Public Health Units generally have the following roles:

- monitoring and investigating health status trends in the population, and the factors influencing these;
- investigating and responding to identified public health risks and potential health hazards;
- developing and implementing strategies to maximise population health gains and reduce health inequities; and
- developing the capacity of health services, other sectors and the community to implement strategies to address priority public health issues.

Health Promotion Units

Health Promotion Units generally have the following roles:

- assessing the health needs of their local population;
- establishing and maintaining partnerships with other sectors to design and deliver health promotion;
- providing incentives and training for all health professionals (including those in general practice and community health) to promote the health of their clients, patients and the wider community; and
- providing incentives and training for community members and personnel from sectors other than health to engage in activities which promote health.

Local Councils

Local government plays an important role in protecting and promoting health in New South Wales. The *Local Government Act 1993* sets out clear and comprehensive responsibilities for Councils in relation to environment protection and sustainable development, and states that Councils are 'to promote and to provide and plan for the needs of children'. Councils have public health responsibilities under various other Acts such as:

- The *Food Act 1989* (inspection of food, inspection and closure of food premises);
- The *Public Health Act 1991* (inspection of systems for the purposes of microbial control such as the maintenance and use of air-conditioning systems);
- The *Noise Control Act 1975* (noise control); and
- The *Swimming Pool Act 1992* (restriction of access to swimming pools).

Councils also have a general power to require someone to cease an activity if the activity constitutes a threat to public health.

Specific areas of partnership with local councils include immunisation, food safety, and control of arboviruses and legionnaire's disease.

It should be noted that expenditure by local councils on public health was not captured in the 1998–99 public health expenditure collection and is not reported here.

5.2 Data collection methodology

Details of expenditure on public health in 1998–99 were collected in a supplementary survey to the New South Wales Hospital Cost Data Collection. This survey used various public health sub-programs, which were mapped to the eight public health core categories defined by AIHW.

All AHSs, The New Children's Hospital and the NSW Department of Health provided data that made up the 1998–99 public health data collection. A total of $187.2m was spent on public health in New South Wales, which represents 2.7% of the $6.9 billion spent in the New South Wales Health System (*NSW Health Annual Report 1998–99*).

The expenditure reported is based on accrual accounting. New South Wales reported direct expenditure, program-wide function expenditure and overhead expenditure separately. The overhead component includes expenditure reported by the AHSs and The New Children's Hospital. It excludes corporate overheads. But note that most of the head office expenditure was included in the core categories, either as direct expenditure or 'program-wide function' expenditure, which includes expenditure on public health information systems, disease surveillance and epidemiological analysis, public health communication and advocacy, policy, program and legislation development and public health research and workforce development, and public and environmental health laboratory services (Table 5.10).

Discussion of variances

New South Wales recognises that there are variations in the way that data are collected across the States and Territories. Comparability of data will be achieved when States and Territories have had further experience with the collection of the data, and strategies to standardise the approach and increase quality are developed and implemented.

5.3 Overview of results

New South Wales public health expenditure

Total expenditure on public health reported in 1998–99 includes direct expenditure, program-wide functions expenditure and overheads. Of the $187.2m reported: direct expenditure was $153.2m; program-wide functions expenditure was $28.7m; and overheads were $5.2m. These are 81.8%, 15.4% and 2.8% of total expenditure.

Table 5.1 and Figure 5.1 display the distribution of this expenditure across the eight public health expenditure categories.

Table 5.1: Expenditure for total core public health, NSW Department of Health, 1998–99 ($)

Category	Direct expenditure	Program-wide expenses	Overheads	Total	Proportion
	$	$	$	$	%
Communicable disease control	37,848,209	7,101,859	1,297,041	46,247,109	24.7
Selected health promotion	35,649,819	6,689,353	1,221,703	43,560,875	23.3
Immunisation	31,035,082	5,823,441	1,063,559	37,922,082	20.3
Environmental health	8,607,575	1,615,130	294,978	10,517,683	5.6
Food standards and hygiene	3,402,433	638,435	116,600	4,157,468	2.2
Breast cancer screening	26,130,350	4,903,114	895,475	31,928,939	17.1
Cervical screening	4,122,359	773,522	141,271	5,037,152	2.7
All other core public health	6,397,852	1,200,497	219,252	7,817,601	4.2
Total core public health	**153,193,679**	**28,745,351**	**5,249,879**	**187,188,909**	**100.0**
Proportions	81.8%	15.4%	2.8%	100.0%	

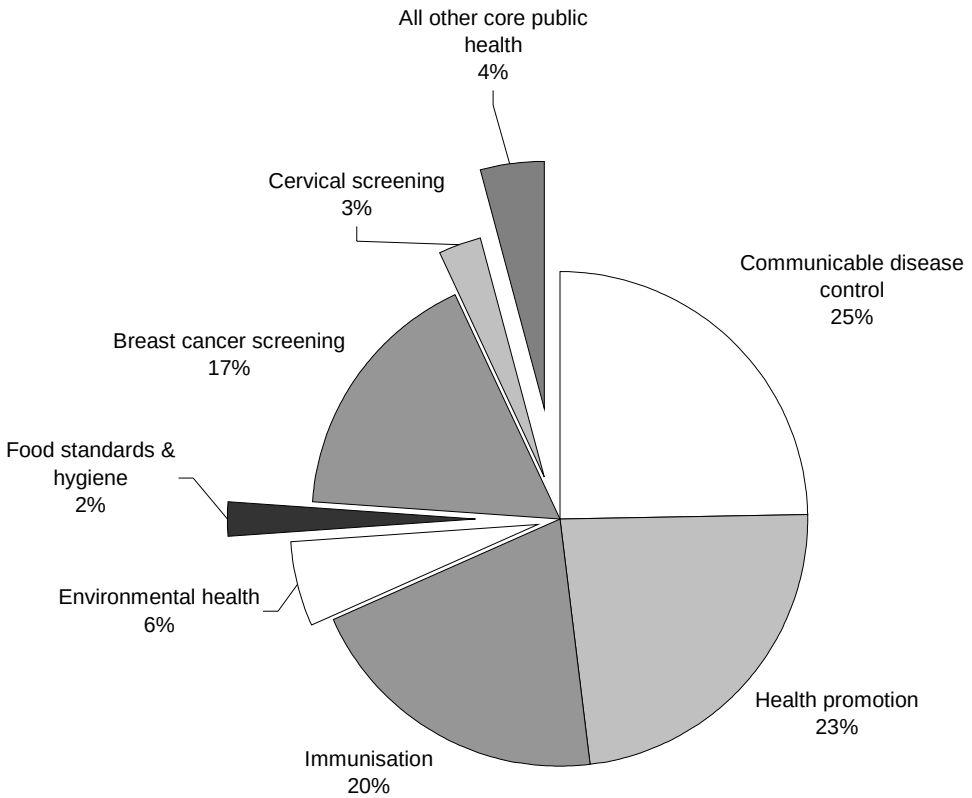

Figure 5.1: New South Wales core public health expenditure by categories

5.4 Public health expenditure by categories

The following sub-sections outline the results found for each of the defined public health core categories.

Communicable disease control

Total expenditure by the NSW Department of Health on *Communicable disease control* during 1998–99 was $46.2m (Table 5.2). This was 25% of the State's total expenditure on public health during 1998–99.

This core public health category has three major components:

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

The HIV/AIDS component did not include expenditure related to treatment services. However, the *Other communicable disease control* sub-category did include expenditure incurred in the promotion of safe sexual health activities.

Table 5.2: State Government expenditure on components of *Communicable disease control*, NSW Department of Health, current prices, 1998–99 ($)

Expenditure	HIV/AIDS, hep.C & STI programs	Needle & syringe programs	Other communicable disease control	Total communicable disease control
Direct	20,664,064	9,141,782	8,042,363	37,848,209
Program-wide functions	3,877,417	1,715,369	1,509,073	7,101,859
Overhead	708,148	313,285	275,608	1,297,041
Total expenditure	**25,249,629**	**11,170,436**	**9,827,044**	**46,247,109**

Selected health promotion activities

Total expenditure by the NSW Department of Health reported for the core public health category *Selected health promotion activities* was $43.5m (Table 5.3). This is 23% of the total expenditure on public health during 1998–99.

The main activities reported under the *Selected health promotion activities* were:

- injury prevention;
- health promotion related to drugs of dependence;
- general health promotion and education; and
- other disease prevention, detection and control.

Table 5.3: State Government expenditure on components of *Selected health promotion activities*, NSW Department of Health, current prices, 1998–99 ($)

Expenditure	Injury prevention	Health promotion for drugs of dependence	General health promotion and education	Other disease prevention, detection and control	Total Selected public health activities
Direct	1,035,058	9,377,343	22,324,161	2,913,257	35,649,819
Program-wide functions	194,219	1,759,570	4,188,919	546,645	6,689,353
Overheads	35,471	321,357	765,039	99,836	1,221,703
Total expenditure	**1,264,748**	**11,458,270**	**27,278,119**	**3,559,738**	**43,560,876**

Immunisation

Total expenditure by the NSW Department of Health on *Immunisation* was $37.9m (Table 5.4). This was 20% of total expenditure on public health during 1998–99.

There were two classes of *Immunisation* reported in the New South Wales public health survey. They were:

- *Childhood immunisation*, and
- *Other immunisation*.

The major expenditures related to the *Other immunisation* component were for *Pneumococcal and influenza immunisation*.

In almost all cases, staff costs related to AHSs' community health personnel who were involved in delivering the immunisation services have not been included in this expenditure.

Table 5.4: State Government expenditure on *Immunisation*, NSW Department of Health, current prices, 1998–99 ($)

Expenditure	Childhood immunisation	Other immunisation	Total
Direct	15,649,774	15,385,308	31,035,082
Program-wide functions	2,936,533	2,886,908	5,823,441
Overhead	536,311	527,248	1,063,559
Total expenditure	**19,122,618**	**18,799,464**	**37,922,082**

Environmental health

Total expenditure by the NSW Department of Health on *Environmental health* was $10.5m (Table 5.5). This was 6% of the total expenditure on public health during 1998–99.

It should be noted that some AHSs capture expenditure for *Food standards and hygiene* together with expenditure for *Environmental health*. Some of these AHSs experienced problems when splitting up expenditure between the two categories. Consequently, it is believed that *Environmental health* may be slightly over-estimated and *Food standards and hygiene* may be slightly under-estimated.

Table 5.5: State Government expenditure on *Environmental health*, NSW Department of Health, current prices, 1998–99 ($)

Expenditure category	Amount
Direct	8,607,575
Program-wide functions	1,615,130
Overheads	294,978
Total expenditure	**10,517,683**

Food standards and hygiene

Total expenditure for *Food standards and hygiene* by the NSW Department of Health in 1998–99 was $4.1m (Table 5.6). This was 2% of the public health expenditure reported in 1998–99.

Table 5.6: State Government expenditure on *Food standards and hygiene*, NSW Department of Health, current prices, 1998–99 ($)

Expenditure category	Amount
Direct	3,402,433
Program-wide functions	638,435
Overheads	116,600
Total expenditure	**4,157,468**

Breast cancer screening

Expenditure on *Breast cancer screening* by the NSW Department of Health was $32m in 1998–99 (Table 5.7). This is 17% of its total public health expenditure reported in 1998–99.

BreastScreen NSW is a joint initiative funded by the New South Wales and Commonwealth Governments under the PHOFA. Its aim is to reduce morbidity and mortality resulting from breast cancer and it is managed by the Western Sydney AHS on behalf of the NSW Department of Health under a performance and funding agreement.

The program involves ten screening and assessment services across the State with 36 fixed screening locations and 14 mobile/relocatable units. While most of the screening and assessment services come under the jurisdiction of particular AHSs, BreastScreen NSW has performance and funding agreements with each of them. In 1998–99 they carried out 268,848 mammography screens throughout New South Wales.

The main activities of BreastScreen NSW reflected in the expenditure reported in the survey were:

- recruitment;
- screen taking;
- assessment;
- biopsies (open and core);
- training and education;
- data management;
- quality improvement;
- monitoring, evaluation and research;
- resources, reports and publications;
- service administration and management; and
- program coordination and management.

Table 5.7: State Government expenditure on *Breast cancer screening*, NSW Department of Health, current prices, 1998–99 ($)

Expenditure category	Amount
Direct	26,130,350
Program-wide function	4,903,114
Overhead	895,475
Total expenditure	**31,928,939**

Cervical screening

Total expenditure on *Cervical screening* by the NSW Department of Health during 1998–99, was $5m (Table 5.8). This was 3% of the total public health expenditure reported in 1998–99.

The Cervical Screening Program is a joint initiative funded by the Commonwealth and the New South Wales Governments under the PHOFA. Its main objective is to reduce morbidity and mortality resulting from cervical cancer.

The Program supports state-wide and AHS activities that encourage women to have regular Pap smears every two years; ensure appropriate follow-up of women with screen-detected abnormalities and ensure the optimal quality of Pap smear taking and reporting. The New South Wales Pap Test Register, which is managed and operated by the New South Wales Cancer Council, is an important part of the Program.

The State coordination unit for the Program is managed by the Western Sydney AHS under a performance and funding agreement with the NSW Department of Health. The New South Wales Pap Test Register comes under a separate performance and funding agreement between NSW Health and the New South Wales Cancer Council.

The main functions of the New South Wales Cervical Screening Program, which are reflected in the reported expenditure, are:

- recruitment initiatives—state-wide and local AHS projects;
- community and medical practitioner information and education;
- monitoring, evaluation and research;
- quality improvement initiatives;
- resources, reports and publications; and
- program coordination.

Table 5.8: State Government expenditure on *Cervical screening*, NSW Department of Health, current prices, 1998–99 ($)

Expenditure category	Amount
Direct	4,122,359
Program-wide functions	773,522
Overheads	141,271
Total expenditure	**5,037,152**

All other core public health expenditure

The expenditure reported for this category by the NSW Department of Health was $7.8m (Table 5.9). This was 4% of the total public health expenditure reported in 1998–99.

The expenditure reported in this category represented public health initiatives that could not be readily identified as falling into one or more of the core categories described earlier in this chapter.

The main activities that come within *All other core public health* expenditure are:

- health related aspects of alcohol regulation;
- tobacco control;
- illicit drugs/substance control;
- cost of regulation and enforcement of occupational health and safety, excluding cost of compliance and compensation payouts;
- 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.

Table 5.9: State Government expenditure on *All other core public health*, NSW Department of Health, current prices, 1998–99 ($)

Expenditure category	Amount
Direct	6,397,852
Program-wide functions	1,200,497
Overheads	219,252
Total Expenditure	**7,817,601**

Public health program-wide functions

The expenditure reported for public health program-wide functions was $28.7m. This expenditure has been apportioned to the eight core categories (Tables 5.1 to 5.9).

The public health workforce development expenditure presented in Table 5.10 represents the expenditure incurred at the NSW Department of Health level only. AHSs did not report this type of expenditure separately.

As the National Public Health Expenditure Project—Stage 2 (collection of public health expenditure for 1998–99) was at a developmental stage, both the reporting of expenditure on program-wide functions and the apportionment of these at a core category level was optional.

NSW Department of Health reported discrete expenditure for the various program-wide functions and allocated expenditure at a core category level using one of the recommended methodologies in the AIHW collection manual; that is, the proportion of direct expenditure in each of the public health sub-programs defined in the collection, compared with the total direct expenditure reported. The same methodology was also applied to apportion the overhead expenditure to the core categories.

A consistent methodology is expected to be defined by the TAG for the 1999–00 public health expenditure collection that will be used across all States and Territories.

Table 5.10: Expenditure in program-wide functions, NSW Department of Health, 1998–99 ($)

Program-wide functions	Total expenditure
Public health information systems, disease surveillance and epidemiological analysis, public health communication and advocacy and public health policy, program and legislation development	12,140,811
Public health workforce development	1,501,000
Public and environmental health laboratory services	5,012,870
Public health research and development	10,090,671
Total	**28,745,352**

6 Public health expenditure by Victorian health authorities

6.1 Introduction

Overview

The Department of Human Services covers the responsibilities of the Ministers for Health, Aged Care, Youth and Community Services, Housing, and Aboriginal Affairs. The Department funds or directly delivers a diverse range of services within this broad portfolio, whose mission is to ensure that the people of Victoria have access to services that protect and enhance their social wellbeing and to best allocate available resources to meet their needs.

Most services are provided by agencies under funding and service agreements or contracts with the Department. These include government-related agencies such as public hospitals, health care networks, public nursing homes, local government, community health centres, ambulance services, and a range of NGOs providing mainly community services. The Department also provides some services directly—in particular, public rental housing, intellectual disability accommodation, child protection and some mental health services.

The principal responsibilities of the Department of Human Services cover:

- high-quality, efficient health care services through the public hospital system;
- residential and rehabilitation care to older and disabled persons, and funding to enable older persons to continue to live at home;
- adequate and affordable housing assistance to those Victorians most in need of housing;
- a wide range of other human services programs which concentrate on the provision of services to the vulnerable;
- promotion and protection of the health and wellbeing of all Victorians by providing leadership, support and services, in partnership with key stakeholders and the community;
- programs to promote the economic and social development of Aboriginal communities and their cultural heritage; and
- government concessions designed to ensure that low-income groups are not denied reasonable access to essential services.

Public Health & Development Division

The structure of the Public Health & Development Division is underpinned by the following three functions:

- **Strategy and capacity building**

  This function integrates the core business areas of public health services as well as system development. It provides strategic development, legislative review, business processes, budget and finance, human resources management, information technology and communication services. This function also includes cemeteries and crematoria, nursing, allied health and public health workforce development.

- **Health intelligence and disease control**

  This function addresses the prevention of premature death, disability, disease and other adverse health outcomes. The commitment to controlling disease and improving the health system is being strengthened through evidence based planning, ethical and efficient responses to need, and intelligent resource allocation.

- **Social and environmental health**

  This function focuses on food hygiene, nutrition and physical activity. Other target areas also include reducing the misuse of tobacco, alcohol and other drugs including pharmaceutical drugs, protection of the community from other environmental dangers arising from air, land or water, radiation and other poisonous substances. Some of the major priorities in this function comprise improvement of Koori health and delivery of culturally appropriate services.

Victoria's health will be challenged in a number of new and significant ways over the next two decades. The Public Health & Development Division initiated a strategic planning process in 1998 to develop partnerships across the State to meet those challenges. The first stage of the process involved working with key stakeholders to determine the future strategic directions for public health in Victoria. The aim was to create a shared strategic framework over the next five to ten years.

6.2 Data collection methodology

The Public Health & Development Division is responsible for programs that support the health and wellbeing of all Victorians. Non-government agencies and local government authorities also perform some of the services on behalf of the Division. As most of the public health outputs are delivered by agencies funded by the Division, the collection of information on the core public health expenditure categories defined for the purposes of this document was performed within the Division.

The first step towards the data collection was to download raw figures from the Department's general ledger on Oracle Financials, followed by a verification process which was performed to ensure the integrity of data collected. The flexible structure of the general ledger enables the data to be sorted against activities, or outputs, which in turn facilitates the further classification of these data into the eight core public health expenditure categories. Manual categorisation was then performed by way of sorting each activity against its description.

A reconciliation process was carried out to ensure that reliable data were included in this report. It was determined that only functions that were funded or provided directly by the Public Health & Development Division were to be included in the data collection. As a consequence, public health activities that were carried out by the Department's Acute Health Services have been excluded. Also excluded from the report was expenditure in areas such as corporate overheads allocated by the Department; Information Technology; Research and Development; Alcohol and Drug Services; and Workforce and Infrastructure Development. These exclusions amounted to $40.5m and a breakdown is provided in Table 6.10.

6.3 Overview of results

Table 6.1: Expenditure for total core public health, Victorian health authorities, 1998–99

Expenditure category	Direct expenditure	Overhead	Total expenditure	Proportion of total
	$'000	$'000	$'000	%
Communicable disease control	20,877.2	1,313.1	22,190.2	17.9
Selected health promotion	26,113.2	434.3	26,547.5	21.4
Immunisation	24,677.4	1,552.1	26,229.5	21.1
Environmental health	5,140.0	323.3	5,463.3	4.4
Food standards and hygiene	2,546.0	160.1	2,706.2	2.2
Breast cancer screening	17,751.0	1,116.4	18,867.4	15.2
Cervical screening	6,550.2	412.0	6,962.2	5.6
All other core public health	14,244.9	895.9	15,140.8	12.2
Total expenditure	**117,899.9**	**6,207.2**	**124,107.1**	**100.0**

Total expenditure by the Public Health & Development Division in the core expenditure categories during 1998–99 was $124.1m. The Department's 1998–99 annual report shows an overall operating expense of $164.6m (including the $40.5m that was excluded from the core categories) by the public health output groups, which agrees with the total amount summarised by this report.

The $6.2m Divisional overhead that comprises mainly output management expenditure has been allocated across the eight core categories. This is done through apportionment. Direct expenditure in each category was firstly proportioned against total expenditure to get the percentage; this percentage was then multiplied by the total overhead to get the relevant portion for each category. It is important to note that the $24.0m funding to the Victoria Health Promotion Foundation (VicHealth), which performs the majority of health promotion activities for the Department, has been excluded from this exercise as VicHealth does not consume any material overhead from the Division.

Since the State Government has adopted an accrual accounting concept, data collected for this report were based on an accrual method. Accordingly, depreciation charged to the Public Health & Development Division amounting to $842,151 has been included, which represents 0.68% of the total reported expenditure.

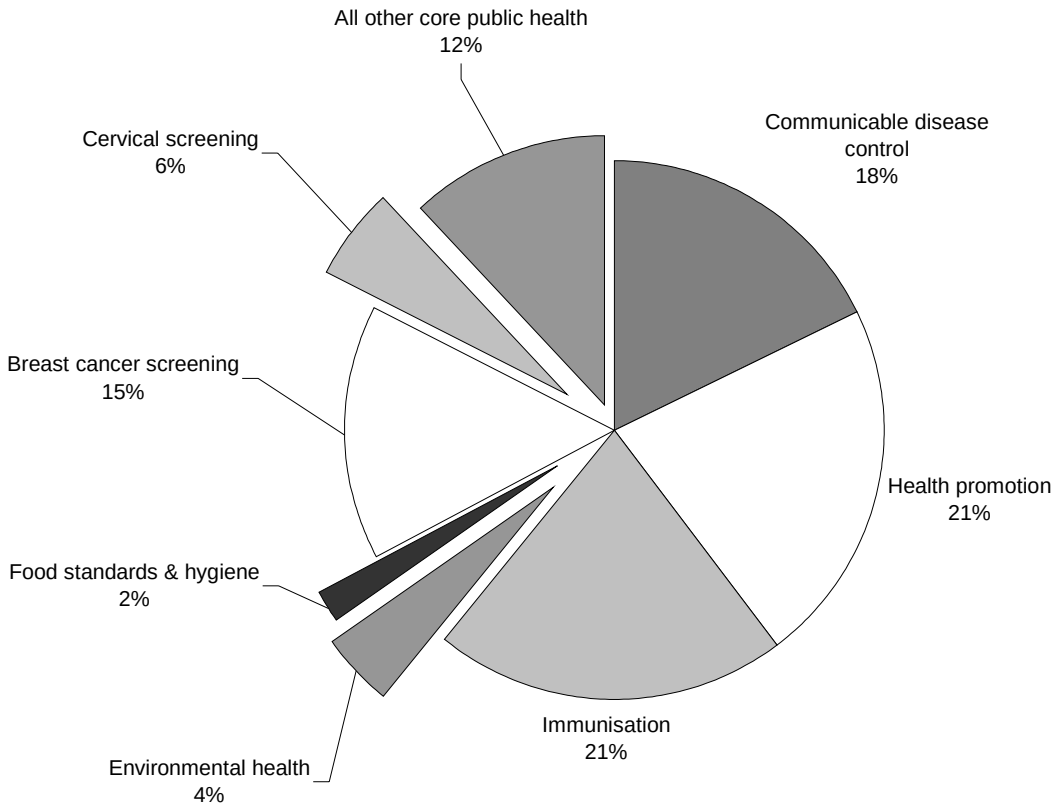

Figure 6.1: Victoria—core public health expenditure by categories

6.4 Public health expenditure by categories

Communicable disease control

HIV/AIDS, hepatitis C and sexually transmitted infection programs

This component includes the provision of HIV and associated testing, and the provision of counselling and support services for HIV/AIDS and hepatitis C patients. These services are provided by a range of agencies, including Melbourne Sexual Health Centre, which is managed and staffed by Public Health & Development Division, some non-government agencies and various research laboratories.

The needle exchange program

The needle exchange program ensures the provision of sterile injecting equipment for injecting drug users. This is undertaken solely by non-government agencies funded by the Public Health & Development Division.

Other communicable disease control services

This incorporates the collection, collating and reporting on data relating to notifiable infectious diseases, the provision of advice to health care professionals and the public on infectious diseases, the coordination of outbreak investigations, and the provision of tracing, counselling and testing of contact cases of tuberculosis. Also included in this sub-category is the expenditure on the Vector Borne Virus Program, which associates with the Virology and Entomology Services. Expenditure on monitoring and controlling of vector mosquito species during November to April in high-risk local government areas has also been taken into account.

Total direct expenditure for *Communicable disease control* by Victorian health authorities in 1998–99 was $22.2m (Table 6.2). This was 17.9% of total core public health expenditure.

Table 6.2: State Government expenditure on *Communicable disease control*, Victorian health authorities, current prices, 1998–99 ($)

Expenditure category	HIV/AIDS, hep.C and STI programs	Needle exchange programs	Other communicable disease control	Total
Direct	9,229,782	2,811,600	8,835,774	20,877,156
Overheads	580,506	176,835	555,724	1,313,065
Total	**9,810,288**	**2,988,435**	**9,391,498**	**22,190,221**

Selected health promotion activities

The promotion of healthy lifestyles in Victoria is undertaken jointly by the Department of Human Services and the Victorian Health Promotion Foundation (VicHealth). VicHealth is funded directly by the Public Health & Development Division to promote health to all Victorians through programs such as Quit. Total funding for VicHealth in 1998–99 was $24.0m, including $4.8m for research and development which, pertaining to the collection methodology, has been excluded from this category. Programs that are exclusively run by the Department support developmental projects, which enhance health promotion in health and community agencies, schools and local government.

Public Health & Development Division also provides grants for projects which will improve health promotion practice and increase awareness and knowledge of physical activity in the general community and in vulnerable groups. This funding is also to increase the skills of health professionals and other workers in the promotion of physical activity, and to develop coherent strategies to reduce differentials in health status between rural and metropolitan areas of Victoria, with particular emphasis on the prevention of non-communicable diseases in general and cardiovascular disease. Major promotions undertaken in 1998–99 were Rural Men's Health Promotion and Regional Health Promotion.

