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CLERK OF THE SENATE

SIXTH INTERIM REPORT

of the

PARLIAMENTARY JOINT COMMITTEE ON SOCIAL SECURITY

on

A COMPREHENSIVE HEALTH SCHEME.

PART 1 - THE PROBLEM.

Terms of Reference.

1. Associated with the terms of reference of the Joint Committee on Social Security as resolved by Parliament on the 3rd July, 1941, viz., "To enquire into and from time to time, report upon ways and means of improving social and living conditions in Australia and of rectifying any anomalies in existing legislation", are health services for the Australian people.

2. Included among the specific proposals referred to the Committee by the Government, through the Minister for Social Services and Health on the 21st July, 1941, was "A Comprehensive Health Scheme" including -

(a) Child Welfare
(b) Maternal Welfare
(c) Nutrition
(d) Community Medical Service including Hospitalization.

3. On the 17th October, 1942, a letter was received from the Federal Treasurer requesting the Committee's advice concerning health services, with particular reference to such measures as it might be possible to introduce during the period of the war.

4. Compliance with this request necessarily involved consideration of health services as a whole, so that any measures recommended for introduction during the war should be integrated with a complete plan of health services for Australia, for introduction at a later stage.

WAR TIME MEASURES AND PLANNING.

5. In its advance recommendations to the Government by letter dated the 13th January, 1943 (Appendix "A") the Committee dealt particularly with wartime measures including -

(1) Services to be planned - some of which may be partially introduced - during the war, and

(2) Measures recommended for early introduction including -

(a) Financial measures to provide economic assistance to

(i) persons suffering from temporary incapacity;

(ii) expectant and nursing mothers; and

(iii) tuberculosis sufferers and their dependants;

(b) A grant of £50,000 to provide treatment for venereal disease and for educational purposes in this regard; and

(c) A grant of £100,000 for child welfare.

6. In this letter, the Committee drew attention to the shortcomings of the National Health and Pensions Insurance Act, 1938, and recommended that no action be taken to implement any of the provisions of that legislation in its present form; the Committee also gave it as its considered opinion that it is not possible successfully to introduce a comprehensive health scheme during the war, but stated that it proposed to proceed with the planning of such a scheme.

HEALTH SERVICE REQUIREMENTS.

7. The task confronting the Committee was to determine the nature and extent of Health Services necessary and adequate for the Australian people, and to make such proposals as would provide these services.

8. The conception of health services adequate for this purpose is one which provides the highest degree of physical and mental health attainable, through :-

(a) healthy social and living conditions, and the maintenance of economic standards sufficient to provide adequate nutrition for all in the community and facilities for

(b) the pursuit of positive health, the prevention and early detection of disease or physical defect, and

(c) the treatment and care of disorders and diseases.

9. As it concerns the control of Health Services generally in Australia, it is worthy of note that the decisions of the convention at Canberra in November, 1942, in enumerating desirable extensions of Commonwealth legislative power, included the clause "National Health Services in co-operation with the States". While there is uncertainty as to the legal interpretation of this clause and particularly of the words "in co-operation with", the fact that the convention's decisions have not been ratified leaves the present constitutional position unaffected unless some measure of further agreement between the Commonwealth and the States is reached. The alternative to a constitutional change is a financial grant by the Commonwealth to such States as agree to give effect to the proposed scheme for health services. Whatever may be the solution of the legal problem it is necessary to point out also that the successful introduction of any comprehensive scheme for health services could be accomplished only after discussions between all interested parties had resulted in mutual agreement on details. This implies inevitably complete co-operation between the Commonwealth and the States, the medical profession and the general public.

EXISTING FACILITIES.

10. Medical care in Australia is provided under two main headings, as follows :-

(1) "Positive Health", i.e. preventive medicine - which includes public health and research, and is financed very largely by Governments. Private medical men are not sufficiently associated with it at present.

(2) "Curative Medicine" - which includes :-

(a) general medical work, largely the province of private medical practitioners; and

(b) hospital care, partly the province of private hospitals, but increasingly controlled by public hospitals under Government or part-government direction.

POSITIVE HEALTH.

11. The Commonwealth and all State Governments undertake various aspects of "positive health" work or preventive medicine.

12. Protection against any invasion of the Commonwealth by infectious disease from abroad is afforded by the quarantine service which is staffed by the Commonwealth Department of Health.

13. The control of infectious diseases, the standards of food and drugs, the cleanliness of premises and the adequacy of water supplies and disposal services, are all the responsibility of State Health Departments, with decentralised control in the hands of local authorities. Research is undertaken by the Commonwealth and all State Departments, by a few hospital organisations and by still fewer specially endowed scientific institutions.

14. The general co-ordination of these aspects of medical care is attempted through the National Health and Medical Research Council of the Commonwealth, set up in 1937. This body, which meets twice yearly, includes representatives (three) of the Commonwealth Department of Health; the Directors of Health of each State Department of Health; one representative each of the British Medical Association, the Royal Colleges of Surgeons and of Physicians of Australasia; and of the (combined) Australian Universities having medical schools, and also two lay representatives. The Council discusses all important aspects of public health from time to time, compiles reports, and makes recommendations as to the best means of attaining uniformity in health policy, or undertaking any action that these discussions demonstrate to be appropriate. It also examines applications for assistance with scientific research proposals of a medical nature, and determines the distribution of Commonwealth funds available for research purposes. It has made important recommendations, among others, concerning public health, maternal and child welfare, national fitness, health protection by immunisation and other prophylactic measures, the investigation and treatment of cancer etc., and has set up a number of semi-permanent sub-committees to deal with particular aspects of the problem of medical care in Australia.

15. The powers of the Commonwealth are limited by the Constitution to "quarantine", but these have been expanded by agreement to include many other fields of activity. One of the most valuable of these is the establishment of laboratories at strategic points throughout the Commonwealth, e.g. at Cairns, Townsville, Rockhampton, Toowoomba, Lismore, Bendigo, Hobart, Launceston, Port Pirie, Kalgoorlie, Broome and Darwin. These not only assist medical practitioners with facilities for diagnosis and by the provision of protective serum, but they make special attempts to investigate local problems, e.g., silicosis at Kalgoorlie, W.A; tropical diseases at Cairns and Townsville, Queensland, and so on. The serums distributed are provided by the Commonwealth Serum Laboratories at Parkville, Victoria, which have grown to be an organisation of the very greatest importance, now supplying not only the needs of Australia and New Zealand but also, during the war, making valuable contributions to the needs of Africa and Southern Asia.

16. The School of Public Health and Tropical Medicine associated with the University of Sydney was erected by and is staffed from the Commonwealth Department of Health.

17. The Commonwealth has also initiated and financed pre-school child welfare clinics in each of the capital cities, and has co-ordinated and assisted the organisations for national fitness, which are operating successfully in all States.

18. War necessity has greatly advanced throughout Australia, the matter of industrial hygiene, especially from the point of view of workers in hazardous industries, and has brought some aspects of it into the Commonwealth field.

19. Originally, the responsibilities that were financed by governments were, until 1900, restricted almost entirely to the care of sanitation and control of infectious diseases. For this purpose the State governments have the ultimate assistance of all local authorities in the local government areas into which the whole populated portion of the Commonwealth has, for many years, been sub-divided.

20. The public has become so accustomed to the routine maintenance of sound sanitary conditions in premises in all the cities and towns that, mass interest has, during the last 40 years, been deflected to personal hygiene - the protection of the health of the individual from the cradle (and before it) to old age by the departments of public health; and mass attacks on problems such as tuberculosis, venereal disease, cancer etc. Governments, moreover, in pursuing these objectives, have found it necessary more and more to enter the field of public curative medicine, and to provide the essentials of general medical care to larger and larger sections of the public. This had led to a realization of the need for organisation of these multiple activities, and the study of means for that purpose has demonstrated a conspicuous lack of uniformity in the health services, both preventive and curative, existing in Australia.

21. The deficiencies in the public health provision may be summarised as being :-

(a) the restricted powers on the Commonwealth in respect of health;

(b) a lack of uniformity in the legislation for health and the organisation of health (including hospital) services in the six self-governing States;

(c) a needless separation of the health problem into unrelated parts under separate controls by failure to recognise their unity in essence;

(d) a lack of adequate training of medical students in public health as part of their medical course, with a consequent ignorance of and indifference to the subject among medical practitioners;

(e) the tendency for medical men to seek their living where they can best find it, which is neither in public health work nor in research, and

(f) the fact that far too few full time medical positions exist in State or Commonwealth health services and those that do are often unattractive because of the excess amount of office routine and because of lay control or interference in respect of specialised programmes;

(g) the lack of standardization with regard to infectious diseases hospitals and technique; and the need for the establishment of infectious diseases hospitals on a basis plan throughout the Commonwealth in accordance with population distribution and infection risk.

MEDICAL CARE.

22. Though the standard of medical practice in Australia is undoubtedly high, the conditions of private practice under which by far the greater part of it is carried on, exert undue strain on the doctor while at the same time they render the service unequally available to all sections of the population. To that section - the middle income group - of the population which is ineligible to receive the free treatment provided to the poor by combined charitable and government agencies, and by individual doctors, and which at the same time is not financially able, as are the rich, to meet the large unexpected increases of expenditure which illness may bring about - real hardship is often caused. Only a relatively small proportion of this section is relieved from this position to any extent by the various benefit and insurance funds set up by Friendly Societies and other such organisations.

23. In general, curative services, except for the indigent, have until recently been provided by private medical practitioners and practising specialists in private and public hospitals. For efficiency and economy, the organisation of public hospital services has gone on increasingly, and the number of full time salaried medical men, now working in public hospitals, is great and is increasing. There is beginning to be, therefore, an appreciable proportion of medical men occupied either as full-time government medical officers, medical superintendents and medical officers in hospitals, and research workers, although this tendency is more marked in some States than in others.

24. In Tasmania it has recently become the policy of the government to provide salaried medical officers to carry out both preventive and curative medical work over a large part of the whole State; in Queensland the policy of providing fulltime officers and, occasionally, complete full-time staffs to the base hospitals dominating various health districts, has been increasingly evident.

25. In certain remote areas of Western Australia, salaried medical officers are appointed for a limited term as members of the Flying Doctor Service and provide both preventive and curative care.

26. In the Northern Territory of the Commonwealth a full-time government salaried service exists to the exclusion of all private medical practice.

27. In Queensland, alone among the States, an endeavour has recently been made to define the conditions under which medical men may set themselves up as specialists, by the institution of a "Register of Specialists" governed by statute; moreover, the specialist services provided to the large Brisbane Hospital, which were formerly, as in all other States, provided on an honorary basis, have now been made part-time salaried posts.

28. Nevertheless, the great mass of medical care is undertaken by medical men under private practice conditions and an unfortunate result of such conditions is seen in the distribution of doctors in relation to population. The more attractive residential suburbs, where need for medical care might be expected to be less, are generously supplied with doctors. Unattractive industrial suburbs, where economic factors operate most strongly to produce accidents and diseases, are under supplied. Country districts, particularly

those remote from a large town, are badly supplied with medical aid.

29. An obligation rests on any government desiring to safeguard adequately the health of its people and the welfare of all sections, which can be expressed in simple terms thus -

(a) To render good medical aid equally available to all classes and so far as possible all individuals in the community; and

(b) To work for the improvement of the standard of the medical profession generally by -

(i) increasing facilities for research;

(ii) by making possible to every medical practitioner frequent refresher courses of post graduate study; and

(iii) lessening the strain on individual members of the profession.

HOSPITAL CARE.

30. Hospital services are provided under a system of government, public and private hospitals of very great variety and of different standards of efficiency.

31. The government and public hospitals generally provide accommodation and treatment for public patients unable to make any, or more than a partial contribution towards the cost of their maintenance. This necessitates the major cost of the service being provided at government expense, or from funds raised by public subscription or organised appeals.

32. Some public hospitals, however, have in recent years developed "intermediate" and "private" sections where accommodation is provided for patients able to pay in full.

33. In the Northern Territory medical and hospital services are financed by a tax for this purpose imposed on all residents, and these services, therefore, are provided free by a salaried medical service and by government hospitals.

34. Private hospitals are conducted as business undertakings or as a form of denominational service and, in all cases, patients are required to pay the full cost of the service provided.

35. Some of the larger of these institutions are well equipped and do substantially relieve the demand on public hospitals. For economy reasons the smaller type of private hospital, however, is not organised or equipped to give adequate service to patients in accordance with modern standards.

36. Special hospital services are provided for tuberculosis and mental diseases, but these are, in the main, controlled and financed by the Government.

37. It is here necessary to make some general observations to indicate the nature and extent of the hospital problem -

38. The quantity of hospital accommodation : Assuming the present population of Australia to be 7,150,024 the standard requirements of beds in general hospitals is 64,350, in hospitals for tuberculosis 5,492 and in mental hospitals 32,169. The beds available in the 1,809 hospitals in Australia are general hospitals 57,660; tuberculosis hospitals 2,439 and hospitals for mental diseases 25,175.

39. Deficiencies of beds are, therefore, general beds 6,774; (allowance is made for 84 beds for venereal diseases for which there is no accepted standard); tuberculosis beds 2,963 and beds for mental diseases 6,994 total 16,731 beds. This approach considers the problem on a broad basis for the whole of Australia. It must, however, be viewed in relation to each metropolitan area and each country district of each State. It is evident that there is a serious deficiency of hospital accommodation in Australia, which, on dissection, is most acute in the capital cities of the mainland.

40. There is evident also, a failure to classify hospital beds. The chief deficiencies exist in the provision of sufficient accommodation for sub-acute and chronic diseases and for convalescent patients.

41. It would seem that very little relief can be expected from the use of military hospitals after the war.

42. The quality of hospital accommodation : The quality of hospital accommodation for both patients and staff in the hospitals of Australia leaves much to be desired. The number of hospitals which can be regarded as measuring up to world standard of quality is extremely small.

43. Location is in many cases bad; there are defects of construction and planning for expansion; equipment generally is of low standard especially in facilities for the primary need of surgical asepsis; there are menaces due to uncleanliness and to unnecessary exposure to infection and many hospitals lack adequate staff.

44. Proper diagnostic facilities (X-ray and laboratory) are very deficient in country areas.

45. It will be seen, therefore, that there is need for considerable increase in the quantity of hospital accommodation and for a vast improvement in the quality of hospital equipment and service, especially in the direction of additional diagnostic services in the country.

46. Outpatients services; Persons seeking outpatient treatment in our capital cities must attend centralised outpatient departments and here congestion and a long waiting period is the rule. This frequently involves the patient in many visits, each possibly covering wearisome travelling and expense which imposes hardship and unduly long absence from work or neglect of household duties.

47. Maternal and Infant Welfare : Apart from a few modern maternity hospitals throughout Australia, facilities for maternal and infant welfare are conspicuously lacking in proper standards of accommodation and equipment and many such hospitals should not be permitted any longer to function.

48. Tuberculosis : Facilities for the accommodation and treatment in hospitals and sanatoria of tuberculous patients are tragically short of urgent requirements. Arrangements for the early detection of tuberculosis by systematic examination and for the occupational rehabilitation of those who are past the infective stage, are hopelessly inadequate. There is also no proper provision for the financial relief of the dependants of patients who, in the interests of the community, must be placed in hospital and sanatoria.

49. Mental Diseases : The bed accommodation available for patients suffering from mental diseases falls short by 6,994 beds of standard requirements. The provision of this type of accommodation is remarkably constant in all States (mean provision for Australia 3.4 beds per 1,000 population) but gross overcrowding is apparent everywhere. Generally the treatment of mental diseases throughout Australia is in a most unsatisfactory state and urgently requires modernising and improving.

NURSING SERVICES.

50. There are anomalies in conditions of training, rates of pay and conditions of employment in the various States. The standard of accommodation in hospitals for nursing staff is deficient in quantity and, on the average, poor in quality in a great number of hospitals. There is a gap between the school leaving age and the age at which a girl enters on nursing training. There is evidence of a decreasing number of girls entering the nursing profession and the quality of the type offering is not up to the standard previously applied.

ANCILLARY SERVICES.

51. These include Laboratory, X-ray, Physio-therapy, Almoner, Dietitian etc. There is a great deficiency in the provision of a good standard of service in these aids to diagnosis and treatment which is particularly marked in country districts. Even in some districts where buildings and equipment are provided, they are not functioning because of lack of trained staff.

National Health Insurance.

52. National Health Insurance has never been part of the Health and Medical Services of this country. In Great Britain and in some other countries, it has become, during the last 30 years, one of the major factors in the Medical care of the public, though its incompleteness has been freely admitted.

53. At the time of its introduction, it was hoped that the National Health and Pensions Insurance 1938, might represent an advance upon the health services then available to the general public throughout Australia. It was certainly an acknowledgment that in some respects there were deficiencies in such services and that there was a need for more comprehensive services of a uniform nature. This need has never been met.

54. The Committee is impressed by the existing widespread opposition to the proclamation of this Act, and concludes from it that the scheme there suggested is unsuitable as a permanent basis for social benefits or health services for the people of Australia. In particular, the Committee has observed:-

(a) the absence of medical benefits for the dependants of an insured person;

(b) the absence of provisions for hospital service, or maternal and child welfare;

(c) the limitation of benefits to a specified income group;

(d) the association of medical benefits and cash benefits under one administration;

(e) the absence of any provision for assistance during periods of unemployment (one of the chief causes of malnutrition and ill health); and

(f) the disadvantages inherent in the method of payment for medical services proposed, viz. capitation fee and panel system.

55. In our opinion, this Act lacks provisions that are essential to any comprehensive health service adequate for the needs of the

community as a whole, and fails to provide an acceptable basis upon which any such service may be satisfactorily planned. We, therefore, favour the repeal of this Act.

ALTERNATIVE PROPOSALS.

56. There are many divergent views within the medical profession in Australia as to the health service best suited to Australian conditions. Both the National Health and Medical Research Council, however, and the Federal Council of the British Medical Association in Australia, agree that its essential principles must be :

(a) to provide a system of medical services directed towards the achievement of positive health and the prevention of disease and the relief of sickness; and

(b) to render available to every individual all necessary medical services both general and specialist and both domiciliary and institutional.

57. Throughout its inquiry into health sergices the Committee has sought the opinions of representative members of all sections of the people over the widest possible field including State Governments, Commonwealth and State health authorities, the medical profession and related activities and the general public including social, political and industrial organisations.

58. At the outset, the chief proposals for investigation before the Committee were two, viz :-

(1) The recommendations of the National Health and Medical Research Council, as contained in the reports of the 11th and 12th sessions (July-November, 1941). These set out a tentative outline for a comprehensive health service for Australia, including both the preventive and curative aspects of medical care under Commonwealth control and by means of a full-time salaried medical service (see Appendix "B")

(2) A General Medical Service for Australia, as outlined by the Federal Council, B.M.A., in Australia, in its memorandum dated September, 1941 (See Appendix "C")

59. In addition, the Committee had available to it details of the plan provided by the New Zealand Social Security Act 1930, for health and other benefits and, in particular, Medical benefits (provided under two alternative systems of payment to doctors, viz. a capitation fee system and a fee-for-service system), Maternity benefits, hospital benefits, pharmaceutical benefits, and ancillary services benefits including massage, dental and diagnostic aid services. The Committee also had the advantage of discussions in Australia with the Chairman, Social Security Commission and the Secretary, Department of Health, New Zealand.

60. Although the proposals for health and rehabilitation services contained in Sir William Beveridge's report to the British Government (Assumption "B"), leaves much detail to be developed, access to this document has also been of considerable assistance to the Committee.

61. All the proposals mentioned may be accepted as aknowledgments of the need for improved and more complete Health Services more fully available to all sections of the people under existing conditions.

Health Council Plan.

62. The proposals of the National Health and Medical Research Council were prepared as a basis of discussion. At the request of this Committee, these were later supported by estimates of the costs of the various services suggested and other financial details.

63. The Council prefaced its recommendations by a statement of certain general principles. The first and most important of these was that health is no simple matter but is determined by a complex of social conditions; the next that the obligations of the community in the maintenance of community health cannot be discharged if the community does not provide sufficient funds to enable the public health departments to do those things which in their opinion should be done; that it was of the utmost importance that a higher state of personal health should be established and maintained throughout the whole community, and that all the necessary powers and resources of both Commonwealth and State should be applied to ensure this result; that the rapid development of medical practice along lines of specialised work had produced a complex of unco-ordinated activities all concerned with the care of individual health but becoming more and more divorced from the principles of prevention of disease, because of a lack of any proper administrative organisation for bringing together all aspects of medical care.

64. The Council accordingly recommended that :-

(a) the whole populated area of the Commonwealth should be divided into Health Districts which should also be hospital districts as far as possible;

(b) A District Health Officer should be appointed to each Health District (or to two or more combined) Each District Health Officer should be an Officer of the Central Health Department of the State and should be directly appointed by Commonwealth or State. His activities should cover a wide range and, among other things, the supervision of all health legislation and preventive medicine in his district and co-operative association with hospital services;

(c) the hospital services throughout the populated area of the Commonwealth should be arranged on a district hospital system with base and subsidiary hospital centres. Local centres should be staffed by local medical men, the central hospitals kept for specialist cases. (Elaborate provisions were laid down for staffing the whole system by salaried medical men with the proviso that the Council considered that these proposals were not inconsistent with the retention of private medical practice and private hospitals).

65. The far reaching nature of the proposals - particularly those relating to a full-time salaried medical service and the establishment of health centres in strategic localities, including country towns, as bases for such a service - provoked keen discussion and differences of opinion among members of the medical profession.

66. The scheme (other than certain schedules) was published in detail in the Medical Journal of Australia of December 20th, 1941, and was thus made available to the great majority of medical practitioners in Australia. In 1943, following a revival of interest in proposals for a salaried service, special meetings of State branches

and of the Federal Council of the B.M.A. in Australia were called to discuss the future of medical practice and, especially, any proposals for a salaried medical service.

67. The Committee, after considering the published reports of certain of these meetings, and the evidence given before it by witnesses, is of the opinion :

1. That a substantial majority of medical practitioners object to a general salaried medical service on lines laid down by the National Health and Medical Research Council or any other lines put forward up to date.

2. That, on the other hand, there is general agreement that a salaried medical service may be justified in remote areas;

3. That there is practical unanimity of opposition from all private medical witnesses to any proposal for control of any general health service by any government department; and support for control by an independent body or commission, including a majority of medical men, if such a general health service should be introduced.

4. That there are indications that a more favorable attitude towards a salaried medical service may exist among medical officers of the fighting services; but it is not possible accurately to assess the situation without consulting every member individually.

68. There is general agreement among witnesses that hospital services should be greatly improved and placed under a uniform system of control, and also that uniform standards should be established and strictly maintained. There is general support of the proposal for the establishment of health clinics in suburbs to decentralise out-patient services and, generally, as an encouragement to the development of group medical practice.

British Medical Association Plan.

69. Recently the Federal Council British Medical Association reviewed its 1941 plan and in its place submitted to the Committee on 20th May, 1943, a new set of proposals containing a statement of "general principles" governing health services.

These were primarily four in number as follows :-

I. That the system of medical service should be directed to the achievement of positive health and the prevention of disease no less than to the relief of sickness.

II. That there should be provided for every individual the services of a general practitioner or a family doctor of his own choice.

III. That consultants and specialists, laboratory services, and all necessary auxiliary services together with institutional provision when required, should be available for the individual patient, normally through the agency of the family doctor.

IV. That the several parts of the complete medical service should be closely co-ordinated and developed by the application of a planned national health policy.

70. Apart from this general declaration the chief features of this document are :-

(a) Opposition to any drastic change in medical services during the war and for one year thereafter.

(b) Opposition to a Nationalised Salaried Medical Service with consequent abolition of private practice.

(c) Offer of willing co-operation in effecting certain improvements considered essential by the B.M.A., in existing medical services.

(d) As a development of III above :

Optimum efficiency of medical service by utilising the existing consultant, general practitioner and hospital services but with additions including nutrition and housing standards; research; decentralised diagnostic centres; extended consultant services; group practice; extended flying doctor services; subsidisation of practitioners in outback centres; extended industrial, venereal, immunological and other preventive medical services, and maternity services;

Extended hospital and equipment facilities for tuberculosis and mental diseases, the crippled, bedridden and aged "private" and "intermediate" wards in hospitals, and

Subsidised extended post-graduate training.

(e) Control by a corporate body including lay members and medical men - the latter to constitute a majority and to be nominated by the practising medical profession; and

(f) Disciplinary control by the medical profession only, of members accepting service.

71. The experience of National Health Insurance and the prolonged but inconclusive negotiations to arrive at a basis of payment for medical service under the 1938 Act have unquestionably influenced the attitude of the medical profession generally to any national health service. Notwithstanding this, good relations have been established between the Committee and the Federal and State Councils of the B.M.A., and with medical practitioners generally including non-members of the Association. We record our appreciation of the co-operation of all witnesses and the frank way in which they have expressed their views. The Committee believes that it has thus been enabled to correctly assess the merit and acceptability of the various views and proposals submitted to it.

PART II - SUGGESTED SOLUTION.

PREVENTIVE HEALTH.

72. At this point the Committee thinks it imperatively necessary to declare, with the utmost possible emphasis, that no policy of preventive or curative solicitude for public health can succeed in a community which does not give economic security to all its people.

Adopting an ancient maxim, the Committee affirms that a nation must guarantee to each of its members an assured livelihood before it can promise him that irreducible minimum of health without which he can be neither a fully useful citizen nor a normally happy human being. Having sounded this warning note, the Committee returns to the task, that Parliament has set it, of reporting upon one phase only of national life, considered for the moment, as if it could be isolated from all other phases.

73. Up to the beginning of the present century it was commonly believed that 'public health' consisted only of measures for the sanitation of premises, the inspection of foods and drugs, the distribution of pure water supplies, the regulation of buildings, the provision of sewerage, the adequate disposal of nuisances and refuse, regulations for marketing and the lighting of towns, provisions for the burial of the dead without injury to the living, and the control of infectious diseases and of causes that might set them up.

74. The utilization of government funds for these purposes was regarded as normal, but there was some tendency to consider that, except for the provision of hospitals for the destitute, any other expenditures were unjustified.

75. In the more recent years it has come increasingly to be recognised that a considerable number of measures effected the health of the public and, that in fact, expenditures upon any one of these, or all of them are not only justified but are economic measures of great value which saves considerable costs later on. It is also becoming recognised that it is extravagant to go to great lengths to cure people of the immediate effects of disease and then to allow them to return to circumstances likely to break down the good work done or to re-establish the disease itself.

76. It follows from this conclusion that the problem of health must be regarded as a single problem and that the preventive aspect must permeate every section of it. This indeed is the teaching in the most advanced medical school. Moreover, it is recognised that the government may logitimately spend money upon any aspect in which private enterprise is unable to handle situations detrimental to the welfare of the people, or to initiate action in any neglected field.

77. Recognising the unity of the problem, its main section may be set out under appropriate headings such as :

Protective activities;
Specialised activities for safeguarding maternity;
Corrective activities;
Adaptative activities, sociological as well as medical;
Economic accessory activities; and
Educative Activities.

78. Since these activities form a complete picture of health work and since there is a definate public health aspect in every one of them, as will be obvious, they may be set out in detail as follows :-

<u>Protective activities</u>, including -

(a) the sanitation of environment; the health standards of housing;
(b) the care of the quality, quantity, and balance of foods;
(c) the specialised protection of certain age-groups and states, e.g. mothers; infants and pre-school children; school children; young workers in industry; aged persons; etc.

(d) specialised measures against certain diseases, e.g. active immunisation against diphtheria and whooping cough; routine X-ray examination of chests in some occupations and age groups; risks in respect of industrial diseases; prophylactoria of various kinds, etc;
(e) isolation or quarantine measures for infected persons, carriers and contacts;
(f) the provisions of recreation facilities and other deliberate provision for physical fitness and positive health.

79. Specialised activities for safeguarding maternity :

(a) training the mother in ante-natal and post-natal needs;
(b) infant feeding and infant welfare centres in conjunction with 1(c);
(c) the care of parturient women in hospitals; and in their own homes;
(d) district nursing in certain circumstances;
(e) see 5 (a), (c) and (d).

80. Corrective activities - including -

(a) hospitals for the treatment of infectious diseases;
(b) hospitals for general surgical and medical cases;
(c) hospitals for special remedial measures, e.g. fracture clinics; venereal disease clinics; tuberculosis clinics and sanatoria; orthopaedic hospitals; special senses clinics; cancer hospitals, etc;
(d) hospitals for chronic and convalescent cases;
(e) hospitals for mental sickness;
(f) the provision of adequate nursing and ancillary personnel for the medical care of all sick persons.

81. Adaptative activities - sociological as well as medical, having as their objective, the rehabilitation of persons recovered from immediate illness, or, the conservation of remaining physical or mental capacities in persons handicapped by permanent injuries;

(a) institutions for the blind; the deaf and dumb; or persons otherwise crippled;
(b) institutions for occupational therapy applied to the needs of epileptics, mental defectives, etc.

82. Economic accessory activities - including -

(a) "follow up" assistance for convalescents; or for recently confined mothers returning with infants to their homes;
(b) allowances to assist to maintain family or home security during the treatment of a breadwinner in hospital, e.g., for tuberculosis;
(c) the provision of creches and kindergarten facilities for the day care of the children of working mothers;
(d) actual domestic assistance during late pregnancy, childbirth, and for an adequate period thereafter;
(e) other allowances and pensions.

83. Educative activities :

(a) Research;
(b) medical, nursing and ancillary training to prescribed standards;

(c) educative health propaganda.

(All three are shared with university bodies and other voluntary or quasi-governmental agencies).

84. The Royal Commission of 1871 in England "diagnosed with unfailing accuracy", as Sir George Newman points out, the defects which at that date hindered adequate sanitary protection of the population. They were set down by that Royal Commission as follows :-

(a) the variety and confusion of authorities concerned in the public health;

(b) the want of sufficient motive power in the central authority.

(c) the non-coincidence of areas of various kinds in local sanitary government;

(d) the number and complexity of enactments;

(e) the needless separation of subjects;

(f) the leaving some general of Acts to voluntary adoption, and the permissive character of other Acts; and

(g) the incompleteness of the law.

85. The whole of these defects are present in Australian public health administration today, and must be corrected if the efficiency in public welfare is to be achieved. It is recommended, therefore, that -

(1) there should be a definition by agreement of the responsibilities respectively of the Commonwealth, the State, and local governments;

(2) that in order to obviate the non-coincidence of health and hospital areas that the whole populated portion of the Commonwealth should with the consent of the States be sub-divided into "Health Districts", each sufficiently large, well populated, and affluent, to cope with all the administrative problems of health efficiently.

(3) that, in particular, the treatment of infectious diseases should be restricted to appropriately staffed and suitably built hospitals, bearing in mind the fact that at the present time there is an unnecessary multiplicity of small infectious diseases wards attached to country hospitals; that they are seldom used, and almost never efficiently equipped or conducted in accordance with the dictates of preventive medical practice, insofar as isolation of patients and staff is concerned.

(4) that training in the principles of public health be considerably higher than is now the custom, be obligatory inclusion in all universities having medical schools subsidised by the State and, the rudiments of health education be included in the school courses in all States.

86. Apart from the immediate considerations affecting sanitation and the control of infectious diseases, there is an urgent need for appropriate government action to control as a national

problem mental disease, tuberculosis and venereal disease among a variety of other social problems discussed elsewhere.

TUBERCULOSIS.

87. The present position regarding tuberculosis in Australia is a reproach to all who, possessing knowledge of the facts, have not done everything in their power to secure substantially improved facilities and increased financial provision to provide for early detection of the disease, economic security for the tuberculous and their dependants, and modern facilities for treatment and, in suitable cases, occupational rehabilitation. Had these adequate services been provided, tuberculosis in Australia would nowbe a rare rather than a relatively common disease.

88. It is estimated by public health authorities that there are in Australia today approximately 30,000 cases of tuberculosis most of whom are in need of, and would greatly benefit by, modern treatment. But as notification of this disease, though legally compulsory, is very ineffectively carried out, it is impossible to estimate the total incidence of the disease in its various forms. Most important, although the numbers cannot be assessed, are those who are unknowingly suffering from the disease in an incipient form and who would also benefit from early treatment and a period of industrial convalescence.

89. In its recommendations to the Government (see Appendix "A" dated 13th January, 1942, the Committee dealt with the economic aspects of the tuberculous. We drew attention to the unanimous opinion of medical authorities that the economic factor was of primary importance and was considered the most important factor in the campaign against tuberculosis, and recommended payment of special rate pensions to the tuberculous and dependants allowances approximating a weekly amount of £4.3.0 for a man, wife and children.

90. The matter has on several occasions been considered by the National Health and Medical Research Council whose recommendations have not been given effect. It was dealt with exhaustively by Dr. M.J. Holmes in a noteworthy report (Appendix "D") to the Federal Health Council dated the 1st March, 1929, which, had it been acted upon, would have resulted in a marked improvement in the position. Regrettable as the delay has been, it is not too late to remedy the situation, though in the interim valuable lives have been lost and needless suffering has been caused.

91. How then is this insidious disease to be effectively combatted?

92. Expert medical opinion considers that the essential activities of a tuberculosis service can be broadly grouped under three main headings :-

(1) Search for persons who have a tuberculosis infection sufficiently developed to warrant the use of the word "disease", either active or inactive.

(2) Treatment of the disease in a sanatorium; and

(3) After-care and rehabilitation of patients discharged from the sanatorium.

92. Because of the economic factors already referred to, the patient - where he is the breadwinner - is reluctant to stop work and leave his family unprovided for, until with the development

of the disease, his physical condition compels him to do so. He is then in a much more serious condition and the prospects of a cure are proportionately lessened. Meanwhile his family and associates have been exposed to active infection.

93. In evidence before the Committee, Dr. Bruce White, who has considerable specialist experience in tuberculosis stated :-

> "I regard the tuberculosis problem as being essentially an economic one. The disease, in my opinion, definitely thrives in conditions of poverty. Those patients whose economic status is good on the whole do far better than the poor. I attribute this largely to freedom from want, and, to a certain extent, freedom from worry - although even amongst the wealthy a certain amount of worry about the complaint must always exist.
>
> The remedy must be full provision for food with the very best, including unlimited supplies of milk, eggs, butter and other goods, not only for the individual affected, but for his immediate contacts. In addition, there must be full provision for housing and clothing of the contacts, particularly where the breadwinner is the victim. The present pension rate together with child endowment and other allowances is ridiculously low".

This view is supported generally by medical witnesses.

94. For the reasons set out in the Committee's letter of the 13th January, 1943, we most strongly urge the earliest possible adoption of the recommendations therein made for the payment of special rate pensions to the tuberculous and allowances to dependants. It is realised that this will involve a considerable expenditure, but it should be remembered that this is inescapable if we are to grapple with this disease which, while it remains unchecked, will continue to account for a great deal of economic wastage in manpower apart from the distress and loss of life occasioned thereby.

95. Having established economic conditions conducive to a successful anti-tuberculous campaign, much systematic remedial action remains to be initiated.

DETECTION OF THE DISEASE IN EARLY STAGES.

96. Proposals for the locating of sufferers from tuberculosis in its early stage, when a complete cure is most likely to result from prompt and expert treatment, which are endorsed by high medical authorities include :-

(1) skin testing by the "Mantoux" method of young children at school age, and continued at five yearly intervals;

(2) mass miniature X-ray examinations of the population on a systematic and uniform scale, and particularly of adolescents at the age of 15 years and into adult life.

(3) provision of chest clinics and chest hospitals, where patients could be examined and can be accommodated for observation, diagnosis and treatment, and where X-ray and other diagnostic aids would be readily available;

(4) improvement in, and modernisation of, methods of diagnosing and treating tuberculosis as taught to students at teaching hospitals attached to medical schools.

97. Skin testing is a very simple process and only involves the application of harmless fluids. If properly organised, it could be undertaken by school medical officers when children first attend school, or by attendance at a clinic equipped with suitable facilities for this service. If done in the home, the co-operation of the medical profession would be necessary. In any case, the public would need to be educated to the advantages of skin testing so as to secure the co-operation of parents, and the organisation of a programme on a systematic basis for testing all children.

98. The public would need also to be educated to the value of submitting to mass miniature X-ray examinations, which can be carried out at very small individual cost. A valuable 35 millimetre X-ray survey has been initiated by the anti-Tuberculosis Association of New South Wales, and carried on for the past three years. It recently carried out the examination by this process of the employees of a large industrial concern, with very successful results. Such an examination of the public has, for some time, been conducted by the City Medical Officer of Health in Adelaide, with distinctly beneficial results. Efforts are being made to institute similar examinations by other local health authorities in several States, but difficulty is being experienced in securing the necessary equipment, of which there is a scarcity owing to war time priorities. Much preparatory work can now be done, however, and at the termination of hostilities a considerable amount of valuable and suitable equipment will be released for civil use by the defence medical services, who have successfully used miniature X-ray photography for the examination of all enlisted personnel. In view of the particular susceptibility of tuberculosis of adolescents special facilities should be provided for such examinations to be made of all in this age group, and continued, periodically, until the early years of adult life. While miniature X-ray examination is not claimed to be conclusive in its results, it is acknowledged as the most valuable <u>preliminary</u> examination that can be made for a large number of people at a reasonable cost, and the most important single procedure in the diagnosis of tuberculosis.

99. There is unanimous agreement among competent medical authorities as to the essential need for the establishment of well equipped chest clinics at general hospitals in all the larger centres of population, where suitable facilities and equipment should exist for observation and diagnosis, and where suspected tuberculosis sufferers should be accommodated under congenial conditions. Severe criticism has been made of the locality and conditions surrounding at least one such clinic in a large city. It is recognised that valuable work is being done at the few existing clinics in Australia. In his report already referred to, Dr. M.H. Holmes makes a strong case for the provision of chest clinics, and this also is strongly advocated by the National Health and Medical Research Council (see Report dated 3rd February, 1937) and by all tuberculosis specialists who have submitted evidence on the subject. It has been estimated that a suitable and well equipped clinic with accommodation for twelve beds would cost in the region of £20,000 - one clinic per 150,000 people has been suggested. A specially trained staff would need to be provided, but this could be arranged in consultation with the hospital authority concerned, or, if found necessary, by special courses of training to be instituted. It is considered that the Tuberculosis physician in charge of such a clinic should be a salaried medical officer devoting his full time to the work.

100. In furtherance of its active campaign against tuberculosis, the Anti-Tuberculosis Association of New South Wales has established a diagnostic and therapeutic clinic in the Sydney metropolitan area, complete with radiological and laboratory facilities, and with a professional staff and technicians in attendance. Honorary medical officers attend at set hours. Modern out-patient treatment is provided but in-patient treatment is unavailable owing to the absence of bed accommodation. In twelve months there were 19,426 attendances (not all tuberculous) and 4,780 X-ray photographs were taken. A Government subsidy for the Association of £2,125 per annum is paid for the work at this clinic. We desire to highly commend the work of the Association in this field and for its activities generally.

101. It is alleged that because of the limited facilities at chest clinics at teaching hospitals, the methods and standards of treatment of tuberculosis are (with some exceptions) not in conformity with modern methods in other countries; also that the instruction given to medical students is often antiquated, and that there is considerable room for improvement in, and modernisation of, methods of diagnosing and treating tuberculosis as taught to medical students.

102. As laymen, we are unable to confirm or refute this statement but, if upon expert inquiry it is sustained, it is a matter of serious importance calling for immediate correction.

TREATMENT IN SANATORIA.

103. The Report of the Medical Survey Sub-Committee (see Appendix "D" discloses a serious shortage of suitable sanatoria and preventoria accommodation, and facilities for occupational therapy and rehabilitation of tuberculous patients. Also, a serious position is disclosed concerning the apparently advanced stage of the disease at which patients now enter sanatoria. This is evidenced by the report of the Director of Tuberculosis, N.S.W. in 1939, that on investigation of the after-histories of 767 patients admitted in 1934 to various sanatoria in N.S.W., it was found that during the five years up to 1939, 350 had died of tuberculosis and 329 had been re-admitted to sanatoria. It is estimated that an additional 2,439 beds in sanatoria throughout Australia are needed immediately to meet active cases now in need of treatment. This disclosure, which is confirmed by medical evidence in all States is most disturbing, and the Parliament and public generally will be concerned to learn that it is not an uncommon experience for active and, in many instances, advanced cases of tuberculosis to be refused admission to sanatoria, because of the shortage of accommodation. Frequently such patients have to wait three months for a bed and instances have occurred where patients have died from the disease while awaiting admission. In the interim, of course, they are highly infectious and therefore can hardly avoid spreading the disease among their associates and families and the community generally. The position has unfortunately been further aggravated by shortages of domestic nursing staffs resulting in the closing of wards in Sanatoria, and also by the fact that hospitals and sanatoria for civil needs are unfavourably placed in the order of war-time priorities. The latter, as it concerns hospital provision and personnel should be corrected with the least possible delay.

104. There have been for many years waiting lists at all sanatoria, and often list includes as many as 200. The measures already recommended for early detection of the disease will, as a

natural sequence, increase demands for accommodation as fresh cases are discovered, and this emphasises - if such be necessary - and makes even more serious, the existing bed shortage.

105. Unfortunately, the deficiency does not only apply to bed accommodation, but medical opinion indicates that there is a serious shortage of up-to-date facilities and equipment, to provide treatment on lines recognised in other countries as essential in certain cases, including an absence of adequate surgical apparatus and operating theatre facilities. Tuberculosis specialists have stressed the need for separate accommodation for the patients in various stages of the disease, as being essential to proper segregation, control and treatment. This is an important aspect for which the earliest possible provision should be made.

106. It was urged by many medical witnesses that notifications of tuberculosis should be made more effective and that doctors should be compelled to report all active cases. Patients should also be compelled to undergo such treatment as is directed by an authorised medical officer. In view of the highly infectious nature of the disease in such cases, and the irreparable harm that may result to the patients and to their associates, by neglect or absence of proper treatment, the Committee agrees with these proposals and recommends accordingly. It is again stressed, however, that the payment of the special rate pensions and allowances are an imperative preliminary to such action.

OCCUPATIONAL THERAPY AND REHABILITATION.

107. The experience overseas - particularly in such institutions as the Papworth Settlement, England, and the Altro Workshops in New York for the rehabilitation of Jewish cases, demonstrates conclusively the value of, and great need for providing, adequate facilities for the systematic development of occupational therapy and economic rehabilitation of patients whose condition has improved sufficiently to justify discharge from a sanatorium.

108. The Employment Committee of the Tuberculosis Council of Great Britain thoroughly investigated this field, and in an excellent report covering the whole field of rehabilitation of the tuberculous published in 1942, stressed the following points :-

(1) Employment of patients in sanatoria.

(2) Use of training colonies where gardening, poultry farming and pig raising are taught.

(3) Introduction of Village settlements where certain industries are carried on, and where the patient and his family can be cared for as a unit.

The report included the following :-

"The definition of rehabilitation of the tuberculous to be that part of the treatment of a patient which prepares him for employment consistent with his physical condition and personal aptitudes.

"Rehabilitation schemes of all kinds should be reserved for the medically necessitous, of whom the sputum-positive group should be given priority.

"Care and rehabilitation of the tuberculous is desirable, not merely as a means of restoring the working capacity of the individual, but for the purpose of raising the standards of living by providing an income adequate for the demands of his family as a whole.

> "There is no longer any debate on the need for medical and social supervision of open cases of tuberculosis over a prolonged period. This is an insurance against failure of whatever procedure is adopted in the individual case".

109. It is claimed that at the Papworth Settlement in England no child born at the Settlement has contracted tuberculosis. The spread of infection has been prevented through the care and attention given to the patients and through education.

110. At Papworth a considerable quantity and variety of manufactured goods are produced, and these are disposed of on the open market.

111. The patients commence to work for two hours a day and this is gradually increased to six hours per day. They are paid at the award rate according to the number of hours worked. The Managers of the different departments are all ex-patients. The scheme is considered by medical authorities to be suitable for adoption in Australia.

112. We have been impressed with the necessity for much greater activity in the campaign against tuberculosis, a disease still responsible for some 2,500 annual deaths and, according to public health authorities, approximately 30,000 cases at the present time in Australia.

113. The Committee recommends as essential principles of the campaign :

1. An increase in special rate pensions to the tuberculous and allowances to dependants (approximating the basic wage).

2. Extended and improved facilities at chest clinics for early diagnosis of cases detected by the preliminary survey methods of "Mantoux" testing and miniature X-ray photography; consideration should be given to making compulsory the examination of certain age groups.

3. Adequate follow-up of contacts and examination by these facilities;

4. Improved accommodation and facilities for treatment, especially of early cases, in hospitals and sanatoria, by the most modern methods and technique;

5. Greater development of after care and of rehabilitation, including occupational therapy and village settlement of 'arrested' cases.

MENTAL HYGIENE.

114. Evidence has been adduced that much more might be done for the prevention and treatment of nervous and mental illness and for the specialised education and social utilisation of the mentally deficient. The preventive aspect is being applied more and more in the work of the Departments of Mental Hygiene in all States. Especially is this so, as it should be, in the case of the mentally handicapped child. Good work has been instituted and the Departments have freely collaborated with Education and Child Welfare Departments and other agencies in this field. Child guidance clinics, opportunity classes and special schools have done much in cases of functional mental disease and mental deficiency in children; treating and alleviating the condition when it is curable, training

the incurable to the limit of capacity.

114a. There is still much room for research and application of modern method in this field. Beyond the achievement which is possible in the individual case, any advance will help to solve those problems of modern life in which mental deficiency, character maladjustment and neurosis enter so largely - for example, child delinquincy and crime; prostitution and venereal disease; and a quota of the unemployable. The Committee is of opinion that -

(1) There should be a survey by competent experts into all aspects of the problems of mental deficiency and of mental illness throughout the Commonwealth;

(2) Such a survey should concentrate especially on existing activities and future possibilities of action for the care and treatment of the mentally handicapped child.

(3) In any future developments, it is very desirable that collaboration in the field of mental hygiene should embrace all medical and health services since psychological and mental aspects enter into every field of health.

(4) There should be uniformity of legislation in respect of control of mental sickness throughout Australia.

VENEREAL DISEASE.

115. Special venereal disease legislation has been in force in every State (excepting S.A.) since 1918-19. The relevant Acts and regulations provide for an anonymous system of notification of cases. Notified sufferers who make default in submitting to treatment are followed-up and prosecuted if they do not resume treatment. Treatment by persons other than medical practitioners is prohibited. In no State is notification completely observed but by comparing notifications with attendances at clinics the figures do give an indication of the incidence of infection in the Community. Since 1920 the trend of incidence was downwards. Less marked with Gonorrhoea than with Syphilis, in which disease primary cases became almost a rarity. Following the Sesqui-centenary Celebrations in 1938 there was a definite increase in Syphilis and also in Gonorrhoea. With the onset of war in 1939 there was, only in Queensland, any increase in total notifications. In 1941 an increase of Syphilis occurred in Victoria. In 1942 there was, in those states involved in certain troop movements, a rising incidence most marked in New South Wales, Queensland and Western Australia, and to a lesser extent in Victoria. This importation from overseas resulted in a definite increase in Syphilis and also in Gonorrhoea and occasioned what was new in Australian experience the infection of girls in their early 'teens, in 1943 there has been an indication of a decrease in infection. Over the last two years the figures have shown a preponderant increase amongst females. The males in the age groups most subject to infection have been in the Services. Amongst servicemen and servicewomen there has been reported a very satisfactorily low rate of infection. The problem of venereal diseases as revealed by this wartime experience is the undoubted value of personal prophylaxis under service conditions. The other is the difficulty of control of the promiscuous girl in the 'teens and early adult life. In order to bridge the gap in State legislation the Commonwealth Government in 1942 introduced National Security Regulations which empowered Chief Health Officers of the States to take uniform steps for the compulsory medical examination of persons suspected of venereal disease and infection with detention for treatment upon proof of infection. In practice these powers came to be utilised for the control of promiscuous girls and women suspected in those states where the situation presented most pressing problems - in Queensland and Western Australia. This

matter has been the subject of protest by some women's organisations but those responsible for the venereal disease measures have stressed the necessity for this control whilst insisting on administration remaining in the hands of responsible medical authorities and not become a general Police power.

115a. The Committee is concerned with this problem of venereal disease as a matter which concerns the social life of the Australian Community. We have taken evidence on many aspects of the problem and recommend the following measures which should form part of a wide campaign against venereal diseases throughout Australia:-

(1) A continued improvement and extension of clinic facilities.

(2) Provision of more bed accommodation for "in" patients treatment of cases of venereal disease.

(3) Provision of prophylactic facilities for civilians as well as servicemen.

(4) Continued education of the public provided that such education remains in the hands of responsible medical and health authorities.

(5) Provision for all forms of sports and for recreational and social contacts during hours of leisure.

(6) The social rehabilitation and treatment of the promiscuous girl.

REGISTRATION OF MEDICAL PRACTITIONERS.

116. The registration of medical practitioners is a State function under State Medical Acts. In each State, a medical board examines the medical qualifications of applicants for registration and controls the professional conduct of registered medical practitioners.

116a. There is a general uniformity between the legislation in the several states but there are some important inconsistencies. Registration and the control which is thereby exercised over the profession extend only to a State. For these and other reasons a Commonwealth wide system of medical registration has been urged for many years. We are of the opinion that there would be many advantages in a uniform system of registration throughout Australia and that ultimately a Commonwealth system of registration should be established; and we recommend accordingly.

FOOD, DRUGS AND POISONS.

117. Commonwealth powers in respect of foods and drugs and poisons relate only to control of import and export under commerce legislation; the international obligations covering narcotic drugs (under the Geneva Opium Convention) are administered by the Department of Trade and Customs. Inspection and sale of food and drugs are dealt with in each State under Health and Pure Food Acts or special statute. Problems arise especially in the control of such an article as milk which is both a product and a food and so subject to control by agricultural, veterinary and health services. Poisons are controlled in four States by Pharmacy Boards and in two by Health Departments. Some uniformity has been achieved in standards of food and drugs through Commonwealth and State Conferences and in recent years by the regular sessions of the National Health and Medical Research Council. A proposal was revived during 1941, for a further Conference representative of Governmental, professional and trade interests, to formulate greater uniformity in State legislation and administration. The National Health and Medical Research Council considered that in normal times it should be possible to achieve material progress towards a greater uniformity. The Committee concurs with this decision and urges it should be put into effect.

MEDICAL SERVICES.

118. The Committee believes that the issues of primary importance arising from its inquiry and the foregoing proposals are :-

(1) Whether a general medical service available for all is in the best interests of the community;

(2) Whether such a service can be provided under existing conditions or private medical practice; and

(3) If not, under which of the following alternative systems of payment to medical practitioners, should such a service, if any, be introduced :-

(a) A capitation fee under the panel system;

(b) a fee-for-service under a system of private practice;

(c) a salary for full-time employment;

(d) a salary for part-time employment, with the right of private practice, or

(e) a combination of any of these systems.

General Medical Service.

119. Medical witnesses generally have been more directly interested in the nature of and conditions under which medical services would be provided, than in the policy of providing a general medical service to all in the community.

120. The need for, and desirability of, such a service is questioned by some, who consider it would not be in the best interests of the community as a whole, and that if the services were rendered entirely gratuitously to such patients it would be unfairly used by many. Against this, however, is the general acknowledgment that the best medical attention should be available to all in the community, irrespective of financial circumstances. The best medical service, including specialist service, is now available to the rich who can pay for it, and to the poor to whom it is provided free. Upon the large middle-income group, prolonged illness or major surgery frequently imposes very considerable hardship, and, in consequence, a lowering of living standards, and results in a failure to seek advice in early stages of illness when treatment is relatively easy. In our opinion, such conditions are unjustified and inequitable. Moreover, it is unreasonable that the doctor, be he general practitioner or specialist, should be expected to give his services free to any section of the people.

121. We consider, therefore, that a general medical service should be instituted, as the best and most equitable means of providing medical care for the community as a whole; and that this should be financed from a central fund specifically raised for the purpose by a tax on income, having regard to the capacity of the individual to pay.

Capitation and Panel System.

122. There has been considerable opposition to the system of payment for medical service by a capitation fee under the panel system, which is generally associated with National Health Insurance. This system is also one of those in operation under the New Zealand Social Security Act (Health Benefits) 1938. The official attitude

of the Federal Council B.M.A. as advised in May, 1943, is opposed to this system. It would appear that this opposition is influenced by conditions and experience of it under National Health Insurance in Great Britain, where, it is alleged, it has resulted in a lowering of the standard of medical practice owing to practitioners having enrolled on their panel lists numbers of patients out of all proportion to the number that they could effectively attend medically; and in New Zealand, where it is claimed the capitation fee and conditions were unreasonable and unacceptable to practitioners. The system is also subject to abuse by patients making unnecessary calls for medical attention. On the other hand, the capitation fee systems with strict limitation of the panel list, was strongly urged in evidence by Dr. R.J. Verco, President, South Australian Branch, B.M.A., and by Dr. T.A. Price, a past president, Queensland Branch B.M.A. Both these witnesses gave this as their personal and not their official opinion.

Fee-for-Service System.

123. The weight of medical evidence is strongly in favour of a system of fee-for service payments to medical practitioners in any general medical service except in remote areas. This, no doubt, is genuinely influenced by a desire to retain private medical practice in its present form and to relieve the medical profession of the responsibility of continuing to provide a free general practitioner service to the poor, and free specialist services as "honoraries" at public hospitals. In Queensland, the latter system has been replaced by a part-time salaried specialist service which has proved satisfactory and acceptable to all parties. The medical profession would have much to gain by the introduction of a fee-for-service system of payment, but the system is open to grave abuse by both patient and doctor, and against this no adequate means of protection has been suggested. Neither has there been any suggestion as to any compensating reduction in fees or other concession, in return for the increased incomes practitioners would receive under fee-for-service payments for all attendances. Fee-for-service is one of the alternative methods of payment under the New Zealand Social Security Act (Health Benefits) 1938.

124. There is general support from the Medical profession for the organisation of medical practice in groups where complete modern equipment could be provided at a more reasonable cost to patients.

125. There has been considerable evidence in favour of a full-time salaried medical service as affording the only satisfactory basis for a National Health Service, and, at the same time, providing more acceptable and more reasonable conditions of practice for the practitioner and of security for him and his family, under a system providing a salary, superannuation and adequate provision for regular post-graduate studies. It is claimed that such a system would tend to direct the chief interest of the medical practitioner towards preventive rather than curative medicine. Support for a salaried medical service appears to be growing, and this is perhaps influenced to some degree by the deterrent effect upon the earning of very high incomes of the present very high rates of taxation. Notwithstanding this statement, the support of a salaried medical service by many leading practitioners and specialists is undoubtedly inspired by the highest motives and a sense of public duty. The weight of medical opinion appears to be against a full-time salaried service but, as mentioned earlier in this report, it has not been possible to obtain the views of the large numbers of medical practitioners in the defence forces, and it is possible that these, if known, might affect the attitude of the profession as at present indicated.

126. While, therefore, there is pronounced opposition to the scheme outlined by the National Health and Medical Research Council

which visualises a system of governmental control of all health services, there is considerably less opposition to such a service if control is vested largely in the medical profession, through an independent body with statutory authority and removed from political control. Indeed, upon this aspect of administration, there is almost complete unanimity. Such freedom from political control ~~so extensive~~ essential for the success of any scheme. Undoubtedly, a large section of opinion regards a full-time salaried medical service as a revolutionary proposal which might seriously affect the medical profession and its services, and, in fact, the existing social order. For this also they oppose it.

Part-time Salaried Service.

127. It has been suggested generally in evidence that any change in Health Services should be by evolutionary development and we agree with this principle. A proposal has been made that for all cities and large country towns, a part-time salaried medical service be introduced, under which medical practitioners would voluntarily devote a portion of their time on a salaried basis, to provide a general medical service. This service would be provided at decentralised health clinics which, in reality, would become out-patient consulting centres. At such centres - placed in the areas of population density in suburbs and in country towns - all modern equipment and diagnostic aids (X-ray pathological, biochemical etc.) would be provided. Such a service would be correlated with other clinics, public hospitals and the local health authority through a full-time medical Liaison Officer. Practitioners would retain their private practices and would be free to nominate the number of half-day sessions - if any - they would be prepared to devote to the work of the clinic. The following are suggested as the chief advantages of such a system:-

(1) It is an evolutionary development and not a revolutionary change;

(2) It retains the right of private practice, either whole-time or part-time as desired by the practitioner;

(3) It provides free choice of doctor at the clinic, within certain limits;

(4) It leaves patients the option of a "general medical" service at the clinic, or "private" attention at the doctor's surgery;

(5) It reduces the cost per patient of the most modern equipment and diagnostic aids, which few general practitioners are able to provide privately and should provide for the services of experienced consultants.

(6) It vests local control in a Committee consisting of the clinic medical personnel;

(7) It relieves practitioners of routine clerical work which would be done by lay staff, and of the collection of fees;

(8) It provides a valuable potential field of re-employment for medical officers in the forces, particularly young graduates without experience of private practise (the latter now number about 1,000 and this increases annually) and young consultants.

The following disadvantages are suggested:-

(1) That the part-time practitioner will naturally be more interested in his private practice than in his public duty. The practice has, in many cases, cost him

a large sum and will be cherished by him as an asset of ever-increasing value. In his interest the part-time duty will invariably come second.

(2) Part-time patients may be made by the part-time practitioner to feel that they should pay for medical attention and that, unless they do so, they are receiving charity. Medical practitioners may combine to discourage all but the very poor from taking advantage of the part-time service.

(3) As a result of the foregoing, the system of part-time service may not be in anyway an adequate alternative to a whole-time salaried medical service.

(4) The failure of a part-time service would discredit any other proposal for organised and directed medical service and would thus make it more difficult to adopt a whole time salaried medical service.

Group Practice

128. The progress in medical knowledge and the development of diagnostic and therapeutic technique have been so great that it is not possible for the average medical practitioner to become thoroughly expert in more than a limited section of medical science, and, because of the heavy expense involved in securing modern equipment, general practitioners, except in the most favoured circumstances, find it impossible to provide such equipment in their private surgeries or consulting rooms, particularly as they would be infrequently used and, in consequence, overhead costs per patient treated would be unreasonably high.

129. It follows that the general practitioner in private practice must always be at a disadvantage when compared with a group service or hospital with modern equipment at its disposal, and where the overhead cost can be spread over a large number of patients. Moreover, the patient attending a group centre or clinic would have the choice or benefit of the doctor most experienced to deal with his particular ailment and, usually, the service of a specialist would be available on the premises, and at a much less cost than if consulted privately.

130. Medical service provided at a group centre has the great advantage to the practitioner that he would attend at specified hours and the service would be removed from his own home where he now remains on call for a 24 hours-a-day service.

131. The B.M.A. has expressed its approval of group practice subject to certain conditions, of which the chief is free choice of professional associates. The Committee is impressed by the fact that, in spite of the evident advantages in group practice set out above, there has, nevertheless, been an exceptionally small establishment of group clinics by voluntary association among local practitioners. Unless some further inducement or more deliverate organisation of such group clinics is provided, it believes that the successful establishment of any large measure of voluntary group practice, however desirable, is unlikely to be realised.

132. It has been suggested that such inducement might be provided by the government undertaking to establish and equip such group practice clinics as part of an evolutionary programme for establishing a national health service. One handicap to voluntary group practice is the heavy initial costs involved.

133. It will be realised that if the health centres or clinics previously discussed be accepted as an expression of group practice on a part-time salaried basis, they might provide a method of

meeting by sessional payments some of the present loss on non-paying patients, who are said to represent from 15-20% of total consultations in general practice.

134. A part-time salaried service in a group clinic is one means by which medical practitioners could assist in providing a general medical service in return for each payment.