Total reported expenditure on *Selected health promotion activities* by Victorian health authorities was $26.5m (Table 6.3). This was 21.4% of total core public health expenditure.

Table 6.3: State Government expenditure on *Selected health promotion activities*, Victorian health authorities, current prices, 1998–99 ($)

Expenditure category	Total
Direct	26,113,222
Overheads	434,303
Total	**26,547,525**

Immunisation

Childhood immunisation

Expenditure in this sub-category includes the purchase of vaccines and the provision of immunisation services to children according to the National Health & Medical Research Council (NHMRC) schedule. This program is carried out with the assistance of private general practitioners and local government. During 1998–99 about 88% of children turning 12 months of age and 75% of children turning 24 months of age were fully immunised. These figures were sourced from the Australian Childhood Immunisation Register.

Pneumococcal and influenza immunisation

Expenditure on influenza immunisation includes costs associated with the purchase of influenza vaccines. This program is a national program for persons over 65 years of age, for Indigenous people over 50 years of age, and for those aged 15–49 at high risk. In 1998–99, 560,000 vaccines were distributed in Victoria, with 75.8% of persons aged 65 and over being immunised.

Pneumococcal pneumonia immunisation includes the purchase of pneumococcal vaccine for immunisation of persons aged 65 and over and for Indigenous people aged over 50 years, and those aged 15–49 at high risk. The service is solely provided through general practitioners. Victoria is the only State in Australia that provides pneumococcal pneumonia immunisation to people aged 65 and over. The pneumococcal pneumonia immunisation for Indigenous people is part of the national campaign. In 1998–99, 27.3% of persons aged 65 and over received pneumococcal immunisation, giving Victoria a cumulative coverage rate of nearly 50%.

Other immunisation

Other Immunisation expenditure includes: the purchase of vaccines, the provision of other immunisation services according to the NHMRC schedule, the Australian Childhood Immunisation Register, issuing school entry immunisation certificates, provision of hepatitis B immunisation to eligible Human Services staff and clients, and the provision of funding for several pilot projects including mobile immunisation services.

The funding made available for immunisation comes from State Appropriations and the Commonwealth PHOFA.

Total expenditure on *Immunisation* in 1998–99 by Victorian health authorities was $26.2m (Table 6.4). This was 21.1% of total core public health expenditure.

Table 6.4: State Government expenditure on *Immunisation*, Victorian health authorities, current prices, 1998–99 ($)

Expenditure category	Childhood immunisation	Pneumococcal and influenza immunisation	Other immunisation	Total
Direct	10,858,500	10,996,200	2,822,700	24,677,400
Overheads	682,943	691,604	177,533	1,552,080
Total	**11,541,443**	**11,687,804**	**3,000,233**	**26,229,480**

Environmental health

Expenditure on *Environmental health* comprises mainly the funding for development and employment of environmental health officers within regions. Other areas include:

- investigation of the effects and public health risk of environmental contaminants;
- radiation safety and adverse events surveillance;
- maintenance of emergency plan, protocols and procedures;
- maintenance of emergency response capability and provision of a coordinated approach when a major health risk is detected;
- laboratory testing of cooling towers, pools, spas and water treatment plants in response to public health risks;
- licensing to persons with appropriate qualifications and training, and registering of appropriate radiation equipment;
- provision of information and advice to home department, community, other Government Departments, pest control industry and radiation users; and
- provision of appropriate training and advice to persons who are applying registered chemicals for commercial pest control.

Total direct expenditure on *Environmental health* by Victorian health authorities was $5.5m (Table 6.5). This was 4.4% of total expenditure on core public health during 1998–99.

Table 6.5: State Government expenditure on *Environmental health*, Victorian health authorities, current prices, 1998–99 ($)

Expenditure category	Total
Direct	5,140,026
Overheads	323,281
Total	**5,463,307**

Food standards and hygiene

Expenditure on this category is related to the following areas:

- food recall and emergency response;
- food-borne illness investigation;
- representation on national forums and committees;
- collection, collation and reporting on non-compliance of foods against food standards code;

- food surveillance microbiology to facilitate the collection, analysis and interpretation of population based information;
- food hygiene surveillance;
- food safety and hygiene strategy research;
- analysis and report on possible unsafe contaminated food;
- surveillance of food premises on crown land; and
- provision to the community, stakeholders and government of information and advice on food safety issues legislation and implementation of new legislation.

Total expenditure for *Food standards and hygiene* during 1998–99 by Victorian health authorities was $2.7m (Table 6.6). This was 2.2% of total core public health expenditure.

Table 6.6: State Government expenditure on *Food standards and hygiene*, Victorian health authorities, current prices, 1998–99 ($)

Expenditure category	Total
Direct	2,546,036
Overheads	160,132
Total	**2,706,168**

Breast cancer screening

The provision of a breast cancer screening service is achieved through the funding of BreastScreen Victoria. The funding for breast cancer screening is provided under a joint Commonwealth/State arrangement via the PHOFA. In 1998–99 some 171,000 women were screened, approximately 57% of the target population over a two-year period.

BreastScreen Victoria is a free breast cancer screening service for women without breast cancer related symptoms or breast problems. Through early detection, the program aims to reduce the morbidity and mortality associated with breast cancer. Although women aged 40–49 and older than 69 are able to attend, BreastScreen Victoria is specifically targeted at women aged 50–69 years. This is because breast X-ray screening has been found to be most effective among women in this age group. If an abnormality is found on screening, BreastScreen Victoria provides women with assessment of the screen-detected abnormality to the point of definite diagnosis.

BreastScreen Victoria has a network of services around the State. These include eight assessment centres and 31 screening centres. All of these sites are specially designated centres operating under strict controls and standards. The program also employs a relocatable mammography machine in the western region of Melbourne and a mobile van in rural Victoria to ensure that the service reaches women in all areas.

BreastScreen Victoria manages a breast screen registry that keeps data on the number of women screened and the cancers detected. There is also a comprehensive recruitment and education strategy in place for the BreastScreen program.

Total expenditure on *Breast cancer screening* during 1998–99 by Victorian health authorities was $18.9m (Table 6.7). This was 15.2% of total core public health expenditure.

Table 6.7: State Government expenditure on *Breast cancer screening*, Victorian health authorities, current prices, 1998–99 ($)

Expenditure category	Total
Direct	17,750,984
Overheads	1,116,445
Total	**18,867,429**

Cervical screening

The provision of a cervical testing service, a state-wide database and individual reminder system for Pap screens are included in this service. Also included was expenditure on strategies to encourage women to have regular Pap smears.

Funding for this service is provided under a joint State/Commonwealth arrangement via the PHOFA. About 609,000 screens were performed during 1998–99. This was about 68% of the target population. The main goal of the Victorian Cervical Screening Program is to achieve optimal reductions in the incidence, morbidity and mortality associated with cervical cancer at an acceptable cost through an organised approach.

In accordance with the Commonwealth/State Agreement, the program mainly deals with the following areas:

- recruitment and education of all population groups according to need;
- work with consumers and NGOs in planning, operating, monitoring and evaluating the Pap screen recruitment program;
- development and support of strategies to promote best practice and standard setting; and
- improvement wherever possible of information collection and analysis, workforce development and research.

Total direct expenditure on *Cervical screening* by Victorian health authorities during 1998–99 was $7.0m (Table 6.8). This represented 5.6% of total core public health expenditure.

Table 6.8: State Government expenditure on *Cervical screening*, Victorian health authorities, current prices, 1998–99 ($)

Expenditure category	Total
Direct	6,550,221
Overheads	411,975
Total	**6,962,196**

All other core public health expenditure

Expenditure related to public health which could not be readily classified into one or more of the above core categories is reported as *All other core public health* expenditure. This category is made up of the following major components:

- 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).

Total expenditure for *All other core public health* by Victorian health authorities in 1998–99 was $15.1m (Table 6.9). This was equivalent to 12.2% of total core public health expenditure.

Table 6.9: State Government expenditure on *All other core public health*, Victorian health authorities, current prices, 1998–99 ($)

Expenditure category	Total
Direct	14,244,861
Overheads	895,928
Total	**15,140,789**

Table 6.10: Expenses excluded from all expenditure on core public health categories by Victorian health authorities ($m)

Type of expenditure	Total
Corporate overheads	6.0
Professional development	4.7
Information and advice	1.0
Other	28.8
Total	**40.5**

7 Public health expenditure by Queensland Health

7.1 Introduction

Queensland Health was restructured in 1996 in order to separate funding, purchaser and provider responsibilities within the department. The Health Planning and Systems Division fulfils the funding and purchaser functions while the Health Services Division fulfils the provider functions.

Queensland Health provides public health functions through Public Health Services and 39 health service districts throughout Queensland, and service funding to support the public health activities of NGOs. Queensland Health Pathology and Scientific Services (QHPSS) provides essential support in delivering public health activities. The roles of each of these major players are addressed below.

Public Health Services

Public Health Services comprises:

- the Office of the State Manager;
- ten units with state-wide responsibilities; and
- three Public Health Unit Networks comprising a total of fourteen public health units across the State (see Figure 7.1).

The key role and responsibility of Public Health Services is to coordinate and provide leadership for state-wide planning and strategy development for public health functions, and the implementation, monitoring and evaluation of public health activities. Within this role, the Service provides specialist policy and planning advice to the Minister, Office of the Director-General, Corporate Office branches and other state-wide services, and provides support to health service districts in the planning, delivery and evaluation of public health activities.

Public Health Services aligns internal state-wide strategic planning, monitoring and reporting to national, state and local priorities and the department's corporate planning and reporting cycle. The strategic objectives are achieved through a structure of outcome areas that form the basis of the services delivered (see Figure 7.2).

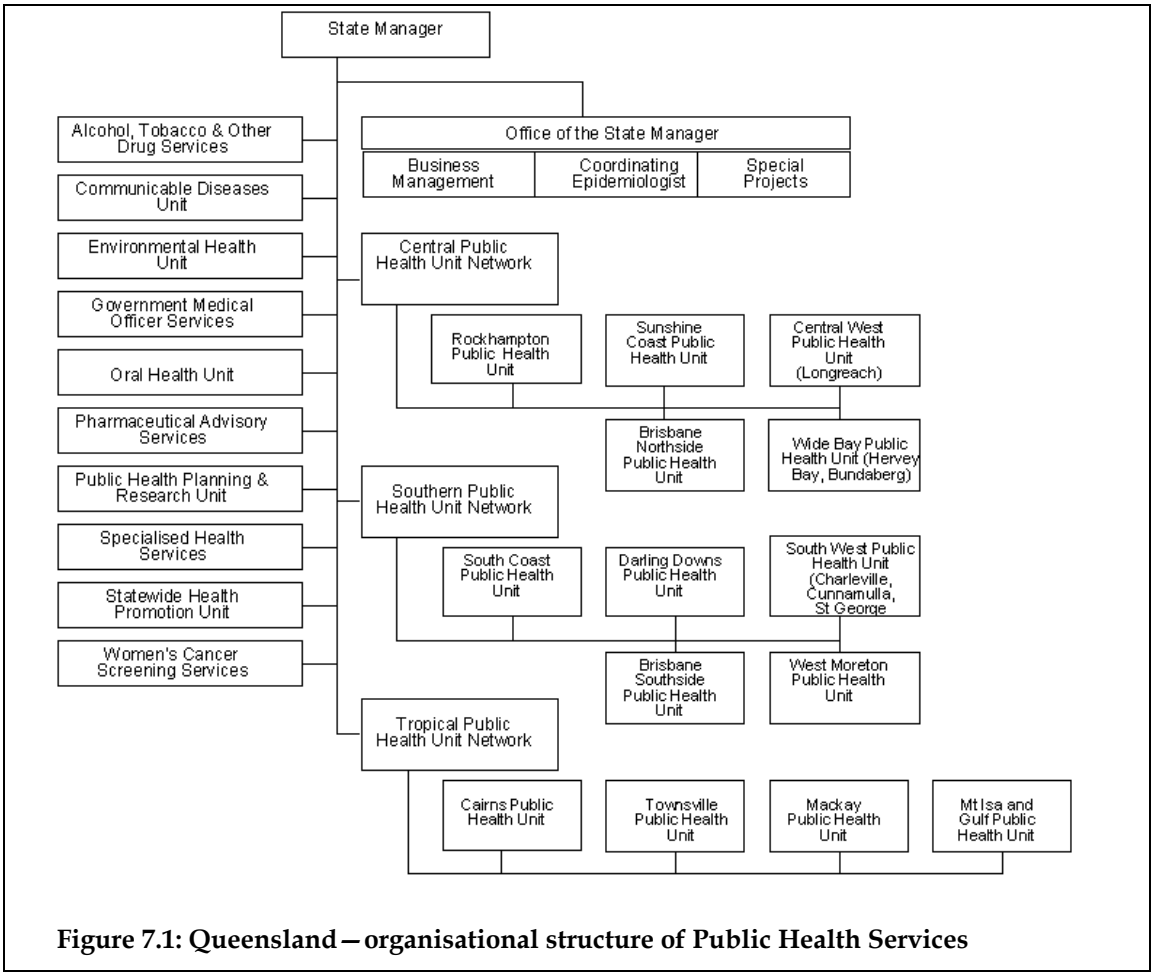

Figure 7.1: Queensland—organisational structure of Public Health Services

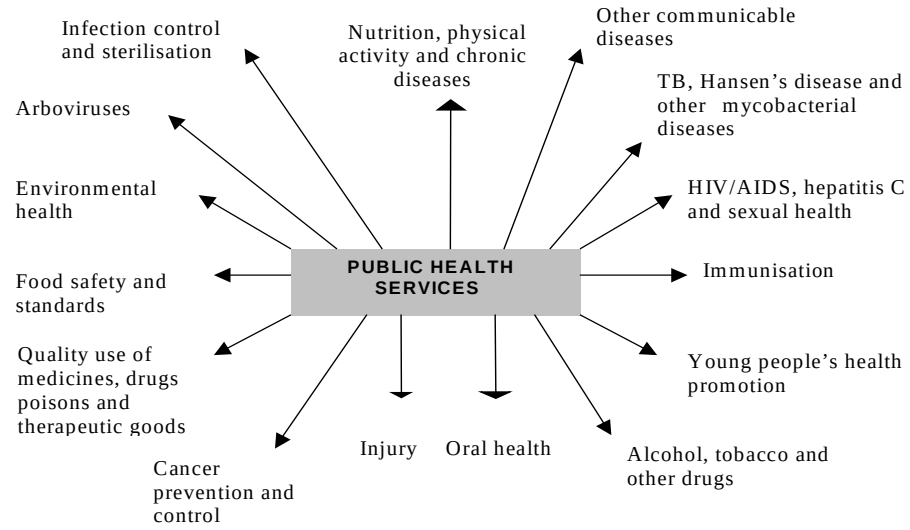

Figure 7.2: Queensland Public Health Services' outcome areas

Health service districts

Queensland Health has 39 health service districts, organised into three zones: northern, central and southern. The health service districts provide hospital, mental health, allied health, aged care, oral health and community health services. The organised public health activities provided by the health service districts are largely a component of state-wide programs coordinated or supported by Public Health Services, but managed by the districts. Such programs are coordinated largely through the community based health services and primary health centres. This includes sexual health services, alcohol and drug services, immunisation, school oral health, and breast and cervical screening programs. Additional programs and services are developed and coordinated directly by the districts.

Queensland Health Pathology and Scientific Services

QHPSS provides a network of laboratory and scientific services across the public sector that support public health initiatives. The Queensland Health Pathology Service (QHPS) provides pathology services through a network of 32 laboratories based at hospitals across the State. The pathology services that support public health activity include specimen collection, analytical testing, results interpretation, clinical consultation, teaching and research. Queensland Health Scientific Services is a comprehensive public health science laboratory providing services for health investigations, and testing for environmental contaminants and food/water quality.

The data presented in this report do not include expenditure within QHPSS cost centres. At the time of collection, the QHPS was developing an information database to record the workload of each laboratory in Queensland. The requirement of the Stage 2 collection—to allocate the respective costs to public health categories—was not possible at the time of collection. However, once developed, the database will be able to provide the necessary information for the Stage 3 collection.

A number of factors need to be taken into consideration when addressing the issue of identifying the public health aspects of pathology costs. For example, it is unlikely that the information systems will include detailed information on why a particular test was performed. Therefore, it would not be possible to identify, for example, whether particular testing for antibodies for HIV/AIDS and hepatitis C related to a patient who was admitted with a clinical condition or to the screening program. Similarly, separating the costs associated with the testing of urine samples for the Methadone Program from other clinical conditions requiring urine samples will be difficult. Additionally, tests that measure for antibody status as a follow-up service after the initial immunisation will not be specifically identified in the information system.

Non-government organisations

The Statewide Health and Non-Government Services Unit (SHANGU) is responsible for the purchase of health related services from the non-government sector, and research, tertiary and academic sectors. SHANGU contributes to the delivery of specific health outcomes, priorities and targets through the formulation of service agreements and the management of funding negotiated with providers.

7.2 Data collection methodology

Scope

In collaboration with relevant services of Queensland Health, the NPHEP identified cost centres that related to public health activities as defined by the TAG, regardless of the setting of the service. The collection included hospital services, community health centres, primary health centres, community based sexual health services, mental health services, community based alcohol, tobacco and other drug services, public health units, and services administered or funded from within Corporate Office (see Table 7.2). As noted above, pathology and scientific services were not included in the collection due to the current unavailability of appropriate information systems.

Queensland Collection Guide

The Queensland Collection Guide was distributed to project liaison officers within the respective services requesting the apportionment of cost centre expenditure to the respective public health categories using the Queensland Health Collection Tool.

The Queensland Collection Guide was developed using the NPHEP definitions with some modifications to ensure an efficient collection of expenditure data. The modifications to the NPHEP definitions excluded the *All other core public health* category and included an additional category—'Alcohol, tobacco and other drugs'. The modifications were made to limit the collection to well-defined categories and to ensure the information was consistent and comparable within the services of Queensland.

The 'Alcohol, tobacco and other drugs' services category was created for the Queensland collection to ensure all relevant services were included that are outlined in the NPHEP definition of the *All other core public health* expenditure category.

However, in order to present the Queensland data in a format consistent with that of other jurisdictions, an *All other core public health* category needed to be created for this report. Public health programs addressing illicit drugs, the methadone program and other drug related programs were the only relevant services collected that could be allocated to the *All other core public health* category.

NOTE: *Each jurisdiction was given the option to include in the* All other core public health *category additional services that are not outlined in the NPHEP definitions but are considered to be core public health by that jurisdiction.****Queensland opted not to collect services that were not identified as inclusions in the NPHEP definitions.*** *Services that may be considered as core public health in Queensland, such as school dental health services, are not presented in this report.*

In addition, a category labelled 'Public health related activities' was created during the review of the expenditure data. It comprises expenditure on services which, it was considered, did not fit under core public health expenditure categories but which were related to public health.

Treatment of the addition of the 'Alcohol, tobacco and other drugs' category in this report

The request to services divided the 'Alcohol, tobacco and other drugs' category into three sub-categories:

- 'Alcohol and tobacco health promotion activities';
- 'Illicit drugs and methadone program'; and,
- 'Other drug related programs'.

The additional category required the NPHEP definitions to be modified by removing alcohol and tobacco health promotion from the *Selected health promotion activities* category.

To present the expenditure for Queensland in a format consistent with that of the national category definitions the following alterations were made:

- Expenditure allocated against 'Alcohol and tobacco health promotion activities' was included in the *Selected health promotion activities* category.
- Expenditure against the 'Illicit drugs and methadone program' and 'Other drug related programs' sub-categories is presented under the *All other core public health* category.

Treatment of Corporate and Overhead Cost Centres

Corporate cost centres that contained indirect expenditure on public health through strategic support services such as the Coordinating Epidemiology and the Public Health Planning and Research Unit were identified and recorded as a separate aggregate. The same procedure was used to record the indirect expenditure within health service districts—for example, Health Service District Administration cost centres. Once all the data had been collected, the aggregate amounts for the corporate cost centres and the health service district overheads were apportioned on a pro rata basis to the different public health categories according to the proportions of the total service expenditure on the individual categories. Corporate Office overheads, such as Building Services, Finance Unit and Human Resource Unit, have not been included in the Stage 2 collection.

NOTE: *It is acknowledged that the pro rata method used to allocate corporate and overhead cost centres involves a large error. The error is due to the pro rata of overheads associated with areas requiring large administration support but moderate total expenditure (for example,* Environmental health*) and areas that reported high total expenditure but do not require large administration support (for example,* Immunisation*). A more accurate method for apportioning corporate and overhead cost centres will be used in the Stage 3 collection.*

Evaluation of the collection

Each service that provided expenditure information was requested to complete an evaluation form. The evaluation forms were reviewed in conjunction with the expenditure information provided.

On review of the expenditure data, an audit was deemed necessary as inconsistencies and inaccurate interpretation of the definitions were found in the data reported from various services. Services such as community health centres that provide multiple health initiatives varied greatly in the proportion of the total expenditure allocated to public health. In particular, the *Selected health promotion activities* and 'Alcohol, tobacco and other drugs' categories varied greatly between districts in the amount allocated from community health cost centres—a result of different subjective allocations by the reporting officers rather than a real difference in the investment in services provided. The services that used vastly different proportions were contacted and, following discussions, the proportions were adjusted accordingly.

During the evaluation the services reported confusion in regard to the definition and scope of the *Selected health promotion activities* category, as well as reporting difficulty in identifying the actual costs for the public health activities paid for from within multi-purpose cost centres (for example, general community health cost centre). Where a district had identified expenditure against *Selected health promotion activities* but no organised program was identified, the expenditure was considered outside the category definition and reallocated to the 'Public health related' category.

Cost centres that include expenditure on treatment services were often reported by services within the core public health categories. In particular, substantial adjustments were made to remove expenditure from within the core categories for HIV/AIDS and alcohol, tobacco and other drugs treatment services.

7.3 Overview of results

The total public health expenditure reported by services in Queensland Health for the 1998–99 collection was $114.3m, of which $84.2m (74.1%) was allocated to the core public health categories. Table 7.1 presents the expenditure reported as direct expenditure and overheads. The proportion of expenditure reported against core public health categories is presented in Table 7.1 and graphically in Figure 7.3.

Table 7.1: Expenditure for total core public health, Queensland Health, 1998–99

	Total core public health expenditure			
Category	**Direct expenditure**	**Overheads**	**Total expenditure**	**Proportion of total core public health**
	$	**$**	**$**	**%**
Communicable disease control	18,498,253	657,988	19,156,241	19
Selected health promotion activities	23,179,916	913,391	24,093,307	23
Immunisation	13,755,434	430,161	14,185,595	14
Environmental health	6,276,098	279,198	6,555,296	6
Food standards & hygiene	1,987,593	75,543	2,063,136	2
Breast cancer screening	14,926,419	476,206	15,402,625	15
Cervical screening	2,627,675	78,494	2,706,169	3
All other core public health	18,513,608	556,819	19,070,427	18
Total core public health	**99,764,996**	**3,467,800**	**103,232,796**	**100**
Public health related activities	10,739,560	29,120	10,768,680	

The highest proportion of public health expenditure was reported against *Selected health promotion activities*, comprising 23% of the total core public health expenditure. Due to the aforementioned problems in reporting against this, caution should be exercised when applying or interpreting the *Selected health promotion activities* expenditure presented in Table 7.1, Table 7.2 and Figure 7.3.

Other categories that reported high proportions of total core public health expenditure were *Communicable disease control* (19%), *Breast cancer screening* (15%) and *Immunisation* (14%). Communicable disease control, breast cancer screening and immunisation activities were identified mainly within unique cost centres, resulting in a more reliable collection of actual expenditure against these categories. The *All other core public health* category, which consists entirely of 'Illicit drugs and methadone program' and 'Other drug related programs', contributed 18% of the total public health expenditure collected. As explained earlier, drug

treatment services were commonly incorrectly reported during the collection as core public health, and therefore this figure should be read with caution.

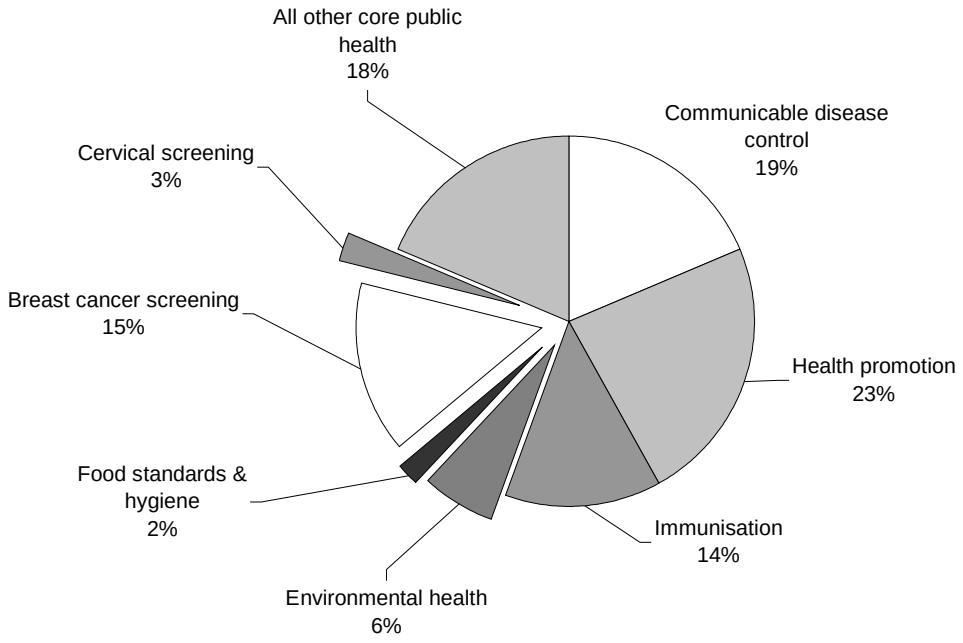

Figure 7.3: Queensland Health core public health expenditure by categories

The collection process identified that the settings for the provision of public health activities varies across Queensland. Table 7.2 indicates that the greatest proportion of public health activities, 41% of total expenditure, was conducted from within the Statewide service of Public Health Services (which includes public health unit networks and services organised state-wide). Hospital based services (15% of total expenditure) and community health centres (23% of total expenditure) were also major providers of public health activities to the Queensland public. Funding to NGOs contributed a further 17% to the total public health expenditure reported. It should be acknowledged that QHPSS also provides an important role in providing public health services; however, as mentioned before, the respective expenditure has not been included in this collection.

It has been acknowledged previously that the interpretation and scope of the collection differed from jurisdiction to jurisdiction (see 'Methodology used by jurisdictions' in Chapter 3 for further details). Therefore, Table 7.2 has been prepared to present the Queensland Health 1998–99 public health expenditure against the public health categories and the type of health service that reported the expenditure. It is important to note that the collection in Queensland expanded across all of Queensland Health (excluding QHPSS).

Table 7.2: Total expenditure collected on core public health categories by health service, Queensland Health, 1998–99

Public health category	Public health services	Hospital	Community health centre	Pathology and scientific services[1]	Oral health services	Corporate/ overhead[2]	NGO funding	Total	Proportion of total core public health (%)
Communicable disease control	9,652,096	623,554	3,784,673	n.a.	—	657,988	4,437,930	19,156,241	19
Selected health promotion activities	13,281,859	153,814	3,827,321	n.a.	339,379	913,391	5,577,543	24,093,307	23
Immunisation	11,394,373	261,782	1,849,279	n.a.	—	430,161	250,000	14,185,595	14
Environmental health	5,870,191	—	147,906	n.a.	—	279,198	258,000	6,555,296	6
Food standards & hygiene regulation	1,401,331	4,696	581,566	n.a.	—	75,543	—	2,063,136	2
Breast cancer screening	1,584,168	13,342,251	—	n.a.	—	476,206	—	15,402,625	15
Cervical cancer screening	1,254,691	1,310,285	—	n.a.	—	78,494	62,700	2,706,169	3
All other core public health	2,186,649	1,088,103	11,085,225	n.a.	—	556,819	3,592,641	19,070,427	18
Total core public health	**46,625,358**	**16,784,485**	**21,275,970**	**n.a.**	**339,379**	**3,467,800**	**14,178,814**	**103,232,796**	**100**
Public health related activities	—	82,378	5,436,766	—	108,098	29,120	5,112,318	10,768,680	. .
Grand Total	**46,625,358**	**16,866,863**	**26,712,736**	**—**	**447,478**	**3,496,920**	**19,291,132**	**114,001,476**	**. .**

n.a. not available

— nil, as far as is known

. . not applicable

Notes

1. Expenditure for QHPSS not available for Stage 2 of the NPHEP Collection.
2. Refer to the methodology section for an explanation on the apportionment of, and errors associated with, corporate/overhead costs.

7.4 Public health expenditure by categories

Communicable disease control

Total expenditure on *Communicable disease control* by Queensland Health during 1998–99 was $19.2m (Table 7.3). This represents 19% of the total core public health expenditure during this period.

Queensland Health provides the leadership in State-wide strategy development, service planning and implementation in relation to:

- surveillance, notification, prevention and control of communicable diseases;
- immunisation;
- HIV/AIDS, sexual health;
- hepatitis C;
- infection control and sterilisation; and
- arboviruses (includes vector and vermin control).

The services identified in the collection of expenditure for the *Communicable disease control* category included combined efforts of a range of organisations and sectors. Public Health Services' Communicable Disease Unit and the Public Health Unit Networks provide most of the services for which data was collected. Health services districts (including community and hospital services) assist in the response to disease outbreaks, surveillance, distributing information to public, implementation of prevention programs and liaison with clinicians, pharmacy services and laboratories.

NGOs provide the majority of services (funded by Queensland Health) for HIV/AIDS and other sexual health issues.

QHPSS provided substantial support in notifications, information regarding results, surveillance, new techniques and mass screening.

NOTE: *Expenditure relating to the QHPSS contribution to* Communicable disease control *is not included in the Queensland Stage 2 collection.*

HIV/AIDS, hepatitis C and sexually transmitted infection programs

Queensland strategies to address prevention of the transmission of HIV, hepatitis C and sexually transmitted infections include models such as community development, policy development, supportive legislation, awareness strategies and health surveillance. They are broadly directed to the entire Queensland population; however, targeted education and prevention strategies are aimed at gay men, people living with HIV/AIDS, injecting drug users, sex workers, Indigenous people and prisoners. Large proportions of the programs are delivered by NGOs on behalf of the Government. Funding to Health Service Districts for HIV/AIDS is used predominantly for the delivery of clinical and treatment services. Under the definitions provided in the collection the majority of the Health Service Districts' expenditure should not be included. **However, the Districts did report a high level of expenditure, and therefore it is likely that the reported expenditure includes a significant component of clinical and treatment services.**

It is important to acknowledge the difficulties encountered during the collection in allocating expenditure on the Well Persons Health Check Program. The Well Persons Health

Check Program is a screening program focusing on Indigenous populations to identify asymptomatic illnesses in the context of a primary health care response. The requirement to separate the expenditure dedicated to HIV/AIDS and sexual health from expenditure on other related health issues was difficult and required broad estimations.

The difficulties outlined above will need to be addressed in the following collections and should be noted when interpreting the 1998–99 expenditure included in this report.

Queensland Needle Availability and Support Program

Queensland Needle Availability and Support Program (QNASP) programs are located in a variety of agencies such as community health centres, hospitals, injecting drug user organisations and Aboriginal and Torres Strait Islander and sexual health services. Some programs provide mobile services via health vans or street workers. A significant proportion of Queensland pharmacies also sells injecting equipment.

The identification of the Program as a separate activity from *HIV/AIDS, hepatitis C and sexually transmitted infections* activities does not reflect the purpose of the Program. The costs associated with support services developed within the QNASP may have been reported in the *HIV/AIDS, hepatitis C and sexually transmitted infections* category or not included in the collection due to the difficulty in identifying QNASP as a separate expenditure category.

Other communicable disease control

There are several issues that distinguish Queensland Health expenditure on communicable diseases, largely the result of the geography and a decentralised population. One such distinguishing issue is the need to prevent the spread of mosquito borne diseases. The tropical and subtropical climate, with a vast stretch of coastline, leaves Queensland vulnerable to the spread of mosquito borne disease, evidenced by its having the highest reported number of cases of Ross River virus infections in Australia and its being the only State or Territory to have dengue fever and Japanese encephalitis transmission. Imported cases of malaria have occurred in the Torres Strait Islands due to the proximity of these island communities to mainland Papua New Guinea.

The reported expenditure for *Communicable disease control* includes a substantial investment in research aimed at managing communicable diseases. In particular, Public Health Services expended funds on investigating diseases such as Hendra virus, Australian bat lyssavirus and Japanese encephalitis, and on vaccinating at-risk populations where this is a management option. Included in the expenditure on *Communicable disease control* is a substantial investment in the maintenance, upgrade and management of the Notifiable Conditions Surveillance System.

Table 7.3: State Government expenditure on *Communicable disease control*, Queensland Health, current prices, 1998–99 ($)

Expenditure	HIV/AIDS, hep. C & STI programs	Needle and syringe programs	Other communicable disease control	Total
Direct	9,278,540	1,570,579	7,753,610	18,602,729
Overheads	276,092	46,716	230,704	553,512
Total	**9,554,632**	**1,617,295**	**7,984,314**	**19,156,241**

Selected health promotion activities

Total expenditure on *Selected health promotion activities* by Queensland Health was $24.1m during 1998–99. This is 23% of total expenditure on core public health for this period.

Across Queensland, a wide range of professional staff participates in health promotion initiatives that range from 'opportunistic' or 'individual' health promotion to 'population based' programs. The NPHEP definition for Stage 2 excludes health promotion activities that are not 'organised population based programs'. Health promotion activities that do not meet these criteria have been included in the 'Public health related activities' category. The Queensland Health Collection Guide provided the following major areas of expenditure as examples of activities to be collected:

- Health promotion settings and capacity building programs;
- Young people at risk;
- Women's health;
- School Based Youth Health Nurse Program;
- Nutrition;
- Skin cancer; and
- Injury prevention.

Expenditure identified against the following activities was collected in Queensland against the 'Alcohol, tobacco and other drugs' category. The expenditure is presented under the *Selected health promotion activities* category to ensure the scope of the collection is consistent with other jurisdictions.

- Development and introduction of the Queensland Tobacco Strategy targeting tobacco availability, promotion, cessation, passive smoking and community education;
- Training packages covering prevention aspects of alcohol use;
- 100% In Control; and
- Rock Eisteddfod Challenge.

Public Health Services provides expert advice and coordination of health promotion activities across Queensland Health in collaboration with other health agencies, local government and other sectors to address priority health issues. The majority of the Public Health Services expenditure related to this role is collected in separately identifiable cost centres.

Expenditure on resources and staff dedicated to conducting the programs outlined above was often allocated from cost centres that included a wider comprehensive approach to health issues (for example, community health centres). Therefore, many health service districts reported difficulty and confusion in identifying the actual costs associated in conducting population based health promotion activities and often over-reported expenditure against this category. A review was required to reallocate expenditure on health promotion activities that did not meet the criteria or list of inclusions outlined above for the 'Public health related activities' category.

Table 7.4: State Government expenditure on *Selected health promotion activities*, Queensland Health, current prices, 1998–99 ($)

Expenditure category	Amount
Direct	23,179,916
Overheads	913,391
Total	**24,093,307**

Immunisation

Total expenditure on *Immunisation* by Queensland Health was $14.2m (Table 7.5) during 1998–99. This represents 14% of total expenditure on core public health during this time.

Public Health Services is responsible for the establishment and maintenance of collaborative planning and strategy implementation mechanisms, as well as policy, planning and service purchasing advice. Other major stakeholders in the administration of the vaccines are Health Service Districts, private and non-government service providers, Divisions of General Practice, local government authorities, other State and Commonwealth Government departments and community based organisations.

Many of the services that administer the vaccines (for example, general practitioners, councils, child and community health, hospitals, public health unit networks and Aboriginal medical services) receive delivery of free vaccines from the Communicable Disease Unit, Public Health Services.

Table 7.5: State Government expenditure on *Immunisation*, Queensland Health, current prices, 1998–99 ($)

Expenditure	Childhood immunisation	Pneumococcal & influenza immunisation	Other immunisation	Total
Direct	2,383,938	3,717,702	7,817,558	13,775,708
Overheads	70,932	110,617	232,606	409,887
Total	**2,454,870**	**3,828,319**	**8,050,164**	**14,185,595**

Environmental health

The total expenditure recorded against *Environmental health* by Queensland Health was $6.6m (Table 7.6). This was 6% of total core public health expenditure during 1998–99.

Queensland Health undertakes a wide range of environmental health activities, including an advisory or support role to local government and other State Departments—for example, water management and water quality.

Queensland Health has the leading role in state-wide environmental health policy, environmental health surveillance and law enforcement, waste management, research into emerging environmental health issues and the provision of advice to the community. Within Queensland Health, Public Health Services has responsibility for the following areas:

- control of poisons
- therapeutic goods
- pest control
- fumigation

- toxicology
- radiation health.

Although Public Health Services has the responsibility for environmental health surveillance and law enforcement, the Health Service Districts and QHPSS provide essential support in the management of environmental health issues.

Table 7.6: State Government expenditure on *Environmental health*, Queensland Health, current prices, 1998–99 ($)

Expenditure category	Amount
Direct	6,365,883
Overheads	189,413
Total	**6,555,296**

Food standards and hygiene

Total expenditure for *Food standards and hygiene* for Queensland Health in 1998–99 was $2.1m (Table 7.7). This was 2% of total expenditure on core public health reported in 1998–99.

The Queensland data on *Food standards and hygiene* included costs and revenues associated with services that provide:

- assistance and support/coordination on state-wide food matters;
- advice on food legislation and other food issues;
- coordinating the food recall process in Queensland;
- development and communication of policies, guidelines and procedures on food issues;
- participation in, and coordination of, strategies to improve food safety (such as training, community awareness, mass media and working with schools); and
- development, amendment, implementation and review of food safety, food standards and other food legislation.

Public Health Services provided leadership, direction and management through the Environmental Health Unit and Public Health Unit Networks in regard to food safety, food standards and other food matters. QHPSS provides the laboratory services essential for the surveillance, investigation and development of food standards.

Table 7.7: State Government expenditure on *Food standards and hygiene*, Queensland Health, current prices, 1998–99 ($)

Expenditure category	Amount
Direct	1,987,593
Overheads	75,543
Total	**2,063,136**

Breast cancer screening

Expenditure reported for *Breast cancer screening* in Queensland was $15.4m in 1998–99 (Table 7.8). This is 15% of total expenditure on core public health reported in this period.

Breast cancer screening services are provided through BreastScreen Queensland, which is a component of the Commonwealth and State funded BreastScreen Australia Program. The

1998–99 expenditure presented in this report represents activities that are provided through the BreastScreen Queensland program—that is, the report excludes any activity within Queensland Health that may contribute to breast cancer screening but is not part of the program. The expenditure represents the complete screening pathway up to the point of histological diagnosis or referral for open biopsy. Laboratory services such as fine needle aspiration biopsy and core biopsy associated with the diagnosis procedures performed within BreastScreen are included in the expenditure reported.

Women's Cancer Screening Services, a unit of Public Health Services, provides coordination, planning and policy advice for BreastScreen Queensland. The Unit works with an established network of screening services in the Health Service Districts that includes eleven fixed services, four mobiles, four relocatable services and six satellite sites.

The TAG definitions excluded costs associated with post-diagnosis counselling from the public health categories. However, there were considerable difficulties associated with separating expenditure on post-diagnosis from pre-diagnosis counselling. Therefore, the expenditure reported is inflated by the inclusion of some post-diagnosis counselling.

Table 7.8: State Government expenditure on *Breast cancer screening*, Queensland, current prices, 1998–99 ($)

Expenditure category	Amount
Direct	14,957,572
Overheads	445,053
Total	**15,402,625**

Cervical screening

Total expenditure on the organised approach to *Cervical screening* by Queensland Health, which includes State coordination, Pap Smear Registry, quality assurance and special screening services, during 1998–99 was $2.7m (Table 7.9). This was 3% of total expenditure on core public health reported for this period.

The Queensland Cervical Screening Program (QCSP) is a component of the Commonwealth and State funded National Cervical Screening Program. About one-third of the funding under the QCSP is provided to Health Service Districts to implement the Mobile Women's Health Service, which provides outreach screening services to women in rural and remote areas. An additional significant component of expenditure for the QCSP is the development, maintenance and operation of the Pap Smear Registry which was 44% of expenditure in 1998–99.

Expenditure under the QSCP represents only a small part of total expenditure on *Cervical screening* in Queensland. The majority of cervical screening is undertaken in the private sector by general practitioners and funded through Medicare. Many non-QCSP screening and follow-up services captured in the data are provided through health service district facilities (i.e. hospitals, community health services, primary health centres and sexual health services). In addition, the Queensland Cytology Service, a fully State Government funded laboratory, is the major public provider of cytology and pathology services associated with cervical screening in Queensland.

It should be noted that the identified funding for some cervical screening services provided by NGOs might not include all the costs associated with those services. The Rural and Remote Women's Health Program, managed by the Royal Flying Doctor Service, is jointly

funded by Queensland Health and the Commonwealth Department of Health and Aged Care, which contribute 34% and 66%, respectively, of the funding for this service.

Table 7.9: State Government expenditure on *Cervical screening*, Queensland Health, current prices, 1998–99 ($)

Expenditure categories	Amount
Direct	2,627,6756
Overheads	78,494
Total	**2,706,169**

All other core public health

Total expenditure reported for the *All other core public health* category for Queensland Health during 1998–99 was $19.1m (Table 7.10). This represents 18% of the total core public health expenditure during this period.

As explained earlier, **the Queensland collection did not request services to report expenditure under this category**. The expenditure reported against the 'Illicit drugs and methadone program' and the 'Other drug programs' sub-categories was used solely to construct this category. The following activities were identified in the collection and reported as *All other core public health*:

- development, implementation and evaluation of methadone programs;
- illicit drugs education;
- screening and case finding activities and other community interventions;
- strategies addressing adult alcohol intoxication, violence and injury;
- Young Adults and Drugs Project;
- Alcohol, Tobacco and Other Drugs State Funding Program—for example, St Vincent Community Services (NGO grants); and
- National Drug Strategy grants.

Table 7.10: State Government expenditure on *All other core public health*, Queensland Health, current prices, 1998–99 ($)

Expenditure categories	Amount
Direct	18,513,608
Overheads	556,819
Total	**19,070,427**

Public health related activities

Total expenditure reported for the 'Public health related activities' category for Queensland Health during 1998–99 was $10.8m (Table 7.11).

The collection of public health expenditure in Queensland did not request services to report against this category. The category was developed during the review of the expenditure data from expenditure on services which, it was considered, did not fit under the definitions of the core public health expenditure categories but were related to public health. For example, if a service reported expenditure against the *Selected health promotion*

activities, but during the review could not identify the organised health promotion program, the expenditure reported was moved to 'Public health related activities'.

The following activities or programs (or proportions of the following activities or programs) were allocated to the 'Public health related activities' category:

- Aboriginal and Torres Strait Islander Health Improvement (NGO grants);
- Indigenous health worker training;
- Indigenous health services;
- Aboriginal and Torres Strait Islander Health Welfare projects;
- Preventing Violence Against Women program;
- Child health services;
- Women's reproductive health;
- Ad hoc, or not population based, health promotion activities;
- General apportionment of community health and primary health care centres;
- General apportionment of allied health services—for example, nutritionist and social worker; and
- Health promotion activities within Home and Community Care services.

Table 7.11: State Government expenditure on 'Public health related activities', Queensland Health, current prices, 1998–99 ($)

Expenditure categories	Amount
Public health related activities	10,739,560
Overheads	29,120
Total public health related activities	**10,768,680**

8 Public health expenditure by the Health Department of Western Australia

8.1 Introduction

The Health Department of Western Australia's mission, as the State's principal health authority, is to protect, promote and restore health, and to care for the sick and disabled people of Western Australia.

In 1998–99, the health output based management structure introduced a single outcome objective, with three intervention strategies operating as key output groups.

The three output groups established included:

- prevention and promotion,
- diagnosis and treatment, and
- continuing care.

Through the prevention and promotion output, Public Health aims to improve the health of Western Australians by reducing the incidence of preventable disease, injury, disability and premature death.

Public Health distinguishes itself from other parts of the health system by primarily focusing on the health and wellbeing of populations (health outcomes), rather than on individuals.

Public Health is comprised of:

- the Office of the General Manager including the Executive Director, Public Health;
- four Public Health Branches with state-wide responsibilities; and
- ten Public Health Units, regionally located throughout the State, which complement state-wide services as well as providing a range of regional specific public health services.

Office of the General Manager

The Office of the General Manager is responsible for the delivery of state-wide public health services, which are conducted by the public health branches within the Health Department of Western Australia. A significant portion of the workload is related to the formulation of policy, advice and information to the Minister, State and national committees, the media, universities and the community. This office also provides the strategic direction for the further development of public health services in Western Australia.

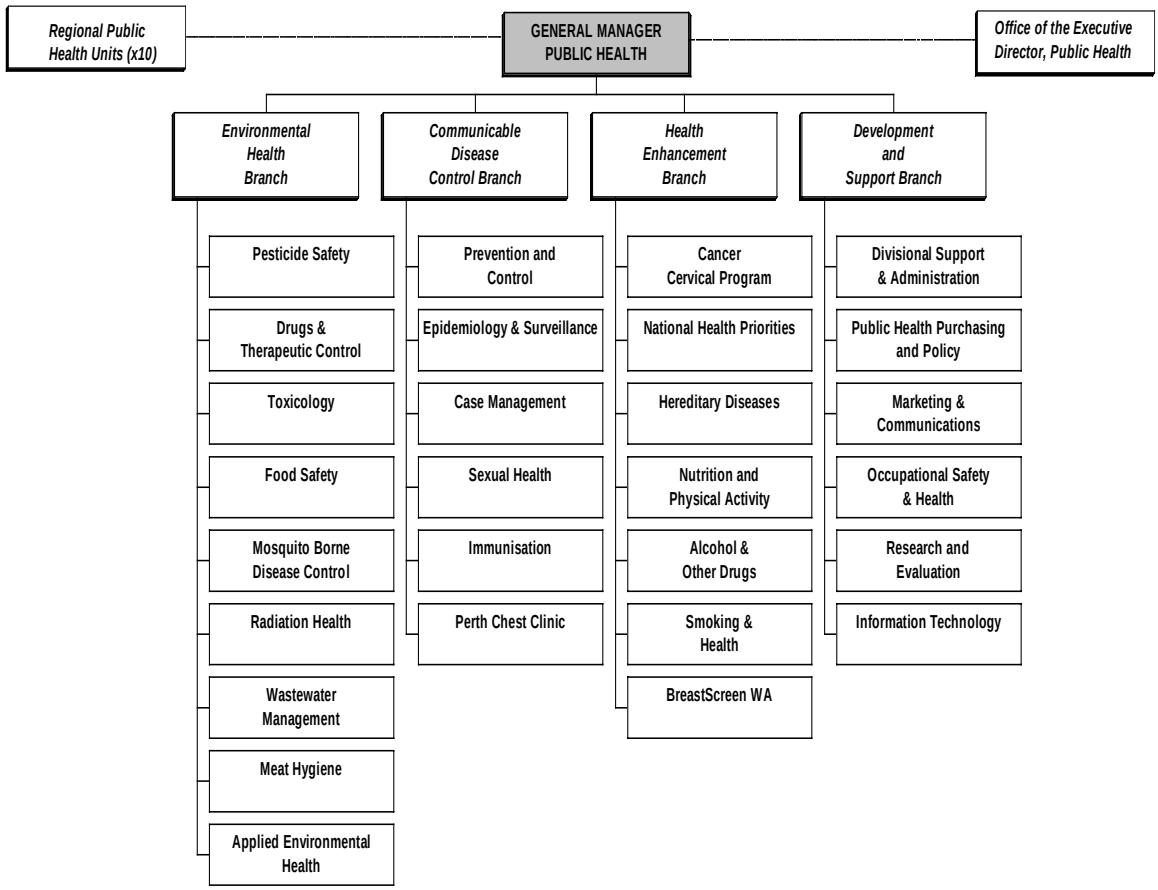

Figure 8.1: Organisational chart: Management structure for public health within the Health Department of Western Australia

State-wide public health programs

State-wide public health programs operate through the four main branches of:

- Communicable disease control
- Health enhancement
- Environmental health
- Development and support.

Regional public health units

Public health units are regionally located within a host health service, and cover a geographical area of the State. There are two metropolitan public health units, as well as one each in the Kimberley, Pilbara, Gascoyne, Goldfields, Coastal Wheatbelt, Mid-West, Great Southern and South-West Regions. They provide a range of regionally focused programs, which are run in conjunction with state-wide programs. Public health units also conduct

specific programs, which meet special regional public health issues pertinent to the social and cultural aspects of their regions.

Other agencies and organisations

Other government agencies outside the Health Department of Western Australia also deliver programs which relate directly and/or indirectly to public health. The Police Department and Family and Children's Services are two examples of government agencies to which an investment in public health was attributable in 1998–99. There are also some NGOs, such as the Cancer Foundation, where public health expenditure was recorded.

8.2 Data collection methodology

The collection of state-wide public health data represented 65% of total expenditure associated with public health in 1998–99. The financial data were 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. In the majority of cases each cost centre was linked to a core category; however, in some instances where a cost centre was attributable to more than one core area, and it was necessary to delineate costs between each core category, a modelling approach was required to apportion expenditure across categories. The modelling sometimes required subjective percentage allocations as inputs. A reconciliation process was adopted to ensure the validity of these data. The data associated with the Office of the General Manager were collected in a similar manner.

The data associated with the Regional Public Health Units expenditure were not located in one centralised Oracle financial system. Financial systems varied from health service to health service. Chart of accounts also differed, which meant that a consistent delineation between categories was difficult. Consequently, it was deemed necessary and more appropriate to model expenditure between some categories. Category modelling was based on the public health purchasing model, which specified which public health products were purchased. A correlation between public health services purchased and expenditure was derived.

It is important to note the following caveats in relation to the collected data for Western Australia:

- Expenditure associated with Community Health services in rural areas is not included in the data.
- Local government authorities' expenditure related to public health is not included.
- Data provided represent cash payments and receipts rather than accrual expenses and revenues.
- Unless otherwise indicated, payments are net of receipts.
- Expenditure for general pathology testing, dental health and Red Cross blood transfusion service is not included.
- Overheads have been apportioned to each of the categories.

8.3 Overview of results

The amount expended by the Health Department of Western Australia in 1998–99 in relation to public health was $57.3m. Table 8.1 and Figure 8.2 illustrate the composition of public health expenditure by each of the core categories.

Table 8.1: Expenditure for total core public health, Health Department of Western Australia, 1998–99 ($)

Category	Expenditure ($)	Proportion of total (%)
Communicable disease control	11,787,210	20.57
Selected health promotion	18,707,914	32.65
Immunisation	8,739,200	15.25
Environmental health	6,836,721	11.93
Food standards & hygiene	1,740,300	3.04
Breast cancer screening	7,665,400	13.38
Cervical screening	1,090,100	1.90
All other core public health	734,900	1.28
Total	**57,301,745**	**100.00**

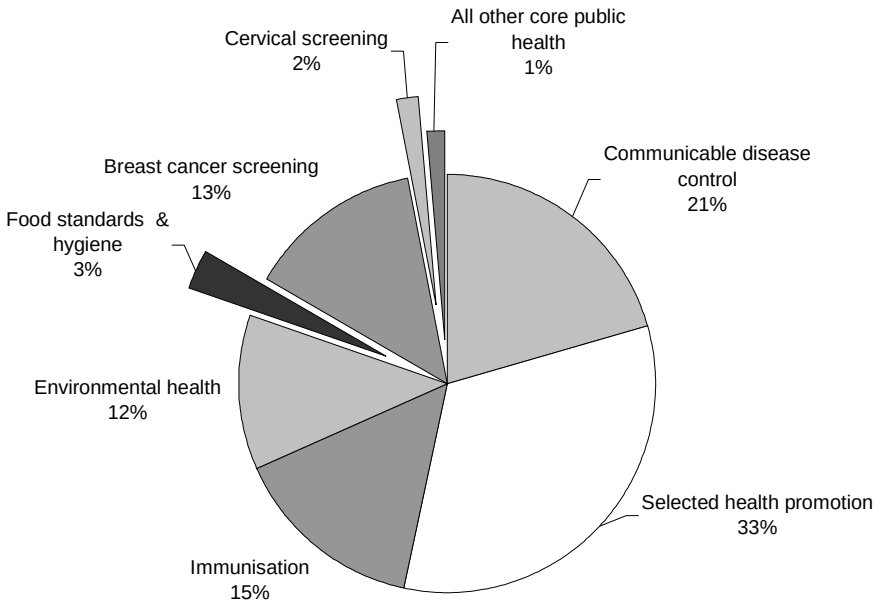

Figure 8.2: Western Australia core public health expenditure by categories

It should be noted that the total expenditure amount given above includes the $3,829,245 spent by the Office of Aboriginal Health on Indigenous health programs in Western Australia. This expenditure was in the core public health categories of *Communicable disease control*, *Selected health promotion activities*, *Environmental health* and *Cervical screening*, and amounts are given under these categories.