135. However, the proposed arrangement for the working of each clinic on a roster arrived at by mutual consent of the practitioners of each group, would permit the men engaged some respite from the 24 hours-aday accessibility to the public, that is at present their position.

136. It is recognised that medical men, as others, must seek their living where their services are most appreciated and best rewarded.

137. Group practice, if founded on a basis of goodwill and willing co-operation, and with an acceptance of the view that the health of the public is a national asset, might go far to ensure that the best of medical care is available to every individual by a physician of his own choice.

138. The nation cannot afford to allow the poor - because they are poor - to become or remain sick. It must see that they receive the best medical care, including specialist care, and that the practitioners who supply such service are adequately remunerated.

PROPOSED MEDICAL SERVICE.

139. The Committee has heard a great deal of evidence on, and has given very careful consideration to a medical service for Australia, probably the most important aspect of Health Services that we are called upon to determine. We feel that the existing deficiencies in the nature and availability of medical services can only be remedied by a substantial reorganisation of, and improvement in, such services. We have carefully deliberated upon the "Capitation Fee and Panel", and the "Fee-for-service" systems for the payment of general medical services, but are unable to agree that either would, if adopted, be anything more than an expedient and we feel that neither is likely to provide a permanent and satisfactory solution. Moreover, both these systems are open to abuses against which no adequate protection has been suggested.

140. We believe, in view of the comprehensive nature of the services required and the difficulties in otherwise providing such services satisfactorily; the need for placing the health of the people above all other consideration; the need for elevation of the medical practice to the highest plane of public duty, and the need to provide the greatest possible incentive for medical scientific research and also facilities for post-graduate study, that the ultimate solution will probably be found in a full-time salaried medical service with standardised uniform hospital provision, within which complete medical, hospital and public health services will be available to all and will be financed by a tax on incomes for this purpose. Within such a service promotion should be purely on merit. Such solution, however, must be regarded as the long range objective, since, apart from the insuperable obstacles to its introduction at this stage or until after the War, it is opposed, at present, by a large majority of the medical profession whose co-operation is vital to the success of any plan. So drastic a change would be considered revolutionary and, therefore, should not be introduced, except by evolutionary developments over a period of years. Moreover, the gradual development, in controlled stages,

of a long range plan, would enable its real merits to be thoroughly tested by practical experience.

141. Having regard to all the circumstances and to the need for early and substantial reorganisation of, and improvement in health services generally as indicated herein, we consider that subject to further discussions as indicated in paragraph 163 of this report, such services should now be planned, for introduction as and when the war situation permits, as follows :-

(1) For Remote Areas (i.e., areas which now have difficulty in maintaining one general practitioner or where difficulty is experienced in securing adequate medical services) -
A Voluntary Full-time Salaried Medical Service, under a limited-term appointment; with improved hospital and transport services, including extended ambulance and flying doctor services, and facilities for consultant services; such services to be established and extended as necessary.

(2) For all other areas:
i.e. cities and country towns -
A Part-time Salaried Medical Service, under a system of voluntary participation by general practitioners who would retain their private practices, and would nominate the number of half - day sessions they would be willing to devote to a general medical service on a part-time salaried basis. Such service should be provided at out-patients and consulting clinics located in the centres of population in suburban areas and country towns. Clinics would be equipped with all modern diagnostic aids and treatment facilities, and would be supervised by a salaried Medical Liaison Officer responsible to the Central Health Administration. General control of the clinics would be vested in the medical personnel of each clinic.

HOSPITAL AND ANCILLARY SERVICES.

Hospitals

141. It has already been pointed out that according to the inspection of the Medical Survey Committee there were very few hospitals indeed in Australia which measured up to the standard laid down as ideal by world experience. The defects were partly in respect of construction and planning; partly in respect of accommodation and arrangement for patients; partly for staff; and partly in respect of location with regard either to centres of population or to the existence of other hospital facilities. Plans for hospitals are frequently drawn in Works Departments of the State services without other than passing reference to medical men skilled in the detail of medical needs and administrative facilities in respect of handling of patients. There is, moreover, no authoritative body to whom reference can be made either for standard plans or for the solution of a specialised problem. It would appear that this situation could only be met by

(1) The establishment of an expert body competent to advise on hospital planning, construction and equipment for the Commonwealth.

(2) The provision by this body of uniform standards for hospitals of various types and bed capacity to meet existing deficiencies.

(3) The making good from a central fund of existing defects in hospital accommodation and equipment passing from more urgent to less urgent problems.

(4) A process of regionalisation of hospitals in co-operation with State hospital authorities,
- (a) to reduce the number of inefficient hospitals.
- (b) to direct patients to community hospitals properly equipped to provide accommodation for treatment for public, intermediate and private patients.
- (c) to draw into recognised base hospitals adequately staffed with specialists, those patients requiring highly specialised treatment.

142. The difficulty of transport that existed a generation or two ago owing to bad roads and the utilisation mainly of horse drawn vehicles has passed away. A planned and organised hospital scheme as above, is incomplete, unless it provides adequate means of transport which leads to the recommendation that there should be -

(5) Improvement in facilities for sick transport by organising ambulances and relating them to hospitals; and in the more remote districts extending the provision for Flying Doctor Services.

143. The greatest problem with which hospitals have at present to deal is the continually increasing outpatient department which in some instances (where records are kept) has been found to have trebled during the last ten years. The greater part of outpatient work is what formerly constituted a large part of general practice and the private practitioner feels that this considerable section of his former field has been removed from him. He [illegible] a gap between the private practitioner and the larger hospital services where this problem is at its maximum. This fact has the further disadvantage of reducing his professional skill by limiting his opportunities for further developing it.

144. The outpatient also endures curable hardships. He must leave his work, forfeit pay for the time of absence and sit often for hours in the outpatients' department, anxiously awaiting his turn. Even worse is the case of the female outpatient - often a mother. Prompt attention must be given the outpatients. It is therefore recommended that there should be -

(6) Decentralisation of outpatient clinics; an invitation to all practising medical men where the outpatient problem is large to co-operate on its solution on a sessional payment basis. This suggestion is enlarged elsewhere in this report.

145. The proposal that there should be a standardisation of hospitals with the consent and co-operation of the State leads naturally to the suggestion that there should be a classification of hospitals. It might be considered desirable that an evolutionary programme of hospital standardisation in various categories might be laid down over a ten year period; that from its inception no new hospital should be permitted to be built unless it corresponded with the standard for the appropriate category;

and that, within the ten year period, all existing hospitals should under penalty of deregistration be brought up to an adequate standard of constructional and technical efficiency.

NURSING SERVICES.

146. The Report of the Medical Survey Committee has revealed many deficiencies in these services. There is unnecessary variation in the States in rates of pay and conditions of employment of nurses. Provision for accommodation is on the average poor. It is estimated that at least 25% of nurses in Australia are sleeping on verandahs or sharing rooms. There is little attention paid to facilities for recreation. There is a falling off in the number and type of nurses offering for training and there is a serious gap to be filled between school leaving age and the age at which a nurse enters training.

(1) The establishment of a standard course in nursing training approved at a conference of representative medical men and nurses for institutions throughout the Commonwealth.

(2) The establishment of standard conditions of employment i.e. pay, leave, accommodation &c. for the Commonwealth.

(3) Filling the gap between school leaving age and the age at which a girl enters on nursing training by an extension of the system of preliminary training schools or the establishment of a college of nursing.

(4) Measures to be taken to attract suitable girls to enter the nursing profession.

(5) The setting up of a new classification of workers in hospitals i.e., Assistants in nursing to relieve nurses of much of the domestic work they are now required to perform.

(6) Nursing lectures to be taken in duty time and not in the nurse's off-duty time.

ANCILLIARY SERVICES.

147. Ancilliary services, laboratory, X-ray &c. are markedly deficient in many hospitals. This is particularly noticeable in country centres. These services are vital to the efficient practice of medicine.

(1) Where constructional and equipment facilities already exist it should be staffed by trained personnel.

(2) Those districts which lack these facilities should be provided with them at the earliest opportunity.

(3) Arrangements for the training of both medical and lay staff in these aspects of hospital care should be extended to provide :-

(a) An adequate supply for initial staffing.
(b) A steady and regulated flow of trained personnel for replacement purposes.

ADMINISTRATION.

148. Important among the basic principles of any Health Scheme to be determined, is the form of administration, and this involves a clear conception of the nature of the service to be provided. Assuming that health services, are to be Commonwealth-wide in scope, and are to be financed from a Commonwealth fund raised by taxation for the purpose, it will need to be determined whether -

(a) with the consent of the States, the scheme will be administered by the Commonwealth, as a Commonwealth service, under a system of decentralised authority, or

(b) the Commonwealth will lay down the broad principles of a health service and general hospital standards, and subject to acceptance of these principles and standards, will finance the States under a system of grants-in-aid, in order that uniformity of health services and hospital standards may be established generally throughout the whole of the Commonwealth.

149. Under a Commonwealth controlled and financed comprehensive health service, i.e., embracing public health, preventive medicine including research, general medical services and hospital services, a central Commonwealth authority such as a Commonwealth Health Commission would be necessary, to lay down and direct a policy to establish approved standards for public and private hospitals, to control medical personnel and service and, generally, to co-ordinate the activities of the various subsidiary State authorities. The personnel of such Commission might consist of -

( ) A Chairman selected from a small panel nominated by the Medical Profession.

(b) A Medical-hospital administrator selected from a small panel nominated by the medical profession; and

(c) The Commonwealth Director General of Health and Chairman, National Health and Medical Research Council appointed for a term of five years.

150. An alternative to the above personnel might be a Commission of five consisting of -

(a) A Chairman and two medical members selected from a panel nominated by the medical profession one of whom shall be a medical hospital administrator and one a general practitioner;

(b) the Commonwealth Director General of Health and Chairman, National Health and Medical Research Council; and

(c) one lay representative, with special qualifications and wide experience of finance.

As compared with a Commission of three medical men, the latter proposal has the advantage that the lay member could also be regarded as the representative of the public, appointed by the Government.

151. While, as this report has already noted, the Commonwealth Parliament's express power over Health is limited, that power may be widened by the people's vote or by the State's agreement. And without any such express extension, the Commonwealth Parliament may grant to such States as are willing to co-operate the money

required for the decentralised administration of Health Scheme. It would, of course, be legally possible for a State to refuse to co-operate but in practice, it would be impossible for any State to refuse to become the instrument by which the great benefits of the Scheme would be showered upon its own electors. But no matter how the Scheme becomes law, it can be given life and force only by the complete and sincere agreement of all the Governments and Parliaments of Australia.

SPECIFIC PROBLEMS.

Research

152. Research work in Australia is at present undertaken by Commonwealth and State laboratories, some few large hospitals, and still fewer specially endowed private or subsidised institutions.

153. Recently the Commonwealth Government set up a fund for research and delegated to the National Health and Medical Research Council the right of recommending approval of any grant for a specific piece of research. In effect, no present grant is made without such recommendation. Nevertheless there appears to be a lack of co-ordination in the work now being carried out.

154. The power is advisory only and the period of annual grant for the purpose is liable to terminate at any time.

155. The provision might well be of a permanent annual sum and the powers of the National Health and Medical Research Council might be made complete and not merely advisory.

TREATMENT OF CANCER AND RESEARCH.

156. The treatment of cancer and research into this disease is not properly organised in Australia. There are many defects in the present system which must be made good if we wish to make any further progress in our attack on this disease which is exacting such a toll.

157. The present position calls, in our opinion, for urgent attention to the following proposals for betterment:-

(1) That all the resources of surgery, X-ray, and radium treatment, physical laboratory services and other methods of combating the disease be aggregated together in one centre in each State (a central institute) which should be associated with the research facilities available.

(2) That the experience of the most competent specialist staffs obtainable be concentrated and applied to the early diagnosis and treatment of cancer in its earliest stages.

(3) Convalescent accommodation for the continuance of treatment under the supervision of the staff of the Central Institute.

(4) More accommodation for patients in the late stages of the disease.

(5) Hostel accommodation for patients undergoing outpatient treatment.

158. The erection and equipping of such a central cancer hospital is necessary in order to centralise and to ensure as far as possible the most economical use of the very costly apparatus required for research and some forms of treatment. In addition to these major needs which should at the earliest possible moment be planned under expert supervision there are other aspects of the problem which should receive attention :-

(1) An education campaign to induce the public to present themselves at once to their medical attendant where there is any reason to suspect the presence of cancer.

(2) The granting of subsidies for the purpose of research on approved subjects connected with the origin and treatment of cancer.

(3) The creation of a cancer registry for the statistical study of cancer of all kinds.

(4) The formation of a liaison between private practitioners in city and country and the appropriate hospitals, which will ensure as speedy admission as possible of recommended patients.

(5) The encouragement of practitioners in the use of central laboratories and of highly expert pathologists for the histological study of suspected tissues.

(6) The extension of the follow-up services at the main hospitals to enable them better to keep in touch with patients under and after treatment.

(7) A resumption of the Australasian Conference on cancer problems (the last Conference was held in New Zealand in 1939).

PROPRIETARY MEDICINES.

159. An exceedingly great sum is spent in Australia annually on proprietary or patent medicines. Some of these medicines are ordinary prescriptions of value, bottled under a trade name; some others are valueless; others again are undesirable. There are three matters which have engaged the attention of the Committee

(a) a doubt as to whether the high cost of proprietary medicines is justified in relation to their actual value for health;

(b) the fact that these are secret remedies; and

(c) the misleading and sometimes false claims often made for some of these medicines.

160. It is considered that a comprehensive enquiry should be made into these aspects of the subject with the deliberate intention of remedial action if these discrepancies are confirmed.

NEED FOR CONTINUED PLANNING.

161. Pressure of time has not allowed us to cover all the subjects which properly enter into the full range of the task allotted to us. We have, for instance, not had the time to deal adequately with :-

National Fitness

School Medical Services

Health education for children and adults

Planning of Community Health Centres in new Building Schemes

Baby Welfare Clinics

Nutrition and Diet including milk supply, especially for children

Dental Services

Optometrical services

Pharmaceutical services

Almoner Services

Health aspects of the population problem

Child and Maternal welfare including antenatal care and Home Aid

Specialists, qualifications of, and availability, particularly to country residents;

Medical Transport and Flying Doctor Services.

162. During the course of the investigation we have collected a large amount of valuable evidence which will repay study by future Committees dealing with the Health Services. In particular, we wish to draw attention to the comprehensive report drawn up by the Social Security Medical Survey Sub-Committee. This report gives a complete factual survey of the medical and hospital facilities existing today in Australia, and will form a valuable basis for further recommendations regarding the reform and improvement of the Health Services in the Commonwealth.

163. Because of the recent unforeseen parliamentary situation the Committee has felt obliged to record, in this report, the progress results of its enquiry at this stage. For the same reason, our deliberations and proposals are unavoidably inconclusive and need to be continued by further consideration and development. Moreover, in accordance with our conviction that a complete outline of Health Services for Australia should be discussed by the Committee with interested parties including the Medical Profession - which is vitally concerned in any such scheme - and the National Health and Medical Research Council, we have already advised these bodies to this effect and had actually fixed the date for a conference. We consider it imperative that this conference be continued by this Committee, or its successor, as soon as circumstances permit and, subsequently, that more complete details, of a comprehensive Health Scheme be determined for submission to Parliament, in accordance with our terms of Reference.

164. Though it is extraneous to the subject matter of this report there is one subject to which we particularly desire to refer. This is the question of the future of education in the Commonwealth. We have taken some evidence on this matter but more evidence will be necessary before it is possible to make any recommendations. All that we are able to do for the present is to emphasise the importance of this matter as affecting the future of Australia, to state that; in our opinion, the present standard and type of education in all the States is very unsatisfactory and to record our conviction that the time has come for education to be regarded as a national matter than of State concern. We express the hope that this matter will receive serious consideration by the future Parliament.

165. For the reasons given above, therefore, our task is still

incomplete, and we recommend that the investigations that have been carried and the point shown in the present report, be continued at some future date and brought to conclusion.

APPRECIATION.

166. Our thanks are also due to the President and officials of the British Medical Association in Australia who have been throughout, most helpful in their suggestions and advice.

167. Firstly, we wish to express our great appreciation of the valuable assistance given to the Committee by its Secretary, Mr. Roy Rowe. Throughout the investigations of the Committee, which covered not only the present enquiry but also many other aspects of the problem of Social Security, Mr. Rowe has been untiring in his devotion to his work. The administrative arrangements made by him for the conduct of the Committee's business have never failed and his help in the compilation of the Committee's Reports has been throughout of a very high standard.

168. In conclusion, we desire to express our sincere thanks to the many persons and organisations who have assisted us in our enquiry. Owing to the great number who have been good enough to come forward, it is not possible to express our thanks to each individual case. We wish, however, to record our deep appreciation of the work done by the Chairman, Members and Staff of the Medical Survey Sub-Committee. During the short time at its disposal, just over three months, the Sub-Committee has carried out comprehensive investigations on medical and hospital conditions in all the States of the Commonwealth. It has spared neither its time nor its energy in gathering the facts of the situation and it has, working under great pressure, compiled a report which will remain of great value for years to come. But for the work of this Sub-Committee, the task of the Committee would have been rendered much more difficult.

(Signed)	H. C. BARNARD,	Chairman.
	W. J. COOPER ,	Deputy Chairman.
	J. J. ARNOLD,	Member.
	M. BLACKBURN,	Member.
	J. A. PERKINS,	Member.
	R. S. RYAN,	Member.

Canberra,
1st July, 1943.

APPENDIX "A".

13th January, 1943.

My dear Treasurer,

re Health Services.

In response to the request of the Government, conveyed in your letter dated 17th October, 1942, (copy attached), the Joint Committee on Social Security has during the past month taken a considerable volume of evidence in several States. The evidence which has been representative of the medical profession and public interests dealt with all aspects of health services. Because of the limited time available, the inquiry has necessarily been of a general character with the view to determining the broad principles of a comprehensive scheme for Australia and the relation of such a scheme to any measures to be recommended for introduction during the war.

Although some sections of the medical profession are strongly opposed to any change in existing conditions there is general acknowledgment of the need for improved health services, including medical, hospital, and child and maternal welfare services, on a Commonwealth-wide basis. But in view of the decision of the recent Constitution Convention at Canberra to grant only conditional approval for Commonwealth powers over health (subject to co-operation with the States), consultation with the States before Commonwealth legislation is drafted, appears desirable. Moreover, some delay in finalising the details of new health services for Australia would seem to be inevitable in view of the very considerable financial interests the States now have in hospitals and other established State health services, and in order to avoid misunderstandings which otherwise might ultimately prejudice the success of any new scheme.

National Health Insurance.

On the evidence submitted there is unanimous objection to National Health Insurance as contained in the Commonwealth National Health and Pensions Insurance Act, 1938. Special attention has been directed to the restriction of benefits to a particular income group, to the very limited health and social benefits and to the absence of any provisions covering the dependants of an insured person, hospital treatment and unemployment.

As the Government will be aware, the Commonwealth Widows' Pensions Act, 1941, supersedes the National Health Insurance provision in this respect.

There is general hostility to the scheme among the medical profession in Australia. No basis of agreement between the profession and the Government has at any time been reached, and there is general opposition to the panel and per capita system for medical benefits which has been discredited in Great Britain, and more recently in New Zealand, where a fee-for-service system has been introduced. There is also opposition to the principle of Approved Societies which, in Great Britain, have been reported against by Sir William Beveridge and the P.E.P. group of economists.

Generally, it is our opinion that the National Health and Pensions Insurance Bill falls far short of any plan of social security, including social services and health services, adequate for the people of Australia, and this Committee does not favour the principle of national insurance for such a purpose. In view of the overwhelming weight of evidence we strongly advise that no action be taken to implement any of the provisions of this legislation in its present form.

Health Services for Australia.

It is our considered opinion that for the reasons which follow it is not possible successfully to introduce a comprehensive health scheme in Australia during the war, but that the planning of such a scheme should be proceeded with. Accordingly, the Committee intends shortly to proceed with its inquiry with the view at no distant date to set out in principle and broad outline the basis of a scheme which it proposes to discuss in conference with representatives of the National Health and Medical Research Council and the medical profession in Australi', preliminary to the preparation of a report to Parliament.

It is our strong conviction that any action at present to implement any major scheme of medical, hospital or other related health services would seriously jeopardise the success of any comprehensive scheme for adoption at a later stage during the war or immediately following the war. It is beyond doubt that any such action at present would be considered precipitate by the medical profession and would be vigorously opposed. Good relations have been established between the Committee and the profession and we feel it is very desirable that these should be preserved. We see no difficulty in cultivating the co-operation of the medical profession so long as adequate time is allowed for working out the necessary details and for consultation, not only with the representatives of the B.M.A. but with individual members of the profession.

The Committee has given careful thought to the practicability and manner of consulting members of the medical profession individually, including some two thousand serving in the defence forces, and feels that this will present no insuperable difficulty. We consider such individual consultation regarding any major departure from existing health services, prior to the launching of any such scheme to be absolutely imperative. It will be appreciated that if the good will and co-operation of the medical profession is to be secured - and we do not mean that this can be secured only by sacrificing important matters of principle - it will be obvious that no action should be taken which may be construed as being likely to prejudice the future of the medical men at present absent on service in the Forces.

Concerning any proposals for the introduction of comprehensive health services during the war, attention is invited to the enclosed copy of correspondence between the President of the Federal Council of the B.M.A. in Australia, Sir Henry Newland, and the Minister for Health, the Hon. E. J. Holloway, M.P., in which an undertaking is given by the Minister that the medical profession will be consulted and that the scheme will not be introduced until after the war. This undertaking is re-affirmed in the Minister's letter of 24th November, 1942 (copy attached).

Wartime Measures.

In order to advise on what we understand to be the Government's immediate purpose, we classify wartime measures in two groups:-

1. Services to be planned - some of which may be partially introduced - during the war, and

2. Measures for early introduction.

Services to be planned during the War.

The planning of a comprehensive health scheme embracing medical, hospital, child and maternal welfare services, health clinics, nutrition and ancillary services and, incidental thereto,

an expert medical survey of existing health services and medical personnel throughout Australia.

The Committee is proceeding with this planning and will report to Parliament as early as possible. Meanwhile, we are giving further consideration to the proposals for:-

(a) *Improved nutrition, in order to encourage the use of proper food values;*

(b) Measures to provide for the uniform registration throughout Australia of Medical Practitioners, Dentists, Nurses, Pharmacists and Veterinary Surgeons; and uniform laws - or a Commonwealth law - covering food and drugs;

(c) Maternal Welfare (supplementary to the economic aid suggested below), having regard to the need for, but difficulty in providing during the war, the additional accommodation and services that are necessary; and

(d) Medical and Hospital Services in remote areas, especially those at present unable to support a medical practitioner.

These services should all form part of a complete health scheme, nevertheless we hope later to suggest means by which they *may be introduced at least partially, during the war.* It is important, however, that no action be taken to introduce any portion until the plan itself has been adopted in principle and so that we may avoid a "piecemeal" policy unrelated to a long-range plan.

<u>Measures for Early Introduction.</u>

1. <u>Social Measures to provide economic assistance to:</u>

(a) <u>Persons suffering from incapacity or temporary unfitness for work.</u>

While it cannot be classified as a health service, sickness benefit is closely related thereto. Persons suffering from temporary illness or from incapacity which is less than 85% or is not permanent, are not eligible for the invalid pension. In most countries where comprehensive Social Security has been adopted, sickness, or some equivalent benefit is included for temporary incapacity and for dependents' allowances.

A benefit comparable to the Invalid Pension rate, with allowances for dependants and providing for a waiting period of 7 days, should be provided. A necessary provision would be to require the person concerned to undergo any reasonable treatment prescribed.

(b) <u>Expectant and Nursing Mothers</u>, for ante-natal and post-natal care covering a period of 12 weeks to enable the mother to make adequate provision for the needs of herself and her child during the period she would otherwise be least able to do so.

It is well established that the proper care and feeding of a mother in the ante-natal and immediate post-natal period has a great influence on the health of both mother and child and therefore on the health of the nation. Child and maternal welfare is a primary responsibility and assistance in this direction is well merited and recommended.

In his recent report, Sir William Beveridge said:

"The low reproduction rate of the British community today makes it imperative to give first place in social expenditure to the care of childhood and the safeguarding of maternity".

The amount of maternity benefit he recommended, viz. 36/- per week for 13 weeks, appears to us to be not less than would be needed by a mother to make adequate provision for several weeks prior to and following the birth of a child.

The matter of medical and hospital care during maternity will be dealt with in our report. This is at present covered only partly by the Maternity Allowance being limited to certain income groups.

(c) Tuberculosis sufferers and their dependents.

Acknowledged medical experts claim that with proper preventive measures and adequate curative facilities tuberculosis could be almost, if not entirely, eliminated from Australia. The present facilities and powers, however, fall tragically short of requirements and in consequence the disease goes on largely uncontrolled, gather in new victims - chiefly children and young people, many of whom, under proper segregation and care would be saved from this fate. In most, if not all States, accommodation for treating diagnosed cases is hopelessly inadequate and largely because of this, little or no progress has been made for advanced types of institutions to provide for the vocational rehabilitation of those who have progressed sufficiently to be discharged from sanatoria, or for segregation of the children of tubercular cases.

It has been stressed frequently by the National Health and Medical Research Council and it is supported by independent medical witnesses before the Committee that "the economic factor is definitely the most important aspect of the campaign against tuberculosis." Medical opinion confirms the fact also that in numerous cases the breadwinner - when threatened with early tuberculosis and being unable to provide for his family should he cease employment to undergo treatment or to voluntarily enter a sanatorium - continues his employment until he becomes badly affected. In such cases, because of the advanced stage of the disease, cure is both difficult and rare and in the meantime the members of his family and his workmates have been exposed to infection. Moreover, the psychological reactions on the patient are disastrous.

It is a melancholy fact that, due to the stress of war conditions, the urgently needed facilities - both preventive and curative - for dealing effectively with tuberculosis, are unobtainable. But we desire to most strongly recommend to the Government the payments of special pensions and allowances to tuberculosis sufferers and their dependents in order that improved economic circumstances may help to prevent the further spread of the disease among families and so that sufferers in the early stages may be given every possible opportunity of a cure and subsequent rehabilitation.

In its report the Committee will deal in detail with other measures it considers necessary to combat tuberculosis. Our desire here is to urge the payment of the undermentioned pensions and allowances.

In 1937 the National Health and Medical Research Council recommended, in cases of tuberculosis, payment of a pension similar to that paid by the Repatriation Department and the Commonwealth Invalid Pension combined in respect of tuberculosis soldiers receiving a service pension. This would now be equal to £3.6.6 per

week for a man, wife and 4 children and for a war service pensioner free medical treatment in a repatriation institution. Child endowment would increase the weekly amount paid to £4.1.6.

We recommend:-

1. Acceptance of diagnosed cases of tuberculosis as eligible for an Invalid Pension in the meaning of the Invalid and Old Age Pensions Act.

2. Continuance of Invalid Pension to the pensioner at the full rate upon entrance to a hospital or institution for treatment.

3. Payment to tuberculosis pensioners of an additional special rate pension to bring the income up to the maximum provided for any Invalid Pensioner (38/- per week), until his earning capacity is restored.

4. Payment to his wife of an allowance of £1 per week, and to each dependent child under 16 years of a tuberculosis pensioner, 2/6 per week - exclusive of child endowment. (2/6 per week is paid for the children of a tuberculosis war service pensioner).

These payments would make the family income for a man, wife and 4 children £4.3.- per week during treatment for tuberculosis. Proper treatment involves prolonged segregation and incapacity for work. Such payments would materially assist in providing the food and other necessaries in the building up and maintenance of good health, so essential to immunity from the disease.

The foregoing recommendations have for their object the provision of economic conditions essential in cases of tuberculosis. They should be implemented as the Government finds it practicable to do so and as adequate facilities are available. We recommend also the provision, as soon as circumstances permit, of the urgently needed hospital and other facilities for the prevention and cure of tuberculosis, including the segregation of children and the rehabilitation of sufferers. It is probable that a sum of £1,000,000 spread over several years, will be required for this purpose.

Venereal Disease.

The attention of the Committee has been directed to the serious position regarding venereal disease in Australia, which has shown a substantial increase during the period of the war.

The method of control of the disease is well established under the State Health Departments and under recent National Security Regulations additional powers have been conferred in respect of the examination of suspected sufferers and detection of infected persons. While in some centres treatment clinics appear to be adequate, in most cases there is a pressing need for a greater number of clinics for early treatment. The serious nature and consequences of the disease are well known but under concealment and inadequate treatment these assume grave and often tragic proportions.

Three serious aspects indicating the need for an active educational policy are:-

1. Secrecy and neglect through fear of exposure and compulsory treatment.

2. The youth of many female sufferers.

3. Treatment surreptitiously by unqualified persons.

Cases of infection of girls of 13 and 14 years, complicated by pregnancy have occasionally been reported, while infection among young women from 18 to 23 years is stated to represent the main mass.

We recommend that the Commonwealth provide a sum of £50,000 for the purpose of providing clinics in the States and for educational purposes; the fund to be under the control of the Minister for Health and that the matter of its use be determined after consultation with the States.

Child Welfare.

The extension of facilities for caring for young children, particularly those of pre-school age and during school age, and the children of mothers engaged in war industries is desirable in the interests of the nation as a whole. This could best be done in co-operation with established child welfare organisations in the States under grants-in-aid by the Commonwealth. An amount of £100,000 should be adequate to commence with, subject to review after 12 months. If the proposal is approved we suggest the appointment of an honorary Federal Advisory Committee consisting of six women - one from each State - experienced in Child Welfare, to advise the Minister regarding the use of the grant.

The Committee will later make recommendations concerning other aspects of child welfare related to the serious population prospect confronting Australia but, meanwhile, suggests that the Commonwealth undertake more active responsibility for child welfare generally; also that a special obligation rests on the Commonwealth concerning the younger children of women who are assisting the war effort by working in war industries. The child is the best asset of the State and we neglect it to our loss.

Conclusions.