8.4 Expenditure on core public health categories

Communicable disease control

The total direct expenditure for *Communicable disease control* by the Health Department of Western Australia in 1998–99 was $11.8m. This was 20.57% of the total core public health expenditure.

The majority of expenditure associated with this category is coordinated through the Communicable Disease Control Branch. It is responsible for state-wide surveillance, coordination of public awareness and education, development of policy and strategies for control and prevention, direct response to outbreaks in the metropolitan area and coordination of control activities across the State.

Expenditure in this category included:

- disease surveillance;
- case and outbreak investigation and management;
- management of communicable disease issues, including information and advice;
- management of the state-wide tuberculosis control program;
- NGO expenditure associated with provision of sexual health services;
- HIV laboratory expenditure related to testing; and
- migrant health screening.

There was also expenditure through the Office of Aboriginal Health in this category. Expenditure in the sub-categories of *HIV/AIDS, hepatitis C and sexually transmitted infections* ($245,410) and *Needle and syringe programs* ($180,000), amount to a total expenditure on *Communicable disease control* by the Office of Aboriginal Health of $425,410. These amounts are included in those given in Table 8.2 below.

Table 8.2: State Government expenditure on *Communicable disease control*, Health Department of Western Australia, current prices, 1998–99 ($)

	HIV/AIDS, hepatitis C and STI programs	Needle and syringe programs	Other communicable disease control	Total communicable disease control
Expenditure	5,382,110	975,500	5,429,600	**11,787,210**

Selected health promotion activities

The total expenditure for *Selected health promotion activities* by the Health Department of Western Australia in 1998–99 was $18.7m. This was 32.65% of the total core public health expenditure.

The majority of expenditure associated with this category is coordinated through the Health Enhancement Branch (formerly Chronic Disease and Health Enhancement). One of the responsibilities of this branch is to identify and act on opportunities for primary and secondary prevention.

Expenditure in this category included:

- State-wide alcohol and other drugs community education campaigns, including the Drug Aware Campaigns Be a Good Host Campaign and Respect Yourself Campaign;
- Health promotion, including information and awareness in relation to hereditary disease issues;
- Health promotion associated with national health priorities (excluding breast and cervical cancer);
- Nutrition and physical activity campaigns and associated strategies; and
- Smoking and health campaigns such as the Quit Campaign.

The Office of Aboriginal Health also contributed to the total expenditure in this category, spending $2,255,814 on *Health promotion activities*. This is included in the total amount for the category of *Selected health promotion activities*.

Immunisation

The total expenditure for *Immunisation* by the Health Department of Western Australia in 1998–99 was $8.7m. This was 15.25% of total core public health expenditure.

The majority of expenditure associated with this category relates to programs conducted by the State Immunisation Clinic, including:

- distribution, packaging and reporting of vaccines for the State;
- provision of a clinical and advisory immunisation service;
- provision of immunisation and travel consultation services;
- enhanced measles program; and
- provision of lectures and training to immunisation providers.

Pneumococcal and influenza immunisation programs include the National Influenza Program for adults over the age of 65, as well as the National Indigenous Pneumococcal and Influenza Program.

Expenditure associated with immunisation services provided by general practitioners and community nurses in regional areas is not represented in these data.

Table 8.3: State Government expenditure on *Immunisation*, Health Department of Western Australia, current prices, 1998–99 ($)

	Childhood immunisation	Pneumococcal and influenza immunisation	Other immunisation	Total immunisation
Expenditure	3,356,900	2,598,300	2,784,000	**8,739,200**

Environmental health

The total expenditure for *Environmental health* by the Health Department of Western Australia in 1998–99 was $6.8m. This was 11.93% of total core public health expenditure. Included in this figure is expenditure by the Office of Aboriginal Health of $1,048,021.

The majority of expenditure associated with this category is coordinated through the Environmental Health Branch. It is responsible for delivering many state-wide programs to ensure that trends and developments in environmental health occurring in the community are monitored. Trends and developments that are monitored include food safety, land management, public building safety, public events, use of radiation, pesticides and chemical waste-water utilisation, use of drugs and medicine, and protection from mosquitoes.

Expenditure in this category included:

- improvement of environmental health in remote communities;
- monitoring and assessing the safety of drinking water, recreational water facilities and natural water bodies;
- drugs, poisons and therapeutic goods control;
- mosquito-borne disease control including surveillance, education and advice;
- pesticide safety including issue of licences;
- radiation health including monitoring, compliance and advice;
- assessment and management of contaminated land; and
- waste-water management, including administering of policy and legislation.

Local government authorities also incur expenditure that is public health related. This has not been included in these data.

Food standards and hygiene

The total expenditure for *Food standards and hygiene* by the Health Department of Western Australia in 1998–99 was $1.7m. This was 3.04% of the total core public health expenditure.

The expenditure associated with this category includes:

- food monitoring (including meat);
- food related infectious disease surveillance;
- food hygiene legislation review, monitoring and education;
- investigations associated with defective labelling; and
- food safety promotion.

Breast cancer screening

The total expenditure for *Breast cancer screening* by the Health Department of Western Australia in 1998–99 was $7.66m. This was 13.38% of total core public health expenditure.

The majority of expenditure associated with this category is coordinated through BreastScreen WA. BreastScreen WA forms part of the national program. It performs state-wide screening using fixed and mobile units, as well as dedicated assessment sites at metropolitan teaching hospitals.

Cervical screening

The total expenditure for *Cervical screening* by the Health Department of Western Australia in 1998–99 was $1.09m. This was 1.9% of total core public health expenditure.

The majority of expenditure associated with this category is coordinated through the WA Cervical Cancer Prevention Program. This program aims to achieve optimal reduction in the instance of, and morbidity and mortality attributed to, cervical disease, at an acceptable cost to the community. Major aspects of this program include the maintenance of a cervical cytology register and the development of primary recruitment programs, including support of national education campaigns.

An amount of $100,000 was outlaid by the Office of Aboriginal Health on cervical screening activities. This amount has been included in the total expenditure figure for this category.

All other core public health

Total expenditure for *All other core public health* by the Health Department of Western Australia for 1998–99 was $0.7m. This was 1.28% of total core public health expenditure.

Western Australia has attempted, where possible, to allocate expenditure against specific core categories. Expenditure for the *All other core public health* category includes occupational safety and health, incentive projects funded separately by the Commonwealth, and other small programs.

9 Public health expenditure by the South Australian Department of Human Services

9.1 Introduction

The State public health system in South Australia consists of numerous health units, community health centres and other related organisations, all reporting to, and under the administration of, the Department of Human Services (DHS). DHS comprises six divisions: Aboriginal Services, Country, Metropolitan, Statewide, Strategic Finance and Corporate Services and Strategic Planning and Policy, as well as other service providers (refer to Figure 9.1). The majority of information for this collection has come from Statewide Division, which is responsible for the planning and coordination of South Australia's eight largest hospitals and incorporates Public and Environmental Health (refer to Figure 9.2).

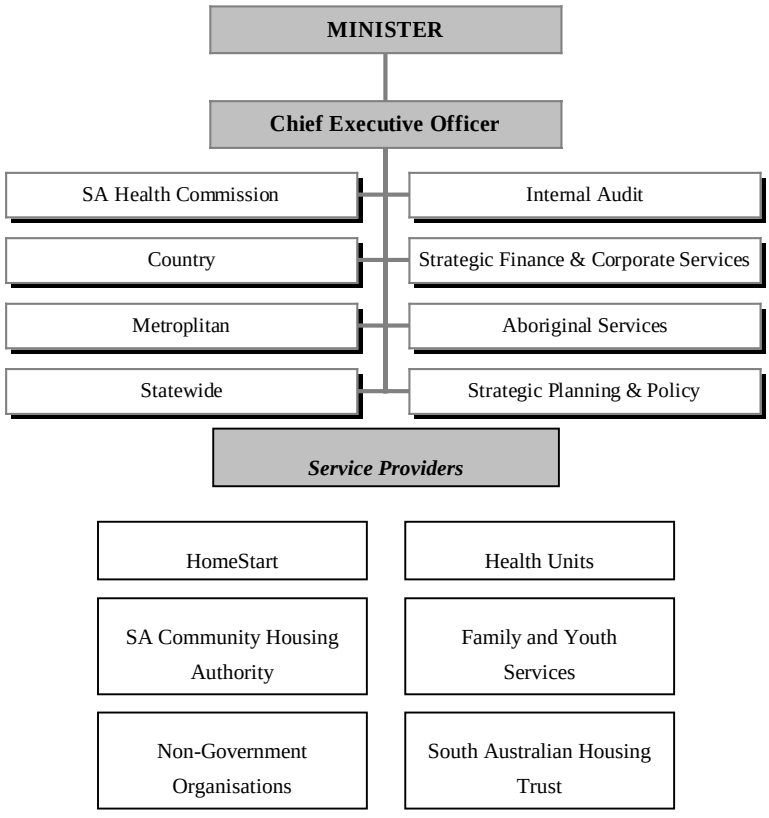

Figure 9.1: Organisation Structure of South Australian Department of Human Services

In addition to the core public health system, other State Government organisations, local government and NGOs contribute to public health delivery within the State. Local government plays a particularly significant role in the areas of *Environmental health*, health promotion and *Immunisation*. There are 67 local councils (18 metropolitan, 49 country) and it is estimated that they contribute 60–70% of the total *Environmental health* expenditure for the State.

The South Australian data include expenditure by other State Government departments separately presented in the core public health areas as defined by this collection. In most cases, expenditure in these areas is not primarily aimed at public health; however, the outcomes include a significant public health aspect. For instance, the Department of Primary Industries' main aim is to safeguard the agricultural and farming industries by employing hygienic handling practices and controlling animal and plant disease. A major outcome of these practices is safe meat, plant and dairy produce, which is essentially a public health concern.

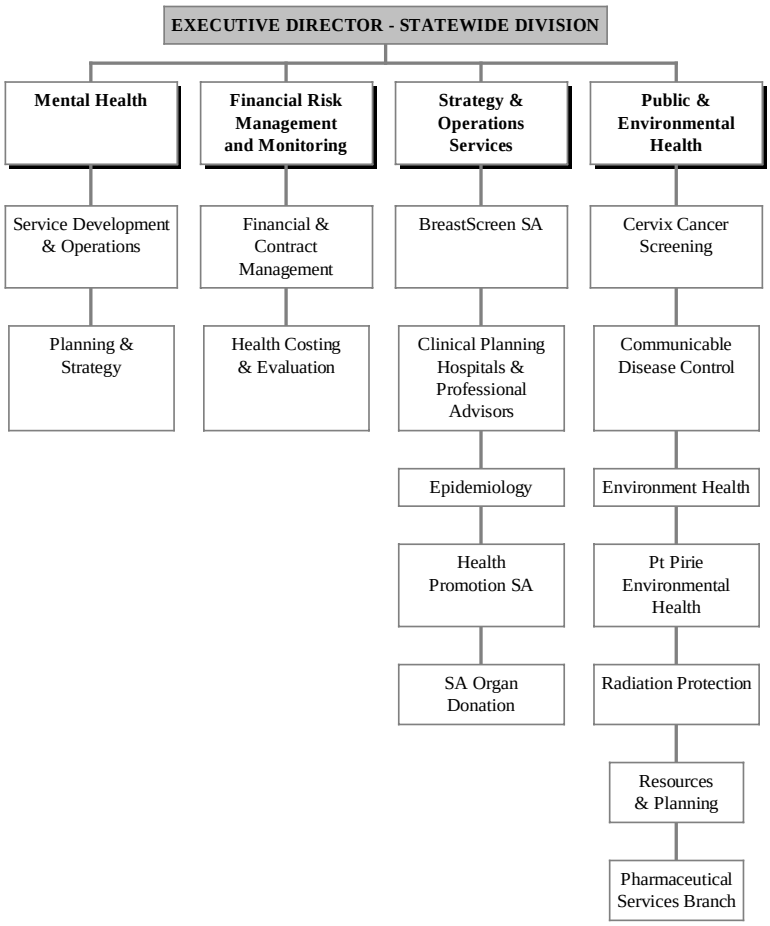

Figure 9.2: South Australia Organisation Structure of Statewide Division (incorporating Public Health Services) in 1998–99

9.2 Data collection methodology

Information for this collection was sought 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%.

Initial written correspondence, detailing the aims and expectations of the project and endorsed by the Executive Director of Statewide Division, was the starting point of contact. It was requested that a contact person be nominated from each area or organisation. Further correspondence with the contact person was generally by email. The collection spreadsheet was provided to contacts with explanatory instructions regarding the content and type of information requested. Meetings were also arranged where necessary, usually with the larger organisations and health units. This type of 'face-to-face' contact often saved a significant amount of time and confusion.

All organisations involved in the collection were asked to report their financial data on an accrual basis. The costs associated with program-wide functions have been allocated to the relevant core categories as part of direct expenditure. Corporate overhead costs such as finance, human resources and information technology were not included in the Stage 2 collection.

Assessment

Most organisations required additional clarification of the aims and details of the project and guidance with what information to include and exclude. The Excel spreadsheet provided for the collection of expenditure information proved to be quite cumbersome for many people.

The major difficulty for most organisations was aligning their cost centre information with the nominated categories for core public health. In particular, most community health centres and smaller organisations found it difficult to separate treatment or welfare based services from 'public health' strategies. Additionally, the budgets of these smaller organisations often comprised one allocation of money to be distributed amongst various services. In many cases, estimations for each category have been made based on salaried time commitment and/or allocation of materials and space.

Expenditure was reported twice in some cases (where grant money is provided to a health unit or smaller organisation from a major provider, such as SA Cervix Cancer Screening). However, double counting was avoided where possible.

A major difficulty for South Australia was that all agencies utilise and administer their own financial systems, as opposed to having a standard financial system with a unique cost centre structure.

General reasons for variances

One of the major difficulties with the project occurred when attempting to limit and differentiate the various categories. Programs that included public health strategies and screening/treatment for specific diseases (e.g. HIV/AIDS) were particularly difficult to separate, as were programs pertaining to sexual health and the avoidance of sexual violence. Community health programs, such as those aimed at ethnic, Aboriginal or disadvantaged groups, are often based on holistic lifestyle changes and therefore include public health aspects, such as mental health promotion, as well as welfare aspects such as domestic and sexual violence education. Depending on the main objective of these programs, this

expenditure was either partially or wholly included. In the case of HIV/AIDS, the proportion of purely public health expenditure was estimated from the various programs and funding.

Overhead and program-wide costs were dealt with in various ways. Legislative development costs were assigned to the appropriate categories. Corporate/central office overhead costs such as strategic development, financial, IT, human resources and legal services have not been included in the final numbers for this collection. Public health research and workforce development expenditure was not specifically collected, although some expenditure on training and education was inherent to the programs operating within categories and was therefore included in the collection. Epidemiology has been included under the *All other core public health* category, rather than distributing the costs across all core public health areas.

9.3 Overview of results

Total core public health expenditure by DHS in 1998–99 was $62.9m. Table 9.1 summarises public health expenditure by the Department of Human Services for 1998–99 by the core categories.

Table 9.1: Expenditure for total core public health, SA Department of Human Services, 1998–99 ($)

	Total core public health expenditure	
	Recurrent expenditure	**% of expenditure**
Communicable disease control	10,208,480	16.2
Selected health promotion	17,779,171	28.3
Immunisation	8,457,870	13.4
Environmental health	4,842,388	7.7
Food standards & hygiene	1,059,017	1.7
Breast cancer screening	6,263,003	10.0
Cervical screening	1,806,176	2.9
All other core public health	12,512,996	19.9
Total	**62,929,101**	**100.0**

Note: Central overhead expenses not included. Other overhead and program-wide costs allocated to public health categories in various ways.

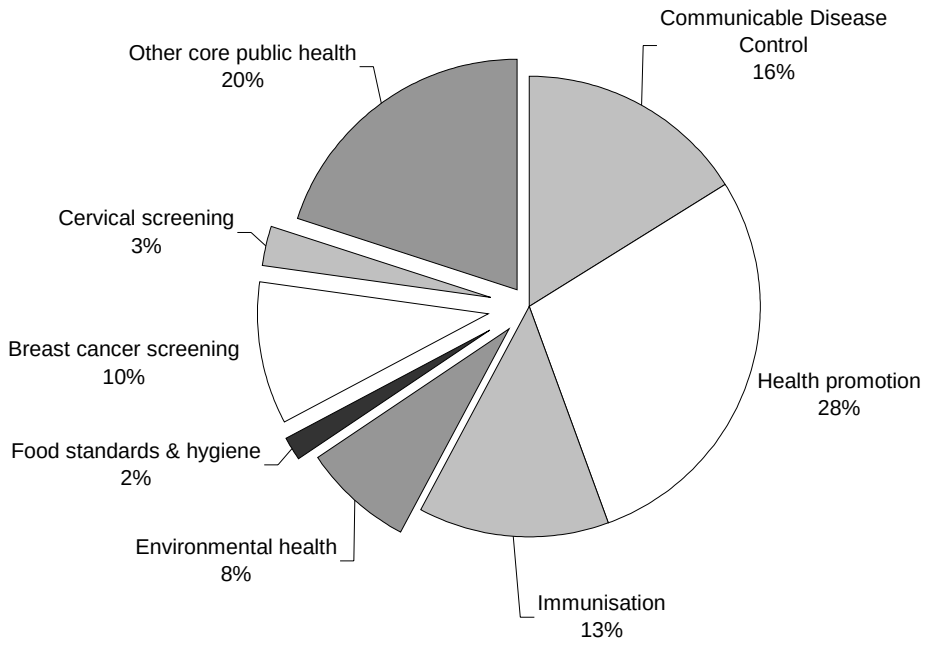

Figure 9.3: Department of Human Services' core public health expenditure by category

9.4 Public health expenditure by categories

Communicable disease control

Communicable disease control aims at reducing the transmission of communicable diseases and minimising the personal and social impact of these diseases. In South Australia, the majority of this work is conducted via the Communicable Disease Control Branch (CDCB), within DHS. The Branch meets its responsibility through surveillance and investigation of communicable diseases, coordination of immunisation across the State, and programs focusing on HIV and hepatitis C control.

HIV/AIDS, hepatitis C and sexually transmitted infection programs **expenditure**

The major areas of expenditure in this sub-category comprise programs and funding provided by HIV, Hepatitis C and Related Programs (HHARP), a section of the CDCB. Other significant expenditure is connected with the testing of blood products and an Aboriginal Services HIV program (partially funded by the Commonwealth and State).

HHARP provides funding to the AIDS Council of SA, Centre for Personal Education, Hepatitis C Council, Offenders Rehabilitation Service and the Heroin Users Project as well as a variety of other organisations. A significant amount of expenditure goes towards training and development and hepatitis C prevention. The Care and Prevention Practice is a

HHARP funded project based in a general practice, aimed at collecting health status information on gay men and connecting that information to their HIV status. The funding for this project includes treatment, education and data collection costs since these elements are not easily distinguished in this program.

Sexual Health Information and Education (SHine SA) is funded by DHS and contributes to HIV/AIDS/hepatitis C prevention as integrated into all professional education. This training is funded by the Commonwealth through the PHOFA (70%) and DHS (30%). The figure attributed to this training is based on 10% of the total program expenditure of SHine SA.

Needle exchange programs

Expenditure in this area was primarily by the Drug and Alcohol Services Council (DASC) who provide funding and kits for needle and syringe programs to health units and community health services.

Other communicable disease control

Expenditure in this sub-category was primarily within the CDCB, with an extraordinary expenditure included in the collection for the Kosovar refugees. Other areas of expenditure for this category were in the control of sexually transmitted diseases. The Sexually Transmitted Diseases Service provides the majority of public health services in this area and expenditure includes clinic time, data management, research, education and surveillance.

Also included in this category was SHine SA, which provides prevention and education programs for school age children and early school leavers on substance use, relationships and self-esteem. All these programs are sourced from State and PHOFA funding.

Total *Communicable disease control*

Total expenditure for *Communicable disease control* by DHS in 1998–99 was $10.2m. This was 16% of total core public health expenditure.

Table 9.2: Expenditure for *Communicable disease control*, SA Department of Human Services, 1998–99 ($)

	HIV/AIDS, hepatitis C & STI programs	Needle and syringe programs	Other communicable disease control	Total
Expenditure	3,218,350	735,800	6,254,330	**10,208,480**

Note: Central overhead expenses not included.

Selected health promotion activities

Total expenditure for *Selected health promotion activities* by DHS in 1998–99 was $17.8m (see Table 9.1). This was 28% of total core public health expenditure.

Within South Australia, health promotion is coordinated by Health Promotion SA (part of DHS). Health Promotion SA brings together Living Health, which was previously a separate government authority, and the Health Promotion Unit of the department. This new unit, formed in September 1998, provides leadership and aims to develop a whole-of-government approach to health promotion in South Australia.

Health Promotion SA undertakes programs aimed at mental health, heart health, smoking, schools, workplaces, hospitals, local government, the elderly, farm safety and gambling. The

Living Health Budget includes sponsorship of the Asthma Foundation, Mental Health Project, Nutrition Project, Community Projects, Anti-Smoking Initiative ($1,400,000), and Skin Cancer and Alcohol Abuse programs.

Significant expenditure for this category was reported for many cost centres including the metropolitan community health services, the Drug and Alcohol Services Council (via the Alcohol and Drug Information Service), the Child Health Development Foundation and Women's Health Statewide. The Adelaide Central Community Health Service and the Northern Metropolitan Community Health Service identified health promotion activities throughout all programs. The budgets for these community health services do not maintain separate costing for programs; therefore, figures were calculated as an estimate of worker time spent on health promotion.

Immunisation

Total expenditure for *Immunisation* by DHS in 1998–99 was $8.5m, which is 13% of its total core public health expenditure.

Expenditure for *Childhood immunisation*

Expenditure in this category includes the cost of purchasing and administering immunisation within SA. The SA Immunisation Coordination Unit of the CDCB, which coordinates the purchase, distribution, packaging and reporting of vaccines for the State, reported the bulk of the expenditure for South Australia in this category. Other significant expenditure for this category within CDCB included specialist support, research activities and administration.

Other expenditure was recorded against the major health units, Child and Youth Health, community health services and the Royal District Nursing Services of SA Inc.

Expenditure for *Pneumococcal and influenza immunisation*

The majority of expenditure for this category was for staff vaccinations and the cost of providing vaccines to 'at-risk' populations. Expenditure in this category was reported by the Inner Southern Community Health Service and the Intellectual Disability Services Council, and included influenza and adult diphtheria tetanus programs for clients and staff. The SA St John Ambulance Service showed expenditure for immunisations and staff vaccinations.

All other immunisation expenditure

The major source of expenditure in this area was for the provision of staff hepatitis B vaccinations by various health services. Other sources of expenditure included Sexually Transmitted Disease Control services and the Intellectual Disability Services Council Inc.

Table 9.3: Expenditure for *Immunisation*, SA Department of Human Services, 1998–99 ($)

Expenditure	Childhood immunisation	Pneumococcal/ influenza immunisation	Other immunisation	Total immunisation
Direct	6,389,138	1,887,273	181,459	**8,457,870**

Note: Central overhead expenses not included.

Environmental health

Total expenditure for *Environmental health* by DHS in 1998–99 was $4.8m (see Table 9.1). This was 8% of total core public health expenditure. The majority of *Environmental health* expenditure in South Australia is based in the Environmental Health Branch of the department. The Branch is responsible for the assessment, correction, control and prevention of environmental factors arising from a range of chemical, microbiological and physical agents that can adversely affect health. It is also involved in the enhancement of environmental factors that can improve health. Its activities address acute and chronic hazards affecting food, water, soil and air through processes including: the development and implementation of strategies, standards, guidelines and legislation; environmental surveillance and monitoring; and the provision of advice to government agencies and the public.

Expenditure on the Port Pirie Environmental Health Centre was also part of this category. The Centre is responsible for lead abatement issues arising from smelters located in the town. This involves health promotion, screening for blood lead levels in infants and lead abatement activities in homes and the community.

Expenditure for the water environment includes environmental testing of shellfish growing areas and management of algal blooms.

Other areas where major expenditure occurs in the *Environmental health* category are in monitoring contaminated sites and water quality testing.

The Radiation Protection Branch of DHS has responsibilities in the surveillance and management of radiation risks. It is responsible for protecting South Australians from the harmful effects of radiation by controlling activities related to radioactive substances and apparatus, which produce ionising or non-ionising radiation.

Food standards and hygiene

Total expenditure for *Food standards and hygiene* by DHS in 1998–99 was $1.1m (see Table 9.1). This was 2% of total core public health expenditure.

Expenditure on *Food standards and hygiene*

In South Australia, the majority of food standards and hygiene regulation is undertaken by the Food Standards Section and Food Legislation Section within the Environmental Health Branch of DHS. The Food Standards Section is responsible for the surveillance of food products and undertakes projects related to food and nutrition. Other areas of expenditure in this category are resources, planning, legislative review and the cost of formal training for food handlers.

Due to the structure of the central organisation, costs associated with management and senior committees are divided equally between *Food standards and hygiene* and *Environmental health* categories.

Breast cancer screening

Total expenditure for *Breast cancer screening* by DHS in 1998–99 was $6.3m (see Table 9.1). This was 10% of total core public health expenditure.

BreastScreen SA, within DHS, aims to reduce mortality and morbidity attributable to breast cancer through a free government screening mammography service to asymptomatic women in the target group on a state-wide basis.

Recurrent expenditure

All breast cancer screening done by government in South Australia is coordinated through BreastScreen SA. Other expenditure is by country health units and Aboriginal health services, mainly attributable to transportation costs.

Cervical screening

Total expenditure for *Cervical screening* by the Department of Human Services in 1998–99 was $1.8m (see Table 9.1). This was 3% of total core public health expenditure.

Cervical screening in South Australia is part of the National Cervical Screening Program. This program aims to achieve optimal reduction in the incidence of, and morbidity and mortality attributed to, cervical disease, at an acceptable cost to the community. The program increases the proportion of women who are screened at appropriate intervals and promotes high-quality screening and follow-up services.

Expenditure on *Cervical screening*

Cervical screening is undertaken by a number of health services, with the majority of these programs funded by SA Cervix Screening, which administers the program on behalf of DHS. Areas of expenditure include central strategic planning, data management, promotion, cost of screening and reporting (public laboratory), staff wages and information literature.

All other core public health expenditure

Total expenditure for *All other core public health* by DHS in 1998–99 was $12.5m (see Table 9.1). This was 20% of total core public health expenditure.

Expenditure was recorded in this category by a number of cost centres, including the Epidemiology Branch within DHS. 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. The AIDS Council of SA also reported some expenditure in this category. The Therapeutic Goods Section of DHS reported public health expenditure in processing poisons and pest control licences and dealing with contaminated land issues. Expenditure was also reported in this category by the methadone program, which provides the prescription and administration of methadone to clients. The aim of this program is to provide assistance in reducing or abstaining from the use of illicit opioids. The Independent Living Centre promotes independent living for people with a psychiatric disability. The Centre's budget is included in this category due to its significant mental health and 'quality of life' components.

Public health related activities expenditure

Two areas reported 'Public health related activities' expenditure.

The Office of the Public Advocate is funded by DHS and undertakes a general advocacy role on behalf of people with a psychiatric disability, including the provision of information regarding the Mental Health Act. Although this activity is not part of core public health, it incorporates public health advocacy and communication.

A small cost was noted for dog control (de-sexing and vaccination) by the Pika Wiya Health Service, an Aboriginal health service in the far north of the State. It is included as a non-core public health measure due to the diseases that dogs spread in remote Aboriginal communities.

Public health expenditure in other State Government departments

The South Australian collection of core public expenditure included government departments other than DHS. These departments also fund and undertake public health activities. This information is presented separately, as most other jurisdictions did not collect these data in Stage 2.

Department of Correctional Services

The Department of Correctional Services reported on a number of public health categories, including *Cervical screening*, *Immunisation* and *All other core public health*, which included a methadone program run by this department. The amount of expenditure was estimated, as the information is not collected routinely in this way.

Department of the Premier and Cabinet

The Department of the Premier and Cabinet reported expenditure in *Selected health promotion activities*, which involved funding for the Men's Contact and Resource Centre for the maintenance of services for disadvantaged men.

Department of Primary Industries and Resources

This department plays a major role in the provision of public health. Their activities are summarised here:

- Primary Production Processing Standard—Includes advice to operators on food handling and safety, and aid in developing industry's role in maintaining food quality (*Food standards and hygiene*).
- Occupational health education, such as the farm chemical users course (*All other core public health*).
- Animal health surveillance and control—Surveillance and control of specific animal diseases of public health importance where the affected animal products are intended for human consumption (*Food standards and hygiene*).
- Management of compliance for the Primary Production Processing Standard through the enforcement of the Meat Hygiene Act and the accreditation of meat processing facilities and also by the testing of milk and dairy products (*Food standards and hygiene*).
- Regulatory control of agricultural and veterinary chemicals. This includes the monitoring of chemicals in foods and fibres. Although the primary rationale is not human health, health and injury risk to handlers is considerable (*All other core public health*).
- Monitoring which includes environmental testing of shellfish growing areas and the management of algal blooms. Management of potential public health risks associated with widespread fish kills through the public health disaster management plan (*Environmental health*).

Environment Protection Authority

Expenditure on public health by this department is in the area of *Environmental health* via the development and enforcement of environment protection policies, monitoring of contaminated sites, water quality, and air and noise pollution.

Office for Recreation and Sport

This department reported expenditure in the *Selected health promotion activities* category via the funding of sports programs with health promotion messages.

Work Cover Corporation

Work Cover reported expenditure against *Selected health promotion activities* for injury prevention activity through the provision of information, advice and support to workers. The whole of Work Cover's budget has been included here since the main purpose of the organisation is to promote health and injury prevention in the workplace.

Australian Red Cross

The Australian Red Cross is an NGO which is funded by the State (60%) and the Commonwealth (40%). It has a significant role in the screening of blood products for communicable diseases. As the main aim of screening is to provide a safe blood supply so that the spread of blood communicable diseases is prevented, it can be argued that this cost is a public health activity. It can also be argued that this testing is a necessary part of ensuring that blood products are not dangerous, and so is a compliance cost. Compliance costs are not included in the National Public Health Expenditure Collection.

Expenditure for the testing of blood products for HIV/AIDS and hepatitis C and for staff immunisation, which includes hepatitis B staff vaccination, was recorded. Also included was the cost involved in the training of food handlers working in the donors' cafeteria.

Expenditure reported by the organisation for the Therapeutic Goods Administration Licence Audit costs, general quality control and cost of compliance was not included.

The total expenditure by the Australian Red Cross for public health was $1,652,848.

Table 9.4 shows the totals reported by all the other State Government departments on core public health activities.

Table 9.4: Expenditure for core public health by other (non-health) government departments, for South Australia, 1998–99 ($)

Public health category/sub-category	Amount ($)
HIV/AIDS	1,747,566
Needle and syringe programs	—
Other communicable disease control	31,500
Health promotion	12,623,505
Childhood immunisation	500
Pneumococcal and influenza immunisation	2,835
All other immunisation	3,113
Environmental health	1,193,704
Food standards and hygiene	738,677
Breast cancer screening	—
Cervical screening	—
All other core public health	759,336
Total core public health	**17,100,736**
Public health related activities	646,303

10 Public health expenditure by the Tasmanian Department of Health and Human Services

10.1 Introduction

In Tasmania, the Department of Health and Human Services (DHHS) is involved in a wide range of population based health activities that support the promotion and protection of the health and wellbeing of Tasmanians. Generally, the State's public health activities comprise monitoring and implementing legislative requirements, whilst actual service provision occurs at the local government level. The Department's public health role incorporates monitoring quality and performance, development of public health policy and provision of advice to other levels of government and the community, as well as surveillance of social, economic and environmental health indicators.

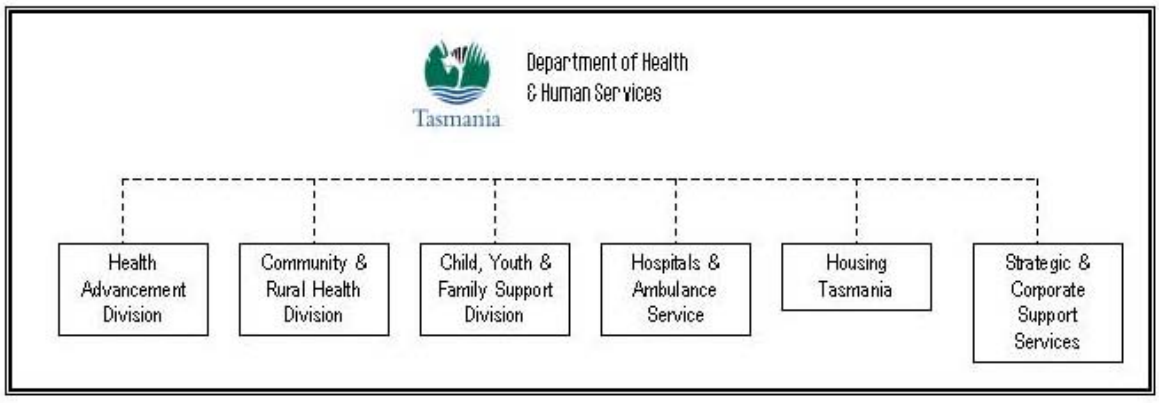

Figure 10.1: Structure of the Department of Health and Human Services

The Health Advancement Division is the main administrative unit for public health activities in DHHS. However, other DHHS divisions, as well as other State Government departments and local government jurisdictions, also provide a range of public health services, which are not included in this phase of data collection.

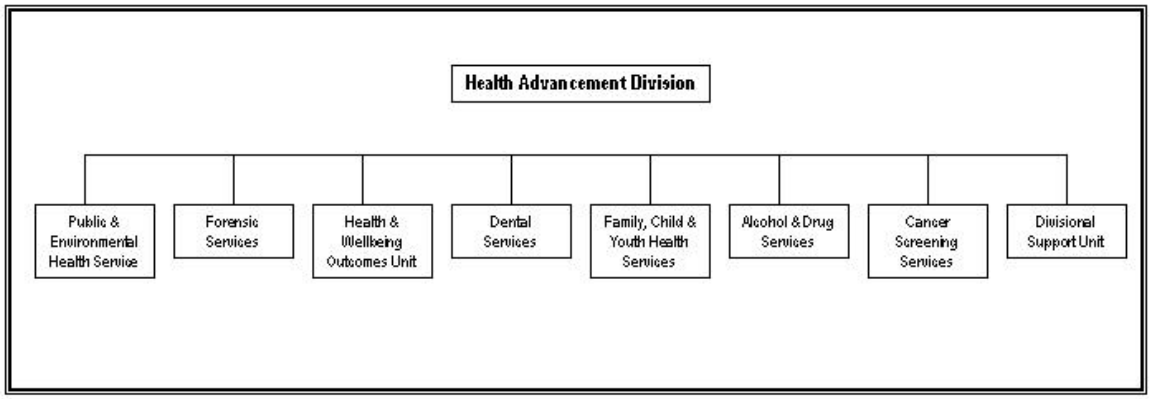

Figure 10.2: Structure of the Health Advancement Division, 1998–99

The key areas of the Health Advancement Division that provide public health outputs according to the criteria for this stage of data collection for the NPHEP are:

- The Public and Environmental Health Service that incorporates areas such as communicable disease, sexual health, food and water safety, pharmaceutical services and radiation monitoring.
- The Health and Wellbeing Outcomes Unit that analyses population health and wellbeing among specifically targeted population groups such as young people, men and women as specific groups, Aboriginal and Torres Strait Islanders, migrants and the elderly. The Unit also provides policy and planning advice in these areas.
- Alcohol and Drug Services, which supply services, information and support to people with substance abuse problems and their families, together with preventive community education.
- Cancer Screening and Control Services that provide breast and cervical cancer screening and prevention programs.

Tasmania's Stage 2 involvement in the NPHEP has specifically focused on the above output areas for this project stage, in order to develop a systematic basis from which to develop wider data collection mechanisms for Stage 3.

10.2 Data collection methodology

The DHHS uses a centralised financial reporting system. Financial data for this report were assimilated from the Department's main financial data collection by matching DHHS cost centres to public health categories, as far as possible. However, as departmental finance data are administratively focused rather than activity-directed, data collection according to NPHEP guidelines was problematic. For example, some aspects of Tasmania's needle and syringe programs are delivered as part of sexual health related services. Therefore, some administrative expenses are costed, and accounted for, under sexual health based expenditure and not as separate or specific activities. Hence delineation between these two types of activity was difficult, and the expenditure estimates presented in this section may not be a true reflection of actual expenditure on these activities.

The data supplied for Tasmania should be interpreted with the following caveats:

- The data supplied for Tasmania are from cash based accounting systems.
- Public health expenditure associated with community health or child health centres has not been included in these estimates.
- Expenditure by local government is not included.
- Expenditure estimates are total expenditure, not net expenditure.
- Program-wide and corporate overheads have been allocated proportionately across NPHEP categories and may not reflect actual indirect expenditure.
- Costs per person are based on total number of persons residing in Tasmania.

10.3 Overview of results

The total expenditure on core public health by DHHS for 1998–99 was estimated at $15.33m using the agreed categories. Of this total, $12.6m was direct public health expenditure, and $1.9m could be attributed to program-wide expenses, such as information systems, and policy and legislation development within the Health Advancement Division. A further $0.7m was estimated for corporate overheads, which is a proportion of the total departmental expenditure on centralised corporate services such as human resources, finance and executive services.

Table 10.1 summarises the total core public health expenditure by DHHS for 1998–99. It provides a breakdown of national public health categories to illustrate direct expenditure on services, and program-wide and corporate overheads.

Table 10.1: Expenditure for total core public health, Tasmanian Department of Health and Human Services, 1998–99

Category	Direct expenditure	Program-wide & overhead expenditure	Total	Proportion
	$	$	$	%
Communicable disease	906,714	171,955	1,078,669	7.04
Selected health promotion	1,267,044	240,291	1,507,335	9.83
Immunisation	1,743,524	330,653	2,074,177	13.53
Environmental health	1,241,104	497,805	1,738,909	11.34
Food standards & hygiene	152,660	61,232	213,892	1.39
Breast cancer screening	2,512,671	476,520	2,989,191	19.50
Cervical screening	479,174	90,874	570,048	3.72
All other core public health	4,336,398	822,383	5,158,781	33.65
Total	**12,639,289**	**2,691,713**	**15,331,002**	**100.00**

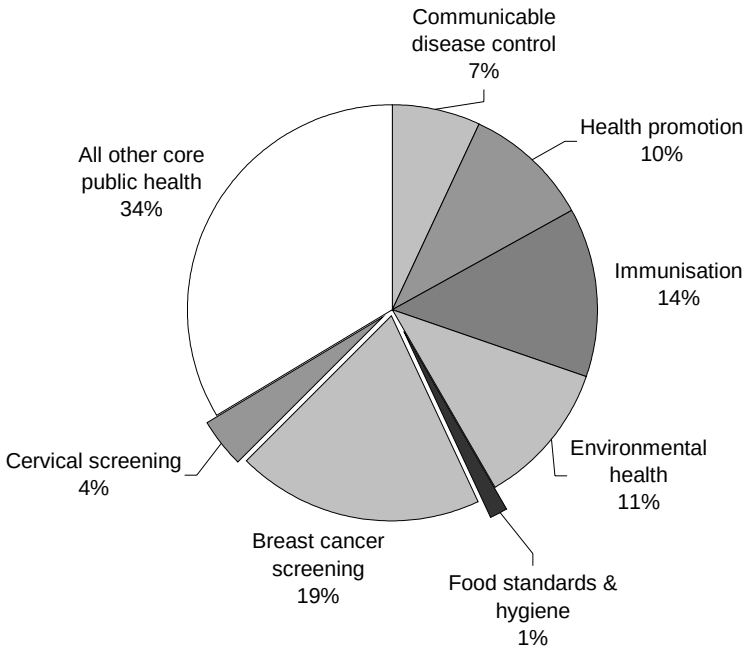

Figure 10.3: Tasmanian core public health expenditure by category

10.4 Public health expenditure by categories

Communicable disease control

Total expenditure for *Communicable disease control* by DHHS in 1998–99 was $1,078,669. This was 7% of total core public health expenditure. Total expenditure for *Communicable disease control* consisted of $906,714 for direct expenditure and $171,955 for corporate expenditure and program-wide allocations.

HIV/AIDS, hepatitis C and sexually transmitted infection programs

Expenditure in this category occurred mainly in the areas of education, prevention and administration. The Public and Environmental Health Service's Sexual Health Branch administered this expenditure.

Needle and syringe program

Expenditure in this area comprised funding of the Tasmanian AIDS Council and a new policy initiative. The needle and syringe program includes a one-off $70,000 expenditure.

Other communicable disease control

Surveillance and contact tracing of notifiable diseases provided the main expenditure in this area. The Public and Environmental Health Service's Environmental Health Branch administered this expenditure.

Table 10.2: Expenditure for *Communicable disease control*, Tasmanian Department of Health and Human Services, 1998–99 ($)

Expenditure	HIV/AIDS, hep. C and STI programs	Needle and syringe programs	Other communicable disease control	Total communicable disease control
Direct	570,714	220,000	116,000	906,714
Program-wide functions	76,320	29,420	15,512	121,252
Overheads	31,914	12,302	6,487	50,703
Total	**678,948**	**261,722**	**137,999**	**1,078,669**

Selected health promotion activities

Total expenditure for *Selected health promotion activities* by DHHS in 1998–99 was $1.5m. This was 10% of total core public health expenditure.

Total expenditure for *Selected health promotion activities* consisted of $1,267,044 for direct expenditure and $240,291 for corporate expenditure and program-wide allocations.

Expenditure in this category was allocated to the areas of tobacco control, child safety and youth suicide. Healthy ageing was also included here as a significant area of expenditure for the International Year of Older Persons. The main areas of expenditure for health promotion include women's health, tobacco control, injury prevention, and national youth suicide prevention.

Table 10.3: Expenditure for *Selected health promotion activities*, Tasmanian Department of Health and Human Services, 1998–99 ($)

Expenditure	Selected health promotion activities
Direct	1,267,044
Program-wide functions	169,439
Overheads	70,852
Total	**1,507,335**

Immunisation

Total expenditure for *Immunisation* provided by DHHS in 1998–99 was $2.1m. This was 13.5% of total core public health expenditure.

Total expenditure for *Immunisation* consisted of $1,743,524 for direct expenditure and $330,653 for corporate expenditure and program-wide allocations.

Expenditure on *Childhood immunisation*

Expenditure for *Childhood immunisation* was reported in the following areas: DTPA (Vaccine Booster), Haemophilus influenzae type b, Triple Antigen, 2nd Dose MMR, ACIR, Vaccination Program, Polio and ADT.

Expenditure on *Pneumococcal and influenza immunisation*

The influenza vaccine program for people aged 65 and over was a major component of expenditure in this area, as was the National Indigenous Pneumococcal and Influenza Program.

Expenditure on *Other organised immunisation*

The main expenditure for this category was for the Enhanced Measles Control Program. This was a one-off expenditure.

Table 10.4: Expenditure for *Immunisation*, Tasmanian Department of Health and Human Services, 1998–99 ($)

Expenditure	Childhood immunisation	Pneumococcal immunisation	Influenza immunisation	Total immunisation
Direct	860,607	411,443	471,474	1,743,524
Program-wide functions	115,087	55,021	63,049	233,157
Overheads	48,124	23,008	26,364	97,496
Total	**1,023,818**	**489,472**	**560,887**	**2,074,177**

Environmental health

Expenditure on *Environmental health*

Major expenditure in this category was performance monitoring of water quality—for example, fluoridation and contamination, and supervising Legionella and radiation safety.

Total expenditure for *Environmental health* by DHHS in 1998–99 was $1.7m. This was 11% of total core public health expenditure.

Total expenditure for *Environmental health* consisted of $1,241,104 for direct expenditure and $497,805 for corporate expenditure and program-wide allocations.

Table 10.5: Expenditure for *Environmental health*, Tasmanian Department of Health and Human Services, 1998–99 ($)

Expenditure	Environmental health
Direct	1,241,104
Program-wide functions	428,404
Overheads	69,401
Total	**1,738,909**

Food standards and hygiene

The Public and Environmental Health Service's Environmental Health Branch recorded expenditure on *Food standards and hygiene*.

Total expenditure for *Food standards and hygiene* by DHHS in 1998–99 was $213,892. This was 1% of total core public health expenditure.

Total expenditure for *Food standards and hygiene* consisted of $152,660 for direct expenditure and $61,232 for corporate expenditure and program-wide allocations.

Table 10.6: Expenditure for *Food standards and hygiene*, Tasmanian Department of Health and Human Services, 1998–99 ($)

Expenditure	Food standards and hygiene
Direct	152,660
Program-wide functions	52,695
Overheads	8,537
Total	**213,892**

Breast cancer screening

Total expenditure for *Breast cancer screening* by DHHS in 1998–99 was $3m. This was 20% of total core public health expenditure.

Total expenditure for *Breast cancer screening* consisted of $2,512,671 for direct expenditure and $476,519 for corporate expenditure and program-wide allocations.

Activities for breast cancer screening were conducted by the BreastScreen program throughout Tasmania, which included a mobile unit and other offices. Some of the expenditure in this category was for services for screening and assessment, training and data management.

Table 10.7: Expenditure for *Breast cancer screening*, Tasmanian Department of Health and Human Services, 1998–99 ($)

Expenditure	Breast cancer screening
Direct	2,512,671
Program-wide functions	336,013
Overheads	140,506
Total	**2,989,190**

Cervical screening

Total expenditure for *Cervical screening* by the Department of Health and Human Services in 1998–99 was $570,048. This was 4% of total core public health expenditure.

Total expenditure for *Cervical screening* consisted of $479,174 for direct expenditure and $90,874 for corporate expenditure and program-wide allocations.

Major areas of expenditure for *Cervical screening* were the maintenance of the cytology register, unit coordination, education, promotion and recruitment. There were other areas of expenditure reported in this category for quality assurance and special screening services.

Table 10.8: Expenditure for *Cervical screening*, Tasmanian Department of Health and Human Services, 1998–99 ($)

Expenditure	Cervical screening
Direct	479,174
Program-wide functions	64,079
Overheads	26,795
Total	**570,048**

All other core public health expenditure

Total expenditure for *All other core public health* by DHHS in 1998–99 was $5.2m. This was 34% of total core public health expenditure.

Total expenditure for *All other core public health* consisted of $4,336,398 for direct expenditure and $822,383 for corporate expenditure and program-wide allocations.

Total revenue reported for this category was $7,276.

This section includes other public health activities not covered in the previous core public health categories, but considered core public health activities in Tasmania. It includes public health activities and public health funding to non-DHHS service providers, supported by the Health Advancement Division.

Other core public health activities include a number of major functions performed by DHHS. These include:

- 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.

Table 10.9: Expenditure on *All other core public health*, Tasmanian Department of Health and Human Services, 1998–99 ($)

Expenditure	All other core public health
Direct	4,336,398
Program-wide functions	579,896
Overheads	242,487
Total	**5,158,781**

The expenditure data by DHHS in 1998–99 reflect the trial status of this phase in data collection. The public health expenditure figures for Tasmania do not include data for public health activities conducted by other areas of DHHS, notably the Community and Rural Health and Housing Divisions. These programs supply public health services that are difficult to quantify with respect to the NPHEP, as they are provided in conjunction with other health programs that are focused on different functional outcomes. For example, community based nursing is functionally directed towards improving community health outcomes. However, a number of activities performed by community nurses reflect public health initiatives, such as advice on immunisation, personal hygiene, nutrition and injury prevention. These initiatives are defined as public health activities but form only part of broader services provided within a different strategic framework. Estimates on expenditure in these areas will be targeted in Stage 3 of the NPHEP, which will collect expenditure data for 1999–00.

11 Public health expenditure by the Australian Capital Territory health authorities

11.1 Introduction

The Australian Capital Territory Department of Health and Community Care's objective is to maximise both community and individual health and wellbeing through the provision of improved health services to the community with better integration and continuity of care. A major strategy in this regard is the promotion of Canberra as the regional centre for the provision of health and community care, with the service system focusing on the needs of individuals and population groups.

Through the ACT Government's vision and directions statement, *Setting the Agenda*, the Department is promoting the concept of an integrated health system providing a seamless service focused on best meeting the needs of individuals and population groups. It aims to strengthen the primary health care sector, to increase the role of community and home based services as an alternative to acute hospitalisation.

The Department plans and implements health policy and provides public health services. It plans and purchases services to meet the needs of residents of the Canberra region in accordance with government outcomes, and evaluates those services. The Department also provides support and information to the Government, other agencies and individuals.

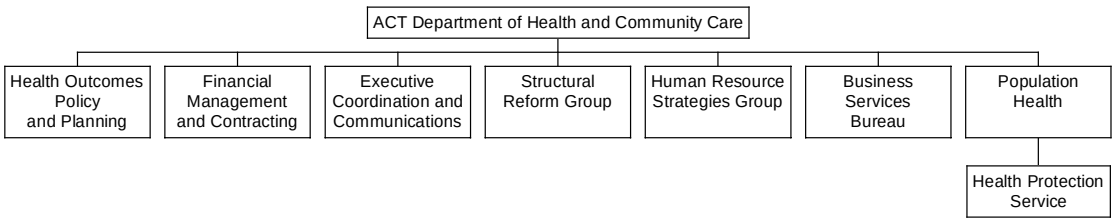

Figure 11.1: Structure of the Department of Health and Community Care, 1998–99

The public health role is predominantly undertaken by the Population Health Group, which is responsible for assessing population based health outcomes, communicable disease surveillance and health protection. Some public health services are also purchased from a range of government and non-government health care providers through purchase contracts. In addition, in 1995 the ACT Government established a statutory authority, titled Health**pact**, whose role is the promotion of healthy lifestyles.

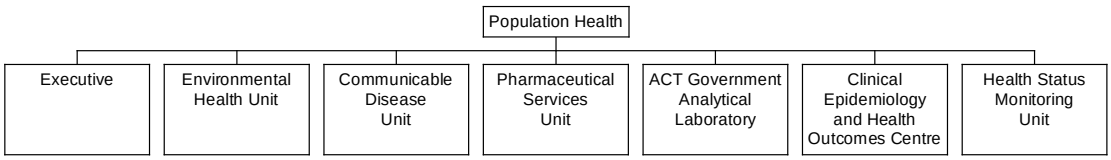

Figure 11.2: Population Health Group Structure, 1998–99

Public health activities conducted in the Australian Capital Territory during 1998–99 included the childhood immunisation program, progressing the anti–tobacco agenda and addressing concerns regarding the inappropriate use of drugs. Other areas where the public health agenda has been involved include the development of a water quality code of practice and contributions to the debate on genetically modified foods.

11.2 Data collection methodology

The information contained in this chapter of the report is in accordance with the core public health definitions for the 1998–99 NPHEP.

The ACT Department of Health and Community Care has a central accounting function that operates on a full accrual basis.

The cost centres within the department's chart of accounts containing expenditure on public health activities were identified. Then the core public health definitions were advised to the relevant cost centre managers. These managers were then tasked with allocating their costs to each of the public health expenditure categories. The expenditure of the Health**pact** statutory authority was then combined with the above data to complete the data collection.

Information technology expenditure was included on a cost centre basis under direct expenditure. Corporate expenditure and overheads such as Finance and Human Resources costs were allocated across all eight core categories on the basis of FTE staff numbers.

11.3 Overview of results

The total expenditure on core public health by ACT health authorities for 1998–99 was $14.72m. Of this, $13.83m was direct public health expenditure and $0.89m was corporate expenditure and overheads.

The data include expenditure on epidemiology, policy, planning and legislation development. Total public health research of $0.069m is not included in any category.