We have regarded the fixing of any base rate of benefits as being primarily a matter of Government policy and therefore have not here dealt with that aspect. We have rather related any new proposals to the accepted base rate, i.e. the Invalid and Old Age Pension rate, plus dependents allowance as recommended in our report of the 24th September, 1941. We would point out, however, the disparity between such rates and those recommended as a "subsistence minimum" by Sir William Beveridge in his recent report to the British Government.

Yours sincerely,

(sgd.) H. C. BARNARD
Chairman.

The Hon. J. B. Chifley, M.P.,
Federal Treasurer,
CANBERRA. A.C.T.

APPENDIX."B"

Extract from the Report of the National Health and Medical Research Council.

Twelfth Session - 26th and 27th November, 1941.

RESOLUTIONS.

Resolution No.1 - Outline of a possible scheme for a salaried medical service.

1. This Council, having perused an outline of a possible scheme for a salaried medical service, which has been submitted to it by a sub-committee of the Council, is of the opinion -

(a) that the present system of providing medical care to the public is capable of considerable improvement in some directions;

(b) that such measures might involve the provision of a general medical scheme for all Australia, available at will to all persons resident in Australia;

(c) that the scheme outlined provides a basis for discussion with representative members of the practising medical profession in Australia; and that such discussion is essential for the correlation of differing but sincerely held points of view.

2. The Council further notes that the scheme outlined aims to improve existing medical facilities -

(a) by providing medical care to outpost and remote areas which at present, for economic reasons, cannot support a medical practitioner;

(b) by co-ordinating medical care for the benefit of the patient on the basis of more effective team work, while safeguarding, generally, free choice of doctor, thus minimizing the over-lapping due to professional competition, and pooling professional knowledge;

(c) by returning general practice (especially out-patient work) to the general practitioner as far as is possible;

(d) by making as widely accessible as possible all specialist, consultant and ancillary services;

(e) by providing for better distribution of medical men in terms of medical needs;

(f) by providing better and more complete records of disease incidence and etiology and thus better facilities for productive research;

(g) by ensuring to medical practitioners adequate remuneration for their services; reasonable opportunities for the maintenance and improvement of the standards of medical knowledge; and relief from the present handicap of their "24 hours-a-day accessibility";

(h) by co-ordinating the health services of a protective nature with the corrective provision for medical care; and

(i) by providing a scheme for development, design, construction and administration of all forms of hospital and institutional services incidental to the foregoing.

3. The Council, while approving in principle the practical details and financial items of the scheme outlined, desires to state that it is of the opinion that these, although expressed in detailed form for purposes of discussion, are necessarily tentative. This is particularly the case in respect of the district centres (Class "D" Centres), and, more especially, in connection with consultation centres in capital cities, where a complete revision of the scheme, in consultation with the medical profession, is essential. Notwithstanding this, however, it is not considered that such revision will materially alter the estimated expenditure.

Subject to the foregoing considerations, the Council believes that a salaried scheme along these general lines is practicable and should receive serious consideration. (see table attached)

~~APPENDIX I.~~

AN OUTLINE OF A POSSIBLE SCHEME FOR A SALARIED MEDICAL SERVICE.

(Report to the National Health and Medical Research Council of a Committee of that Council.)

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1. This Council, having perused an outline of a possible scheme for a salaried medical service, which has been submitted to it by a sub-committee of the Council, is of the opinion :—

(*a*) that the present system of providing medical care to the public is capable of considerable improvement in some directions;

(*b*) that such measures might involve the provision of a general medical scheme for all Australia, available at will to all persons resident in Australia;

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Subject to the foregoing considerations, the Council believes that a salaried scheme along these general lines is practicable and should receive serious consideration.

Recommendations of the National Health and Medical Research Council on the Financial Aspects of a Scheme for Social Reconstruction in Respect of Health and Medical Services.

In its Eleventh Report the National Health and Medical Research Council outlined its views as to the means by which there might be established a higher state of personal health throughout the whole Australian community by the application of the power and resources of both the Commonwealth and the States, and included among its resolutions the following:—

> "This Council believes that the situation thus indicated is well worthy of deliberate examination. This Council is prepared, provided the above principles are accepted, to furnish practical details and to support these with financial evidence as to revenue and expenditure."

It was inevitable that this statement should attract attention, and the Parliamentary Select Committee on Social Security which was appointed to "inquire into and from time to time report upon ways and means of improving social and living conditions in Australia and of rectifying anomalies in existing legislation" has asked the Federal Minister for Health and Social Services whether it would be possible for this Council to give some indication of the general lines along which such a change should proceed and the general financial implications involved.

Notwithstanding the reservation specifically made by the Council in the clause quoted, namely "Provided the above principles are accepted", it is recognized that Governments could not adopt the principles advanced until at least some general estimates of the financial changes and commitments involved had been supplied.

This Council, therefore, has prepared this outline (which it does not suggest is a final and complete scheme) as a basis for the discussion of a reconstructed relationship between the Government, the people, and the medical profession. It seeks to indicate the practical considerations involved in—

(a) making health and medical services available to all the people by means of salaried medical officers rather than, as at present, by private practitioners;
(b) regulating the distribution of medical men and medical practice as much as possible by basing these activities on existing hospitals and clinics throughout the country; and by providing these where they are lacking; and in
(c) bringing the preventive (public health) and the curative (private and hospital practice) services into an organic union; and in this regard giving especial attention to—
    (i) safeguarding childhood as the only permanent national asset; and
    (ii) providing a greater amount of skilled attention for workers in industry, including the workers in the most numerous of female occupations, i.e., the wives and mothers of families.

Part I.—Preliminary Note.

Before proceeding to state and to examine in detail the provision considered desirable, this Council wishes to express its considered opinion that, upon all the points raised in this outline, there should be detailed, deliberate and full consultation with the medical profession.

In this connexion, it is pointed out that a great many medical men are overseas with the Australian Imperial Forces. It is essential that their interests be fully considered and conserved.

The scheme is tentative and readily susceptible of informed criticism and amendment. It is in some respects subject to existing legislation It is obvious also that it requires some modification of the Commonwealth of Australia Constitution Act of 1901.

At the outset, for example, reference should be made again to the Eleventh Report of this Council, where it is made clear that the Council was and is faced with the fact that a National Health and Pensions Insurance Act has actually been passed by the Parliament of the Commonwealth, although it has not as yet been brought into operation, and that, thereby, the Commonwealth Government is at present committed to a social reform which, if introduced, will change the status of a great majority of the members of the medical profession immediately and fundamentally.

The scheme proposed by that Act, however, is so incomplete in range and objective that a very heavy financial commitment would be required to institute what, over a large part of Australia, would be a duplication of existing private practice services, uneconomic to the point of extravagance, if not, in fact, impracticable.

Moreover, in respect of the *per capita* payments on a panel basis contemplated by that Act, the Council has in its Eleventh Report (sections 28 to 31 inclusive) indicated that there are real objections to this method of financing a medical scheme.

The alternatives to such payments appear to be—

(a) an individual fee for every individual service rendered; or
(b) an annual inclusive payment to cover all services; or
(c) the establishment of a full-time salaried service.

It will be observed that this Council assumes the adoption of the last mentioned. It considers the first impracticable. As between (*b*) and (*c*), there is no doubt that a salaried service would be notably easier to administer than a service where individual annual payments would need to be determined for each officer or group of officers by a complicated system of case records and bookkeeping.

This Council does not offer any suggestion as to the manner in which the service recommended should be paid for by the public, though it recognizes that some form of direct or indirect taxation appears inevitable. It considers it essential, however, that, whatever scheme be ultimately adopted, it should be one freely available to all the people of the Commonwealth. Every person, whatever his income or position, should have free right of access to such a national service. It is, of course, inevitable that the fundamental human impulse towards individual freedom of action will urge many persons to continue to consult private medical practitioners and to pay the usual fees instead of using the facilities proffered by the national service. This will not affect the efficiency of the scheme as a whole.

As the Council said in Resolution 19 of its Eleventh Report—" these proposals are not inconsistent with the retention of private medical practice and private hospitals ".

All calculations in this outline have accordingly been made upon a national basis, and it is important to remember that point in discussion of its details. Moreover, this Council has set itself out to remedy, in this outline, two fundamental defects in the National Health and Pensions Insurance Act as it now stands in the Statute Book. These are mentioned as paragraphs (2) and (3) of Section 29, as follow :—

> "(2) This Act does not provide for the integral relationship between clinical treatment, hospital services and health services which the Council regards as indispensable to any scheme which has the two-fold objective of preservation of health and treatment of disease ;
>
> (3) It does not provide for any form of domiciliary advice and assistance auxiliary to the general practitioner service provided by the doctor, which, if provided, would very greatly enhance the value of such a scheme as a health measure."

Part II.—Existing Agencies.

It is assumed that existing agencies for health and medical services, both in respect of personnel, buildings and equipment, will be available to a very large extent for incorporation in the scheme. This applies, for example, to all existing public hospitals.

In the figures that follow, it has been assumed that the present hospital costs (both capital costs and maintenance costs) may be accepted as established figures for the purpose of this scheme. The same applies to services for mental hygiene. The examination of any alternative basis would extend far beyond the limits of present possibilities.

In the statement of comparative expenses, therefore, identical figures for some items appear on both sides. The question of part-time or honorary practice is, however, one that must be considered and reference is made to this question later.

It may be expected that any nation-wide scheme will affect the relation of the public to private hospitals, almost as much as it will affect their relationships with private practitioners. Some of the larger private hospitals are already subsidized by the Government. Many of the smaller private hospitals, particularly in country towns, may be of value to the scheme. The total figure in this regard can be estimated only by the deliberate investigation in detail of conditions existing, town by town, in each State—a matter impossible except as an item in the administrative application of the scheme, if approved.

With respect to expenditure by Departments of Health and expenditure on the medical services provided to the Education Departments where these are separate services, it will be observed that, since they are incorporated in the outline, they appear only in one column.* Nevertheless, to correlate preventive and curative medicine, and to extend necessary preventive activities, an initial increase of expenditure is inevitable. It is hoped that this will result, after a short initial period, in a diminution of hospital, and, especially, out-patient costs.

Several items of importance omitted from this outline require consideration in any final draft. They include, *inter alia*—

- (*a*) the effect of the scheme upon the business of the pharmaceutical chemist ;
- (*b*) the matter of dental and optical provision in so far as that goes beyond the School Health Services , and
- (*c*) the provision of additional institutional accommodation for convalescents, tuberculosis patients and suspects, and similar institutions.

The utilization of the services of medical practitioners at present in private practice is discussed throughout the whole scheme from place to place, particularly in Parts III. and IV. The scheme should be open to every registered medical practitioner who is willing to associate himself with it. It should not, however, be compulsory. It is considered that its provisions will be sufficiently attractive to result in a very great proportion of medical practitioners accepting appointment willingly within its range.

Part III.—The Basis of the Scheme.

The Eleventh Report of the Council has stated the basis of this scheme in its various resolutions, as follows :—

> " 10. The whole populated area of the Commonwealth should be divided into Health Districts which should also be Hospital Districts as far as possible.
>
> 11. A District Health Officer should be appointed to each (or to two or more combined) Health District. This District Health Officer should be an officer of the Central Health Department of the State and should—
>
> - (*a*) supervise all health legislation in his district ;
> - (*b*) act as regional medical officer in supervising Commonwealth pensions work ;
> - (*c*) maintain co-operative association with hospital services ;
> - (*d*) supervise ante-natal clinics, baby health centres, school medical services, and any similar health services in his district (with necessary medical staff) ;
> - (*e*) control a system of female health visitors ;
> - (*f*) supervise industrial hygiene services in his district ;
> - (*g*) act as a co-ordinating link with physical education activities, pre-school institutes and other related work not under any departmental control.

* Note.—So far as the actual figures are concerned, the total should be modified by the fact that the present expenditures by the States would not be wholly transferred, and, moreover, certain items of expenditure by the Commonwealth Department of Health would continue for example, the Northern Territory Medical Service , the Commonwealth Serum Laboratories , the School of Public Health and Tropical Medicine, Sydney , the X-ray and Radium Laboratory, Melbourne , and the Institute of Anatomy, Canberra The expenditure of the Commonwealth Department of Health also includes expenditure on hospitals The figures, nevertheless, are sufficiently accurate to have a real indicative value.

14. The responsibility for all routine sanitation must be effectively imposed upon local authorities and not be attempted as a routine function of the Central Health Department, which should be retained as a supervisory authority and increasingly organized so as to be able to develop the more medical side of health work.

15. The hospital services throughout the populated area of the Commonwealth should be arranged on a District Hospital system (which might in suitable districts include a Base Hospital with subsidiary hospitals). In the metropolitan areas, and in a few of the larger cities, there should be, in addition to the Central Hospitals, a ring of suburban consultation centres for primary consultations and casualty treatment, and a ring of small hospitals for minor cases. These local centres and hospitals would be staffed by local medical men and would relieve the central hospitals, which should be kept for serious and specialist cases. In the country district hospitals, there should be facilities for diagnosis and advice in respect of clinical public health necessities and accommodation for the District Health Officer. This system should do much to relieve the present serious and increasing pressure on the out-patient services of the existing public hospitals.

16. With respect to the specific problem of sparsely settled districts, this Council recommends that these be provided for by a whole-time salaried service of young medical practitioners on short-term services—with adequate transport facilities.

18. This Council sees no insuperable difficulty in complete control by the Commonwealth, even including the transfer of State Health Departments, and, in fact, recommends as an ultimate objective such control or transfer with all aspects of preventive and curative medicine, including hospitals."

For the purpose of this outline, emphasis should be laid upon certain items. It has already been pointed out as an assumption that existing public hospitals will be available for incorporation in the scheme at their present rate of capital and maintenance expenditure. These hospitals will be grouped in relation to base hospitals, and will be reinforced by consultation centres, which will take over from them and return to the general practitioner that large mass of general practice now dealt with at the hospitals as "out-patient" practice. It is more particularly with the latter as an extension of existing facilities that this report concerns itself.

Since it is recommended that the public hospitals should be kept so far as is possible for serious and specialist cases, and that this should be entirely the case with central hospitals, the basic idea of the consultation centre is that every sick person, who is reasonably mobile and who does not need treatment at hospital, should be treated at the consultation centre instead of at his home.

A certain amount of domiciliary visiting, however, will be necessary for persons who do not need in-patient treatment but are unable to attend at the consultation centre.

Above all, the system is based almost entirely upon "group practice", with specialist facilities for cases needing these. These specialist facilities will be available to general practitioners on an almost universal basis.

With this statement of the general principles of the outline, its major features might now be indicated.

Part IV.—Medical Practitioners.

The outline assumes that, so far as is practicable, the 24-hour per day demand upon the doctor will cease. In one-man centres (i.e., A. Class Centres)* it will not be possible to avoid night calls, but a form of recompense to the doctor for this extra service will need to be devised. It has been provided in the estimates of cost by an allowance.

The doctors stationed at these one-man centres should have opportunities for acquiring higher status and all should, by transfer to other centres or absorption into higher posts, leave these isolated practices after a reasonably short tour of duty.

That brief statement illustrates the position generally with regard to all the doctors in the service contemplated in this outline.

Every doctor after graduation should be required to do one year as junior and one year either as a senior hospital resident, or in association with a consultation centre in the city—in either case special attention should be paid to experience in obstetrics.

At the end of this second year, he should be posted as junior general practitioner with the liability to go to an A. class or a B. class centre* if he is sent.

He should soon qualify for promotion to the grade of senior general practitioner when a vacancy occurs. Promotion to senior general practitioner should depend upon proven personal quality and professional ability.

At this stage, also, should begin the allocation to junior posts of suitable men for special training, e.g., public health, pathology, radiology, and other special subjects.

The next stage should be the acquisition of membership, fellowship, degrees, or diplomas, for which facilities should be made available to officers who had proven themselves qualified for such consideration.

The later senior stages would be determined on recognized principles of promotion.

Each doctor of every grade would be entitled to—

Annual leave;
Sick leave on a credit basis according to length of service;
Study leave if the privilege were granted;
Superannuation, with compulsory retirement at 65 years.

For these conditions of service, it would be necessary for the service to be a departmental service under the Public Service Act—this would give two valuable additional rights:—

(*a*) The right of collective approach to an impartial judicial tribunal—the Public Service Arbitrator—in respect of all questions of salary and conditions of service;

(*b*) The right of any individual doctor to appeal against the promotion of any other doctor.

With respect to (*a*) and (*b*), a special Board consisting entirely of medical men should exist to assist the Arbitrator or to hear appeals.

A less rigid constitution such as that of the Council for Scientific and Industrial Research presents some advantages but does not permit of the collective approach or appeals which are available under the Public Service Act.

An essential principle in this outline is that the doctor's home is not his professional centre and no consultation takes place there—it remains as his private home.

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* See Part V.

The grading of the medical service might be—

Hospital residents—

Junior ..	£150 with board and lodging.
Senior ..	£300 at hospital with board and lodging.
	£400 at consultation centre.

General practitioner—

Junior ..	*£700–£900 with £104 allowance in certain districts.*
Senior ..	£1,100–£1,600

In certain remote districts special district allowance should be provided.

Junior in training for special practice ..	£900–£1,000

Responsible specialist—

Junior ..	£1,100–£1,400
Senior ..	£1,500–£1,800
Consultant specialist ..	£1,800–£2,000
Administration Chief ..	£1,750–£2,250

Advancement of salary should in all cases be by annual increments of £50.

It may be assumed that those doctors who intend to leave the service to begin private practice would generally do so at the "senior general practitioner" or "junior responsible specialist" stage.

Leave should be on the basis of 21 days per annum. Class A and Class B should have four weeks, one week of which the doctor should be obliged to give to hospital work, either at the nearest D, E, or F type hospital, or in the capital city. All other grades should have 21 days per annum.

Every five years each doctor up to senior general practitioner or junior responsible specialist stage should be given three months' study leave, which he would be required to devote to a special course of post-graduate study.

Every doctor in A class and B class centres would be required to attend night calls throughout the year. This could be compensated for—one suggestion is that these might be compounded by an annual allowance of £104 on the basis of two calls per week at £1 per call.

In all other classes, night call duty should be taken in rotation and would be equitably met by one full afternoon off duty for each night when a call was actually made.

Every second year selected responsible specialists or consultant specialists in each specialty should be sent to *Europe or America to learn latest developments and should spend the year following their return* in visiting all the States and transmitting this knowledge to others.

Officers in classes A and B, and some officers in class C, should be provided with houses and simple furniture for which they would be charged rental. Officers in other classes would provide their own.

Officers in all classes who need cars might have the purchase price advanced and this be repaid to the Department in mileage at 4d. per mile—this arrangement makes the car available for private use without complications.

In the metropolitan centres, the senior staff provided in this outline would provide the visiting staff at the hospitals, replacing the present honorary system—but the adoption of this principle would not necessarily mean the exclusion of private consultant practitioners, who could be suitably paid for the service.

In all the D class centres at extra metropolitan towns, the hospitals would similarly be staffed by the senior staff of the district.

One question which would have to be separately decided for each district is whether the senior general practitioner would act as hospital superintendent or whether a separate superintendent should be appointed of the senior general practitioner grade. It is not anticipated that the decision would materially affect the total estimates given in this outline.

University medical schools would be staffed by the Universities as at present—these might either be officers of the Service seconded for the purpose or private consultant practitioners This statement includes also the teaching hospitals.

Part V.—Distribution of Consultation Centres.

It will be obvious that the consultation centres indicated in Resolutions 15 and 16 of this Council's Eleventh Report must be adapted to meet a variety of conditions. They will differ in classification according to their size and functions.

For a clear picture of the grouping, the towns of the Commonwealth may be grouped according to population or according to the daily in-patient average. For convenience, six classes have been adopted—

Towns with no hospitals.
Towns with a hospital having a daily average of less than 40 in-patients.
Towns with a hospital having a daily average of from 40 to 50 in-patients.
Towns with a hospital having a daily average of from 50 to 100 in-patients.
Towns with a hospital having a daily average of from 100 to 200 in-patients.
Towns with a hospital having a daily average of from 200 to 400 in-patients.

As this outline develops, it will be seen that four types of Consultation Centres will provide all the requirements of an efficient national medical service.

These four types are—

A Class Centres ..	Places having a doctor but no hospital.
B Class Centres ..	Places having a hospital with a daily average of less than 40 in-patients.
C Class Centres ..	Places having hospitals with a daily average of from 40 to 50 in-patients.
D Class Centres ..	Places having hospitals with a daily average of more than 50 in-patients and which are selected for District Centres.

The detailed description of activities at consultation centres of the four types will now be set out, with the method *for the* distribution of medical personnel in relation to the centres, together with costs, and some discussion of special considerations and special grouping in certain localities.

In some towns, it may not be necessary to build consultation centres, but at this stage the only possible method is to estimate upon the assumption that full building costs will be involved at every place.

In an examination of the conditions existing in any centre of population, it will be obvious that the method of classification which has been adopted will not apply invariably. Some centres of population with a small hospital in-patient average serve very much larger populations scattered over a wide area than other towns with similar hospital average. On the other hand, there are certain areas, particularly mining or manufacturing districts or areas, where smaller populations may require *a centre of a class higher than their nominal status* *Areas of fluctuating population* such as holiday resorts may require supplementary staff for the periods concerned.

These sources of error are recognized, but in such an estimate as this known numerical quantities such as in-patient average, population, &c., must be used.

It is probable that no significant error in estimates will occur by using this basis.

A. Class Centres.

As mentioned above, the A Class Centre is provided for towns without a hospital. It would be staffed by one medical officer without the right of private practice, and subject to the control of the District Medical Officer. The district consultation service would be available to patients on the application of the medical officer. Such additional preventive provisions as could be supplied by the school health service, the dental, optical and other travelling services, would work in co-operation with the local medical man from time to time, and all individual case cards, records, &c., of the area served would remain at the centre itself.

The centre would comprise—

- Waiting room;
- Examination room;
- Surgery and small dispensary combined;
- Bath room;
- Lavatory;

and other necessary offices.

The medical officer would also be provided with a house with simple furniture. The centre might be built under the same roof to form part of the house. Telephone and transport facilities—and, in a few cases, portable radio transceivers—would be provided.

This type of centre could largely replace the bush nursing system, the nurse being brought under the control of the doctor.

A considerable amount of domiciliary visiting would be necessary from such centres owing to the scattered nature of the localities in which they will find their chief use. In some localities they will form part of special aeroplane transport services.

Provision will also be necessary for the cleaning of the centre. The doctor will need to perform his own office work, including records of cases, reports to the District Medical Officer, &c. It will be necessary, probably, to provide professional assistance in the person of one nurse.

The doctor will be required to provide any advice or service in connexion with problems of public health or preventive medicine.

Conditions of Service.—At A Class Centres, commencing salary for junior officers will be £700 per annum, plus an allowance of £104 per annum for night calls. Rental will be charged for both house and furniture on an established percentage basis.

Medical officers will be required to spend at least two years out of the first five years of their service at an A Class Centre or a B Class Centre. If the medical officer remains for a longer period, as some may, his salary range will increase by the prescribed annual increments up to a maximum of £900 per annum.

Number of A Class Centres.—The numbers of these centres can be estimated with fair accuracy, and for the various Australian States are as follow:—

New South Wales	109
Victoria	144
Queensland	38
South Australia	46
Western Australia	10
Tasmania	29
Total	376

The actual localities are shown in Appendix I.

In some places a considerable area and a large scattered population will depend upon the centre. There are even some of them where, at the present time, two or more doctors are resident. These are not sufficiently great in number to affect the general position.

Allowing for the elimination of competition and a better grouping system, the actual requirement of one-man centres in each State is estimated to be as follows:—

New South Wales	125
Victoria	150
Queensland	40
South Australia	55
Western Australia	12
Tasmania	35
Total	417

The costs associated with each unit of these A Class Centres should not exceed—

	£	Unit Cost. £
Capital—		
House	1,750	
Furniture	250	
		2,000
Maintenance—		
Mileage—12,000 miles at 4d. per mile	200	
Drugs, dressings, instruments and sundries	300	
Nurses' keep	50	
		550
Salaries—		
Doctor, £700–£900—mean	800	
Allowance	104	
Nurse	200	
		1,104

The rental of house and furniture can be calculated so as to return the capital cost of the house in 25 years and of the furniture in ten years.

It is possible that with modern transport for both patient and doctor, and the establishment of easily accessible modern diagnostic centres, the numbers of these A Class Centres will diminish, but the existing numbers are taken for the present discussion.

The total expenditure on A Class Centres is shown thus—

—	Number of Doctors.	Capital.	Maintenance.	Salaries.
		£	£	£
Unit cost	..	2,000	550	..
New South Wales	125	250,000	68,750	138,000
Victoria	150	300,000	82,500	165,600
Queensland	40	80,000	22,000	44,160
South Australia	55	110,000	30,250	60,720
Western Australia	12	24,000	6,600	13,248
Tasmania	35	70,000	19,250	38,640
Total	417	834,000	229,350	460,368

B Class Centres.

The next unit in the scheme is provided by those centres having hospitals with a daily in-patient average of less than 40. Of these some have one doctor practising at present; others have more than one.

Of these centres there are in extra-metropolitan localities—

	Hospitals.	Doctors
New South Wales	92	161
Victoria	29	53
Queensland	93	125
South Australia	44	72
Western Australia	76	88
Tasmania	9	13
Total	343	512

The table in Appendix II. shows the numbers of in-patients (daily average) and the numbers of doctors practising *in each town. The numbers of doctors are reasonably, but not absolutely, accurate. In some of these districts more* than one doctor would not be necessary, and in some the numbers can be reviewed under a proper system, but the numbers shown will be accepted for the present discussion.

These units would be classed with A Class Centres as posts for junior officers who would commence at the minimum salary of £700. The doctor would be provided with house, furniture, telephone, and car, on the same terms as A Class Centres. The consultation centre would, however, generally be at the hospital—the accommodation there would, in most cases, need to be supplemented by some additional building, but this would not be large. Probably an extra two nurses would have to be appointed. All consultations as before should be at the centre, except when the patient is not mobile. Discouragement of night calls is necessary here also, but payment of an allowance would apply as in the case of A Class Centres.

The salaries of the doctors can be computed at the mean of the class (£800). The members of the B Class Centre would have generally the same expenditure as shown under A Class Centre, but—

(*a*) the houses and furniture in some cases would need to be of a better class without any consultation facilities;

(*b*) the maintenance expenses would be greater.

As each of these B Class Centres has a small hospital, all consultations will take place there, and for this purpose it might be necessary to spend £500 on building additions and to provide the salaries (£400) and keep (£100) of two *additional* nurses.

On this basis the following estimates might be made for each centre:—

	£	Unit Cost £
Capital—		
Doctor's house	1,750	
Furniture	250	
Hospital additions	750	
		2,750
Maintenance—		
Mileage (12,000 miles)	200	
Drugs, dressings, instruments and sundries	400	
Nurses' keep	100	
		700
Salaries—		
Doctor (£700–£900)	800	
Allowance	104	
Nurses	400	
		1,304

The above applies in respect of one doctor at each hospital for each doctor in excess of one in the town the the expenses will be—

	£	Unit Cost. £
Capital—		
House	1,750	
Furniture	250	
		2,000
Maintenance—		
Mileage	200	
		200
Salary—		
£700–£900	800	
Allowance	104	
		904

These estimates can be tabulated thus—

In respect of one doctor for each hospital—

—	Number of Hospitals.	Capital.	Maintenance.	Salaries.
Unit cost	..	£ 2,750	£ 700	£ 1,304
New South Wales	92	253,000	64,400	119,968
Victoria	29	79,750	20,300	37,816
Queensland	93	255,750	65,100	121,272
South Australia	44	121,000	30,800	57,376
Western Australia	76	209,000	53,200	99,104
Tasmania	9	24,750	6,300	11,736
Total	343	943,250	240,100	447,272

But there are additional doctors as follows :—

New South Wales	69
Victoria	24
Queensland	32
South Australia	28
Western Australia	12
Tasmania	4
Total	169

For each of these the unit cost is—

	£
Capital	2,000
Maintenance	200
Salary	904

The totals in respect of these additional doctors are as follow :—

—	Number of Doctors.	Capital.	Maintenance.	Salaries.
Unit cost	..	£ 2,000	£ 200	£ 904
New South Wales	69	138,000	13,800	62,376
Victoria	24	48,000	4,800	21,696
Queensland	32	64,000	6,400	28,928
South Australia	28	56,000	5,600	25,312
Western Australia	12	24,000	2,400	10,848
Tasmania	4	8,000	800	3,616
Total	169	338,000	33,800	152,776

In quite a large number of towns, however, the hospital is situated some distance from the town. This brings into prominence a consideration which will have to be kept well in the reckoning throughout the whole of this outline. It has been an unfortunate feature of the evolution of social medicine that such activities as baby health centres, school medical inspection, ante-natal work, hookworm campaign examination centres, have steadily become more and more separated from the general medical work of the community. One of the objects to be achieved by the outline now presented is that of restoring the bond between the general practitioner and the social services. It is therefore desirable to bring such activities as those mentioned into close relationship with the general medical scheme, and, for this purpose, to place the consultation centres as near to existing activities such as the baby health centre as is possible in all towns in which the hospital is not centrally situated.

It is difficult to estimate the capital cost which may thus be involved beyond the additional buildings at the hospital. For computation purposes it is being assumed that the necessary building in such cases can be provided at an average capital cost of £1,000 and that such buildings will be necessary in half the total number of B Class Centres.

Taking half the number of centres (343) as 170, the estimated addition to the expenditure would be, for each unit—

	£
Capital	1,000
Maintenance—Drugs, dressings, instruments and sundries	400

or a total of—

Capital	170,000
Maintenance	68,000

For small outlying villages round the larger towns of this type, it may be necessary to contemplate the utilization for visits by the doctor on set days of existing facilities such as the local school, hall, or hotel.

The following table (being a combination of the three above tables) gives the total amount involved for B Class Centres :—

—	Number of Doctors.	Capital.	Maintenance.	Salaries.
		£	£	£
New South Wales	161	391,000	78,200	182,344
Victoria	53	127,750	25,100	59,512
Queensland	125	319,750	71,500	150,200
South Australia	72	177,000	36,400	82,688
Western Australia	88	233,000	55,600	109,952
Tasmania	13	32,750	7,100	15,352
Total	512	1,281,250	273,900	600,048
Additional Centres	170	170,000	68,000	..
Grand Total B Class	..	1,451,250	341,900	600,048

There is one other consideration—provision of leave for the doctors in A and B Class Centres. These are to have four weeks each year and three months every five years. That is, provision must be made for thirty-three (33) weeks' leave in five years for each man, i.e., for one-eighth of his total in every five years he must be relieved, i.e., a relieving staff of one-seventh of the total might well be provided.

The total medical practitioners in these two classes are—

New South Wales	286	Relieving Staff	41
Victoria	203	Relieving Staff	29
Queensland	165	Relieving Staff	24
South Australia	127	Relieving Staff	18
Western Australia	100	Relieving Staff	14
Tasmania	48	Relieving Staff	7
Total	929	Total	133
		Relief doctors for relieving staff	10
		Total	143

The total salaries for relieving staff at £800 per annum would be £114,400. Incidental expenses, such as fares, &c., for relieving officers, would have to be met; the question of whether medical officers on leave would have fares paid to capital cities would have to be decided.

Progressive totals at this stage for all Australia are—

—	Capital.	Maintenance.	Salaries.
	£	£	£
A Class Centres	834,000	229,350	460,368
B Class Centres	1,451,250	341,900	600,048
Relieving Staff	..	..	114,400
Total	2,285,250	571,250	1,174,816

C Class Centres.

This class of centre is that which should be provided in districts having hospitals of daily average of 40–50 beds, and this class should have a consultation centre located at or in close association with the hospital. The locality relationship with existing health agencies such as baby health centres, as described under the B Class Centres, should be remembered. For the consultation centre, speaking generally, the place of greatest accessibility is to be preferred. The unity of preventive and curative medicine should be practically expressed in this way to the fullest practicable extent.

This consultation centre should include—

1 waiting room.
2 consultation rooms.
2 examination rooms.
1 X-ray room.
1 combined instrument and sterilizing room with laboratory bench.
1 room for health services.
1 nurses' duty room.
1 office and records room.
Lavatories.

These centres would be provided in communities approximating 5,000 in population. The actual localities are shown immediately at the end of this section.

For these centres one senior and three junior general practitioners would probably be sufficient with ready access to the specialist services of the district.*

The question of houses for doctors at these centres also would have to be faced—it might mean either building or purchasing from doctors at present in practice. Each centre would need to be considered separately.

In these centres additional emphasis is given to one of the basic principles of the whole of this scheme, namely, that the doctor's residence is not a consultation centre: it is his private home and is indicative of the fact that, with the introduction of this scheme, he closes (to his advantage) the "24 hours per day" accessibility that is, at the present time, one of the greatest handicaps of private practice.

The C Class Centre, working in conjunction with the hospital, will provide all usual curative and preventive services for the community it serves. It will also generally assist A and B Class Centres in problems beyond their immediate capacity, either directly or through the agency of the district consultation services which are next to be described. C Class Centres in their turn will rely upon the district consultation service for assistance with cases beyond their own capacity.

The consultation centre will be the head-quarters for protective and preventive services other than those directly concerned with sanitation, sanitary engineering and the more mechanical aspects of public health.

If the hospital has an efficient X-ray plant, it would not be necessary to provide another. This would have to be determined for each centre.

The building should not cost more than £5,000—the equipment should not cost more than £1,500, and the maintenance costs should not exceed £500.

Three nurses would be required at the centre—salaries £200 each; maintenance £50 each.

Where house and furniture are provided, rental for both house and furniture is assessed on the usual departmental basis.

The expenditure therefore on each C Class Centre would be—

	£	Unit Cost. £
Capital—		
Centre	5,000	
Equipment	1,500	
If house is to be provided with furniture, add—		
House	1,750	
Furniture	250	
		8,500
Maintenance—		
Four cars (9,000 miles each)	600	
Centre	500	
Nurses keep	150	
		1,250
Salaries—		
Doctors—		
One senior general practitioner (£1,100–£1,600)	1,350	
Three junior general practitioners (£700–£900)	2,400	
Nurses—three (£200)	600	
		4,350

In South Australia, only two towns are in this group—Mount Gambier and Port Augusta. One of these does not require a full team as above, the other may require more; both are accepted therefore and included in the group.

Tabulated, this will be as follows:—

The total expenditure on these C Class Centres is shown thus—

—	Number of Centres.	Capital.	Maintenance.	Salaries.
Unit cost	..	£ 8,500	£ 1,250	£ 4,350
New South Wales	11	93,500	13,750	47,850
Victoria	3	25,500	3,750	13,050
Queensland	2	17,000	2,500	8,700
South Australia	2	17,000	2,500	8,700
Western Australia	1	8,500	1,250	4,350
Tasmania	..	..	..	..
Total	19	161,500	23,750	82,650

* In holiday resorts, such as the Berrima, Blue Mountains and Hawkesbury districts, probably more juniors would be required either seasonally or always.

The hospitals having between 40 and 50 beds daily average are—

—	Population.*	Daily Average.	Number of Doctors Practising.
New South Wales—			
Berrima	..	49	5†
Blue Mountains	..	43	11‡
Cootamundra	..	43	5
Forbes	5,355	44	5
Griffith	..	43	3
Hawkesbury	..	47	..
Kyogle	..	50	2
Mudgee	..	45	6
Temora	..	45	3
Walgett	..	48	1
Wyalong	..	42	3
Victoria—			
Ararat	..	44	4
Castlemaine	5,221	50	4
Swan Hill	..	45	4
Queensland—			
Ayr	..	46	4
Kingaroy	..	45	4
South Australia—			
Mount Gambier	5,542	47	6
Port Augusta	3,270	40	1
Western Australia—			
Geraldton	4,984	45	4
Tasmania	Nil	Nil	Nil

* Those not stated are below 5,000; these populations are the numbers within municipal boundaries the population within the hospital district is in many cases much larger.
† Mittagong, Moss Vale and Bowral.
‡ Katoomba, Leura, Wentworth Falls and Blackheath.

D. Class Centres.

ATTENTION IS DRAWN TO PARAGRAPH 3 OF THE INTRODUCTION TO THIS "OUTLINE" WHERE IT IS STATED THAT THIS SECTION MUST BE COMPLETELY REVISED.

With the end of C Class Centres (i.e., 40–50 bed hospital centres) this outline passes from the country town type of population to the larger centres and from this point it is necessary to begin to visualize the appearance of district centres (D Class Centres). It may be that it would be wise to elevate one or more of the C Class Centres to district centres but that could be ascertained only by closer study than is possible at this stage and for the purposes of this study it would be well to take the present distribution.

The localities involved are shown here so that discussion may proceed progressively—

Centres with Hospitals having from 50–100 Beds.

—	Population (1933.)*	Daily Average.	Number of Doctors Practising.
New South Wales—			
Armidale	6,794	65	8
Bathurst	10,413	59	7†
Casino	5,287	52	4‡
Corowa	..	72	3§
Grafton	6,411	93	7
Kurri	..	75	3
Lithgow	13,444	76	3
Kempsey	..	54	4
Moree	..	57	3‖
Narrandera	..	59	4
Orange	9,634	93	16
Inverell	5,305	51	6
Taree	..	66	4
Murwillumbah	..	59	6
Wallsend	..	90	4
Victoria—			
Colac	..	79	7
Echuca	..	60	4
Hamilton	5,786	59	5
Horsham	5,273	93	4
Maryborough	5,631	52	5
Sale	..	96	5
St. Arnaud	..	57	3
Warragul	..	67	5
Warrnambool	8,906	99	8

* † Orange. ‡ Lismore. § Albury. ‖ Inverell.

Centres with Hospitals having from 50–100 Beds—continued.

—	Population, 1933.*	Daily Average.	Number of Doctors Practising.
Queensland—			
Atherton	..	62	1
Bundaberg	11,466	100	8
Charters Towers	6,978	52	4
Gympie	7,749	78	6
Innisfail	..	72	5
Mackay	10,665	97	7
Mount Morgan	..	55	1
Warwick	6,664	54	6

South Australia.—There is no town with a hospital of this size, or larger, in South Australia outside the metropolitan area. It is obvious, however, that certain centres will be necessary and these are discussed in Appendix III.

—	Population.	Daily Average.	Number of Doctors Practising.
Western Australia—			
Northam	4,917	53	3
Tasmania—			
Latrobe (Devon)	5,151	83	7
Australian Capital Territory—			
Canberra	7,325	88	7

Centres with Hospitals of between 100 and 200 Beds.

—	Population, 1933.	Daily Average.	Number of Doctors Practising.
New South Wales—			
Albury	10,543	106	11
Broken Hill	26,925	171	8
Cessnock	14,385	123	7
Dubbo	8,344	109	4
Goulburn	14,849	100	9
Lismore	11,762	129	15
Maitland	8,191	141	7
Tamworth	9,913	105	10
Wagga	11,631	125	13
Waratah (Mater)	..	128	1
Wollongong	11,403	114	10
Victoria—			
Ballarat	37,411	172	30
Geelong	39,223	145	31
Mildura	6,617	157	6
Mooroopna	5,698	128	7
Wangaratta	..	103	7
Queensland—			
Cairns	11,993	133	8
Ipswich	22,498	124	10
Maryborough	11,415	104	6
Rockhampton	29,369	126	11
Toowoomba	26,423	148	26
Townsville	25,876	160	12
South Australia	Nil	Nil	Nil
Western Australia—			
Kalgoorlie	17,326	155	15
Tasmania	Nil	Nil	Nil

Hospitals having 200–400 Beds.

—	Population.	Daily Average.	Number of Doctors Practising.
New South Wales—			
Newcastle	104,485	327	36
Victoria—			
Bendigo	29,131	227	27
Queensland	Nil	Nil	Nil
South Australia	Nil	Nil	Nil
Western Australia	Nil	Nil	Nil
Tasmania—			
Launceston	32,833	281	23

* The populations shown are those within the municipal boundaries: the population within the hospital district is in most of these cases much larger.

It is clear that these large centres of population will be the natural bases for administrative and consultative specialist purposes. In addition to these services applying to and serving the whole district of which this centre is a base, the ordinary services for the people resident in the town will need to be provided on a C Class basis. In some towns one extra C Class Centre will be needed in addition to the District (D Class) Centre; in a few of the larger towns more than one such centre will be necessary.

The special conditions applying in the different towns are specially discussed in Appendix III. At this stage in this outline the District Centre will be described and the requirements of the various towns tabulated so that the aggregate result can be shown.

It must be remembered, however, that the actual towns named as D Class Centres represent a schematic distribution only. Close study of geographical conditions, of transport facilities, and similar factors will be necessary before the actual location of these D Class Centres can be determined. It is unlikely, however, that the total number for Australia will be materially altered whatever distribution is adopted and, accordingly, the estimates given may be considered as reasonably approximate.

These District Centres will be, as the name implies, the centres for the health and administrative, as well as the clinical, activities of the district.

In respect of their local functions they should be located—as was indicated for the C Class Centres—at strategic points in the town. The principle of bringing the patient to the practitioner should be maintained as far as possible but ample specialist facilities are provided in the outline and these should be freely available to the whole population on the advice of the general practitioner attending. The maternal and child welfare services, the school medical services and other similar health agencies will have their head-quarters at the D Class Centre.

A District Centre will need larger accommodation than a C Class Centre. It might well consist of—

2 waiting rooms.
3 consultation rooms.
3 examination rooms.
1 X-ray room.
1 out-patients' theatre.
1 combined instrument and sterilizing room.
1 plaster and splint room.
1 special senses examination room.
1 laboratory.
1 room for health services.
1 nurses' duty room.
1 office and records room.
Lavatories.

Probably this will cost about £12,000 to build, £4,000 to equip and £1,500 per annum to maintain.

Staff.—The staff must consist of the local staff assigned to a C Class Centre, i.e., one senior and three junior general practitioners, for all the local services. An additional nurse would be required at the centre at £200 per annum.

The staff then would be—

One senior and three junior general practitioners and four nurses.

No houses would be provided for the doctors at these centres.

Night and holiday duty would be taken on a roster basis without any allowance but with a satisfactory equivalent of leave or time off duty to compensate.

In addition, there should be the district consultant specialist services. These might be as follow :—

	Salary at mean £
1 senior physician	1,650
1 junior physician	1,250
1 senior surgeon	1,650
1 junior surgeon	1,250
1 junior ophthalmologist	1,250
1 junior otologist	1,250
1 senior obstetrician	1,650
1 junior pediatrician	1,250
1 junior radiologist	1,250
1 junior pathologist	1,250
1 junior orthopaedist	1,250
1 psychiatrist	1,250
Total salaries	16,200

These district specialists would not be provided with houses, but would be provided with telephones and transport. For the twelve specialists and consultants, not more than six cars should be necessary, but this is subject to review as they would have to be available for the whole district.

The radiologist, pathologist, psychiatrist and orthopaedist would need to travel rarely, and in the other groups it is unlikely that the senior and junior would be travelling at the same time in more than one group.

Mileage, at £200 per annum, would amount to £1,200.

In addition to the above, there are the public health services for the district.

There should be for districts of the sizes visualized—

	£
Four junior public health and school officers (£900–£1,000)	3,800
One senior public health and school officer (£1,100–£1,400)	1,250

These will require cars—total mileage of £1,000.

Female health visitors would be necessary; of these, eight for the district would probably be sufficient (one of them being supervising senior)—at an average salary of £250 per annum = £2,000.

For transport small cars would be necessary for each, at a total capital cost of £2,400, and annual mileage cost of £800.

Finally, there must be a district administrative staff. This might well be—

	£
1 senior medical administrative officer	1,650
1 junior medical administrative officer (clinical)	1,250
1 junior medical administrative officer (health)	1,250

These would require office accommodation with three clerks and three typists. Total annual amount of £1,500.

Some visiting would be necessary, but the mileage would be limited.

Summarizing this expenditure for a typical town in which there would be one D Class Centre comprising one C Class Centre with the additional administrative and specialist services the typical unit cost can be shown thus—

	£	£	£
Capital—			
District centre	12,000		
Equipment	4,000		
		..	16,000
Maintenance—			
Centre	..	1,500	
Mileage—			
Clinical	1,200		
Health	1,000		
Health visitors	800		
Administrative	100		
Nurses, keep	200		
		3,300	
Office and records	500	500	5,300
Salaries—			
C Centre Staff (7)		4,350	
Additional nurse (1)		200	
District staff, clinical (12)		16,200	
Health officers (5)		5,050	
Health visitors (8)		2,000	
Administrative (3)		4,150	
Clerical		1,500	
			33,450

The unit cost therefore of a D Class Centre is—

	£
Capital	16,000
Maintenance	5,300
Salaries	33,450

The discussion in Appendix III. shows the schematic distribution of D Class Centres, but it also shows that there are certain towns with hospitals, having a daily in-patient average of over 50, which might well be provided with C Class Centres. The distribution in the Appendix and the estimates which accompany them result in the following table of the total estimated cost :—

—	Number of Centres.	Capital.	Maintenance.	Salaries.
		£	£	£
New South Wales	16	341,000	99,800	572,000
Victoria	15	291,000	86,000	527,850
Queensland	8	196,000	53,400	307,400
South Australia	5	80,000	27,000	90,850
Western Australia	6	104,500	33,050	127,250
Tasmania	3	49,000	13,100	80,600
Australian Capital Territory	1	17,000	2,500	13,700
Total	54	1,078,500	314,850	1,719,650

Progressive totals at this stage therefore are—

—	Number of Centres.	Capital.	Maintenance.	Salaries.
		£	£	£
A Class	417	834,000	229,350	460,368
B Class	343	1,451,250	341,900	600,048
Relieving A and B	..	..	..	114,400
C Class	19	161,500	23,750	82,650
D Class	54	1,078,500	314,850	1,719,650
Totals	833	3,525,250	909,850	2,977,116

Capital Cities.

Attention is Drawn to Paragraph 3 of the Introduction to this "Outline" where it is stated that this Section Must be Completely Revised.

The capital cities may be tabulated thus—

—	Metropolitan Population.	Number of Doctors Practising.
Sydney	1,288,720	1,024
Melbourne	1,035,600	869
Brisbane	325,890	238
Adelaide	321,410	242
Perth	220,330	150
Hobart	63,250	49

The number of doctors are taken from Knox's Medical Directory (1938)—no more accurate distribution is available, nor is any distribution amongst the specialties available.

The populations are as at the 1933 census, and, although it is known that the populations are actually larger, these are the only reliable figures available.

A tentative distribution can be made on the following basis :—

For every 10,000 of population—

1 senior general practitioner.
3 junior general practitioners.

For every 50,000 of population—

2 senior physicians } Physicians include dermatologists and tuberculosis specialists.
2 junior physicians }
2 senior surgeons } Surgeons include gynæcologist and venereal specialists.
2 junior surgeons }
1 junior obstetrician.
1 junior special senses.
1 junior radiologist.
1 junior pediatrician.

For every 100,000 of population—

2 senior obstetricians.
2 senior special senses.
2 senior radiologists.
2 senior pediatricians.
1 psychiatrist.
1 pathologist.

The grouping would be as in the following table :—

—	£	Sydney.	Melbourne.	Brisbane.	Adelaide.	Perth.	Hobart.
Senior general practitioner	(1,350)	125	104	32	32	22	6
Junior general practitioner	(800)	375	312	96	96	66	18
Senior physicians	(1,650)	50	42	12	12	8	2
Junior physicians	(1,250)	50	42	12	12	8	2
Senior surgeons	(1,650)	50	42	12	12	8	2
Junior surgeons	(1,250)	50	42	12	12	8	2
Senior obstetricians	(1,650)	25	20	6	6	4	1
Junior obstetricians	(1,250)	25	20	6	6	4	1
Senior special senses	(1,650)	25	20	6	6	4	1
Junior special senses	(1,250)	25	20	6	6	4	1
Senior radiologists	(1,650)	25	20	6	6	4	1
Junior radiologists	(1,250)	25	20	6	6	4	1
Senior pediatricians	(1,650)	25	20	6	6	4	1
Junior pediatricians	(1,250)	25	20	6	6	4	1
Senior pathologist	(1,650)	12	10	3	3	2	1
Senior psychiatrist	(1,650)	12	10	3	3	2	1
Total		924	764	230	230	156	42
Total now practising		1,024	869	238	242	150	49

This grouping of doctors represents in salaries and mileage at £200 per annum—

—	Salaries.	Mileage.	Total.
	£		£
Sydney	1,088,350	184,800	1,273,150
Melbourne	898,600	152,800	1,051,400
Brisbane	269,100	46,000	315,100
Adelaide	269,100	46,000	315,100
Perth	181,900	31,200	213,100
Hobart	49,000	8,400	57,400
Total	2,756,050	469,200	3,225,250

This represents the following distribution according to population :—

Sydney, one doctor to every 1,395 of population.
Melbourne, one doctor to every 1,355 of population.
Brisbane, one doctor to every 1,416 of population.
Adelaide, one doctor to every 1,397 of population.
Perth, one doctor to every 1,412 of population.
Hobart, one doctor to every 1,506 of population.

This number is in excess of that generally regarded as necessary for the medical care of a community.

The alternative method is to group the population according to district centres of the D Class already described.

Assuming first that D Class Centres would be required for every 25,000 of population, this would give the following numbers :—

Sydney	51
Melbourne	41
Brisbane	13
Adelaide	12
Perth	9
Hobart	2

On careful review, these figures will probably be found to be excessive. For example, as a trial distribution, take centres distributed as follows :—

Sydney—

Manly.	Lidcombe.	Randwick.
Collaroy.	Strathfield.	Paddington.
Mosman.	Balmain.	Bellevue Hill.
North Sydney.	Ashfield.	Mascot.
Lindfield.	Leichhardt.	Botany.
Pymble.	Glebe	Bankstown.
Parramatta.	Newtown.	Kogarah.
Ryde.	Erskineville.	Liverpool.
Fairfield.	Waterloo.	

Add eight more and there are then only 34, so that it is probable that 35 would be enough.

Melbourne—

Williamstown.	Richmond.	Oakleigh.
Footscray.	Kew.	Dandenong.
North Melbourne.	Camberwell.	Elsternwick.
Brunswick.	Box Hill.	Brighton.
Preston.	Ringwood.	Frankston.
Fitzroy.	Prahran.	Essendon.
Heidelberg.	Malvern.	

For Melbourne 24 centres would be enough.

Brisbane—

The Valley.	Clayfield.	Kangaroo Point.
Hamilton.	Indooroopilly.	

For Brisbane estimate ten centres.

Adelaide—

Prospect.	Port Adelaide.	Unley.
Thebarton.	Glenelg.	Norwood.

For Adelaide estimate nine centres.

Perth—

Victoria Park.	Subiaco.	Fremantle.
Marylands.	Claremont.	

For Perth estimate six centres.

Hobart—

Newtown.	Bellerive.	Sandy Bay.

For Hobart three centres would be enough.

Instead, therefore, of 126 metropolitan centres estimated on one centre for every 25,000 of population, probably 87 would be sufficient.

A detailed study of each metropolitan area would be needed to determine precisely the number and location of the doctor and the centres, but for this general discussion the figure given may be taken as a reasonable basis for discussion.

This would result in the following distribution :—

Sydney	35
Melbourne	24
Brisbane	10
Adelaide	9
Perth	6
Hobart	3
Total	87

To recapitulate so that the position is clear, a district centre would be a building consisting of—

2 waiting rooms.
3 consultation rooms.
3 examination rooms.
1 special senses examination room.
1 X-ray room.
1 out-patients' theatre.
1 combined instrument and sterilizing room.
1 plaster and splint room.
1 laboratory.
1 room for health services.
Nurses' duty room.
Office and records room.
Lavatories.

This would cost £12,000 to build, £4,000 to equip, and £1,500 per annum to maintain. The total maintenance costs would be as shown for D Class Centres—£5,300.

The staff would be—

	£
1 senior general practitioner	1,350
3 junior general practitioners (£800)	2,400
1 senior physician	1,650
1 junior physician	1,250
1 senior surgeon	1,650
1 junior surgeon	1,650
1 junior ophthalmologist	1,250
1 junior otologist	1,250
1 senior obstetrician	1,650
1 senior pediatrician	1,650
1 junior pediatrician	1,250
1 junior radiologist	1,250
1 junior pathologist	1,250
1 psychiatrist	1,250
Total—Sixteen doctors	20,350

But it is considered that, for capital cities, the balance between general practitioners and specialists is too uneven.

It is therefore considered that each centre should have four (4) senior and twelve (12) junior general practitioners, and that the group of specialists shown should be available for each four of the city centres.

There would be also at each centre four nurses, at an average salary of £250, and there would be mileage which might be estimated at £3,000.

Medical officers engaged in health duties and health visitors will be discussed under the State administrative staff. No administrative staff would be necessary at these district centres, but one senior medical administrative officer would be desirable at £1,750–£2,000—mean salary £850.

This would give as expenditure—

Capital Cost at £16,000 per Centre.

—	Number of Centres.	Total Cost.
		£
Sydney	35	560,000
Melbourne	24	384,000
Brisbane	10	160,000
Adelaide	9	144,000
Perth	6	96,000
Hobart	3	48,000
Totals	87	1,392,000

Maintenance Costs at £5,300 per Centre.

—	Number of Centres.	Total Cost.
		£
Sydney	35	185,500
Melbourne	24	127,200
Brisbane	10	53,000
Adelaide	9	47,700
Perth	6	31,800
Hobart	3	15,900
Totals	87	461,100

Salaries.—Salaries must be shown separately for each capital city.

Sydney—35 Centres—	£	£
140 senior general practitioners	(1,350)	189,000
420 junior general practitioners	(800)	336,000
10 senior physicians	(1,650)	16,500
10 junior physicians	(1,250)	12,500
10 senior surgeons	(1,650)	16,500
10 junior surgeons	(1,250)	12,500
10 junior ophthalmologists	(1,250)	12,500
10 junior otologists	(1,250)	12,500
10 senior obstetricians	(1,650)	16,500
10 senior pediatricians	(1,650)	16,500
10 junior pediatricians	(1,250)	12,500
10 junior radiologists	(1,250)	12,500
5 psychiatrists	(1,250)	6,250
35 junior pathologists	(1,250)	43,750
35 administrative officers	(1,850)	64,750
735		780,750

Melbourne—24 Centres—	£	£
96 senior general practitioners	(1,350)	129,600
288 junior general practitioners	(800)	230,400
6 senior physicians	(1,650)	9,900
6 junior physicians	1,250)	7,500
6 senior surgeons	(1,650)	9,900
6 junior surgeons	(1,250)	7,500
6 junior ophthalmologists	(1,250)	7,500
6 junior otologists	(1,250)	7,500
6 senior obstetricians	(1,650)	9,900
6 senior pediatricians	(1,650)	9,900
6 junior pediatricians	(1,250)	7,500
6 junior radiologists	(1,250)	7,500
3 psychiatrists	(1,250)	3,750
24 junior pathologists	(1,250)	30,000
24 administrative officers	(1,850)	44,400
495		522,750

Brisbane—10 Centres—	£	£
40 senior general practitioners	(1,350)	54,000
120 junior general practitioners	(800)	96,000
3 senior physicians	(1,650)	4,950
3 junior physicians	(1,250)	3,750
3 senior surgeons	(1,650)	4,950
3 junior surgeons	(1,250)	3,750
3 junior ophthalmologists	(1,250)	3,750
3 junior otologists	(1,250)	3,750
3 senior obstetricians	(1,650)	4,950
3 senior pediatricians	(1,650)	4,950
3 junior pediatricians	(1,250)	3,750
3 junior radiologists	(1,250)	3,750
2 psychiatrists	(1,250)	2,500
10 junior pathologists	(1,250)	12,500
10 administrative officers	(1,850)	18,500
212		225,800

Adelaide—9 Centres—	£	£
36 senior general practitioners	(1,350)	48,600
108 junior general practitioners	(800)	86,400
3 senior physicians	(1,650)	4,950
3 junior physicians	(1,250)	3,750
3 senior surgeons	(1,650)	4,950
3 junior surgeons	(1,250)	3,750
3 junior ophthalmologists	(1,250)	3,750
3 junior otologists	(1,250)	3,750
3 senior obstetricians	(1,650)	4,950
3 senior pediatricians	(1,650)	4,950
3 junior pediatricians	(1,250)	3,750
3 junior radiologists	(1,250)	3,750
2 psychiatrists	(1,250)	2,500
9 junior pathologists	(1,250)	11,250
9 administrative officers	(1,850)	16,650
194		207,700

Perth—6 Centres—	£	£
24 senior general practitioners	(1,350)	32,400
72 junior general practitioners	(800)	57,600
2 senior physicians	(1,650)	3,300
2 junior physicians	(1,250)	2,500
2 senior surgeons	(1,650)	3,300
2 junior surgeons	(1,250)	2,500
2 junior ophthalmologists	(1,250)	2,500
2 junior otologists	(1,250)	2,500
2 senior obstetricians	(1,650)	3,300
2 senior pediatricians	(1,650)	3,300
2 junior pediatricians	(1,250)	2,500
2 junior radiologists	(1,250)	2,500
1 psychiatrist	(1,250)	1,250
6 junior pathologists	(1,250)	7,500
6 administrative officers	(1,850)	11,100
129		138,050

Hobart—3 Centres—	£	£
12 senior general practitioners	(1,350)	16,200
36 junior general practitioners	(800)	28,800
2 senior physicians	(1,650)	3,300
2 junior physicians	(1,250)	2,500
2 senior surgeons	(1,650)	3,300
2 junior surgeons	(1,250)	2,500
2 junior ophthalmologists	(1,250)	2,500
2 junior otologists	(1,250)	2,500
2 senior obstetricians	(1,650)	3,300
2 senior pediatricians	(1,650)	3,300
2 junior pediatricians	(1,250)	2,500
2 junior radiologists	(1,250)	2,500
1 psychiatrist	(1,250)	1,250
3 junior pathologists	(1,250)	3,750
3 administrative officers	(1,850)	5,550
75		83,750

The cost of these centres therefore would be—

—	Number of Centres.	Capital.	Maintenance.	Salaries.
		£	£	£
Sydney	35	560,000	185,500	780,750
Melbourne	24	384,000	127,200	522,750
Brisbane	10	160,000	53,000	225,800
Adelaide	9	144,000	47,700	207,700
Perth	6	96,000	31,800	138,050
Hobart	3	48,000	15,900	83,750
Total	87	1,392,000	461,100	1,958,800

The number of medical men in this arrangement would be—

—	Number of Centres.	Number of Doctors.	Proportion to Population.	Number of Doctors now Practising.	Proportion to Population.
Sydney	35	735	1,753	1,024	1,258
Melbourne	24	495	2,092	869	1,191
Brisbane	10	212	1,537	238	1,369
Adelaide	9	194	1,657	242	1,328
Perth	6	129	1,708	150	1,468
Hobart	3	75	843	49	1,291
Total	87	1,840	..	2,572	..

This table shows that, with this distribution, Sydney would have more than the number required for one doctor to every 2,000 of population. Melbourne has about the right number. The other four capitals would have too many doctors.

But, considering the total numbers—the number shown for the six capital cities is 1,840; the number necessary for the six capitals on the 1933 population in the ratio of 1 to 2,000 of population is 1,611. Allowing for a 10 per cent. increase in population since 1933, and for some redistribution of the figures as between capitals, the number shown in these tables is not excessive for the purposes of this estimate (one in every 1,946 of population).

State Administrative Expenses.

Each State must have a central administrative staff. This might well consist of—

	Per annum. £
1 Commissioner	2,000
(This should essentially be a medical officer preferably trained in public health administration.)	
1 public health deputy	1,750
2 clinical deputies	3,500
1 staff deputy	1,750
1 hospitals deputy	1,750
Total	10,750

These six officers would form the Consultative Council for the State, the ultimate executive authority resting with the Commissioner.