Table 11.1: Expenditure for total core public health, ACT health authorities, 1998–99

Category	Direct expenditure	Overheads	Total expenditure	Proportion of total expenditure
	$	$	$	%
Communicable disease control	1,628,603	101,003	1,729,606	11.7
Selected health promotion	2,281,686	188,002	2,469,688	16.8
Immunisation	1,102,548	73,845	1,176,393	8.0
Environmental health	598,673	12,931	611,604	4.1
Food standards & hygiene	373,495	4,877	378,372	2.6
Breast cancer screening	1,365,900	96,774	1,462,674	9.9
Cervical screening	434,200	30,763	464,963	3.2
All other core public health	6,044,904	385,948	6,430,852	43.7
Total	**13,830,009**	**894,143**	**14,724,152**	**100.0**
Proportions	93.9%	6.1%	100%	

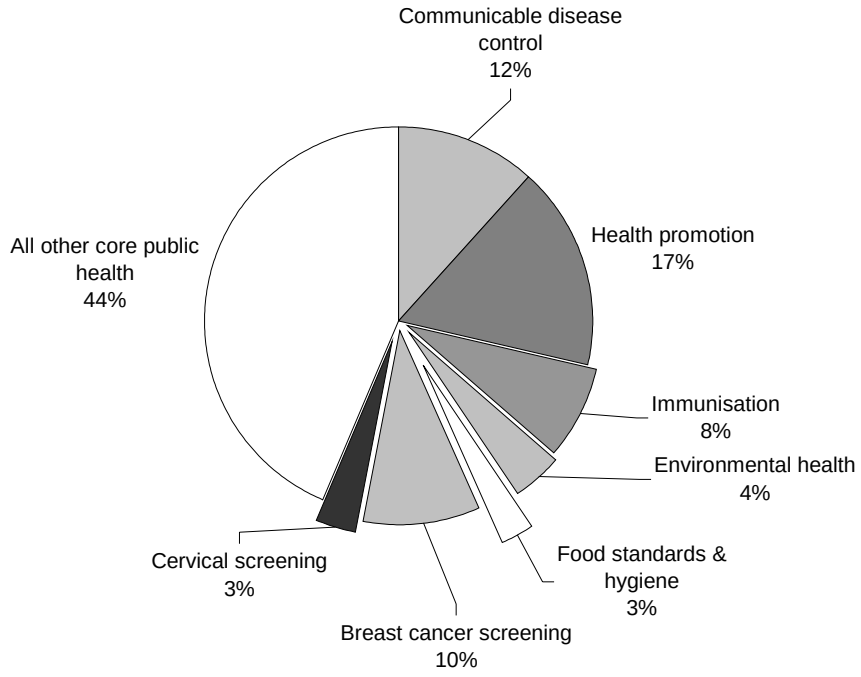

Figure 11.3: ACT core public health expenditure by category

11.4 Public health expenditure by categories

Communicable disease control

Total expenditure for *Communicable disease control* by ACT health authorities in 1998–99 was $1.7m. This was 12% of total core public health expenditure.

The bulk of expenditure was for payment to both government and non-government organisations for the provision of education and support services to the Australian Capital Territory community for HIV/AIDS, hepatitis C and the needle and syringe program. The figures do not include non-current expenditure of $0.107m for the HepC Lookback program, which was designed to identify and provide financial assistance to those who may have contracted hepatitis C from contaminated blood products during the late 1980s when a definitive test was not available.

HIV/AIDS, hepatitis C and sexually transmitted infection programs

Expenditure on HIV/AIDS in the Australian Capital Territory was toward providing education, support and counselling to people affected by HIV/AIDS and hepatitis C.

Needle and syringe program

Needle and syringe funding goes to both government and non-government needle and syringe outlets.

Other communicable disease control

Expenditure on *Other communicable disease control* in the Australian Capital Territory was on vaccines, surveillance, outbreaks and infection control. Activities included:

- communicable disease surveillance;
- investigation and management of vaccine-preventable diseases;
- provision of education and advice on infection control; and
- inspection and licensing of premises which undertake skin penetration.

Table 11.2: Expenditure for *Communicable disease control*, ACT health authorities, 1998–99 ($)

Expenditure	HIV/AIDS, hep.C and STI programs	Needle and syringe programs	Other communicable disease control	Total communicable disease control
Direct	1,074,566	329,800	224,237	1,628,603
Overheads	76,133	23,366	1,504	101,003
Total	**1,150,699**	**353,166**	**225,741**	**1,729,606**

Selected health promotion activities

Expenditure on *Selected health promotion activities*

Total expenditure for *Selected health promotion activities* by ACT health authorities in 1998–99 was $2.5m. This was 17% of total core public health expenditure.

Expenditure includes the expenditure of Health**pact**, the Healthy Cities program and a wide range of educational activities undertaken by the Department.

Health**pact** is a statutory authority established through the *Health Promotion Act 1995* with responsibilities in the area of health promotion. The three main areas of activity are grants and sponsorship, direct health promotion and development, and training. The areas where expenditure was recorded to promote health were 'Smoke–free', 'Sun smart behaviour', 'Physical activity' and 'Good nutrition'. Other areas of expenditure by Health**pact** were for mental health, community wellbeing and other safe behaviours.

Table 11.3: Expenditure for *Selected health promotion activities*, ACT health authorities, 1998–99 ($)

Expenditure	Selected health promotion activities
Direct	2,281,686
Overheads	188,002
Total	**2,469,688**

Immunisation

Total expenditure for *Immunisation* by ACT health authorities in 1998–99 was $1.2m. This was 8% of total core public health expenditure.

Childhood immunisation

Non-recurrent expenditure of $0.081m for the Measles Campaign has been excluded.

Expenditure for *Childhood immunisation* in the Australian Capital Territory includes:

- coordination of the ACT Immunisation Program;
- providing advice and education to vaccine providers and the public;
- maintaining and managing the ACT Immunisation Register;
- providing data to Australian Childhood Immunisation Register;
- follow-up of children overdue for immunisation;
- adverse events surveillance and management; and
- implementation of Australian Capital Territory school entry legislation.

Pneumococcal and influenza immunisation

Expenditure for *Pneumococcal and influenza immunisation* in the Australian Capital Territory was mostly in the areas of vaccinations and an immunisation seminar. Pneumococcal vaccine was provided free through the Indigenous Influenza and Pneumococcal Program. Influenza vaccine was provided free to adults over 65 years of age and to Indigenous Australians over 50 years of age.

Table 11.4: Expenditure for *Immunisation*, ACT health authorities, 1998–99 ($)

Expenditure	Childhood immunisation	Pneumococcal immunisation	Influenza immunisation	Total
Direct	879,484	1,440	221,624	1,102,548
Overheads	58,042	—	15,803	73,845
Total	**937,526**	**1,440**	**237,427**	**1,176,393**

Environmental health

Total expenditure for *Environmental health* by ACT health authorities in 1998–99 was $0.6m. This was 4% of total core public health expenditure.

Expenditure includes policy and legislation development, auditing and monitoring, and scientific services performed by the ACT Government Analytical Laboratories (ACTGAL). Audit and monitoring activities include:

- auditing and monitoring of cooling towers and warm water systems for Legionella;
- auditing and monitoring of swimming and spa pools;
- auditing and monitoring of accommodation facilities; and
- auditing and monitoring of hairdressing establishments.

Scientific service activities in this category include:

- air quality monitoring;
- recreational water testing for microbiological quality (lakes, streams, spas, pools);
- water quality testing for clients (Jervis Bay, Domestic Aerated Sewage Treatment plants); and
- regulatory testing of ionising radiation emitting devices (e.g. X-ray machines).

Table 11.5: Expenditure for *Environmental health*, ACT health authorities, 1998–99 ($)

Expenditure	Environmental health
Direct	598,673
Overheads	12,931
Total	**611,604**

Food standards and hygiene

Total expenditure for *Food standards and hygiene* by ACT health authorities in 1998–99 was $0.4m. This was 3% of total core public health expenditure.

Expenditure for this category includes standardisation, regulatory and safety activities including:

- food safety surveillance;
- food premises fit-out approval;
- food handler education;
- food safety enforcement; and
- policy and legislation development.

Scientific safety and sampling activities undertaken by ACTGAL include:

- food testing programs for microbiological and chemical compliance and safety;
- testing of complaint samples; and
- commercial testing of food quality and safety.

Table 11.6: Expenditure for *Food standards and hygiene*, ACT health authorities, 1998–99 ($)

Expenditure	Food standards and hygiene
Direct	373,495
Overheads	4,877
Total	**378,372**

Breast cancer screening

Expenditure in this category was for breast cancer screening services and the Cancer Registry. Total expenditure for *Breast cancer screening* by ACT health authorities in 1998–99 was $1.5m. This was 10% of total core public health expenditure.

Table 11.7: Expenditure for *Breast cancer screening*, ACT health authorities, 1998–99 ($)

Expenditure	Breast cancer screening
Direct	1,365,900
Overheads	96,774
Total	**1,462,674**

Cervical screening

Expenditure for this category was for cervical screening services and the Cancer Registry.

Total expenditure for *Cervical screening* by ACT health authorities in 1998–99 was $0.5m. This was 3% of total core public health expenditure.

Table 11.8: Expenditure for *Cervical screening*, ACT health authorities, 1998–99 ($)

Expenditure	Cervical screening
Direct	434,200
Overheads	30,763
Total	**464,963**

All other core public health expenditure

Total expenditure for *All other core public health* by ACT health authorities in 1998–99 was $6.4m. This was 44% of total core public health expenditure.

Expenditure in this category is composed of drug treatment services and scientific drug services by ACTGAL including:

- testing and certification of illicit drugs under various Acts, mainly *Drugs of Dependence Act 1989*;
- testing for alcohol and other drugs in drivers under *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 Belconnen Remand Centre and Periodic Detention Centre; and
- testing of post-mortem tissues for drugs and poisons in coronial matters.

Other activities include compliance monitoring, enforcement and education associated with tobacco retail outlets and control of smoking in public places. A substantial amount of work has been completed in relation to tobacco policy and legislative development.

Table 11.9: Expenditure for *All other core public health*, ACT health authorities, 1998–99 ($)

Expenditure	All other core public health
Direct	6,044,904
Overheads	385,948
Total	**6,430,852**

12 Public health expenditure by Northern Territory Health Services

12.1 Introduction

The Northern Territory constitutes a very large land mass, approximately 17% of the nation, with a small, widely dispersed population which is only 1% of the national population. Of the Northern Territory population, 28% identify as Aboriginal, with 70% living in remote communities. Average life expectancy for Aboriginal Territorians is approximately 20 years less than for other Territory citizens. Furthermore, the burden of disease experienced by Aboriginal Territorians is significantly higher than that experienced by other Territory citizens. The Northern Territory population is younger than the total Australian population, with only 3% being aged over 65 years. The Aboriginal population is particularly young, with 38% being aged under 15 years. This presents Territory Health Services (THS) with a unique challenge in the delivery of effective health services.

Territory Health Services' mission statement for 1996 through 1999 was 'To improve the health status and wellbeing of all people in the Northern Territory'.

The aim of the public health strategy is to 'Strengthen public health services to deliver effective prevention and health promotion strategies with particular emphasis on populations with high levels of sickness and early death'.

Public Health Services organisational structure 1998–99

During 1998–99 Public Health Services in the Northern Territory comprised:

- The Office of the Chief Health Officer
- Three major centres:
  - —Central Office
  - —Operations North
  - —Operations Central.

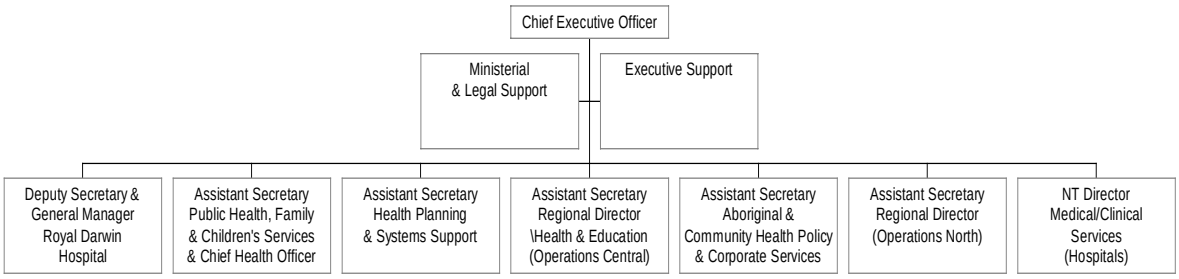

Figure 12.1: Departmental organisational structure in the Northern Territory 1998–99

Central Office provides policy and strategic direction to both the Top End and Central Australian centres (referred to as Operations North and Central). The areas of provision are public health strategies, health promotion, disease control including women's cancer prevention, environmental health, radiation, pharmacy and poisons, medical entomology, and alcohol and other drugs.

Operations North delivers public health services across an area totalling 614,000 square kilometres. Public Health programs are delivered by the Public Health Unit, Operations North, along with health teams that operate through 52 service outlets. These service outlets comprise Community Health Centres and hospitals located in Darwin Urban, Darwin Remote, East Arnhem and Katherine districts.

Operations Central delivers public health services across an area totalling in excess of 1,100,000 square kilometres. Health services are also extended to people who live adjacent to the borders in Western Australia and South Australia. Public health programs are delivered by the Population Health Unit, Operations Central, along with health teams that operate through 43 service outlets. These service outlets comprise Community Health Centres and hospitals located in the Alice Springs Urban, Alice Springs Rural and Barkly districts.

Due to the unique circumstances experienced by the NT, including a relative lack of general practitioners in rural and remote areas, public health programs are often delivered by health centre workers such as district medical officers, community health nurses and Aboriginal health workers, as well as specialised public health workers whose role is then to support these generalist community health teams.

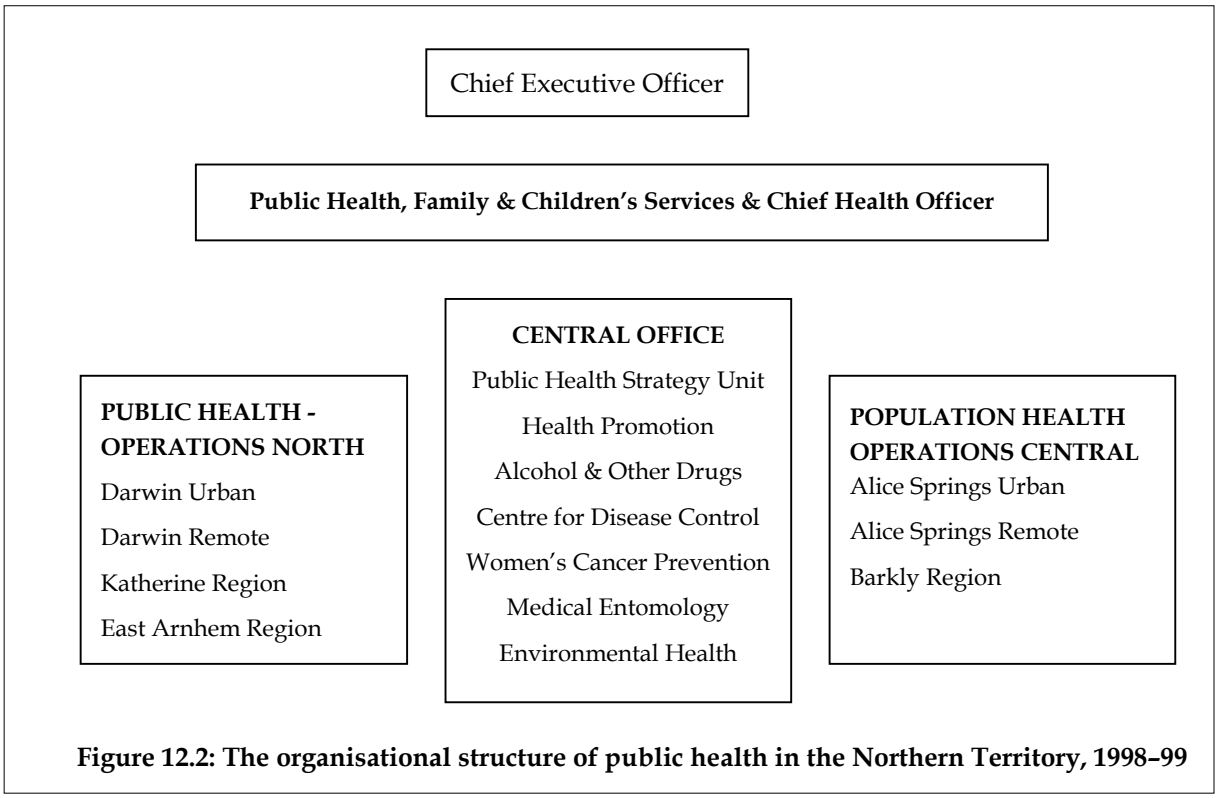

Figure 12.2: The organisational structure of public health in the Northern Territory, 1998–99

12.2 Data collection methodology

This collection reports core public health expenditure information for the Northern Territory (NT) for the financial year 1998–99. The Northern Territory has categorised and collected expenditure on only the core public health programs as defined in the Collection Manual (AIHW November 1999). Therefore this collection relates only to expenditure as defined by the seven core public health categories along with expenditure that the Northern Territory considers to be *All other core public health*.

There remains a component of public health expenditure that does not align with the core public health categories as defined for this collection. This remaining component of public health expenditure is referred to as 'Public health related' expenditure and is not included as core public health. For the 1999–00 collection, TAG will address the issue of providing categories and definitions for expenditure allocated to *All other core public health* and 'Other public health related'.

An 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.

It is acknowledged that the delivery of public health services differs between the States and Territories. Therefore the information contained within this report reflects the structure and administration of public health services, the ability to allocate expenditure to the core public health categories and the availability of information in the Northern Territory during the collection period.

Discussion of variations

Variations to the collection manual definitions

Within some States and Territories, alcohol and other drug services are administered under Community Health Services and are excluded from this national collection. However, in the Northern Territory, alcohol and other drug services are provided as a public health service and therefore are included in this collection as *Selected health promotion* and *All other core public health*. Expenditure for *Alcohol and other drugs* is reported to the Commonwealth as public health and is reported in the public health category of the Government Purpose Classification (GPC) of the Government Finance Statistics (GFS). An appropriate caveat should accompany reporting of this information.

Variations to Government Purpose Classification reporting of public health expenditure

Within remote and rural communities in the Northern Territory, public health programs are provided by District Medical Officers, Community Health Nurses and Aboriginal Health Workers. This expenditure is reported to the Commonwealth as Community Health Services as defined in the GPC of the GFS. THS estimated a public health component of Community Health Services expenditure and apportioned this across the core public health categories. Thus the GPC reporting of public health expenditure varies from the expenditure reported here.

Program-wide expenses

Program-wide expenses for this collection are defined 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
- public health research and development.

Within the Northern Territory, program-wide expenditure was identified according to the above definition and included in direct expenditure. Expenditure allocations to the core public health categories were made according to available statistics to reflect staffing, time and resources.

Overhead expenditure

Within the Northern Territory, corporate, central office and indirect expenditure is included in overhead expenditure. Overhead expenditure for the Northern Territory for 1998–99 was approximately $3.6m.

The indirect services that support Public Health were identified as: legal services, executive support, executive health planning, finance and general services, library services, information services, project review and project management, strategic workforce planning, human resource management, office services, health economics and corporate services for Operations North and Central.

The public health component of overhead expenditure was estimated to correspond with the public health component of total health expenditure.

The public health component of overhead expenditure was then apportioned across the categories to correspond with the public health component of total health expenditure. For example, CDC 1.97%, health promotion 2.86%.

Basis of accounting

THS's financial records are kept on a cash basis, and recognise events on receipt of monies and are reported within the financial accounting period concerned. No accrual entries (recognition of revenues as they are earned and expenses as they are incurred) are recorded in the general ledger.

Depreciation

THS does not include depreciation in its accounting practices. An appropriate caveat should accompany any reporting of this information.

Oncosts—Employer funded superannuation, long service leave liability and workers compensation

Since employer funded superannuation was paid from Treasury rather than by THS it was excluded from this expenditure collection. Future collections will include a component for employer funded superannuation. An appropriate caveat should accompany any reporting of this information.

12.3 Overview of results

The total expenditure on core public health by THS for 1998–99 was estimated at $48.2m. Included in this amount is: approximately $27.1m, consisting of an allocation of $3.6m for overhead expenditure; $10.5m as a component for public health programs delivered by Community Health Centres; and $13m for Alcohol and Other Drugs Programs.

The Northern Territory considers the inclusion of this expenditure as essential in identifying the real costs associated with the provision of public health services in the Territory. The cost attributed to the provision of public health programs in the Northern Territory is therefore expected to be significantly higher, as it reflects the high costs associated with the delivery of programs to populations located in rural and remote communities over the large land mass that makes up the Territory.

The Northern Territory faces the unique challenge of delivering effective public health programs to populations as small as 150 people located in remote and very remote communities. The higher than average costs attributed to the provision of public health programs in the Northern Territory include the high cost of transporting health professionals to the many rural and remote communities that are scattered over the Territory. Some communities are only accessible by air or rely on the existing infrastructure and resources provided by Community Health Services staff to provide public health programs—hence their inclusion.

Another contributing factor to the high cost of public health programs is that the widely dispersed population in the Northern Territory includes the 28% of Territorians who experience a significantly increased burden of disease and decreased life expectancy rates. These challenging circumstances do not allow for economies of scale to be utilised. The higher expenditure associated with the provision of public health services in the Northern Territory is therefore expected.

Table 12.1: Expenditure for total core public health, Territory Health Services, 1998–99

Category	Direct expenditure	Overhead expenditure	Direct and overhead expenditure	Proportion of total core public health expenditure
	$	$	$	%
Communicable disease	7,934,740	620,850	8,555,590	18
Selected health promotion	11,547,530	903,531	12,451,061	26
Immunisation	6,638,937	519,460	7,158,397	15
Environmental health	3,174,389	248,379	3,422,768	7
Food standards & hygiene	957,335	74,906	1,032,241	2
Breast cancer screening	1,020,502	79,849	1,100,351	2
Cervical screening	2,443,639	191,201	2,634,840	5
All other core public health	10,803,134	1,053,025	11,856,159	25
Total	**44,520,207**	**3,691,201**	**48,211,407**	**100**

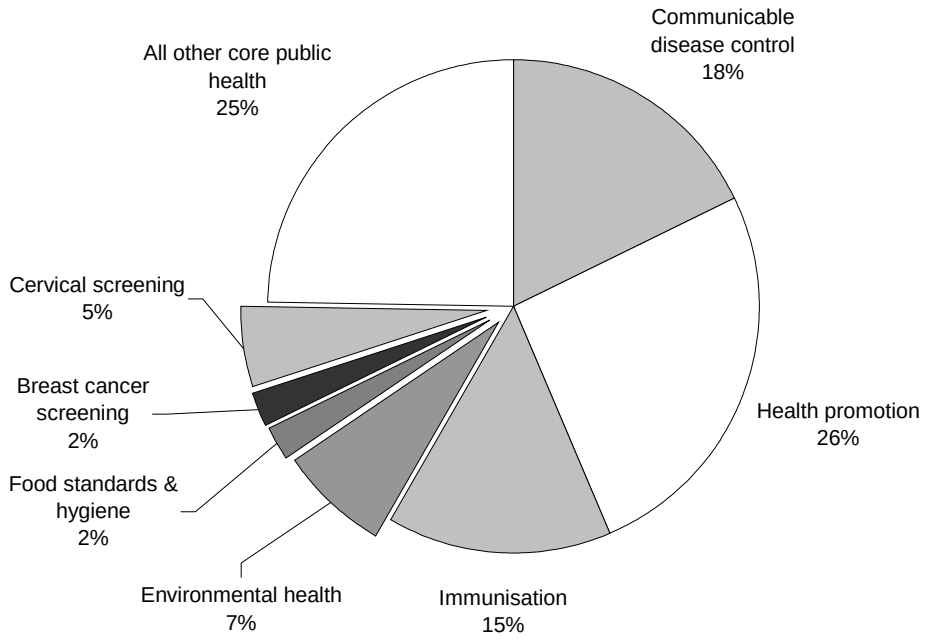

Figure 12.3: Northern Territory core public health by category

12.4 Public health expenditure by categories

Communicable disease control

Total expenditure for *Communicable disease control* by THS in 1998–99 was $8.55m. This was 18% of total core public health expenditure.

The Centre for Disease Control (CDC) Directorate provides services to prevent, monitor and control communicable and non-communicable disease in the Northern Territory. Program activities are coordinated through Disease Control Units in each health district.

Activities include policy development, surveillance of selected communicable diseases and outbreak investigation; initiation of appropriate control measures; development, coordination, promotion and monitoring of immunisation programs; reports on the outbreak of communicable diseases of public health importance; and involvement in research, education and health promotion. Screening and clinical services are provided for tuberculosis, leprosy and sexually transmitted diseases, including human immunodeficiency virus (HIV) and hepatitis C.

District CDC units work with urban and remote primary health care providers to enhance the provision of clinical services, contact tracing and community screening where appropriate and offer ongoing professional education.

Surveillance activities involve the ongoing collection, collation, analysis, interpretation and dissemination of data to identify short- and longer-term trends in disease incidence and to evaluate the impact of prevention strategies. Special surveillance programs monitor invasive Haemophilus influenzae type B (Hib) disease, enteric disease, measles, malaria, TB, influenza, invasive pneumococcal disease, adverse reactions following immunisation and vaccine utilisation.

The TB/Leprosy Control Unit aims to maximise efficiency through joint education and training of staff in the control of tuberculosis and leprosy.

The AIDS/STD Unit works toward the prevention and treatment of sexually transmitted disease and blood-borne viruses, HIV and hepatitis C.

The Needle and Syringe Program provides sterile injecting equipment to minimise the risk of the transmission of blood-borne viruses through injection drug use. Information and referral are provided through most centres. Equipment is distributed through community based organisations which are funded by THS, Clinic 34, district Disease Control Units and some public hospitals.

The amount recorded for the Needle and Syringe Program does not accurately reflect expenditure on this program. Where possible, expenditure was identified and allocated. However, the majority of expenditure for the Needle and Syringe Program is recorded as *Other communicable disease control*.

The constraints on available staff, including a lack of general practitioners, combined with the remoteness and the number of Aboriginal communities scattered throughout the Northern Territory, result in the delivery of public health programs by the district medical officer, the community health nurse and Aboriginal health workers within their respective communities. To ensure that the costs associated with the delivery of these public health programs are included, an estimation of public health expenditure from Community Health Services has been allocated. This expenditure has been apportioned across the core public health categories according to available statistics.

Table 12.2: Expenditure for *Communicable disease control*, Territory Health Services, 1998–99 ($)

Expenditure	HIV/AIDS, hep. C & sexually transmitted infections programs	Needle and syringe programs	Other communicable disease control	Total communicable disease control
Direct	2,085,327	19,901	5,829,512	7,934,740
Overheads	163,165	1,557	456,127	620,850
Total	***2,248,492**	**21,458**	***6,285,639**	***8,555,590**

* A component from Community Health Services is included to cover the cost of delivering public health programs in rural and remote communities.

Note: Included in the direct component of this category are: public health information systems, disease surveillance and epidemiological analysis; public health communication and advocacy; public health policy, program and legislation development; and public health workforce development.