Officers of the junior responsible specialist grade would be needed in the Central State Office to the following numbers :—

Sydney	6
Melbourne	5
Brisbane	4
Adelaide	4
Perth	3
Hobart	3
Total	25

at £1,250 per annum = £31,250.

A supply branch for hospital and medical supplies would be essential.

Vacancies on account of leave and sickness will be filled in every case from a similar specialist of the same grade or one grade below.

A central laboratory should exist in each State; these or the nuclei of them already exist in all States.

Organized post-graduate training systems would be necessary.

Two health visitors should be attached to each metropolitan centre. The numbers of these would be—

Sydney	70	Adelaide	18
Melbourne	48	Perth	12
Brisbane	20	Hobart	6

One hundred and seventy-four at an annual salary of £250, and mileage at £100, amounts to salaries £43,500, and maintenance £17,400.

The State staff should also include—

	£
1 senior matron	500
2 deputy matrons (£400)	800

The State staffs might be summarized—

For all States—	£
Administrative	64,500
Junior medical	31,250
Health visitors	43,500
Matrons	7,800
Clerical services and office expenses	15,000
Maintenance	17,400
	179,450

Commonwealth Administrative Expenses.

As the system is assumed to be a Commonwealth system, a Central Administrative Staff would be necessary. This should consist of—

Three Commissioners—

	£
1 Chief Commissioner	2,500
1 Senior Deputy Commissioner	2,250
1 Junior Deputy Commissioner	2,000
	6,750

These three would constitute a Board which would determine all matters of policy.

Additionally there would be—

	£
1 senior public health officer for all international matters including quarantine ..	1,650
1 senior public health officer for all internal aspects including epidemics	1,650
1 senior officer dealing with hospital construction and administration	1,650
1 senior clinician dealing with all Commonwealth matters such as Public Service pensions, &c.	1,650
6 junior officers for all aspects of departmental work	7,500
1 senior matron dealing with nursing matters and health visitors	750
Total	14,850

The Commonwealth administration expenses would be—

	£
Commissioners	6,750
Medical staff	14,100
Matron	750
Office and incidental expenses	10,000
Total	31,600

Relief staffs to provide medical officers for the C, D, and Administrative Groups would be necessary. These are calculated on the basis of three week's leave and an average over the whole group of one week's sick leave annually, i.e., four weeks per man annually. The total of 1,146 divided by 13 gives 88. Allowing a relieving staff of 90 at an average salary of £1,000, means adding £90,000 to the annual salary total. An additional £10,000 would cover similar relief staff for other officers in the Service.

The summarized expenditure for the whole Service for all States will be-

—	Capital.	Maintenance.	Salaries.
	£	£	£
Extra metropolitan	3,525,250	909,850	2,977,116
Metropolitan	1,392,000	461,100	1,958,800
State administrative	..	32,400	147,050
Commonwealth administrative	..	10,000	21,600
Relieving staffs	..	..	100,000
Total	4,917,250	1,413,350	5,204,566

The total medical staff necessary to give effect to this service would be—

Extra metropolitan	2,463
Metropolitan	1,640
Metropolitan relieving	100
Total	4,203

The number estimated to be in practice at present in Australia is 4,000.

The present expenditure on health, hospitals, lunacy, and education medical services is shown in the following table :—

Health—	£	*Lunacy*—	£
New South Wales	490,000	New South Wales	897,000
Victoria	167,000	Victoria	554,000
Queensland	103,000	Queensland	260,000
South Australia	41,000	South Australia	165,000
Western Australia	73,000	Western Australia	128,000
Tasmania	43,000	Tasmania	71,000
Commonwealth—Northern Territory ..	30,000		
Special	180,000		
General	103,000		
Total	1,230,000		2,075,000

Hospitals—	£	*Education, Medical*—	£
New South Wales	2,932,000	New South Wales	35,000
Victoria	2,141,000	Victoria	16,000
Queensland	1,186,000	Queensland	26,000
South Australia	631,000	South Australia	6,000
Western Australia	489,000	Western Australia (*see* Health).	
Tasmania	165,000	Tasmania	7,000
Commonwealth—Northern Territory	20,000		
Total	7,564,000		90,000

The "special services" indicated in the above table under the heading of Commonwealth Health are Commonwealth Serum Laboratories, Commonwealth X-ray and Radium Laboratory, School of Public Health and Tropical Medicine, and Institute of Anatomy. These would continue under any new scheme but have not been discussed in the outline of new services discussed in the preceding pages.

The position, if the Commonwealth Government took over all existing hospitals, public health services, lunacy services, and school medical officer services is indicated in the following table. It is assumed that hospital and lunacy services would be transferred at their existing costs—definite savings on hospital maintenance would result from the establishment of district centres; these savings would balance any expenditure necessary for hospital improvement:—

—	Present Expenditure.	Expenditure under new Proposals.
	£	£
Hospitals	7,564,000	7,564,000
Lunacy	2,075,000	2,075,000
Education	90,000	..
Health—		
State	1,230,000	..
Commonwealth—General	103,000	..
Special	210,000	210,000
Total	11,272,000	9,849,000

This total of £9,849,000 to which the Commonwealth would be newly committed would be a transfer from State to Commonwealth finance, but no added burden to the taxpayer. The expenditure under Health and Education would be merged in the general medical scheme, which would, as stated above, involve—

	£
Capital expenditure	4,917,250
Maintenance	1,413,350
Salaries	5,204,566

Putting capital expenditure on one side as an item necessary to launch the scheme, the annually recurring expenditure under this scheme would be £6,617,916, from which must be taken £1,320,000, representing present expenditure on health and education medical services, leaving £5,297,916, or approximately £5,250,000 as the cost of the new elements in the scheme, apart from the capital expenditure shown.

While it is not thought that any of the items included in this estimate are unnecessary, it is probable that some have been overlooked.

It is considered desirable, therefore, to add an arbitrary figure of 15 per cent. to these estimates.

This would bring the total figures to—

	£
Capital	5,654,837
Maintenance	1,625,352
Salaries	5,985,250

As against this cost must be considered—

(*a*) that the expenditure by Friendly Societies on medical attendance and medicine (1938) was £864,341;
(*b*) that the estimated payments to medical men under the National Insurance Act amounted to £1,000,000;
(*c*) that the estimated average of annual gross incomes of medical men is £1,800—there are 4,000 doctors listed, amounting to £7,200,000 paid to doctors by the public.

This outline offers one method by which better standards for doctors and better service to the public can be secured.

Two interesting tables are appended—one shows the relative degree of hospitalization of the community in each of the States and the other shows the relative distribution of invalid pensioners. These two tables give rough indications of the relative incidence in each of the States of acute and chronic illness respectively—

—	Population.	Number of Hospitals.		In-patients Admitted 1937.	
		Number.	Per Hundred Thousand of Population.	Number.	Per Hundred Thousand of Population.
New South Waes	2,735,695	207	7	224,504	8,217
Victoria	1,873,760	71	3	88,190	4,777
Queensland	1,004,150	117	12	103,651	10,322
South Australia	595,109	54	9	34,707	5,832
Western Australia	462,461	92	20	41,409	8,960
Tasmania	241,407	19	8	19,187	7,948

Invalid Pensioners.

—	Number of Invalid Pensioners at 30th June, 1939.	Estimated Population at 30th June, 1939.	Invalid Pensioners Per Hundred Thousand of Population.	Annual Liability at 30th June, 1939, to Invalid Pensioners.	
				Total.	Per Head of Population.
				£	s. d.
New South Wales	41,887	2,746,871	1,525	2,110,238	15 4
Victoria	19,471	1,881,433	1,035	983,216	10 5
Queensland	12,070	1,016,498	1,187	611,286	12 0
South Australia	6,749	595,770	1,133	339,508	11 5
Western Australia	5,116	465,429	1,099	258,076	11 1
Tasmania	3,519	236,653	1,487	177,528	15 0

It is felt at this juncture that sufficient has been written to justify the submission of this as a practical scheme for governmental, professional and public consideration.

It is recognized, however, that further investigation would be needed to establish the appropriate place in this scheme of the following activities :—

Nurses' Registration and ancillary services, massage, &c.
Maternity.
Child Welfare.
Retiring age of medical men—
(*a*) Hospitals.
(*b*) From service.
Relation of National Medical to Medical Education.
Registration and Deregistration of medical men.
Private Hospitals.
Compensation payable to medical men.

Appendix II.

B CLASS CENTRES.

The following table shows the hospitals in the different States which have a daily average of less than 40 beds :—

—	Daily Average Beds.	Number of Doctors Practising.
New South Wales.		
Adaminaby	1	..
Ballina	20	2
Balranald	10	1
Barraba	10	2
Bega	35	2
Bellinger River District	28	2
Bingara	8	1
Blayney	8	2
Boggabri	6	2
Bombala	11	1
Bonalbo	1	1
Bourke	29	2
Braidwood	7	1
Brentwood	34	..
Brewarrina	14	1
Bulli	34	3
Bundara	3	1
Burrowa	10	..
Camden	30	2
Coraki	14	2
Canowindra	20	1
Carcoar	11	2
Cobar	19	1
Coffs Harbour	33	2
Collarenebri	11	1
Condobolin	23	1
Coolah	6	1
Cooma	26	3
Coonabarabran	23	2
Coonamble	28	2
Cowra	30	2
Crookwell	30	2
Dangar	19	..
Delegate	4	1
Deniliquin	21	3
Dorrigo	14	1
Dungog	12	2
Finley	6	1
Gilgandra	13	2
Glen Innes	38	6
Goodooga	1	1
Grenfell	22	4
Gulgong	19	3
Gundagai	19	2
Gunnedah	36	4
Hastings	15	..
Hay	37	3
Hillston	11	1
Illawarra	24	..
Ivanhoe	2	..
Jerilderie	26	1
Kentucky	1	..
Kiama	21	2
Lake Cargelligo	12	1
Leeton	36	4
Maclean	17	4
Manilla	15	2
Merriwa	7	1
Milton and Ulladulla	3	1
Molong	19	3
Moruya	5	1
Murrumburrah-Harden	12	3
Murrurundi	6	2
Narrabri	23	3
Nepean District	27	3
Nyngan	12	2
Pambula	18	1
Parkes	36	4
Peak Hill	8	1
Portland	14	1
Queanbeyan	30	3
Quirindi	25	3
Rylstone	12	1
Scone	30	4
Sofala	2	..
Tenterfield	19	3
Tibooburra	3	..
Tingha	7	1
Tottenham	2	1
Tumbarumba	6	1
Tumut	20	2
Urana	6	1
Vegetable Creek	10	..
Walcha	6	2
Warialda	10	1
***New South Wales*—continued.**		
Warren	8	1
Wee Waa	10	1
Wellington	27	4
Wentworth	10	1
Wilcannia	11	1
Yass	29	2
Young	36	4
Victoria.		
Alexandra	9	2
Bairnsdale	33	5
Beechworth	20	1
Camperdown	15	3
Casterton	18	2
Clunes	10	1
Corryong	10	1
Creswick	17	2
Daylesford	19	2
Dunolly	20	2
Heathcote	5	1
Inglewood	24	2
Kelmore	17	1
Kyneton	23	3
Maldon	20	1
Managatang	4	1
Mansfield	12	1
Nhill	19	2
Omeo	4	1
Orbost	11	2
Ouyen	26	1
Port Fairy	13	2
Portland	18	3
Stawell	24	2
Tallangatta	13	1
Warracknabeal	37	3
Wycheproof	12	1
Wonthaggi	31	2
Yarram	30	2
Queensland.		
Adavale	1	..
Aramac	4	1
Augathella	6	..
Babinda	22	1
Baralaba	7	..
Barcaldine	11	1
Beaudesert	23	2
Biggenden	14	1
Biloela	11	1
Birdsville	1	..
Blackall	12	2
Blair Athol	3	1
Boonah	18	2
Boulia	2	..
Bowen	22	3
Burketown	3	..
Camooweal	4	..
Canungra	2	1
Charleville	20	3
Chillagoe	11	1
Chinchilla	11	1
Clermont	19	2
Cloncurry	26	3
Collinsville	18	1
Cook	9	..
Cracow	5	..
Croydon	18	1
Cunnamulla	12	1
Dalby	33	3
Dirranbandi	6	1
Eidsvold	6	1
Emerald	11	1
Esk	13	1
Forsayth	1	..
Gayndah	15	1
Georgetown	1	..
Gin Gin	8	1
Gladstone	35	3
Goondiwindi	31	3
Gordonvale	12	1
Harrisville	2	1
Herberton	27	1
Home Hill	23	2
Hughenden	18	1
Ingham	39	3
Inglewood	5	1

APPENDICES I., II. AND III.

NOTE.—It is known that the numbers given in these appendices representing the numbers of doctors practising in different localities are not invariably accurate. No source of information other than Knox's *Medical Directory and Gazetteer* was available. This was published in 1938 and changes have occurred since then. Various checks have been made and it is considered that the totals upon which the estimates in this outline are based are, as gross figures, reasonably accurate.

APPENDIX I.

A CLASS CENTRES.

Note.—In some places more than one doctor is in practice. This is indicated in brackets in each instance.

NEW SOUTH WALES.

Adelong.
Albion Park.
Alstonville.
Ardlethan.
Ariah Park.
Bangalow (2).
Baradine.
Barellan.
Barham.
Barmedman.
Bateman's Bay.
Belmont (3).
Bermagui.
Berrigan.
Berry.
Bigga.
Binnaway.
Binna Burra.
Bowraville.
Branxton (2).
Broadwater.
Bulahdelah
Bungendore.
Byron Bay (2).
Campbelltown.
Candelo.
Cassilis.
Catherine Hill Bay.
Cobargo.
Coolamon.
Copmanhurst.
Coramba.
Corrimal (2).
Crescent Head.
Cudal.
Culcairn.
Cumnock.
Dapto.
Denman (2).
Dora Creek.
Dunedoo (2).
East Gresford.
Eden.
Eugowra.
Ganmain.
Gladstone.
Gloucester (2).
Gulargambone.
Gunning.
Guyra (2).
Helensburg.
Henty (2).
Holbrook.
Jervis Bay.
Junee (2).
Kandos.
Lawson.
Lockhart (2).
Lyndhurst (2).
Macksville (2).
Mandurama.
Manildra.
Mendooran.
Nabiac.
Narooma.
Narromine.
Nimbin.
Nowra (3).
Oberon.
Ourimbah.
Paterson.
Picton.
Pleasant Hills.
Port Kembla (2).
Port Macquarie (2).
Quandialla.
Raymond Terrace (2).
Richmond.
Rooty Hill.
St. Mary's.
South Woodburn.
Springwood (2).
Stockinbingal.
Stroud.
Tallimba.
Taralga.
Tea Gardens.
The Entrance.
The Rock.
Thirroul.
Tocumwal.
Trangie.
Trundle.
Tullamore.
Tuncurry.
Ulmarra.
Ungarie.
Walla Walla.
Wauchope (2).
Werris Creek.
Weston.
Windsor (2).
Wingham (2).
Woodburn.
Woodstock.
Woolgoolga.
Woy Woy.
Wyong—Yenda.

VICTORIA.

Avoca.
Bacchus Marsh.
Ballan.
Balliang.
Barwon Heads.
Beaufort.
Beeac.
Belgrave.
Benalla.
Berwick.
Beulah.
Birchip.
Birregurra.
Boort.
Bright.
Broadford.
Buninyong.
Bunyip.
Charlton.
Chelsea.
Chiltern.
Cobden.
Coleraine.
Cowes.
Cranbourne.
Croydon.
Dandenong.
Daylesford.
Dimboola.
Donald.
Dromana.
Drouin.
Eaglehawk.
Edenhope.
Elmore.
Euroa.
Ferntree Gully.
Frankston (6).
Foster.
Garfield.
Gisborne.
Glenthompson.
Goroke.
Hall's Gap.
Hastings.
Healesville.
Heyfield.
Heywood.
Hopetoun.
Jeparit.
Kaniva.
Katamatite.
Kerang (3).
Koo-wee-rup.
Koroit.
Korumburra.
Kyabram.
Lancefield.
Lang Lang.
Learmonth.
Leongatha.
Lilydale (3).
Lismore.
Loch.
Lockington.
Macarthur.
Maffra.
Malmsbury.
Meeniyan.
Merbein.
Meredith.
Merino.
Metung.
Minyip.
Mirboo North.
Mitiamo.
Moe.
Mornington.
Mortlake.
Mount Macedon.
Morwell.
Murchison.
Murrayville.
Murtoa.
Myrtleford.
Nagambie.
Nathalia.
Neerim South.
Numurkah.
Nyah West.
Pakenham East.
Penshurst.
Portarlington.
Pyramid Hill.
Quambatook.
Queenscliff.
Rainbow.
Red Cliffs.
Rochester (3).
Rokewood.
Romsey.
Rosebud.
Rupanyup.
Rushworth.
Rutherglen.
Sassafras.
Scotsburn.
Sea Lake.
Seymour.
Somerville.
Sorrento.
Skipton.
Smythesdale.
Sunbury.
Tatura.
Terang.
Tongala.
Toora.
Trafalgar.
Traralgon (4).
Trentham.
Ultima.
Violet Town.
Walwa.
Warburton.
Wedderburn.
Werribee.
Werrimul.
Whittlesea.
Willaura.
Winchelsea.
Wodonga.
Woodend.
Woomelang.
Woori Yallock.
Yackandandah.
Yallourn.
Yarra Junction.
Yarrawonga.
Yea.

QUEENSLAND.

Allora (3).
Beenleigh (2).
Buderim.
Burleigh Heads.
Caboolture.
Caloundra.
Childers (2).
Cleveland (2).
Clifton (2).
Cooktown.
Cooroy.
Crows Nest.
Dayboro.
Duaringa.
Emu Park.
Eumundi.
Gatton.
Glenmorgan.
Goomeri.
Howard (2).
Jandowae.
Killarney.
Lowood.
Marburg (2).
Mount Coolon.
Murgon.
Oakey.
Palmwoods.
Pialba.
Pittsworth.
Pomona.
Redcliffe (2).
Rosewood.
Sarina.
Southport.
Sylvia Vale.
Toogoolawah.
Woodford.

SOUTH AUSTRALIA.

Aldgate.
Ardrossan.
Auburn.
Berri.
Brinkworth.
Bute.
Clarendon.
Crafers.
Cummins.
Curramulka (2).
Freeling.
Gladstone (2).
Glandore.
Gumeracha.
Hahndorf.
Hamley Bridge.
Kadina (3).
Karoonda (2).
Kingston.
Kooringa (2).
Laura.
Lobethal.
MacGillivray.
Mallala.
Moonta (2).
Morphett Vale.
Mount Lofty (2).
Mount Pleasant.
Nairne.
Nuriootpa.
Penola.
Port Broughton.
Port Wakefield.
Quorn.
Robe.
Stirling.
Strathalbyn.
Tailem Bend.
Tanunda (2).
Tea Tree Gully.
Terowie.
Uraidla (2).
Whyalla
Willunga.
Woodside (2).
Yankalilla.

WESTERN AUSTRALIA.

Armadale.
Brunswick Junction.
Carnamah.
Donnybrook.
Dowerin.
Kalamunda.
Koorda.
Meckering.
Mundaring.
New Norcia.

TASMANIA.

Bothwell.
Burnie (3).
Cygnet.
Deloraine.
Derby.
Evandale.
Fingal (2).
Flinders Island.
Franklin.
Geeveston.
Gormanston.
Huonville (2).
Longford (2).
Moonah (2).
Oatlands.
Penguin.
Rosebery.
Rosetta.
Rowella.
St. Helens (2).
Sheffield.
Smithton (2).
Sorrell (2).
Stanley.
Strahan.
Swansea.
Tarraleah.
Waratah (3).
Westbury.

APPENDIX II.

B CLASS CENTRES.

The following table shows the hospitals in the different States which have a daily average of less than 40 beds :—

—	Daily Average Beds.	Number of Doctors Practising.
NEW SOUTH WALES.		
Adaminaby	1	..
Ballina	20	2
Balranald	10	1
Barraba	10	2
Bega	35	2
Bellinger River District	28	2
Bingara	8	1
Blayney	8	2
Boggabri	6	2
Bombala	11	1
Bonalbo	1	1
Bourke	29	2
Braidwood	7	1
Brentwood	34	..
Brewarrina	14	1
Bulli	34	3
Bundara	3	1
Burrowa	10	..
Camden	30	2
Coraki	14	2
Canowindra	20	1
Carcoar	11	2
Cobar	19	1
Coffs Harbour	33	2
Collarenebri	11	1
Condobolin	23	1
Coolah	6	1
Cooma	26	3
Coonabarabran	23	2
Coonamble	28	2
Cowra	30	2
Crookwell	30	2
Dangar	19	..
Delegate	4	1
Deniliquin	21	3
Dorrigo	14	1
Dungog	12	2
Finley	6	1
Gilgandra	13	2
Glen Innes	38	6
Goodooga	1	1
Grenfell	22	4
Gulgong	19	3
Gundagai	19	2
Gunnedah	36	4
Hastings	15	..
Hay	37	3
Hillston	11	1
Illawarra	24	..
Ivanhoe	2	..
Jerilderie	26	1
Kentucky	1	..
Kiama	21	2
Lake Cargelligo	12	1
Leeton	36	4
Maclean	17	4
Manilla	15	2
Merriwa	7	1
Milton and Ulladulla	3	1
Molong	19	3
Moruya	5	1
Murrumburrah-Harden	12	3
Murrurundi	6	2
Narrabri	23	3
Nepean District	27	3
Nyngan	12	2
Pambula	18	1
Parkes	36	4
Peak Hill	8	1
Portland	14	1
Queanbeyan	30	3
Quirindi	25	3
Rylstone	12	1
Scone	30	4
Sofala	2	..
Tenterfield	19	3
Tibooburra	3	..
Tingha	7	1
Tottenham	2	1
Tumbarumba	6	1
Tumut	20	2
Urana	6	1
Vegetable Creek	10	..
Walcha	6	2
Warialda	10	1
***New South Wales*—continued.**		
Warren	8	1
Wee Waa	10	1
Wellington	27	4
Wentworth	10	1
Wilcannia	11	1
Yass	29	2
Young	35	4
VICTORIA.		
Alexandra	9	2
Bairnsdale	33	5
Beechworth	20	1
Camperdown	15	3
Casterton	18	2
Clunes	10	1
Corryong	10	1
Creswick	17	2
Daylesford	19	2
Dunolly	20	2
Heathcote	5	1
Inglewood	24	2
Kelmore	17	1
Kyneton	23	3
Maldon	20	1
Managatang	4	1
Mansfield	12	1
Nhill	19	2
Omeo	4	1
Orbost	11	2
Ouyen	20	1
Port Fairy	13	2
Portland	18	3
Stawell	24	2
Tallangatta	13	1
Warracknabeal	37	3
Wycheproof	12	1
Wonthaggi	31	2
Yarram	30	2
QUEENSLAND.		
Adavale	1	..
Aramac	4	1
Augathella	6	..
Babinda	22	1
Baralaba	7	..
Barcaldine	11	1
Beaudesert	23	2
Biggenden	14	1
Biloela	11	1
Birdsville	1	..
Blackall	12	2
Blair Athol	3	1
Boonah	18	2
Boulia	2	..
Bowen	22	3
Burketown	3	..
Camooweal	4	..
Canungra	2	1
Charleville	20	3
Chillagoe	11	1
Chinchilla	11	1
Clermont	19	2
Cloncurry	26	3
Collinsville	18	1
Cook	9	..
Cracow	5	..
Croydon	18	1
Cunnamulla	12	1
Dalby	33	3
Dirranbandi	6	1
Eidsvold	6	1
Emerald	11	1
Esk	13	1
Forsayth	1	..
Gayndah	15	1
Georgetown	1	..
Gin Gin	8	1
Gladstone	35	3
Goondiwindi	31	3
Gordonvale	12	1
Harrisville	2	1
Herberton	27	1
Home Hill	23	2
Hughenden	18	1
Ingham	39	3
Inglewood	5	1

B CLASS CENTRES—*continued.*

—	Daily Average Beds.	Number of Doctors Practising.
Queensland—continued.		
Isis	15	..
Isisford	3	..
Jericho	5	..
Julia Creek	8	..
Jundah	1	1
Kilcoy	9	1
Kynuna	1	..
Laidley	12	1
Longreach	19	3
Maleny	8	1
Many Peaks	1	..
Mareeba	36	1
Miles	11	1
Mitchell	11	1
Monto	19	1
Mossman	19	..
Mount Perry	3	1
Mount Isa	35	2
Mount Garnet	1	..
Mount Molloy	1	..
Mount Mulligan	1	1
Mundubbera	18	1
Mungindi	9	..
Muttaburra	4	1
Nambour	35	2
Nanango	19	2
Normanton	4	1
Proserpine	25	1
Quilpie	7	1
Richmond	8	2
Roma	35	3
Sapphire	1	..
Springsure	8	..
St. George	21	1
Stanthorpe	38	3
Surat	4	1
Tambo	5	1
Tara	3	1
Taroom	4	2
Texas	9	1
Thargomindah	1	1
Thursday Island	20	1
Tully	26	2
Wallumbilla	1	1
Winton	14	1
Wondai	33	2
Yeppoon	9	1
SOUTH AUSTRALIA.		
Angaston	12	1
Balaklava	16	1
Barmera	21	1
Blyth	8	1
Booleroo Centre	16	1
Border Town	15	..
Burra	18	2
Clare	14	3
Cleve	9	..
Cowell	5	1
Crystal Brook	14	1
Elliston	2	..
Eudunda	13	1
Gawler	20	5
Hawker	3	3
Jamestown	17	2
Kapunda	15	1
Kimba	5	1
Kingscote	5	1
Lameroo	3	1
Loxton	11	2
Maitland	9	1
Mannum	8	3
Millicent	8	1
Minlaton	7	1
Morgan	2	..
Mount Barker	10	2
Murray Bridge	24	4
Narracoorte	27	3
Orroroo	12	1
Peterborough	18	2
Pinnaroo	6	1
Port Lincoln	21	3
Port Pirie	38	4
Renmark	18	3
Riverton	12	1
Snowtown	4	2
Streaky Bay	9	2
Tumby Bay	15	1
Victor Harbour	12	2
Waikerie	6	1
Wallaroo	38	2

B CLASS CENTRES—*continued.*

—	Daily Average Beds.	Number of Doctors Practising.
South Australia—continued.		
Wundinna	7	2
Yorketown	14	1
WESTERN AUSTRALIA.		
Albany	30	6
Beverley	6	2
Big Bell	10	..
Boyup Brook	2	2
Bridgetown	11	2
Brookton	3	..
Broome	5	1
Bruce Rock	5	1
Bunbury	29	4
Busselton	21	3
Carnarvon	9	1
Collie	31	3
Coolgardie	12	..
Corrigin	12	1
Cue	7	1
Cunderdin	4	1
Dalwallinu	8	1
Derby	2	1
Dumbleyung	2	1
Dwellingup	10	..
Esperance	3	1
Goomalling	8	1
Gnowangerup	7	2
Hall's Creek	1	..
Harvey	12	3
Jarrahdale	1	2
Katanning	20	2
Kellerberrin	9	1
Kojonup	6	1
Kukerin	1	..
Kondinin	1	..
Kununoppin	2	1
Lake Grace	9	1
Laverton	8	1
Leonora	9	1
Manjimup	12	1
Marble Bar	4	1
Margaret River	13	1
Meekatharra	6	1
Menzies	1	..
Merredin	22	3
Moora	7	1
Mornington	1	..
Morawa	7	1
Mount Barker	8	1
Mount Magnet	9	1
Mullewa	8	1
Nannup	4	1
Narembeen	1	1
Narrogin	28	2
Norseman	19	1
Northampton	7	1
Onslow	2	1
Pemberton	7	1
Pingelly	4	1
Pinjarra	10	1
Port Hedland	6	1
Quairading	8	1
Reedy	8	..
Roebourne	3	1
Sandstone	1	..
Southern Cross	13	2
Tambellup	1	1
Three Springs	7	1
Toodyay	..	1
Wagin	6	2
Wickepin	3	1
Westonia	1	..
Williams	2	..
Wiluna	10	2
Wongan Hills	7	..
Wyalkatchem	5	1
Wyndham	2	2
Yarloop	22	1
York	9	2
Youanmi	2	..
TASMANIA.		
Beaconsfield	9	1
Campbelltown	14	2
Currie-King Island	5	1
Queenstown	28	2
Scottsdale	12	1
St. Mary's	5	1
Ulverstone	13	2
Wynyard	27	2
Zeehan	21	1

APPENDIX III.

D CLASS CENTRES.

In this Appendix an attempt is made to group country towns with a daily hospital in-patient average of over 50 according to their conditions, allotting full D Class Centres or modified variants according to the presumed local needs. The full table of the towns concerned is given at the commencement of the section relating to D Class Centres.

NEW SOUTH WALES.

Bathurst is between Orange and Lithgow—both Bathurst and Lithgow could be served by C Class Centres, while Orange becomes a District Centre.

Corowa is near to Albury and can be served by a C Class Centre, Albury being the district centre.

Inverell is at the extreme of a branch line of communication and can be served by C Class Centre, Moree being the District Centre.

Casino and Murwillumbah can be served by C Class Centre, Lismore being the District Centre.

So that there will be in New South Wales—

Towns having C Class Centres—

Bathurst.	Corowa.	Casino.
Lithgow.	Inverell.	Murwillumbah.

Hospital towns becoming District Centres—

Armidale.	Kempsey.	Tamworth.
Albury.	Lismore.	Taree.
Dubbo.	Moree.	Wagga.
Goulburn.	Narrandera.	Wollongong.
Grafton.	Orange.	

Newcastle.—This city, including its suburbs, has a population of 104,485, a daily hospital average of 327 beds and 36 medical men practising. There are in the district the following hospitals:—

	Daily average.
Newcastle	327
Maitland	141
Waratah	128
Cessnock	123
Kurri	75

In addition, it is an important industrial centre with industries involving considerable health hazards, and it has a well-populated and important and extensive surrounding district.

It may well have assigned to it three C Class Centres, at Maitland, Cessnock and Kurri, and a full District Centre at Newcastle.

In addition, there should be—

	£
1 junior physician	1,250
1 junior surgeon	1,250
1 junior obstetrician	1,250
1 senior radiologist	1,650
1 senior pathologist	1,650
4 additional health visitors	1,000
2 industrial medical officers	2,500
Total	10,550

An additional £2,500 might be allowed for maintenance expenditure.

Summarizing this expenditure for Newcastle—

—	Number.	Capital.	Maintenance.	Salaries.	Number of Doctors.
		£	£	£	
C Class Centre	3	25,500	3,750	13,050	12
District centres	1	16,000	5,300	33,450	16
Additional staff	..	..	2,500	10,550	6
Total	..	41,500	11,550	57,050	34

This allocation* would give Newcastle one doctor to every 3,073 of population. This allocation may need revision, but apparently it is sufficient as only 36 medical men are practising at present.

Broken Hill, with a population of 26,925 and a daily hospital average of 171, has eight doctors practising in the town. It has, however, an industrial risk but it has not a real rural population. It should, therefore, be well served by one C Class Centre and a central District Centre with the following staff:—

	£
1 senior general practitioner	1,350
3 junior general practitioners	2,400
4 nurses	800
1 junior surgeon	1,250
1 senior radiologist	1,650
1 junior radiologist	1,250
1 junior pathologist	1,250
1 junior pediatrician	1,250
1 health officer	1,250
1 industrial medical officer	1,250
4 health visitors	1,000
Clerical services	1,500
	16,200

The capital cost and the maintenance of this centre would be as elsewhere.

* Exclusive of health officers and administrative staff.

The cost at Broken Hill would be therefore—

—	Capital.	Maintenance.	Salaries.
	£	£	£
One C Class Centre	8,500	1,250	4,350
District centre	16,000	5,300	16,200
Total	24,500	6,550	20,550

This allocation would give Broken Hill ten clinicians, excluding radiologists, pathologist, and health officers. This would be in the proportion of one to every 2,700 of population.

The totals for New South Wales in respect of D Class Centres with their auxiliary C Class Centres in this group will be—

—	Number of Centres.	Capital.	Maintenance.	Salaries.
		£	£	£
C Class	6	51,000	7,500	26,100
D Class	14	224,000	74,200	468,300
Newcastle	..	41,500	11,550	57,050
Broken Hill	..	24,500	6,550	20,550
Total for New South Wales	..	341,000	99,800	572,000

VICTORIA.

In Victoria, the following towns would have D Class Centres:—

Colac.
Echuca.
Hamilton.
Horsham.
Maryborough.
Mildura.
Mooroopna.
Sale.
St. Arnaud.
Wangaratta.
Warragul.
Warrnambool.

Ballarat and Geelong would both also require two C Class Centres in addition to the District Centres.
Ballarat has a population of 37,411 with 30 practising doctors, and a daily hospital average of 172.
Geelong has a population of 39,223, with 31 practising doctors, and a daily hospital average of 145.

This allocation would give Ballarat one clinical doctor to every 1,700 persons, and Geelong one to every 1,780 persons.

That is, for Ballarat and Geelong, the total cost would be—

—	Number of Centres.	Capital.	Maintenance.	Salaries.
		£	£	£
Class C	4	34,000	5,000	17,400
Class D	2	32,000	10,000	66,900
Total	6	66,000	15,000	84,300

Bendigo, with a population of 29,131, has a daily average at the hospital of 227 beds, with 27 doctors practising. It would be a District Centre with the normal local C Class Centre staff and the district specialist services. In addition the town and suburbs would require two further C Class Centres.

The cost would therefore be—

—	Capital.	Maintenance.	Salaries.	Number of doctors*
	£	£	£	
Two C Class Centres	17,000	2,500	8,700	6
One district centre	16,000	5,300	33,450	16
Total	33,000	7,800	42,150	22

* Exclusive of health officers and administrative staff.

This allocation would give Bendigo one clinical doctor to every 1,324 persons.

The total cost of D Class Centres with their auxiliary C Class Centres in Victoria would be—

—	Number of Centres.	Capital.	Maintenance.	Salaries.
		£	£	£
D Class Centres	12	192,000	63,600	401,400
Ballarat and Geelong	..	66,000	15,600	84,300
Bendigo	..	33,000	7,800	42,150
Totals for Victoria	..	291,000	87,000	527,850

QUEENSLAND.

In Queensland—
Atherton and Innisfail are near to Cairns.
Charters Towers is near to Townsville.
Mount Morgan is near to Rockhampton.
Warwick is near to Toowoomba.
Bundaberg and Gympie are near to Maryborough.
All these centres might be classes as C Class Centres. Gympie and Bundaberg might require more than the standard staff but Atherton and Mount Morgan might require less—standard staff will therefore be calculated throughout.
This will give a total of seven C Class Centres.
In Queensland the district centres will be—

Toowoomba.
Ipswich.
Maryborough.
Rockhampton.
Mackay.
Townsville.
Cairns.

A total number of seven.

As, however, a review of local conditions might require some modification of this allocation, it is proposed to estimate on eight centres each of C and D Classes.

In addition, four industrial medical officers might well be allotted to the State as a whole for posting at suitable centres. These should carry the salary of a junior specialist (mean £1,250) and it would be reasonable to allow £1,000 per annum for the total expenses of the four officers.

The cost of D Class Centres, including auxiliary C Class Centres, in Queensland is shown thus—

—	Number.	Capital.	Maintenance.	Salaries.
		£	£	£
C Class	8	68,000	10,000	34,800
D Class	8	128,000	42,400	267,600
Industrial officers	4	..	1,000	5,000
Total for Queensland	..	196,000	53,400	307,400

SOUTH AUSTRALIA.

In South Australia, the natural centres of rural population are Port Pirie, Port Lincoln, Mount Gambier, Wallaroo and Renmark.
Each of these should have a modified D Class Centre with reduced staff which might well be as follows:—

	£
1 junior surgeon ..	1,250
1 junior physician	1,250
1 junior special senses	1,250
1 junior obstetrician	1,250
1 junior pediatrician	1,250
1 junior radiologist	1,250
2 health and school medical officers	2,500
4 health visitors ..	1,000
Total ..	11,000
Mileage—Seven doctors at £200	1,400
Mileage—Four health visitors at £100	400
Total ..	1,800

In addition there should be—

	£
For each district one administrative officer	1,350
Clerical and other expenses	1,000
At Port Pirie an industrial medical officer is needed in addition to health officers	1,250

And £500 might be allowed for the expenses of this officer's work.

The building and equipment will probably not be much less than is required for a D Class Centre and costs might well be estimated on the basis of a D Class Centre for each of the five centres.

The costs can be shown thus—

	£
Capital—	
District Centre ..	12,000
Equipment ..	4,000
	16,000
Maintenance—	
Centre ..	1,500
Mileage—	
Clinical ..	1,200
Health ..	1,000
Health visitors	800
Administrative	100
Nurses, keep ..	200
Office and records	500
	5,300
Salaries—	
C Centre Staff (7)	4,350
Additional nurse (1)	200
District staff, clinical (6)	7,500
Health officers (2)	2,500
Health visitors (4)	1,000
Administrative (1)	1,350
Clerical ..	1,000
	17,900

The total of this expenditure for South Australia on D Class Centres is shown thus—

—	Number.	Capital.	Maintenance.	Salaries.
		£	£	£
D Class	5	80,000	26,500	89,500
Industrial officer	1	..	500	1,350
Total for South Australia	..	80,000	27,000	90,850

WESTERN AUSTRALIA.

The extra-metropolitan service in Western Australia could be covered from six centres—

Albany. Bunbury. Narrogin. Northam. Geraldton. Kalgoorlie.

Of these, the first five could be well served by centres of the kind described for South Australian country centres.

The cost of these would be—

—	Capital.	Maintenance.	Salaries.
	£	£	£
Unit cost	16,000	5,300	17,900
Five centres	80,000	26,500	89,500

Kalgoorlie and district require special treatment. This area should be provided with—

1 C Class Centre.
1 Full D Class Centre.

It is probable that for this D Class Centre, a smaller administrative staff, and perhaps a smaller clinical staff, would be sufficient, but for purposes of simplicity, and having regard to the large area to be served, the unit standards might be accepted. This would make the cost for Kalgoorlie—

—	Capital.	Maintenance.	Salaries.
	£	£	£
C Class	8,500	1,250	4,350
D Class	16,000	5,300	33,450
Total for Kalgoorlie	24,500	6,550	37,750

Combining the costs for Western Australia thus—

—	Capital.	Maintenance.	Salaries.
	£	£	£
Five modified D Class Centres ..	80,000	26,500	89,500
Kalgoorlie..	24,500	6,550	37,750
Total for Western Australia ..	104,500	33,050	127,250

TASMANIA.

In Tasmania.—Devonport is so situated that it should be a District Centre. Launceston should be a District Centre and, in addition, have one other C Class Centre.

Queenstown should have a C Class Centre with additional staff as follows:—

	£
1 junior surgeon	1,250
1 junior radiologist	1,250
1 junior pediatrician	1,250
1 health officer	1,250

The cost of this Tasmanian service would be—

—	Capital.	Maintenance.	Salaries.
	£	£	£
Launceston—			
C Centre	8,500	1,250	4,350
District Centre	16,000	5,300	33,450
Devonport—			
District Centre	16,000	5,300	33,450
Queenstown—			
C Centre	8,500	1,250	4,350
Additional	..	..	5,000
Total for Tasmania	49,000	13,100	80,600

Canberra is in a rather different position from that of other centres. It is, at present, near enough to Goulburn for that city to act as the District Centre. It would, when the population is normal, require two C Class Centres, one for the northern side and one for the southern. The hospital could serve all the needs of the main consultation centre. Each C Class Centre, however, would be sufficiently served by one senior and one junior general practitioner. In addition would be required—

	£
1 junior surgeon	1,250
1 junior special senses	1,250
1 junior pediatrician	1,250
1 junior radiologist	1,250
	5,000

This is expressed in the following summary:—

—	Capital.	Maintenance.	Salaries.
	£	£	£
C Class Centres	17,000	2,500	8,700
Centre staff	..	..	5,000
Total	17,000	2,500	13,700

Canberra has a population of approximately 9,000 with seven doctors now practising.

The above allocation would give a ratio of one doctor to every 1,290 of population.

Appendix "C"

FEDERAL COUNCIL OF THE BRITISH MEDICAL ASSOCIATION IN AUSTRALIA.

22nd September, 1941.

A GENERAL MEDICAL SERVICE FOR AUSTRALIA.

1. "THE PROBLEM".

1. "Health is a precious possession, so precious that one does not ordinarily set a money value upon it. It is not exchanged in the market place. It is personal and intimate, something cherished for the pursuit of happiness."

An efficient health service is essential to the welfare of every progressive nation. The principle that a health service should be complete and available to all citizens is supported by modern developments in medicine, by the universal trend towards co-operative social effort and by the better standard of physical fitness required for national survival in the highly competitive world of today.

2. The past thirty years have been characterized by a widening and a deepening of the public interest in the problems of personal and public health. The establishment of the systematic medical examination of school children, the organization of tuberculosis, venereal disease, maternity and child welfare, mental and mental deficiency services, and the development of the public hospital system, all illustrate the greatly increased interest which the community, through the State, has manifested in health and sickness provision as a form of social service. The Press, the radio, and the public platform have combined to keep continually before the public as a live and personal issue "The Health of the People".

3. The existing health agencies are different in their origin and inspiration and diverse in their form. The State, which forty years ago confined its interest in national health exclusively to the protection of the community from the ravages of infectious disease and the abatement of the grosser dangers to communal health, began in the early years of this century to interest itself in personal health services. In particular it has made forms of provision for the mother and the infant, the school child, and for those of all ages who are suffering from certain diseases or defects or who need institutional treatment. The public hospitals, born of humanitarian motives and intended mainly to serve the poor, now minister, with State aid, to a section of the community which is, in the great majority of cases, neither destitute nor poor. The services of the private practitioner are available to all sections of the community on an individual fee paying or capitation or charitable basis. Different services have been established at different times by different agencies with different motives.

4. The State continues steadily to increase and extend its health and sickness activities. But it cannot be said that each new development is an expression of a unified health policy of ordered development. Still less can it be said that the State, in creating new facilities or services, invariably takes steps to ensure a close correlation with parallel non-State or voluntary provision. The result has been piecemeal and fragmentary growth rather than consistent and systematic development. The public is often served by unrelated and competitive agencies. The individual passes from consulting room to clinic or hospital, from private to official doctor and often back again, to obtain from many unrelated agencies a service which could be more efficiently provided as one co-ordinated whole.

5. A properly planned health service is urgently needed to secure co-ordination and co-operation. The British Medical Association

representing the great majority of doctors in this country, has constantly studied in principle and in detail many aspects of this subject. As an outcome the Association now submits for the consideration of the public a coherent and inclusive scheme of medical service based on a few simple basic principles. The plan of medical provision which the Association advocates is one that would ensure for all who need it every kind of treatment available for the cure of the sick and prevention of disease, and would utilize for this purpose every class of medical practitioner. It is in accordance with the belief and traditions of the medical profession and would have its whole-hearted support.

II. " GENERAL PRINCIPLES".

6. The main basis principles of the scheme are four in number :-

1. That the system of medical service should be directed to the achievement of positive health and the prevention of disease no less than to the relief of sickness.

2. That there should be provided for every individual the services of a general practitioner or a family doctor of his own choice.

3. That consultants and specialists, laboratory services, and all necessary auxiliary services, together with institutional provision when required should be available for the individual patient, normally through the agency of the family doctor.

4. That the several parts of the complete medical service should be closely co-ordinated and developed by the application of a planned national health policy.

7. The system of medical service should be directed to the achievement of positive health and the prevention of disease no less than to the relief of sickness.

Health is something more than the absence of disease. While provision for the treatment of disease is an essential part of any satisfactory health service, the emphasis should rest on the positive prosecution of measures to maintain and enhance mental and physical health.

8. This first principle not only satisfies the demands of enlightened public opinion but it accords with the spirit and trend of modern medicine. Recent years have been characterized by a reorientation of medical thought anda widening of the basis of medical practice. Whereas, until comparatively recently, medicine found its sanction to a large extent in the sciences of pathology and morbid anatomy, it now approaches the problems of health and disease from the standpoint of applied biology, concentrating not only on the causes and treatment of disease in its individual manifestations but on the promotion and maintenance of positive health. It views the individual not as a vehicle of disease processes but as a living organism adapting itself to its environment.

9. By continuous attention to such factors as housing, water and food supply, the prevention of epidemics, and the prevention or abatement of conditions injurious to health, the services administered by local authorities ensure a standard of environmental circumstances which is vastly superior to anything which existed comparatively few years ago. There is no room for complacency, however, for much remains to be done. The nutritional standards of some of our people are too low; such a valuable food as milk is by no means universally safe; facilities for recreation are commonly inadequate; bad housing and overcrowding exists; and preventable

infectious disease still occurs all too frequently.

10. There are signs of a new public interest in the more positive aspects of health. There are signs of improved technique in health education; it is directed more to healthy living and less to particular diseases. Biology and elementary hygiene are being taught more effectively in the schools, while the Press, the poster, the pamphlet, the film, and - potentially the greatest of all - the radio, are all contributing to health education but need adequate supervision and control.

11. But the value of all these contributions can be greatly enhanced by the work of the family doctor. Because of his intimate knowledge of the homes and lives of his patients he has unrivalled opportunities of advising on wise and healthy living. This is made possible, however, only when a family doctor is within easy reach of every citizen and when every citizen avails himself of the advice and help that his doctor can give :

In the modern conception of medical practice great emphasis is placed on the role of the family doctor as health adviser. Owing to the advances of scientific knowledge many specialisms have developed, and there is nothing to suggest that this movement will be less rapid in the future than it has been in recent times. On the other hand, there has emerged a growing public appreciation of the value of health and of the importance of early attention to departures from normal and a demand for the services of the general practitioner as health adviser. This movement is bound to develop rapidly, and the national policy for the promotion of the health of the people should be so framed as to encourage it. The role of health adviser by the family doctor is a natural development of ordinary medical practice, and the training of the student of medicine should be adapted to fit him for it.

12. There should be provided for every individual the services of a general practitioner or a family doctor of his own choice.

It is of primary importance that the organisation of the health service of the nation should be based upon the family as the normal unit, and on the family doctor as the normal medical attendant and guardian. It is not for disease or diseases in the abstract that provision has to be made; but for persons liable to or suffering from disease. The first essential for the proper and efficient treatment of individual persons is, therefore, not institutional but personal service, such as can be rendered in their own homes only by a family doctor who has the continuous care of their health; to whom they will naturally turn for advice and help in all matters pertaining thereto; who will afford them such professional services as he can render personally; and who will make it his duty to see that they obtain full advantage of all the further auxiliary services that may be otherwise provided.

13. The general practitioner has undergone the same training before qualification as all other members of the medical profession, usually supplementing it with hospital and other experience before adopting general practice as his chosen branch or department of practice. His services are used to the best advantage only when he is general health adviser as well as medical attendant in sickness. He is in the best position to advise generally on matters relating to health, to take into account domestic circumstances and environment, and to discover as early as possible when departures from the normal have occurred. It is to him that the public should naturally look for advice and help in increasing or maintaining health, for early diagnosis and treatment, and for reference to agencies providing special services.

14. It is interesting, too, to note the conclusion on this subject formed in England by an independent research body, Political and Economic Planning, which issued a comprehensive survey of health services in that country in 1937:

come the services of the dental surgeon, whose work constitutes one of the most important departments of preventive and curative medicine. Whether he acts as an independent practitioner, or in conjunction with the medical profession, he is a necessary party of a complete medical service. It is essential to the completeness of the scheme here proposed that arrangements be made by the community with the dental profession for a comprehensive dental service.

20. The principal auxiliary services are those provided by almoners pharmacists, nurses, midwives, masseurs, radiographers, dispensing opticians, and medical electricians. The conditions of employment are, first, that all persons so employed shall have been properly trained and found capable of giving the required treatment; and secondly, that no treatment shall be undertaken by such auxiliaries except on the recommendation of and under the responsible care of a qualified medical practitioner. It is necessary that the medical profession and the public should know that persons to whom important, though auxiliary, methods of treatment are entrusted are competent; and it is equally important that it should be clearly understood that no person without a complete medical training (however well trained he or she may be in the particular service which he or she provides) is competent to assess the bearing of the special line of treatment on the case as a whole. The essential preliminary to any rational form of treatment is a thorough examination of the patient by one properly and completely trained in medical science. Diagnosis is an art sufficiently difficult even to those prepared by this training. Half-knowledge is often misleading and sometimes dangerous. The State registers of nurses, midwives, and pharmacists provide the necessary machinery for making available to the medical profession the services of those who are satisfactorily trained in a branch of medical auxiliary work.

21. The several parts of the complete medical service should be closely co-ordinated and developed by the application of a planned national health policy.

Two of the more important criticisms which are directed at modern health services are, first, that with certain striking exceptions, there is little evidence of co-operation between the various health agencies, and secondly, that their development has been piecemeal, sporadic, and fragmentary. An immediate remedy is the development of adequate consultative and advisory machinery and, in particular, of machinery to ensure consultation between state authorities and the practising profession of their areas. A permanent solution, however, can be reached only by making complete the medical provision available to the people, by including in the arrangements statutory provisions for consultation between the administrative authority and the medical profession, and by basing subsequent developments upon a systematic and co-ordinated plan.

III. "THE PLAN".

22. Having set out what, in the opinion of the Association, are the essential features of a complete medical service the next important question is how the service can be provided so that large section of the community who, owing to the increasing cost of medical care and also because such costs are uncertain and irregular, are not able to provide it for themselves in times of sickness. This, obviously, is not a medical question, but it is one to which the Association has given much consideration.

23. The frequency of sickness and the costs of medical care are predictable for a group of people but not for an individual. Consequently, if the costs of medical care are to be deprived of their burdensome qualities they must be distributed amongst groups of people and over periods of time. Insurance is the method by which modern organised society protects itself against life's hazards, such as sickness, accident, invalidity, and unemployment.

24. Health insurance is a practicable method of providing a complete general medical service. Whilst it is true that it really

come the services of the dental surgeon, whose work constitutes one of the most important departments of preventive and curative medicine. Whether he acts as an independent practitioner, or in conjunction with the medical profession, he is a necessary party of a complete medical service. It is essential to the completeness of the scheme here proposed that arrangements be made by the community with the dental profession for a comprehensive dental service.

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24. Health insurance is a practicable method of providing a complete general medical service. Whilst it is true that it really

forms part of the larger field of social insurance, health insurance, however, should be regarded from the great national aspect of the prevention and cure of disease. It is impossible to combine in one measure a huge financial system of cash benefits and an equally vast organisation of professional men. Health insurance should be completely divorced from any Scheme for the provision of cash benefits, e.g. sickness benefits and pensions.

The Royal Commission on National Insurance in its report which was issued in 1926 stated, inter alia, - "Your Commissioners .... after reviewing the reports of the experience of other countries, are of the opinion, that it is not desirable that these provisions (Health) should be included in any scheme providing for financial benefits, but that they should be dealt with under a National Health Scheme which, although closely related to the objects of a National Insurance Fund, can be more effectively dealt with if dissociated from the administration of the financial benefits. Where medical benefits have been administered under a scheme providing for cash benefits also, they have invariably been limited and have proved inadequate, while the increasing cost of the former has had a detrimental effect upon the provision of the latter."

25. During the past hundred years the Friendly Societies with the assistance of the medical profession have built up a great system of voluntary health insurance which provides a fairly complete general practitioner service for about a quarter of the population. Within its limitations the service given to Friendly Society members is of a high order. But a great weakness, and this may be said of all voluntary schemes of insurance, is its incompleteness and inadequacy - it does not provide shelter against "the slings and arrows of outrageous fortune" for those who most need it. <u>No insurance scheme can be regarded as satisfactory which does not provide a complete medical service and which excludes from its provisions the unemployed and unemployable</u>.

26. <u>The Availibility of the Service</u> - Unless a plan is compulsory it defeats the insurance principle of spreading the risk over the entire group.

Consequently all persons, with or without dependents (children up to 16 years), having an income of less than £416 per annum should be included in the plan.

Although it has been assumed to be a responsibility of the medical profession, the medical care of the indigent is a communal one. There is no reason why the medical profession should alone bear the burden of providing one of the necessities of life. It is clearly undesirable that the method of medical provision in the case of the poorest section of the population should differ from that enjoyed by the community generally.

<u>27.</u> <u>General Practitioner Services</u> - The general practitioner can give adequate and satisfactory medical service to upwards of eighty per cent of all those requiring it. The actual content of the general practitioner service would require to be clearly defined, but in general it would comprise all proper and necessary medical services other than those involving the application of special skill and experience of a kind which general practitioners as a class cannot reasonably be expected to possess.

<u>28.</u> <u>Specialist Services</u> - It is proposed that the consultant and specialist service should be comprehensive and include all necessary facilities in medicine, surgery, obstetrics, and their special branches, as well as pathological and radiological services. It is suggested that the consultant and specialist service can be available should be defined as such examination as can be given at a single consultation, together with a report, where necessary, for the information of the attending practitioner. The service should be identical with that now available to private patients, and would be

rendered, as a rule, in the consulting-room of the consultant or in the home of the patient. Although the approach of the patient to the general practitioner should be direct and free, it is essential, in the interest of the patient, that consultant and specialist services should be available on the recommendation of the family doctor. The services in tuberculosis and venereal disease and infectious diseases where provided by state authorities should continue as special services co-ordinated with; but not necessarily merged into, the main consultative arrangements.

29. When a general practitioner decides that a consultation is desirable he himself should make the necessary arrangements direct with the consultant. If he is unable to be present at the consultation he should furnish a written report to the consultant, who, after the consultation, should report to the general practitioner. If the consultation takes place at the patient's house the attending general practitioner would normally be present.

30. Personnel for Specialist Services - It would be necessary to establish lists of consultants and specialists who satisfy a certain standard of eligibility and who desire to render service under the scheme. Before becoming eligible for inclusion on the lists the practitioner should satisfy a representative committee of medical practitioners that :

(a) He has held hospital or other appointments affording special opportunities for acquiring special skill and experience of the kind required for the performance of the service rendered, and has had actual recent practice in performing the service rendered or services of a similar character; or

(b) He has had special academic or postgraduate study of a subject which comprises the service rendered, and has had actual recent practice as aforesaid; or

(c) That he is generally recognised by other practitioners in the area as having special proficiency and experience in a subject which comprises the service rendered.

31. All practitioners satisfying one or more of the criteria (a), (b), and (c) should be eligible to have their names included in the lists. In the published lists the names should be divided into two classes : (1) those practising exclusively as consultants or specialists; (2) those not practising exclusively as consultants or specialists.

32. Doctor and Patient - It is appropriate to refer here to certain general features of medical service to which the medical profession, in the interests of the public, attaches great importance.

(a) That the interposition of any third party between the doctor and the patient should in the latter's interest be as limited as possible.

(b) That, as far as is possible, responsibility should be placed on the medical profession itself for the control of the purely professional side of the service, for the maintenance of the highest possible quality of service, and for the discipline of practitioners taking part.

(c) That the organized medical profession should be consulted on all professional matters by those responsible for the administrative and financial control of the service.

33. In the first place, the relations between doctor and patient are so intimate that both doctor and patient rightly resent any outside interference. Such interference is bad for the doctor and

worse for the patient. It is bad for the doctor because his whole training and traditions of his profession tend to foster the idea of personal responsibility, and this can be undermined only at the risk of rendering the doctor less efficient. It is worse for the patient, because, ex hypothesi, he or she is a sick person whose cure depends very largely on complete confidence in the doctor, and this confidence is built up to a great extent on psychological factors which are disturbed by the intrusion of outside agencies. The poorer sections of the community should have the same consideration in this matter as is demanded as a matter of course by the more wealthy sections of the community. The patient should be able to feel that the doctor is his doctor, acting whole-heartedly and independently on his behalf, and without other relationships which tend to become paramount.

34. Experience has shown that the interests of the public are best served in any organized medical service by putting as much responsibility as possible on the doctors giving the service - responsibility that is, for the quality of the service and for its smooth working. There are no severer critics of delinquent doctors than their own colleagues invested with the control of purely professional affairs. And there is no surer way of securing an efficient service than to enlist the active interest of those whose reputation as a profession is involved in the manner in which they exercise collective responsibility entrusted to them.

35. Maternity Services : The problems of maternity and in particular maternal mortality have received a great deal of public and professional attention in recent years. Nevertheless, there has been no substantial change in the rate of maternal mortality and little progress towards the establishment of a complete maternity service. The main defect has been that, while each development deals with some aspect or phase of the problem, there has been no concerted effort to deal with the problem as a whole. In the view of the Association, what is needed in the interest of the mother is the establishment of a national maternity service based upon the principle of continuity of medical and nursing care throughout pregnancy, labour, and puerperium. The present system, under which it is frequently the case that a woman receives her ante-natal care at the hands of one practitioner, is confined by a midwife, and, in the event of an emergency arising, is then attended by a practitioner who is without previous personal knowledge of the woman's pregnancy, should be replaced by one in which every woman is, throughout pregnancy, labour, and puerperium, under the care of her doctor and midwife, aided when necessary by a specialist and institutional service.

36. Continuous medical care should be provided by the general practitioner. The birth of a child is not a mere mechanical event unrelated to the life-history of the mother, and the incident of pregnancy should not be the signal for the transference of a woman from the care of her general practitioner to that of another practitioner. An illness occurring before a confinement may have an important bearing on it, while subsequent and related disorders may in turn affect the general health of the mother.

37. The General Practitioner and Midwifery - There has been in recent years a considerable increase in the number of women seeking to be confined in institutions. This is sometimes used as an argument in favour of divorcing the general practitioner from midwifery and replacing him by an obstetric specialist. The removal of midwifery from the normal sphere of activities of the general practitioner is likely to damage the interests of the patient and to affect adversely the efficiency of the practitioner. Taking Australia as a whole, the general practitioner still bears a heavy responsibility for midwifery in that he is called in, or remains liable to be called in, to about 100,000 births a year. The serious defect of the present situation is that he is often called in for the first time when something has gone wrong.

38. Many of the adverse circumstances in this sphere of practice are not inherent, but can be mitigated or eradicated. Were general practitioners to be made responsible for the ante-natal care of midwives' cases they would be able during pregnancy to instil confidence into the minds of these women, which would render them more prone to follow the doctor's advice should the labour prove to be prolonged or otherwise abnormal. Were a registered midwife present in every doctor's case he would be saved much anxiety and many unnecessary and tiring calls. Were he able to remove a patient to hospital and continue in attendance, if necessary with the co-operation of the specialist, he would be enabled to undertake certain operations in more suitable surroundings, and the patient would be less likely to object to removal.

39. The Association accordingly has come to the conslusion that continuity of medical care should be secured by the provision in any national maternity service of a general practitioner and a certified midwife for every maternity case. If the training of the medical practitioner in this branch of practice can be shown to be defective the remedy lies in its reorganisation and improvement. In the view of the Association, the remedy for the existing situation lies, not in a more complete separation of the general practitioner from midwifery, but in a full recognition of his position as the person responsible for the continuous care of the mother. General practitioners should be sufficiently equipped to know how to deal with obstetric emergencies, and this can only be achieved if they remain in effective and practical touch with midwifery; this means that steps should be taken to increase the number of maternity cases which the general practitioner will attend rather than to encourage the present tendency to diminish it.

40. An efficient maternity service should include :

(1) Ante-natal care by, or under the responsibility of, a medical practitioner chosen by the patient throughout pregnancy in every case;

(2) Attendance in every case by a certified midwife;

(3) Attendance by the practitioner chosen by the patient during pregnancy, labour, and the puerperal period;

(4) The provision in every case of at least one post-natal examination of the patient by the practitioner;

(5) The services when necessary of a second practitioner - for example, to administer anaesthetic;

(6) The services of a consultant when considered necessary by the practitioner;

(7) The provision of laboratory services;

(8) The provision of beds for such cases as in the opinion of the practitioner require institutional treatment, treatment in the institution being as far as possible continued by the same practitioner;

(9) Supply of sterilized obstetric dressing in every case;

(10) Provision of ambulance facilities for patients requiring to be removed to institutions;

(11) The provision of "home helps" - that is women trained in domestic work - who would relieve the mother of the worries of domestic management during the lying-in period.