Selected health promotion activities

Total expenditure for *Selected health promotion activities* by Territory Health Services in 1998–99 was $12.5m. This was 26% of total core public health expenditure.

Health promotion is an approach to improve the health and wellbeing of individuals, groups and communities through increasing their capacity to control the determinants of health.

Throughout THS, the primary health care services and all primary health care and public health service providers are actively involved in the planning and implementation of a diverse range of health promoting activities. The primary health care service works in partnership with the community in planning, implementing and evaluating health promotion strategies. Health promotion strategies provide a way for primary health care providers and public health staff to work with communities and to strengthen communities' capacity to create and sustain health.

The health promotion approach is entrenched through Essential Primary Health Care Service Standards endorsed in 1999 (Freeman and Rote, April 1999).

The THS Health Promotion Program uses a health promotion model based on three key components:

- working with communities to generate locally tailored health promotion projects;
- supporting primary health care providers in a health promoting role; and
- providing training and professional support to services providers and community based workers.

Health promotion teams work with primary health care providers to enhance their health-promoting role through professional training and collaborate with other THS programs to develop specific projects in response to community concerns. Health promotion teams also work with other government agencies, non-government agencies and community based staff to encourage and support community action through locally initiated health promotion activities.

This model was found by the WHO to be well suited to the community and service context of the Northern Territory and soundly based on national and international experience.

The expenditure information collected for this category is according to the definitions outlined in the collection manual for the category of *Health promotion*. Of the total $12.4m expenditure on *Health promotion*, $2.3m was invested in health promotion programs specifically provided by the Health Promotion Unit and operational health promotion officers in all regions. Significant expenditure from the Alcohol and Other Drugs Program, Community Health Clinics, School Nursing, Child Health, Nutrition, Aboriginal Hearing Program and CDC has been identified as health promotion and allocated to this category.

The constraints on available staff, including a lack of general practitioners, combined with the remoteness and the number of Aboriginal communities scattered throughout the Northern Territory, result in the delivery of public health programs within their respective communities by primary health care teams incorporating Aboriginal health workers, community health nurses and district medical officers. To ensure that the costs associated with the delivery of these public health programs are included, an estimation of public health expenditure from Community Health Services has been allocated. This expenditure has been apportioned across the core public health categories according to available statistics. An appropriate caveat should accompany any reporting of this information.

Health promotion expenditure associated with the Alcohol and Other Drugs, Living with Alcohol and the Tobacco Action Programs is included in this category. All other expenditure relating to alcohol and other drugs is reported under the *All other core public health* category.

Table 12.3: Expenditure for *Selected health promotion activities*, Territory Health Services, 1998–99 ($)

Expenditure	Selected health promotion activities
Direct	11,547,530
Overheads	903,531
Total	**12,451,061**

Notes:

1. Included in the direct component of this category are: public health communication and advocacy; public health policy, program and legislation development; and public health workforce development.
2. A component from Community Health Services is included to cover the cost of delivering public health programs in rural and remote communities.
3. A component from Alcohol and Other Drugs programs has been included.

Immunisation

Total expenditure for *Immunisation* by THS in 1998–99 was $7.1m, which was $37.39 per person. This was 15% of total core public health expenditure.

The CDC provides coordination, promotion and monitoring of immunisation programs in the Northern Territory. A major project was the collaboration with all Northern Territory vaccine service providers to revise and update childhood immunisation records for linking to the Australian Childhood Immunisation Register (ACIR). THS participated in national and local initiatives to improve immunisation coverage rates for adults and children. This initiative was followed up by the provision of courses for District Medical Officers, Community Health Nurses and Aboriginal Health Workers titled 'About giving vaccines'.

The NT School-Aged Hepatitis B Program ensured that all Territorians from 6–16 years of age had the opportunity for vaccination against hepatitis B. Vaccines were administered primarily in schools but also in community health clinics and via non-government vaccine service providers.

Vaccinations against measles, mumps and rubella were provided to school-aged children in the Northern Territory during the Commonwealth Measles Control Campaign.

As previously noted, the constraints on available staff, including a lack of general practitioners, combined with the remoteness and the number of Aboriginal communities scattered throughout the Northern Territory, result in the delivery of public health programs by the district medical officer, the community health nurse and Aboriginal health workers within their respective communities. To ensure that the costs associated with the delivery of these public health programs are included, an estimation of public health expenditure from Community Health Services has been allocated. This expenditure has been apportioned across the core public health categories according to available statistics.

It is not possible at this stage for THS to accurately collect the community health expenditure component down to the level of *Childhood*, *Pneumococcal and influenza* and *Other immunisation* programs. Where information has been recorded only at the broad category level of *Immunisation* it is included in the *Other immunisation* sub-category.

Table 12.4: Commonwealth funding received for *Immunisation*s by Territory Health Services during 1998–99 ($)

Commonwealth funding	Amount
Childhood immunisations	415,000
Pneumococcal and influenza immunisations	60,000
School Age Hep B	318,000
Aboriginal Immunisation Program (Influenza and Pneumococcal – OATSIH)	108,000
ACIR	398,427
Total	**1,299,427**

Table 12.5: Expenditure for *Immunisation* by Territory Health Services, 1998–99 ($)

Expenditure	Childhood immunisation	Pneumococcal/ influenza immunisation	Other immunisation	Total immunisation
Direct	1,348,671	318,561	4,971,704	6,638,936
Overheads	105,526	24,926	389,009	519,461
Total	***1,454,197**	***343,487**	****5,360,713**	**7,158,397**

* A component from Community Health Services is NOT included in this category.

** A component from Community Health Services IS included to cover the cost of delivering public health programs in rural and remote communities.

Note: Included in the direct component of this category are: public health information systems, disease surveillance and epidemiological analysis; public health communication and advocacy; public health policy, program and legislation development; and public health workforce development.

Environmental health

Total expenditure for *Environmental health* by THS in 1998–99 was $3.4m. This was 7% of total core public health expenditure.

The Environmental Health Program within THS consists of two sub-programs, Environmental Health and Medical Entomology.

The Environmental Health Branch provides services that aim to prevent physical, chemical, biological and radiological agents in the environment from adversely affecting the health of all Territorians. The Environmental Health Branch is comprised of several discrete service areas:

- Aboriginal and general community environmental health
- environmental health standards
- environmental planning
- sanitation and waste management
- food safety
- poisons and pharmacy
- radiation health.

Aboriginal and general community environmental health services are responsible for policy and development. Operational Environmental Health Units are located in all major town centres. These units provide services for the enhancement of environmental health standards in urban, rural and remote Aboriginal communities. This includes food safety, environmental planning, sanitation and waste management.

Poison and pharmacy control services are provided by an operational unit in Darwin supported by hospital based pharmacists in regional centres. However, for this collection, pharmacy has been excluded from the *Environmental health* category and is recorded as *All other core public health*.

Radiation health services are provided to minimise any negative health impact of radiation on the Northern Territory population and to ensure that use of beneficial radioactive materials and devices follows sound scientific practices and legislative controls.

Medical Entomology Branch provides services aimed at reducing the impact of biting insects on the people of the Northern Territory. Medical Entomology works with a number of other departments to conduct the control, monitoring and surveillance of mosquitoes. Other clients include: the general public for enquiries, the Department of Lands Planning and Environment on land development for comment, consultants and developers for development and planning advice and environmental health officers in all regions for mosquito and disease control advice. The main community link is through mosquito public awareness programs and the Mosquito Control Advisory Committee. These provide public feedback and information dissemination.

The expenditure information collected for this category is according to the definitions outlined in the collection manual for the category of *Environmental health*.

Table 12.6: Expenditure for *Environmental health*, Territory Health Services, 1998–99 ($)

Expenditure	Environmental health
Direct	3,174,389
Overheads	248,379
Total	**3,422,768**

Note: Included in the direct component of this category are: public health information systems, disease surveillance and epidemiological analysis; public health communication and advocacy; public health policy, program and legislation development; public health workforce development; public and environmental health laboratory services; and public health research and development.

Food standards and hygiene

Total expenditure for *Food standards and hygiene* by THS in 1998–99 was $1m. This was 2% of total core public health expenditure.

The Environmental Health Directorate administers the provisions of the Food Act, develops and updates Northern Territory food standards and hygiene legislation, standards and policy, provides input to the development of national programs, policy and standards, and actions national recalls of unsafe food. The Directorate also provided an intensive food safety auditing training course for Environmental Health Officers, which facilitated the effective implementation of the proposed national food safety standards.

Expenditure includes development of policy and standards in relation to the labelling of genetically modified foods, and alterations to the maximum residue levels of agricultural chemicals used in food production.

The expenditure information collected for this category is according to the definitions outlined in the collection manual for the category of *Food standards and hygiene*.

Table 12.7: Expenditure for *Food standards and hygiene*, Territory Health Services, 1998–99 ($)

Expenditure	Food standards and hygiene
Direct	957,335
Overheads	74,906
Total	**1,032,241**

Note: Included in the direct component of this category are: public health communication and advocacy; public health policy, program and legislation development; and public health workforce development.

Breast cancer screening

Total expenditure for *Breast cancer screening* by THS in 1998–99 was $1m. This was 2% of total core public health expenditure.

The Northern Territory Women's Health Policy 1992 aims to improve significantly the health and wellbeing of women by identifying and responding to their specific and unique health needs.

BreastScreen NT is the Territory component of BreastScreen Australia. Funding is provided under the Territory/Commonwealth PHOFA. BreastScreen NT provides free breast screening services and assessment of screen detected abnormalities for women aged 40 years and over. The target group is women aged 50–69 years. Screening and assessment centres are located in Darwin and Alice Springs and a relocatable screening unit visits Katherine, Tennant Creek and Nhulunbuy.

The small population, combined with the remoteness of the Northern Territory, does not permit economies of scale to be utilised. The Northern Territory does not have a resident radiologist with the necessary expertise to read these X–rays. Therefore during the year a radiologist is flown in to perform assessments and to read X–rays. As a result, the cost of providing this service is considerably higher than it is for other States and the Australian Capital Territory.

The expenditure information collected for this category is according to the definitions outlined in the collection manual for the category of *Breast cancer screening*.

Table 12.8: Expenditure for *Breast cancer screening*, Territory Health Services, 1998–99 ($)

Expenditure	Breast cancer screening
Direct	1,020,502
Overheads	79,849
Total	**1,100,351**

Note: Included in the direct component of this category are: public health information systems, disease surveillance and epidemiological analysis; public health communication and advocacy; public health policy, program and legislation development; and public health workforce development.

Cervical screening

Total expenditure for *Cervical screening* by THS in 1998–99 was $2.6m. This was 5% of total core public health expenditure.

The NT Cervical Screening Program participates in the National Cervical Screening Program, which is a joint initiative of the Commonwealth, State and Territory Governments,

in which an organised approach to preventing cancer of the cervix is implemented. Funding is provided under the Territory/Commonwealth PHOFA.

The organised approach involves all steps of the screening pathway, including: encouraging all eligible women to enter and remain in the screening program; ensuring optimal quality of Pap smears by adequate training of Pap smear takers; ensuring optimal quality of Pap smear reading; following up of abnormal Pap smears; providing recall and reminder systems to ensure adequate follow-up of screen-detected abnormalities; and maintaining women in the screening program by encouraging service providers to set up reminder systems and by the operation of the NT Pap Smear Register.

The expenditure information collected for this category is according to the definitions outlined in the collection manual for the category of *Cervical screening*.

Table 12.9: Expenditure for *Cervical screening*, Territory Health Services, 1998–99 ($)

Expenditure	Cervical screening
Direct	2,443,639
Overheads	191,201
Total	**2,634,840**

Note: Included in the direct component of this category are: public health information systems, disease surveillance and epidemiological analysis; public health communication and advocacy; public health policy, program and legislation development; and public health workforce development.

All other core public health expenditure

Total expenditure for *All other core public health* by THS in 1998–99 was $11.8m. This was 25% of total core public health expenditure.

For the purposes of this collection, *All other core public health* programs are defined as other core public health programs that are not captured by the preceding seven core public health expenditure categories. All activities considered core public or population health not reported elsewhere are allocated to this category.

The expenditure information collected for this category are listed below:

- 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.

Alcohol and other drugs

Information for alcohol and other drugs, other than health promotional activities, has been allocated to this category. The Alcohol and Other Drugs Program (AODP) develops and coordinates strategies to minimise the harmful effects of legal and illicit substances in the Territory. Alcohol, tobacco, petrol and kava are of particular concern in the Territory. AODP manages the Living With Alcohol Program, a Territory initiative aimed at achieving long-term reductions in alcohol-related harm. The Tobacco Action Project addresses smoking

issues with a particular focus on smoking by minors, young adults and Aboriginal and Torres Strait Islander people.

The AODP also delivers services as part of the National Drug Strategy through the PHOFA. Within the Northern Territory, the application of the National Drug Strategy Funds concentrates on substances other than alcohol. The program operates with a high degree of inter-sectoral collaboration.

Most services are delivered through the non-government sector with strong links across government departments including Police, Education, the Liquor Commission, Correctional Services, Transport and Works (Road Safety Council) and the Department of the Chief Minister. Operational units are located in Alice Springs and Darwin, and Living With Alcohol staff are located in Katherine, Nhulunbuy and Tennant Creek to provide local expertise and support. A generic detoxification facility is situated in Darwin and a detoxification service is funded through an NGO in Alice Springs. Public hospitals also have a detoxification capacity but have not been included in this collection.

Food and Nutrition Services

Food and Nutrition Services have allocated a component of their expenditure to the *Health promotion* and *All other core public health* categories, including expenditure for the development of:

- a project for the implementation of the NT Food and Nutrition Policy, with the major focus on the provision of food and nutrition education to community based Aboriginal people, including people employed in stores;
- a standardised system to monitor food supply, cost, availability and variety in remote stores;
- the training model, 'Healthy Food from The Store', and its delivery;
- an accredited scheme, 'Healthy Choices Award', for food service outlets, which was piloted in Alice Springs and Darwin; and
- an information system and publications (specific to the States and Territories).

Table 12.10: Expenditure for *All other core public health*, Territory Health Services, 1998–99 ($)

Expenditure	All other core public health
Direct	10,803,134
Overheads	1,053,025
Total	**11,856,159**

Note: Included in the direct component of this category are: public health information systems, disease surveillance and epidemiological analysis; public health communication and advocacy; public health policy, program and legislation development; public health workforce development; and public health research and development.

13 Australian public health expenditure data 1998–99

In 1998–99, public health expenditure was $889m and represented 1.9% of total recurrent health expenditure.

Table 13.1: Public health expenditure by Commonwealth, State and Territory Governments, and as a percentage of total health expenditure for 1998–99

	Amount
Total core public health expenditure (including overheads and program-wide costs)	$879,739,320
Recurrent health expenditure	$47,080,000,000
Public health as a proportion of total health expenditure	1.9%

Source: AIHW Health Expenditure Database.

Selected health promotion activities was the major area of total public health expenditure in 1998–99 (21%). This category included spending on population health programs aimed at promoting healthy lifestyles, for instance programs promoting good nutrition or safe alcohol use, or programs aimed at preventing suicides. Spending in this category was $187m. The next largest areas of expenditure on public health were *Immunisation* ($178m or 20%) and *Communicable disease control* ($145m or 16%), which included *HIV/AIDS, hepatitis C and sexually transmitted infections programs*, and *Needle and syringe programs*. Spending on *Breast cancer screening* came to $91m or 10% and *Cervical screening* amounted to $81m or 9%. The category of *Environmental health* included such programs as mosquito and rat control, Legionella control and hazardous materials management, and activities such as water quality testing and sampling. Reported spending here came to $72m or 8%. Expenditure on *Food standards and hygiene* amounted to $22m or 3%. The category of *All other core public health* included spending on such diverse things as alcohol and drug control measures, regulation of poisons, quarantine, and pharmaceuticals and therapeutic goods, and amounted to $85m or 10% of total public health expenditure.

The 1998–99 data collection represents expenditure by the various health departments throughout Australia. This is not a complete representation of total core public health expenditure since non-health departments and local governments also have public health responsibilities.

13.1 Expenditure and funding by the Commonwealth, States and Territories

Total spending by the States and Territories on core public health was $613m (Table 13.3). This expenditure was funded by the Commonwealth in the form of grants worth $192m and by $421m from State and Territory Government sources (Table 13.2).

Table 13.2: National public health expenditure (including overheads and program-wide expenditure) by source of funds

	Amount ($)	Funding of public health as a proportion of total public health expenditure (%)
Direct and overhead expenditure by the Commonwealth	266,713,095	30
Payments to States and Territories by the Commonwealth	192,449,825	22
Total Commonwealth funding	*459,162,920*	*52*
Funding by States and Territories	420,576,400	48
Total core public health expenditure including overheads and program-wide costs.	**879,739,320**	**100**

Table 13.3: National expenditure by Commonwealth, States and Territories on core public health categories including overheads and program-wide expenditure ($)

	Commonwealth	States and Territories	Total
Category	Total direct and overhead expenditure by the Commonwealth (excluding grants to States and Territories)	Total direct and overhead expenditure by States and Territories (including Commonwealth grants to States and Territories)	Total expenditure through States, Territories & Commonwealth
Communicable disease control	24,193,170	120,953,126	145,146,296
Selected health promotion activities	40,128,117	147,116,876	187,244,993
Immunisation	72,493,136	105,943,194	178,436,330
Environmental health	31,670,639	39,988,676	71,659,314
Food standards & hygiene	9,006,112	13,350,594	22,356,706
Breast cancer screening	5,133,327	85,679,611	90,812,938
Cervical screening	59,652,592	21,271,644	80,924,235
Research (Commonwealth only)	16,993,750	0	16,993,750
All other core public health	6,602,095	78,722,505	85,324,600
PHOFAs and other general public health grants	840,156	. .	. .
Total expenditure	**266,713,095**	**613,026,225**	**879,739,320**
Percentage of total	30%	70%	100%

(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 running costs, and $341,856 in non-grant program costs. The grants to States and Territories of $192m help to fund the expenditure of the States and Territories of $618m.

. . not applicable

Table 13.4: National public health expenditure as a proportion of total core public health, including overheads and program-wide expenses

Category	Direct expenditure	Overheads & program-wide expenditure	Total core public health expenditure	% of expenditure
Communicable disease control	128,619,556	16,526,741	145,146,296	16.5
Selected health promotion activities	166,127,180	21,117,813	187,244,993	21.3
Immunisation	165,584,090	12,852,240	178,436,330	20.3
Environmental health	54,925,674	16,733,640	71,659,314	8.1
Food standards & hygiene	20,466,701	1,890,005	22,356,706	2.5
Breast cancer screening	80,592,362	10,220,576	90,812,938	10.3
Cervical screening	76,904,5234	4,019,712	80,924,235	9.2
Research (Commonwealth only)	15,740,162	1,253,588	16,993,750	1.9
All other core public health	78,935,035	6,389,565	85,324,600	9.7
Grants to States and Territories	. .	840,156	840,156	. .
Total core public health	**792,419,983**	**91,844,036**	**884,264,020**	**100.0**
General public health grants to States and Territories from Commonwealth			**[(a)]192,005,325**	

(a) General public health grants from the Commonwealth to the States and Territories of $192m contribute to the funding of State and Territory public health expenditure, but it is not possible to say what portion of each public health category is funded by these grants.

. . Not applicable

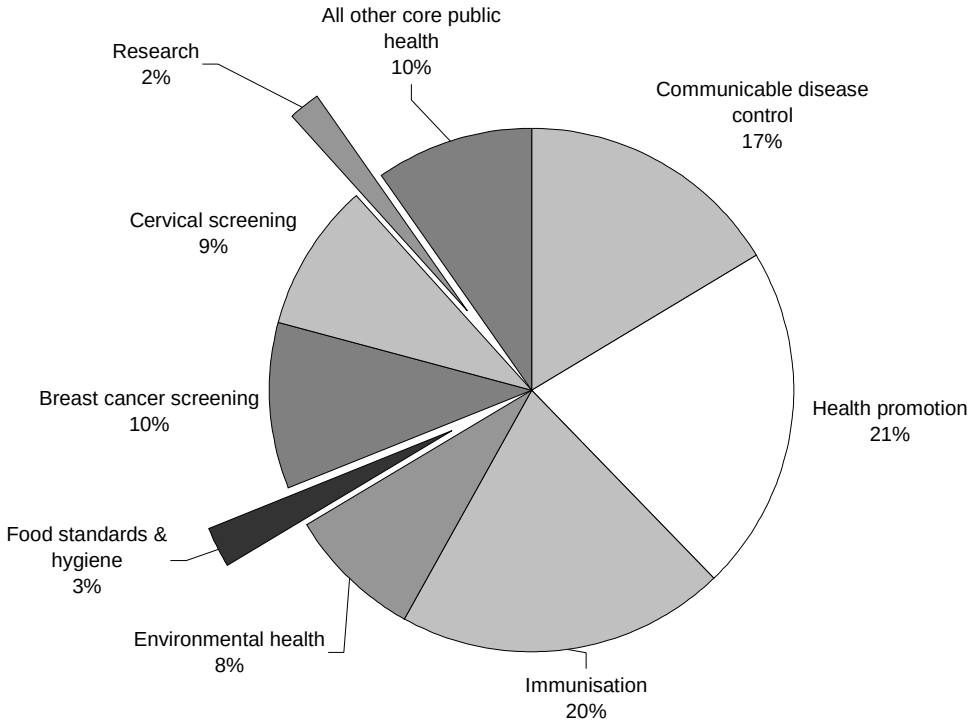

Figure 13.1: Australian public health expenditure by category

The Commonwealth spent $267m on public health activities which it either undertook itself or paid NGOs to do. Total funding by the Commonwealth was $459m ($267m plus $192m funding to the States). This was 52% of public health expenditure.

Public health grants to the States and Territories were provided mainly through the PHOFAs (see Section 4.2 for details). Almost all funding provided under the PHOFAs is used for activities that fall within the core public health activities defined by the project; but there is a small portion of these grants to the States and Territories that may not be captured by these categories. All funding provided under the PHOFAs has been included in Tables 13.2 and 13.3, with the recognition that a small proportion may be funding activities outside core public health expenditure as defined by this project.

Commonwealth, State and Territory expenditure includes $92m in overheads and program-wide expenses needed to support the provision of these public health services by governments.

13.2 Summary of expenditure through States and Territories

Tables 13.5 and 13.6 provide a summary of the public health expenditure figures by States and Territories for each of the core public health categories for 1998–99. They should not be used for comparative purposes, due to the number of data deficiencies and differences that

were outlined in Chapter 3. Some of these data deficiencies and differences amongst jurisdictions relate to the:

- use of cash and accrual accounting methods;
- different scope of collection in jurisdictions—for example, community health is excluded from some jurisdictions;
- lack of a consistent boundary around the *All other core public health* category;
- inclusion/exclusion of corporate and central office costs;
- different methodologies used to collect expenditure figures; and
- interpretation of public health expenditure definitions.

Table 13.5 summarises total public health expenditure for each of the eight core categories by all States and Territories. The first row lists millions of dollars of expenditure. The second row is in the form of an index number, where the average per person expenditure for that category is set equal to 1, and the per person expenditures for each jurisdiction are ratios of the national average. Thus for *Communicable disease control* the index for New South Wales is 1.13, as expenditure per person in this area is 13% higher in New South Wales than the national per person expenditure on *Communicable disease control*.

The data in Tables 13.5 and 13.6 must be interpreted cautiously as this is the first time this method of data collection has been used. The differences between the States and Territories in per person expenditures are due to various factors. Firstly, expenditure data have been classified and collected differently across jurisdictions (see Chapter 3).

Secondly, costs of providing public health services differ from one jurisdiction to the next. Jurisdictions like the Northern Territory, the Australian Capital Territory and Tasmania face higher costs due to diseconomies of scale. States with more remote areas have higher costs in delivering services. Other States have higher costs due to higher wage or other input costs. Some States have developed efficiencies in delivering services.

Thirdly, there are differences in the need for public health services. The proportion of at-risk populations varies from State to State. In the Northern Territory, for example, the 28% of the population who are Aboriginal experience a significantly higher burden of disease on average than the Australian population as a whole with 70% also living in remote communities. Different proportions of people who are from a non-English-speaking background or who are Aboriginal or Torres Strait Islander can affect the cost of communicating a message in culturally appropriate ways. The age and sex structure of a State's population affects the relative need for services such as breast cancer screening.

Fourthly, some State health authorities have responsibilities in the areas of food regulation and environmental health regulation, which in other jurisdictions are covered almost entirely by local government authorities.

Finally, States' expenditures vary because they make different policy judgments about the appropriate amount to allocate to different areas of public health services.

The following table does not include expenditure on the *All other core public health* category as the types of expenditure included within it vary significantly from State to State.

Table 13.5: Public health expenditure by States and Territories for each of the core categories

SUMMARY TABLE*		NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
Communicable disease control	$m	46.2	22.2	19.2	11.8	10.2	1.1	1.7	8.6	121.0
	Per person index	1.13	0.74	0.86	1.00	1.07	0.36	0.87	6.96	1.00
Selected health promotion	$m	43.6	26.5	24.1	18.7	17.8	1.5	2.5	12.5	147.1
	Per person index	0.88	0.73	0.89	1.30	1.53	0.41	1.02	8.33	1.00
Immunisation	$m	37.9	26.2	14.2	8.7	8.5	2.1	1.2	7.2	105.9
	Per person index	1.06	1.00	0.72	0.84	1.01	0.78	0.68	6.65	1.00
Environmental health	$m	10.5	5.5	6.6	6.8	4.8	1.7	0.6	3.4	40.0
	Per person index	0.78	0.55	0.89	1.75	1.53	1.74	0.93	8.43	1.00
Food standards and hygiene	$m	4.2	2.7	2.1	1.7	1.1	0.2	0.4	1.0	13.4
	Per person index	0.92	0.82	0.84	1.33	1.00	0.64	1.73	7.61	1.00
Breast cancer screening	$m	31.9	18.9	15.4	7.7	6.3	3.0	1.5	1.1	85.7
	Per person index	1.10	0.89	0.97	0.91	0.92	1.40	1.04	1.26	1.00
Cervical screening	$m	5.0	7.0	2.7	1.1	1.8	0.576	0.46	2.6	21.3
	Per person index	0.70	1.32	0.69	0.52	1.08	1.07	1.33	12.20	1.00
Total for the first seven core categories	**$m**	**179.4**	**109**	**84.2**	**56.6**	**50.4**	**10.2**	**8.3**	**36.4**	**534.3**
	Per person index	**0.99**	**0.82**	**0.85**	**1.08**	**1.19**	**0.76**	**0.95**	**6.70**	**1.00**

***** *Note:* Due to data deficiencies and differences outlined in Chapter 3, these data should not be used for comparative purposes.

Table 13.6 shows the percentage of expenditure by States and Territories on each of the core public health categories. The three categories with the largest expenditure in 1998–99 were *Selected health promotion activities*, *Communicable disease control* and *Immunisation*.

Table 13.6: Public health expenditure by States and Territories for each of the core categories as a percentage of total public health expenditure for each State and Territory (per cent)

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	All States
Communicable disease control	25.8	20.4	22.8	20.8	20.2	10.6	20.9	23.5	22.6
Selected health promotion	24.3	24.4	28.6	33.1	35.3	14.8	29.8	34.2	27.5
Immunisation	21.1	24.1	16.9	15.4	16.8	20.4	14.2	19.7	19.8
Environmental health	5.9	5.0	7.8	12.1	9.6	17.1	7.4	9.4	7.5
Food standards and hygiene	2.3	2.5	2.5	3.1	2.1	2.1	4.6	2.8	2.5
Breast cancer screening	17.8	17.3	18.3	13.6	12.4	29.4	17.6	3.0	16.0
Cervical screening	2.8	6.4	3.2	1.9	3.6	5.6	5.6	7.2	4.0
Total for the first seven core categories	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

14 Discussion and future direction

The collection of 1998–99 expenditure information across eight distinct public health expenditure categories marks the first collection of this type in the public health or population health arena in Australia. This report presents the information gathered in the 1998–99 collection and focuses on expenditure provided for public health by the various Commonwealth and State health departments.

14.1 Key findings

- Current data indicate that public health expenditure in Australia is approximately 2% of total recurrent health expenditure.
- $266m of public health services were provided by the Commonwealth Department of Health and Aged Care in 1998–99. This was 30% of total public health services expenditure. Commonwealth grants to the States and Territories comprised $192m or 22% of total public health services expenditure. In total, therefore, the Commonwealth in 1998–99 funded $459m or 52% of total public health expenditure provided by Commonwealth, State and Territory Governments.
- Total State and Territory expenditure on public health was $618m. Public health expenditure funded by States and Territories (excluding that portion funded by the Commonwealth) totalled $425m or 48% of government public health expenditure.
- The combined expenditure of Commonwealth and State Governments on core public health activities in 1998–99 was $884m.

14.2 Data deficiencies and differences

Although this report provides the most up-to-date information on public health expenditure in Australia, there are still a number of issues that need to be addressed in the collection of the data. Some of the deficiencies with the data in this report are:

- Some jurisdictions have provided expenditure based on accrual accounting concepts while others have provided cash data. This should be minimised by Stage 3 of the project when the Northern Territory will be the only jurisdiction to use cash data. New South Wales estimated that depreciation was 3% of their total public health expenditure and it is expected that most other jurisdictions using accrual accounting will have similar results.
- Technical Advisory Group members agreed to include in this report public health activities that were carried out by services other than public health services; for example, community based health centres. Jurisdictions will vary on the expenditure reported in this category as not all jurisdictions have included expenditure by community based health centres and those jurisdictions which have reported this expenditure have not necessarily included only the programs that have a population-wide focus.
- Boundaries were not set around the *All other core public health* category. Jurisdictions were advised to include in this category expenditure on public health activities that was not included in the preceding seven core categories and were given a list of some of the possible inclusions.

- Tasmania, the Australian Capital Territory and the Northern Territory are the only jurisdictions that have reported expenditure on centralised corporate and executive overheads in this report.
- Jurisdictions varied in the methodology used to collect the public health expenditure information. While most jurisdictions were able to identify the cost centres that relate to public health on a centralised accounting system, there were still differences found in whether the reporting system was administratively focused or activity focused. There were also differences due to the manual component of the collection. For example, South Australia, which did not have a completely centralised accounting system, had to do a partially manual collection from 97 agencies and seven regional health services. South Australia received responses from 88% of agencies and regional health services.
- Public health expenditure information from local governments was not collected in this report as this was not available due to the changing of the ABS Government Finance Statistics from cash to accrual.
- Public health expenditure information was not collected from non-health government departments or from those NGOs that had non-government funded public health expenditure.

14.3 Interpretation of results

The data must be interpreted cautiously as this information is being presented for the first time using this methodology. Although the definitions used are the same, the scope of the 1998–99 collection differs between 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 method that was used to collect the data and the interpretation that each jurisdiction had of the inclusions and exclusions under the public health expenditure categories. Thus it is not valid to compare the expenditure information contained in the State and Territory chapters.

It is also inappropriate to compare these data with the previous report on 1997–98 public health expenditure as the sources and methodology of collection of the two sets of data are different.

However, public health expenditure for the seven core categories (i.e. excluding 'all other core public health expenditure') as a proportion of total health expenditure *can* be measured validly for each jurisdiction using data from this report (see Table 13.6). Further reports on public health expenditure using the core public health definitions will enable comparative analysis to be made.

14.4 Future directions

The National Public Health Expenditure Project (NPHEP) aims to develop a complete picture of expenditure on public health activities in Australia by developing clear, comprehensive public health definitions to be used in the collection of expenditure information in an automated, routine and consistent fashion. It aims to develop a common agreed process for collecting public health expenditure data in Australia.

Refinement of categories for the 1999–00 report

The public health expenditure definitions for the 1999–00 collection of public health expenditure information have been revised to include two new categories, *Hazardous and harmful drug use* and *Research*. To enable more accurate representations amongst jurisdictions, the loosely defined *All other core public health* category has not been included for the 1999–00 collection. Expenditure from this category will now be included under the *Hazardous and harmful drug use* category, the *Environmental health* category or the *Public health related activities* category.

The 1999–00 core public health categories are:

1. *Communicable disease control*
2. *Selected health promotion*
3. *Organised immunisation*
4. *Environmental health*
5. *Food standards and hygiene*
6. *Breast cancer screening*
7. *Cervical screening*
8. *Hazardous and harmful drug use*
9. *Research.*

There will also be a category called *Public health related activities*. This category will allow jurisdictions to include expenditure on those activities that are related to public health and which are important to the public health strategy of each jurisdiction. The expenditure in this category will be kept separate and will not be included in the aggregate public health expenditure figures.

The NPHEP aims at expanding the Stage 3 collection of 1999–00 expenditure information to include local government and large NGOs that engage in public health activities covered under one of the NPHEP categories. The collection of such information in Australia will enable a more complete picture of public health expenditure to be obtained.

Usefulness of public health expenditure information

The NPHEP also aims to promote the link between public health inputs and outputs, so that constructive cost-effective analyses may be undertaken on public health interventions.

An evaluation of the effectiveness of a program requires collection of information on inputs, outputs and outcomes. For example, it is expected the BreastScreen program will produce a significant drop in mortality rates from breast cancer through early detection of breast cancers. In order to evaluate the effectiveness and efficiency of this measure, the cost of screening must be identified (cost of inputs), the number of screens done must be measured (outputs) and the change in breast cancer mortality rates due to the screening must also be measured (outcomes). If any of these pieces of information are missing then a full evaluation is not possible. The NPHEP is collecting data on the cost of inputs (expenditure), with the objective of collecting it in such a way that it can be related to outputs and outcomes.

Information on public health expenditure is useful for a number of reasons:

1. It allows for the monitoring of government expenditure and assists in making governments more accountable for their decisions.
2. It assists in the measurement of the cost-effectiveness of public health related programs.
3. It provides essential data for setting benchmarks that can be used to improve and monitor performance.

4. It provides a more reliable basis for making comparisons between investment in public health and investments in the rest of the health sector.
5. It enables international comparisons of public health expenditure.

The usefulness of these data will increase over time, as changes in public health expenditure can be monitored.

Defining public health expenditure offers an opportunity to explore and focus on costs of public health activities within an Australian setting. This information will be valuable in planning future public health policy and programs.

Appendices

Appendix 1: Definitions of priority core public health categories used in the 1998–99 collection

A1.1 *Communicable disease control*

- *HIV/AIDS, hepatitis C and sexually transmitted infection programs*
- *Needle and syringe programs* (formerly called 'Needle exchange programs')
- *Other communicable disease control*.

The public health component of the HIV/AIDS and hepatitis C strategies should include all activities associated with the development and implementation of prevention and education programs to prevent the spread of HIV/AIDS and hepatitis C. This includes those activities which aim to reduce the prevalence of sexually transmitted infections (STIs) among at-risk populations.

Public health expenditure in each sub-category should be identified. In some cases this will mean delineating between preventive expenditure and expenditure on treatment or diagnostic services. If it is not possible to delineate, it may be possible to estimate expenditure on prevention.

Expenditure on treatment or diagnostic services is not required.

HIV/AIDS, hepatitis C and sexually transmitted infection programs

Types of activities to be included:

- developing relevant policies and participating in relevant committees;
- consulting with community sector agencies regarding program priorities and delivery;
- promoting access to culturally appropriate services;
- implementing health promotion strategies aimed at increasing safe behaviour amongst at-risk populations including people living with HIV/AIDS (including through community sector agencies);
- providing sexual health services to at-risk populations to reduce prevalence of STIs, including testing for STIs (including HIV and hepatitis C), pre-test counselling for all STIs (including HIV), broad-based screening programs, and contact tracing;
- reorienting Indigenous health programs;
- minimising risk of transmission through occupational and non-occupational exposure through prophylaxis;
- supporting targeted training to ensure provision of best practice sexual health services for at-risk populations;
- surveillance;
- providing high-quality data to health professionals to improve service delivery;
- participating in initiating research to establish data to inform service provision; and

- funding to NGOs (for example, hepatitis councils, HIV/AIDS councils).

Types of activities to be excluded:

- all activities associated with the provision of a continuum of care for people living with HIV/AIDS and/or hepatitis C;
- counselling following diagnosis;
- treatment for sexually transmitted infections;
- specialist general practitioners for primary management of HIV/AIDS;
- access to HIV treatments and viral load testing;
- outpatient and ambulatory services;
- dental health services;
- welfare and housing referral services;
- peer support programs;
- in-patient services;
- diagnostic services;
- mental health services including care for people with dementia;
- community and home based care services;
- palliative and respite care services;
- maternity services; and
- ensuring viability of volunteer programs through access to training and support.

Needle and syringe programs (formerly called 'Needle exchange programs')

Generally, needle and syringe programs aim to reduce and prevent the transmission and spread of infectious diseases to individuals and the broader community through the provision of sterile injecting and disposal equipment.

To be included:

- education and training to needle and syringe labour force;
- provision of safe injecting equipment to needle and syringe sites throughout the State, including the cost of equipment, transport, and staff to deliver the service;
- administration of the program, including identifying new needle and syringe sites, negotiating services costs, addressing public concerns, and policy development;
- negotiation with pharmacies to support needle and syringe initiatives; and
- consultation with community agencies operating needle and syringe sites.

Other communicable disease control

Types of activities to be included:

- surveillance systems, screening, recording, notification and reporting systems;
- case response, contact tracing, investigation, disease outbreak planning and management;
- policy and support services specifically related to, or within, the CDC programs;
- provision and administration of vaccines with respect to disease outbreak management;

- provision of advice, education and training;
- funding for NGOs (for instance, hepatitis councils); and
- initial counselling for those tested.

Types of activities to be excluded:

- clinical and treatment services for CDC infections (including sexually transmitted infections);
- provision and administration of vaccines for immunisation programs (see *Immunisation*);
- referral, treatment and counselling for communicable disease infections;
- staff screening programs, staff immunisation and staff education;
- infection control practices in hospitals; and
- funding to non-government agencies for the provision of treatment based programs. (If possible, this should include discrete funding for each NGO in each category and a description of known services.)

A1.2 *Selected health promotion activities*

This information should be confined to expenditure on designated population health programs aimed at promoting healthy lifestyles, regardless of where the activity is carried out—for example, expenditure in hospitals or in community health centres which are part of the population health program should be included.

Where population health programs have a multipurpose health message, they should be allocated to the most appropriate category depending on their main objective.

Programs administered by non-health agencies or other expenditure such as ad hoc education provided in hospitals or community health centres are not to be included.

Programs may involve the following activities:

- healthy settings;
- nutrition;
- exercise and physical activity;
- personal hygiene and obesity;
- mental health;
- sun exposure and protection;
- school health;
- suicide prevention;
- injury prevention (excluding domestic violence);
- female genital mutilation;
- drugs of dependence (including alcohol and anti-smoking programs); and
- other multi-purpose health promotion.

Types of activities to be included:

- organised population programs—for example, healthy cities;
- health promotion and life promotion officers, public health nutritionists, where they perform duties within population health programs;
- funding for health promotion councils;
- development, administration, implementation and evaluation of policy, programs, guidelines and legislation;
- development and maintenance of health promotion databases (including data collection) where they can be separated from non-public health databases; and
- health sector input to cross-sector health education.

Types of activities to be excluded (only if not part of designated population health programs):

- information programs on specific diseases;
- screening for heart disease risk factors;
- community nurse activity;
- individual counselling and health education;
- research activities (for example, injury surveys);
- compliance with safety codes;
- treatment for stress or other mental health disorders;
- sexual health (see *Communicable disease control*);
- small-scale school education, dental services and baby clinics;
- domiciliary care and home nursing services;
- staff training, occupational health and safety education; and
- other campaigns funded outside of the health sector (*please note:* these campaigns should be described but no expenditure information is necessary).

A1.3 *Immunisation*

Childhood immunisation

This sub-category is organised childhood immunisation, as defined by the NHMRC schedule.

Pneumococcal and influenza immunisation

This sub-category is organised pneumococcal and influenza immunisation, as defined by the NHMRC schedule.

Other immunisation

This sub-category is other organised immunisation, as defined by the NHMRC schedule.

If possible, expenditure should be provided for each of the above sub-categories. If this is not possible, an aggregate of expenditure is acceptable.

Types of activities to be included are:

- promotion, distribution, provision and administration of vaccines listed above;
- immunisation clinics and school immunisation programs;
- immunisation education and awareness;
- immunisation databases and information systems; and
- staff vaccinations, where part of an organised immunisation program.

Types of activities to be excluded are:

- immunisation on detection of illness (this would be included in the *Communicable disease control* category).

Note: Commonwealth grants associated with essential vaccines will be reported separately.

A1.4 *Environmental health*

The definition includes the following programs:

- vector/rodent control (for example, mosquitoes, rats, fleas, ticks and mites);
- chemical regulation (excluding drugs and poisons, therapeutic/pharmaceutical goods regulation and licensing);
- water quality control and water fluoridation;
- Legionella control;
- contaminated sites (public health aspects);
- water environment—natural (public health aspects—for example, algal blooms);
- hazardous materials management (public health aspects);
- disaster management (public health aspects);
- environmental sampling/risk assessment (public health aspects);
- radiation safety and control; and
- solid waste and waste-water management.

Types of activities to be included are:

- development, review and administration of legislation, policy and/or regulations (within programs);
- health protection education (for example, safe chemical storage, water pollutants) and expert advice on specific issues;
- response to complaints, investigation of breaches of legislation and disease outbreaks;
- environmental health/surveillance officers (training and employment);
- surveillance, inspections, investigations to maintain standards (for example, water quality testing, sampling);
- provision of professional and technical support services (for example, vector control);
- administration of relevant legislation (for example, licensing of operators);
- maintenance of related databases (for example, issuing radiation licenses, national notifications);
- regulation and management of water fluoridation;

- public health components of assessment, remediation and management of contaminated land;
- public health components of assessing land development applications;
- health aspects of emergency management and disaster response;
- environmental sampling and risk assessment; and
- control activities for vectors/rodents (for example, land fill, spraying and baiting programs) undertaken by regulatory agency.

Types of activities to be excluded are:

- cost of complying with regulations and legislation;
- hospital infection control;
- treatment for infections;
- workforce testing or monitoring;
- installation and maintenance of systems (for example, waste disposal, storm water, air-conditioning systems);
- assessment of land development applications;
- protection of water courses and National Parks;
- recycling programs;
- infectious waste control (for example, public syringe disposal units); and
- environmental health protection research (if outside *Environmental health* programs).

Note: Local government involvement/administration of the above activities will be reflected descriptively.

A1.5 *Food standards and hygiene*

Includes total expenditure on *Food standards and hygiene*. Qualitative information should also be provided to describe services funded by State Government agencies but administered elsewhere—for example, local government.

Types of activities to be included:

- development, review and implementation of food standards, regulations and legislation;
- surveillance (including inspections), monitoring and enforcement of food standards (including food premises registers);
- testing of food by regulatory agency;
- education such as food safety awareness campaigns (suppliers and consumers);
- training and education for food handlers (including local government); and
- education and advice on food standards/requirements (for example, for food premises).

Types of activities to be excluded:

- compliance costs of industry associated with food regulations (for example, labelling and safe food handling practices); and
- testing of food by industry.

A1.6 *Breast cancer screening*

An aggregate figure is acceptable. Expenditures should be complemented with descriptive information, as necessary.

Types of activities to be included:

- organised breast cancer screening programs, including coordination, provision of screens and assessment services;
- development, review and implementation of breast screening policy and program management;
- management of breast cancer/screening registers;
- funding to non-government agencies for screening services;
- education and risk awareness for women and target groups on benefit of screening; and
- initial counselling prior to mammography.

Types of activities to be excluded:

- follow-up counselling and/or treatment for those diagnosed with breast cancer;
- public health laboratory services;
- workforce development and training if conducted outside programs; and
- breast cancer research if administered outside screening programs.

Note: For the purposes of this project, *Breast cancer screening* only includes: recruitment, screen taking, screen reading and elements for service management and program management. Assessment and fine needle biopsy are interpreted as diagnostic rather than screening services.

A1.7 *Cervical screening*

An aggregate figure is acceptable in this category. Descriptive information should accompany each estimate—for example, the percentage of screening undertaken by general practitioners.

Types of activities to be included:

- organised cervical screening programs, including coordination, provision of screens and assessment services;
- management of cervical cancer/Pap smear registers;
- development, review and implementation of cervical screening policy and programs;
- management (monitoring and evaluation);
- education and risk awareness for women, and target groups on the benefits of screening; and
- initial counselling prior to Pap smear.

Types of activities to be excluded:

- public health workforce education and training (if administered elsewhere);
- counselling and/or treatment for diagnosed patients; and
- public health laboratory services (if administered elsewhere).

A1.8 *All other core public health*

This category may include, but is not limited to, the following public health activities. Please include expenditure information relating to any other public health related activity in which your organisation is involved and which is not included in the core categories listed above. An aggregate figure is acceptable for this category.

- Poisons—regulation;
- Pharmaceuticals and therapeutic goods;
- Alcohol regulation;
- Tobacco control;
- Illicit drugs/substances control (for example, methadone program);
- Quarantine;
- Public Health Orders;
- Non-population health program health promotion;
- Human remains regulation;
- Air and noise pollution control;
- Laboratory regulation and quality control services; and
- Regulation of health facilities and services.

Appendix 2: National public health revenue for jurisdictions by category

Category	NSW	Qld	WA	SA	Tas	ACT	NT
Communicable disease control	888,452	19,694	41,037	89,654	10,359	—	—
Selected health promotion	822,661	47,533	553,344	94,739	—	—	—
Immunisation	117,515	60,617	41,138	81,433	—	—	—
Environmental health	189,236	574,360	1,032,988	936,790	24,849	300,000	64,486
Food standards & hygiene	18,418	—	—	3,241	—	100,000	—
Breast cancer screening	—	22,958	—	20,088	—	9,800	—
Cervical screening	67	—	—	5,989	—	—	—
All other core public health	—	3,507	—	815,425	—	524,990	—
Total	**2,036,349**	**728,669**	**1,168,507**	**2,047,359**	**35,208**	**934,790**	**64,486**

Appendix 3: Estimated resident population figures for the financial year 1998–99

New South Wales	6,376,185
Victoria	4,685,196
Queensland	3,483,373
Western Australia	1,846,233
South Australia	1,489,918
Tasmania	470,946
Australian Capital Territory	308,766
Northern Territory	191,471
Australia*	**18,852,352**
State total	18,852,088

* Includes Jervis Bay and other Territories.

Sources: ABS Cats. 3231.0, 3101.0 June qtr 99.

Appendix 4: Technical Advisory Group (TAG) membership

A4.1 Membership

Commonwealth	Ms Wilawan Kanjanapan, Mr Peter Woodley, Mr Brian Harrison, Mr Paul Currall
NSW	Mr Jim Pearse, Ms Teresa Kresevic
Vic	Mr Guy Nicholson, Mr Bill Vassiliadis
Qld	Mr Graham Jarvis
WA	Mr Alan Philip, Mr Clive Mulroy, Mr Ian Leslie
SA	Ms Joanne Cammans, Ms Barbara Hutchins
Tas	Mr Peter Bobrowski, Mr Craig Knight, Mr Ian Jordan
ACT	Mr Simon Lalor, Mr Andrew Hewat, Mr Raju Mahen
NT	Ms Heather Moyle
AIHW	Mr John Goss, Mr Cid Mateo, Ms Robyn Kingham Edwards, Ms Angelique Jerga, Ms Lucy Tylman

A4.2 TAG meetings

TAG 1	17 February 1999	Sydney
TAG 2	24 June 1999	Sydney
TAG 3	7 October 1999	Sydney
TAG 4	30 March 2000	Hobart
TAG 5	9 June 2000	Darwin
TAG 6	21 August 2000	Adelaide
TAG 7	18-19 April 2001	Perth

A4.3 TAG Teleconferences

17 December 1999

4 May 2000

4 July 2000

30 October 2000

13 November 2000

14 February 2001

Glossary

Accrual accounting	Revenue is recognised in the period in which the inflow of economic benefits can be measured reliably. Expenses are recognised when the consumption of goods and services is capable of reliable measurement.
Cash accounting	Revenues are recorded in the period in which cash is received, and expenses are recorded in the period in which cash is paid.
Centralised corporate services	Includes human resource management, staff development, finance and industrial relations.
Commonwealth Grants Commission (CGC)	Provides recommendations about how the Commonwealth might distribute the untied or general revenue grants it makes to the States and Territories according to the principle of fiscal equalisation.
Collection Manual	Document that lists and describes each of the eight public health expenditure categories. It outlines the expenditure information to be included in the report and provides instructions on completing the collection instrument.
Core public health categories	*Communicable disease control, Selected health promotion, Immunisation, Environmental health, Food standards and hygiene, Breast cancer screening, Cervical screening* and *All other core public health.*
Direct expenditure	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.
Government Purpose Classification (GPC)	Classifies current outlays, capital outlays and selected other transactions of the non-financial public sector in terms of the purposes for which the transactions are made.
Indirect expenditure	Includes public or population health program-wide services that are less specific, such as epidemiology units, or public health policy and strategy units. It will also usually include agency-wide services such as corporate services or the office of the Chief Health Officer. Public health program-wide services and agency-wide services need to be apportioned across categories to estimate the overall expenditure required to deliver a particular public health expenditure output.
Jurisdictions	States, Territories and the Commonwealth.
Koori	A term often preferred by Aboriginal people of SE Australia when referring to themselves.

Program-wide expenditure	Includes expenditure on 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.
Project coordinators	Representatives from State, Territory and Commonwealth Health Departments who coordinated the collection of public health expenditure information within their jurisdiction.
Public health	Organised response by society to protect and promote health, and to prevent illness, injury and disability. The starting point for identifying public health issues, problems and priorities and for designing and implementing interventions is the population as a whole, or population subgroups (NPHP 1998b).
Resource distribution formula	A planning tool that is used to guide the allocation of funding to Area Health Services in NSW.
SAS	A proprietary statistical software package.

Abbreviations and symbols used in tables

Not applicable	. .
Nil or rounded down to zero	—
Not available	n.a.

Abbreviations

ABS	Australian Bureau of Statistics
ACIR	Australian Childhood Immunisation Register
ACTGAL	ACT Government Analytical Laboratories
ADT	adult diphtheria tetanus
AHS	Area Health Service
AIDS	acquired immune deficiency syndrome
AIHW	Australian Institute of Health and Welfare
ANCAHRD	Australian National Council on AIDS, Hepatitis C and Related Diseases
ANZFA	Australian New Zealand Food Authority
AODP	Alcohol and Other Drugs Program
ARPANSA	Australian Radiation Protection and Nuclear Safety Agency
ATOD	Alcohol, Tobacco and Other Drugs
CDC	Centre for Disease Control (Directorate)
CDCB	Communicable Disease Control Branch
CGC	Commonwealth Grants Commission
DASC	Drug and Alcohol Services Council
DHAC	(Commonwealth) Department of Health and Aged Care
DHHS	(Tasmanian) Department of Health and Human Services
DHS	(South Australian) Department of Human Services
DTPa	diphtheria, tetanus, pertussis acellular (triple antigen vaccine)
GDP	gross domestic product
GFS	Government Finance Statistics
GPC	Government Purpose Classification
GPII	General Practice Immunisation Incentive
Health**pact**	Statutory authority concerned with health promotion in the ACT
HHARP	HIV, Hepatitis C and Related Programs
HIC	Health Insurance Commission
HSD	Health Services Division
MCC	Measles Control Campaign
MWHS	Mobile Women's Health Service
MMR	measles, mumps and rubella (vaccine)
NGOs	Non-government organisations
NHMRC	National Health and Medical Research Council
NPHEP	National Public Health Expenditure Project
NPHIWG	National Public Health Information Working Group
NPHP	National Public Health Partnership

NSB	Nuclear Safety Bureau
NSP	needle and syringe program
OATSIH	Office of Aboriginal and Torres Strait Islander Health
OECD	Organisation for Economic Cooperation and Development
PHD	Population Health Division (of the Commonwealth Department of Health and Aged Care)
PHOFA	Public Health Outcome Funding Agreement
QCSP	Queensland Cervical Screening Program
QHPS	Queensland Health Pathology Service
QHPSS	Queensland Health Pathology and Scientific Services
QNASP	Queensland Needle Availability Support Program
RDF	resource distribution formula
SAS	a statistical software package
SHANGU	Statewide Health and Non-Government Services Unit
SHine	Sexual Health Information and Education
SIP	Service Incentive Payment
STD	sexually transmitted disease
STI	sexually transmitted infection
TAG	Technical Advisory Group
TB	tuberculosis
TGA	Therapeutic Goods Administration
THS	[Northern] Territory Health Services
VicHealth	Victorian Health Promotion Foundation
WHO	World Health Organization

Abbreviations of places

ACT	Australian Capital Territory
NSW	New South Wales
NT	Northern Territory
Qld	Queensland
SA	South Australia
Tas	Tasmania
Vic	Victoria
WA	Western Australia

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