41. It is urged that in the meantime any development which takes place should be based on the provision for every mother of a general practitioner, a midwife, and, where necessary a consultant, her care during pregnancy, labour, and the puerperium being under the continuous supervision of her general practitioner.

42. Institutional Services. Hospital service should be included in a comprehensive medical service. The public hospital, which at one time was primarily the place in which the poor could obtain the treatment they needed, is today providing a highly efficient service to the great majority of the population, comprising not only the poor but those who can and do pay, in part or in whole, for the care they receive. In such a service it is desirable that whenever practicable the patient should be attended by a practitioner of his own choice.

43. The Association envisages the evolution of a hospital system on a regional basis. In each region all the hospitals would be grouped around a central or base hospital, either associated with a medical school or possessing outstanding advantages in regard to staff and equipment for undertaking the more specialized methods of treatment. Around such a base hospital or hospitals would be grouped all other hospitals in the area. These, which would include both special and district hospitals, would provide such services as were within their competence, patients being passed on where necessary to the central or base hospital. The services of such a region or area would be developed as an integrated whole, and a patient would be directed to one or other of the institutions according to the conditions from which he suffers and not because of individual prejudice or preference.

44. The Staffing of Hospitals - Certain general principles underlie the Association's policy in this matter. When a hospital is devoting itself entirely to consultant and specialist work, only those practitioners who are equipped with the necessary knowledge and experience should undertake the responsibility for the medical work. On the other hand, where the conditions for which provision is made include those falling within the sphere and competence of the general practitioner, it is highly desirable that he should be freely admitted for the treatment of petients suffering from those conditions. In practice, the larger hospital devoting itself to specialist work is staffed by selected medical practitioners, while the smaller hospital to which the latter type of case is admitted is staffed on an unrestricted basis by general practitioners. Both kinds of hospital accommodation are necessary. There is, however, a growing need for a more extensive provision of a type of hospital or accommodation in which the general practitioner can treat cases falling within his sphere of competence. It commonly happens today that, for a social reason such as unsatisfactory home surroundings, a patient is admitted to hospital for a condition which, in a patient in more fortunate circumstances, would be treated at home by the patient's own doctor. It is contrary to the interest of the patient and damaging to the efficiency of general practice if social conditions lead to a discontinuity of medical treatment.

45. The importance to a general practitioner, and to the efficiency of his service to the community, of an association with a hospital is difficult to exaggerate. The contacts it affords with fellow practitioners and the team work it involves stimulate him to a higher standard of efficiency, with consequent benefit to the community.

46. Further, in the case of those patients who are rightly transferred to the general wards of a hospital for specialist treatment unobtainable from the general practitioner, the transfer to hospital is often marked by an unnecessarily complete break between the patient and his family doctor. A much closer co-operation should be secured by more effective methods of communication and exchange of information between the hospital and the general practitioner.

47. Hospitals should, as a general rule, be staffed on a part-time basis - that is, by a visiting medical staff of practitioners who are

also engaged in private practice. In this way the hospital benefits by the wider experience gained in hospital and private practice by members of its staff, and the general public, whether it seeks its consultant and specialist service at hospital or privately, can avail itself of the best service in the area.

48. Payment of Hospital Staffs - Consideration of the change in clientele and of the change in the law leads inevitably to certain conclusions. The strictly charitable basis of the public hospital now exists only to the extent that some of the poor are still treated gratuitously; the majority of persons obtaining treatment are those who can pay, desire to pay, and do in fact pay, directly or indirectly, towards their maintenance and treatment. Although the medical profession will gladly give, as always, its services gratuitously to those who cannot afford to pay for them, it is inequitable to require it to give its services without remuneration in public hospitals which treat persons able to pay and which, in practice, collect payments from a large number of their patients. The field of private practice has inevitably contracted, with the result that consultants, and in particular the younger consultants, are finding it increasingly difficult to secure and maintain a standard of living which represents a reasonable reward for their services and which enables them to maintain the highest possible standard of professional efficiency. In the view of the Association there should be remuneration of the medical staff in respect of all medical services in hospital for which payment is made, directly or indirectly, by contributory scheme, by staff authority, by employer or by patient.

49. Out-Patient Departments - The responsibility for the examination and treatment at the out-patient department of persons who could obtain what they require from their own practitioners, or from a consultant in his private capacity, rests mainly with the hospital authorities. The desire to maintain or to increase the statistics for out-patient attendances and so to intensify their appeal to the public for financial support plays in some instances a significant part in determining the policy of hospital authorities. Not only does the abuse of out-patient departments constitute an encroachment upon the sphere of the private practitioner, but it damages the efficiency of the hospital itself and the machinery of its out-patient department by the retention of persons who never needed hospital attention or whose condition has reached a stage when they could properly be transferred to other agencies. In the view of the Association the one way of dealing with this problem is to insist that, except in emergency, all patients should, upon presenting themselves at hospital, produce an introductory letter from their own practitioner. Practitioners should help hospitals by sending to hospital only those patients who need the specialized service available there.

50. The chief use of out-patient departments should be for the following classes of case -

(1) casualty cases (mainly accidents and sudden emergencies);

(2) cases bringing recommendation and letter from a medical practitioner for the purpose of consultative opinion.

(3) cases which as a result of such consultation are found to require special treatment which can be given conveniently only at the hospital;

(4) discharged in-patients who for a further period require special supervision and treatment.

51. Existing Public Health Services - Environmental Services - The adoption of the Association's proposals for a general service for the nation would in no way diminish the need for the maintenance and development of the environmental and impersonal protective services such as those directed to sanitation, pure water and food supply, good housing, and the control of infectious disease. Little has been done to deal with the evil of atmospheric pollution by smoke.

The noise of our towns increases, and there is practically no attempt by statutory bodies to abate this evil. Water-borne and milk-borne epidemics still occur, and too little attention is paid to the safety of such an important food as milk. The problems of nutrition and physical education are just beginning to receive the official attention which they deserve.

52. Personal Health Services - It is believed that the adoption of the proposals set out in this document will add greatly to the national health. But they cannot and will not yield their greatest value until greater attention is paid to the economic, social and environmental factors upon which a healthy life depends. Their adoption would, howdver, involve a re-examination of the existing health provision for individuals. Such specialist services as those dealing with tuberculosis and venereal disease should continue much in their present form; such services as those provided for mothers and infants and for school children will need substantial modification if overlapping with the general medical service is to be avoided.

53. Reference has already been made to the proposals for a national maternity service. The utilization of the services of the general practitioner for the ante-natal, natal, and post-natal care of the normal mother would render unnecessary the establishment of ante-natal and post-natal clinics. When there are available to the mother the services of a midwife, a general practitioner, and an obstetric specialist, and the necessary auxiliary facilities, the need for institutional accommodation for normal cases will be greatly lessened. On the other hand, the need for consultant and specialist facilities in the home and in the clinic or out-patient department, and for institutional accommodation for difficult cases, will be increased rather than diminished.

54. The provision of a family doctor for every family would secure for infants and young children the service which the general practitioner is capable of rendering. Whilt this would render unnecessary any other provision for their general medical care, the system of child welfare centres at which mothers can obtain advice and guidance in the care and nurture of their children would continue to be of the greatest value. Instruction in mothercraft and the general care and hygiene of infants, hints on nursing, dressing, and bathing, and regular weighing, are of the greatest possible value and can be efficiently undertaken in infant welfare centres. The centres should continue their educational and social work in collaboration with the family doctor. The provision of a family doctor for every child would enable the clinics to increase the value of their work by concentrating on the more positive aspects of health.

55. One of the most valuable developments in our educational system during the past generation has been the medical inspection of school children and the provision made for securing the treatment of the devects discovered on inspection. The work of regular medical inspection, particularly of those children found to be suffering from serious or persistent defects, should of course continue and develop. It would not, however, be necessary to provide treatment facilities for those conditions normally treated by the family doctor Through his agency the necessary specialist facilities would be available, and the treatment facilities given by the school medical service should be limited to those conditions which can be more effectively dealt with in the clinic or the hospital out-patient department. As a result the school medical doctor, like the infant welfare doctor, would be enabled to concentrate his attention on a field of great potentiality, that of the positive prosecution of mental and physical health.

56. Rehabilitation Services - The phase of after care is the one most commonly neglected today. Excellent primary treatment is of little value in many cases unless it is followed by a phase of active exercise directed to a complete restoration of function. The Association therefore urges the establishment of rehabilitation centres where physical and mental development can be achieved by

Appendix "D"

FEDERAL COUNCIL OF THE BRITISH MEDICAL ASSOCIATION IN AUSTRALIA.

15th MARCH, 1943.

THE PRINCIPLES WHICH SHOULD GOVERN A GENERAL MEDICAL SERVICE FOR AUSTRALIA.

1. "THE PROBLEM"

1. "Health is a precious possession, so precious that one does not ordinarily set a money value upon it. It is not exchanged in the market place. It is personal and intimate, something cherished for the pursuit of happiness."

An efficient health service is essential to the welfare of every progressive nation. The principle that a health service should be complete and available to all citizens is supported by modern developments in medicine, by the universal trend towards co-operative social effort and by the better standard of physical fitness required for national survival in the highly competitive world of to-day.

2. The past thirty years have been characterized by a widening and a deepening of the public interest in the problems of personal and public health. The establishment of the systematic medical examination of school children, the organization of tuberculosis, venereal disease, maternity and child welfare, mental and mental deficiency services, and the development of the public hospital system, all illustrate the greatly increased interest which the community, through the State, has manifested in health and sickness provision as a form of social service. The Press, the radio, and the public platform have combined to keep continually before the public as a live and personal issue "The Health of the People".

3. The existing health agencies are different in their origin and inspiration and diverse in their form. The State, which forty years ago confined its interest in national health exclusively to the protection of the community from the ravages of infectious disease and the abatement of the grosser dangers to communal health, began in the early years of this century to interest itself in personal health services. In particular it has made forms of provision for the mother and the infant, the school child, and for those of all ages who are suffering from certain diseases or defects or who need institutional treatment. The public hospitals, born of humanitarian motives and intended mainly to serve the poor, now minister, with State aid, to a section of the community which is, in the great majority of cases, neither destitute nor poor. The services of the private practitioner are available to all sections of the community on an individual fee paying or capitation or charitable basis. Different services have been established at different times by different agencies with different motives.

4. The State continues steadily to increase and extend its health and sickness activities. But it cannot be said that each new development is an expression of a unified health policy of ordered development. Still less can it be said that the State, in creating new facilities or services, invariably takes steps to ensure a close correlation with parallel non-State or voluntary provision. The result has been piecemeal and fragmentary growth rather than consistent and systematic development. The public is often served by unrelated and competitive agencies. The individual passes from consulting room to clinic or hospital, from private to official doctor and often back again, to obtain from many unrelated agencies a service which could be more efficiently provided as one co-ordinated whole.

5. A properly planned health service is urgently needed to secure co-ordination and co-operation. The British Medical Association, representing the great majority of doctors in this country, has constantly studied in principle and in detail many aspects of this subject. As an outcome the Association now submits what it considers should be the basic principles of a medical service. The adoption of these principles would ensure for all who need it every kind of treatment available for the cure of the sick and prevention of disease, and would utilize for this purpose every class of medical practitioner. These principles are in accordance with the belief and traditions of the medical profession.

11. "GENERAL PRINCIPLES"

6. The main basic principles are four in number:-

1. That the system of medical service should be directed to the achievement of positive health and the prevention of disease no less than to the relief of sickness.

11. That there should be provided for every individual the services of a general practitioner or a family doctor of his own choice.

111. That consultants and specialists, laboratory services, and all necessary auxiliary services, together with institutional provision when required, should be available for the individual patient, normally through the agency of the family doctor.

1V. That the several parts of the complete medical service should be closely co-ordinated and developed by the application of a planned national health policy.

7. The system of medical service should be directed to the achievement of positive health and the prevention of disease no less than to the relief of sickness.

Health is something more than the absence of disease. While provision for the treatment of disease is an essential part of any satisfactory health service, the emphasis should rest on the positive prosecution of measures to maintain and enhance mental and physical health.

8. This first principle not only satisfies the demands of enlightened public opinion but it accords with the spirit and trend of modern medicine. Recent years have been characterized by a reorientation of medical thought and a widening of the basis of medical practice. Whereas, until comparatively recently, medicine found its sanction to a large extent in the sciences of pathology and morbid anatomy, it now approaches the problems of health and disease from the standpoint of applied biology, concentrating not only on the causes and treatment of disease in its individual manifestations but on the promotion and maintenance of positive health. It views the individual not as a vehicle of disease processes but as a living organism adapting itself to its environment.

9. By continuous attention to such factors as housing, water and food supply, the prevention of epidemics, and the prevention or abatement of conditions injurious to health, the services administered by local authorities ensure a standard of environmental circumstances which is vastly superior to anything which existed comparatively few years ago. There is no room for complacency however, for much remains to be done. The nutritional standards of some of our people are too low; such a valuable food as milk is by no means universally safe; facilities for recreation are commonly inadequate; bad housing and overcrowding exists; and preventable infectious disease still occurs all too frequently.

10. There are signs of a new public interest in the more positive aspects of health. There are signs of improved technique in health education; it is directed more to healthy living and less to particular diseases. Biology and elementary hygiene are being taught more effectively in the schools, while the Press, the poster, the pamphlet, the film, and - potentially the greatest of all - the radio, are all contributing to health education but need adequate supervision and control.

11. But the value of all these contributions can be greatly enhanced by the work of the family doctor. Because of his intimate knowledge of the homes and lives of his patients he has unrivalled opportunities of advising on wise and healthy living. This is made

11. (Continued)
possible, however, only when a family doctor is within easy reach of every citizen and when every citizen avails himself of the advice and help that his doctor can give:

In the modern conception of medical practice great emphasis is placed on the role of the family doctor as health adviser. Owing to the advances of scientific knowledge many specialisms have developed, and there is nothing to suggest that this movement will be less rapid in the future than it has been in recent times. On the other hand, there has emerged a growing public appreciation of the value of health and of the importance of early attention to departures from normal and a demand for the services of the general practitioner as health adviser. This movement is bound to develop rapidly, and the national policy for the promotion of the health of the people should be so framed as to encourage it. The role of health adviser by the family doctor is a natural development of ordinary medical practice, and the training of the student of medicine should be adapted to fit him for it.

12. There should be provided for every individual the services of a general practitioner or a family doctor of his own choice.

It is of primary importance that the organization of the health service of the nation should be based upon the family as the normal unit, and on the family doctor as the normal medical attendant and guardian. It is not for disease or diseases in the abstract that provision has to be made; but for persons liable to or suffering from disease. The first essential for the proper and efficient treatment of individual persons is, therefore, not institutional but personal service, such as can be rendered in their own homes only by a family doctor who has the continuous care of their health; to whom they will naturally turn for advice and help in all matters pertaining thereto; who will afford them such professional services as he can render personally; and who will make it his duty to see that they obtain full advantage of all the further auxiliary services that may be otherwise provided.

13. The general practitioner has undergone the same training before qualification as all other members of the medical profession, usually supplementing it with hospital and other experience before adopting general practice as his chosen branch or department of practice. His services are used to the best advantage only when he is general health adviser as well as medical attendant in sickness. He is in the best position to advise generally on matters relating to health, to take into account domestic circumstances and environment, and to discover as early as possible when departures from the normal have occurred. It is to him that the public should naturally look for advice and help in increasing or maintaining health, for early diagnosis and treatment, and for reference to agencies providing special services.

14. It is interesting, too, to note the conclusion on this subject formed in England by an independent research body, Political and Economic Planning, which issued a comprehensive survey of health services in that country in 1937:

> "The needs of the individual or family in health matters vary so very much, and call for so much experience and judgment that they can in practice only be intelligently and sympathetically determined by a person inside the health services who is acquainted with the medical record and the environment of the person requiring attention. In other words, only the general practitioner can keep track of the resources of the health services on the one hand, and the peculiarities and needs of the individual 'consumer' of health services on the other."

15. The value of a family doctor to his patient is immeasurably increased where complete confidence exists. Few conditions of ill-health are without an underlying psychological factor, and if the relationship between doctor and patient is impaired by suspicion or lack of confidence the doctor is less capable of fulfilling his role

15. (Continued)
of adviser and healer, and the patient is less likely to enjoy the full benefit of his doctor's capacity and desire to help him. For this reason the interest of the public demands that free choice of doctor should be the right of every citizen, whatever his social position or medical need.

16. The specialist in medicine is the complement of the family doctor and not a substitute for him. To short-circuit the family doctor is uneconomic, bad for the patient, and bad for the medical profession. The average member of the public is not fully competent to choose the specialist he ought to consult - assuming that he needs to consult one at all. Selection without such guidance is uneconomic. Even if the patient happens to be right in thinking he needs the services of a specialist, and is doubly fortunate in choosing the right one, he cannot obtain full value for his expenditure of time and money if he goes to the specialist unprovided with the valuable information the family doctor could have given - information as to physical and mental characteristics, family history, and previous personal history, and as to what methods of treatment have already been adopted. These considerations apply whether the individual patient seeks treatment at a clinic, a hospital, or privately.

17. Consultants and specialists, laboratory services, and all necessary auxiliary services, together with institutional provision when required, should be available for the individual patient, normally through the agency of the family doctor.

The work of the family doctor must be supplemented by the provision of specialist aids for diagnosis and treatment with regard to specific points, or in special circumstances. The increasing complexity of medical science has been accompanied by the development of a considerable number of special methods and techniques, both in diagnosis and in treatment, the successful employment of which involves specialized knowledge and experience, and, in many cases, complex and expensive apparatus.

18. The second opinion or consultation, with or without treatment, must be available. It may be sought from the general physician, the general surgeon, the obstetrician and gynaecologist, or from a specialist in a more restricted field. Again, the help of a practitioner specializing in a particular method or group of methods of diagnosis or treatment, such as a pathologist, a radiologist, or a practitioner concentrating on physical or on psychological methods, may be desired. These, too, should be available. Such consultant and specialist provision should be available in the home, the consulting-room, the clinic, or the hospital, according to the circumstances. In short, all classes of special knowledge and specialized technique should be available when the circumstances require them for every member of the community

19. The work of the medical practitioner, whether he be general practitioner or specialist, often needs to be supplemented by contributions from those not medically qualified. In a special class come the services of the dental surgeon, whose work constitutes one of the most important departments of preventive and curative medicine. Whether he acts as an independent practitioner, or in conjunction with the medical profession, he is a necessary party of a complete medical service. It is essential to the completeness of the scheme here proposed that arrangements be made by the community with the dental profession for a comprehensive dental service.

20. The principal auxiliary services are those provided by almoners, pharmacists, nurses, midwives, masseurs, radiographers, dispensing opticians, and medical electricians. The conditions of employment are, first, that all persons so employed shall have been properly trained and found capable of giving the required treatment; and secondly, that no treatment shall be undertaken by such auxiliaries except on the recommendation of and under the responsible care of a qualified medical practitioner. It is necessary that the medical

20. (continued)
profession and the public should know that persons to whom important, though auxiliary, methods of treatment are entrusted are competent; and it is equally important that it should be clearly understood that no person without a complete medical training (however well trained he or she may be in the particular service which he or she provides) is competent to assess the bearing of the special line of treatment on the case as a whole. The essential preliminary to any rational form of treatment is a thorough examination of the patient by one properly and completely trained in medical science. Diagnosis is an art sufficiently difficult even to those prepared by this training. Half-knowledge is often misleading and sometimes dangerous. The State registers of nurses, midwives, and pharmacists provide the necessary machinery for making available to the medical profession the services of those who are satisfactorily trained in a branch of medical auxiliary work.

21. The several parts of the complete medical service should be closely co-ordinated and developed by the application of a planned national health policy.

Two of the more important criticisms which are directed at modern health services are, first, that with certain striking exceptions, there is little evidence of co-operation between the various health agencies, and secondly, that their development has been piecemeal, sporadic, and fragmentary. An immediate remedy is the development of adequate consultative and advisory machinery and, in particular, of machinery to ensure consultation between state authorities and the practising profession of their areas. A permanent solution, however, can be reached only by making complete the medical provision available to the people, by including in the arrangements statutory provisions for consultation between the administrative authority and the medical profession, and by basing subsequent developments upon a systematic and co-ordinated plan.

22. The frequency of sickness and the costs of medical care are predictable for a group of people but not for an individual. Consequently, if the costs of medical care are to be deprived of their burdensome qualities they must be distributed amongst groups of people and over periods of time. Insurance is the method by which modern organised society protects itself against life's hazards, such as sickness, accident, invalidity, and unemployment.

23. A complete medical service is essential for the preservation of the health of the community. Such a medical service however should be regarded from the great national aspect of the prevention and cure of disease and should be completely divorced from any scheme for the provision of cash benefits, e.g., sickness benefits and pensions.

The Royal Commission on National Insurance in its report which was issued in 1926 stated, inter alia, - "Your Commissioners ..... after reviewing the reports of the experience of other countries, are of the opinion that it is not desirable that these provisions (Health) should be included in any scheme providing for financial benefits".

24. During the past hundred years the Friendly Societies with the assistance of the medical profession have built up a great system of voluntary health insurance which provides a fairly complete general practitioner service for about a quarter of the population. Within its limitations the service given to Friendly Society members is of a high order. But a great weakness, and this may be said of all voluntary schemes of insurance, is its incompleteness and inadequacy - it does not provide shelter against "the slings and arrows of outrageous fortune" for those who most need it. No medical service can be regarded as satisfactory which does not provide a complete medical service for the whole community and which excludes from its provisions the unemployed and unemployable.

25. Although it has been assumed to be a responsibility of the medical profession, the medical care of the indigent is a communal one. There is no reason why the medical profession should alone bear the burden of providing one of the necessities of life. It is clearly undesirable that the method of medical provision in the case of the poorest section of the population should differ from that enjoyed by the community general

26. General Practitioner Services -
The general practitioner can give adequate and satisfactory medical service to upwards of eighty per cent of all those requiring it. The actual content of the general practitioner service would require to be clearly defined, but in general it would comprise all proper and necessary medical services other than those involving the application of special skill and experience of a kind which general practitioners as a class cannot reasonably be expected to possess.

27. Specialist Services.
It is proposed that the consultant and specialist services should be comprehensive and include all necessary facilities in medicine, surgery, obstetrics, and their special branches, as well as pathological and radiological services. The service should be identical with that now available to private patients and would be rendered, as a rule, in the consulting room of the consultant, or in the home of the patient. Although the approach of the patient to the general practitioner should be direct and free, it is essential, in the interests of the patient, that consultant and specialist services should be available on the recommendation of the family doctor. The services in tuberculosis, venereal disease and infectious diseases, where provided by State authorities should continue as special services co-ordinated with, but not necessarily merged into, the main consultative arrangements.

28. When a general practitioner decides that a consultation is desirable, he himself should make the necessary arrangements direct with the consultant. If he is unable to be present at the consultation he should furnish a written report to the consultant, who, after the consultation, should report to the general practitioner. If the consultation takes place at the patient's house the attending general practitioner would normally be present.

29. Personnel for Specialist Services -
It would be necessary to establish lists of consultants and specialists who satisfy a certain standard of eligibility and who desire to render service under the scheme. Before becoming eligible for inclusion on the lists the practitioner should satisfy a representat.. committee of medical practitioners that:

(a) He has held hospital or other appointments affording special opportunities for acquiring special skill and experience of the kind required for the performance of the service rendered, and has had actual recent practice in performing the service rendered or services of a similar character; or

(b) He has had special academic or postgraduate study of a subject which comprises the service rendered, and has had actual recent practice as aforesaid; or

(c) That he is generally recognized by other practitioners in the area as having special proficiency and experience in a subject which comprises the service rendered.

30. All practitioners satisfying one or more of the criteria (a), (b), and (c) should be eligible to have their names included in the lists. In the published lists the names should be divided into two classes : (1) those practising exclusively as consultants or specialists; (2) those not practising exclusively as consultants or specialists.

31. Doctor and Patient.
It is appropriate to refer here to certain general features of medical service to which the medical profession, in the interests of the public, attaches great importance.

(a) That the interposition of any third party between the doctor and the patient should in the latter's interest be as limited as possible.

(b) That, as far as is possible, responsibility should be placed on the medical profession itself for the control of the purely professional side of the service, for the maintenance of the highest possible quality of service, and for the discipline of practitioners taking part.

(c) That the organized medical profession should be consulted on all professional matters by those responsible for the administrative and financial control of health services.

32. In the first place, the relations between doctor and patient are so intimate that both doctor and patient rightly resent any outside interference. Such interference is bad for the doctor and worse for the patient. It is bad for the doctor because his whole training and traditions of his profession tend to foster the idea of personal responsibility, and this can be undermined only at the risk of rendering the doctor less efficient. It is worse for the patient, because, ex hypothesi, he or she is a sick person whose cure depends very largely on complete confidence in the doctor, and this confidence is built up to a great extent on psychological factors which are disturbed by the intrusion of outside agencies. The poorer sections of the community should have the same consideration in this matter as is demanded as a matter of course by the more wealthy sections of the community. The patient should be able to feel that the doctor is his doctor, acting whole-heartedly and independently on his behalf, and without other relationships which tend to become paramount.

33. Experience has shown that the interests of the public are best served in any organized medical service by putting as much responsibility as possible on the doctors giving the service - responsibility, that is, for the quality of the service and for its smooth working. There are no severer critics of delinquent doctors than their own colleagues invested with the control of purely professional affairs. And there is no surer way of securing an efficient service than to enlist the active interest of those whose reputation as a profession is involved in the manner in which they exercise collective responsibility entrusted to them.

34. Maternity Services.
The problems of maternity and in particular maternal mortality have received a great deal of public and professional attention in recent years. Nevertheless, there has been no substantial change in the rate of maternal mortality and little progress towards the establishment of a complete maternity service. The main defect has been that, while each development deals with some aspect or phase of the problem, there has been no concerted effort to deal with the problem as a whole. In the view of the Association, what is needed in the interest of the mother is the establishment of a national maternity service based upon the principle of continuity of medical and nursing care throughout pregnancy, labour, and puerperium. The present system, under which it is frequently the case that a woman receives her ante-natal care at the hands of one practitioner, is confined by a midwife, and, in the event of an emergency arising, is then attended by a practitioner who is without previous personal knowledge of the woman's pregnancy, should be replaced by one in which every woman is, throughout pregnancy, labour, and puerperium, under the care of her doctor and midwife, aided when necessary by a specialist and institutional service.

35. Continuous medical care should be provided by the general practitioner. The birth of a child is not a mere mechanical event unrelated to the life-history of the mother, and the incident of pregnancy should not be the signal for the transference of a woman from the care of her general practitioner to that of another practitioner. An illness occurring before a confinement may have an important bearing on it, while subsequent and related disorders may in turn affect the general health of the mother.

36. The General Practitioner and Midwifery -
There has been in recent years a considerable increase in the number of women seeking to be confined in institutions. This is sometimes used as an argument in favour of divorcing the general practitioner from midwifery and replacing him by an obstetric specialist. The removal of midwifery from the normal sphere of activities of the general practitioner is likely to damage the interests of the patient and to affect adversely the efficiency of the practitioner. Taking Australia as a whole, the general practitioner still bears a heavy responsibility for midwifery in that he is called in, or remains liable to be called in, to about 100,000 births a year. The serious defect of the present situation is that he is often called in for the first time when something has gone wrong.

37. Many of the adverse circumstances in this sphere of practice are not inherent, but can be mitigated or eradicated. Were general practitioners to be made responsible for the ante-natal care of midwives' cases they would be able during pregnancy to instil confidence into the minds of those women, which would render them more prone to follow the doctor's advice should the labour prove to be prolonged or otherwise abnormal. Were a registered midwife present in every doctor's case he would be saved much anxiety and many unnecessary and tiring calls. Were he able to remove a patient to hospital and continue in attendance, if necessary with the co-operation of the specialist, he would be enabled to undertake certain operations in more suitable surroundings, and the patient would be less likely to object to removal.

38. The Association accordingly has come to the conclusion that continuity of medical care should be secured by the provision in any national maternity service of a general practitioner and a certified midwife for every maternity case. If the training of the medical practitioner in this branch of practice can be shown to be defective the remedy lies in its reorganization and improvement. In the view of the Association, the remedy for the existing situation lies, not in a more complete separation of the general practitioner from midwifery, but in a full recognition of his position as the person responsible for the continuous care of the mother. General practitioners should be sufficiently equipped to know how to deal with obstetric emergencies, and this can only be achieved if they remain in effective and practical touch with midwifery; this means that steps should be taken to increase the number of maternity cases which the general practitioner will attend rather than to encourage the present tendency to diminish it.

39. An efficient maternity service should include:

(1) Ante-natal care by, or under the responsibility of, a medical practitioner chosen by the patient throughout pregnancy in every case;
(2) Attendance in every case by a certified midwife;
(3) Attendance by the practitioner chosen by the patient during pregnancy, labour, and the puerperal period.
(4) The provision in every case of at least one post-natal examination of the patient by the practitioner;
(5) The services when necessary of a second practitioner - for example, to administer anaesthetic;
(6) The services of a consultant when considered necessary by the practitioner;
(7) The provision of laboratory services;
(8) The provision of beds for such cases as in the opinion of the practitioner require institutional treatment,

39. (contd.)
treatment in the institution being as far as possible continued by the same practitioner;
(9) Supply of sterilized obstetric dressing in every case;
(10) Provision of ambulance facilities for patients requiring to be removed to institutions;
(11) The provision of "home helps" - that is women trained in domestic work - who would relieve the mother of the worries of domestic management during the lying-in period.

40. It is urged that in the meantime any development which takes place should be based on the provision for every mother of a general practitioner, a midwife, and, where necessary a consultant, her care during pregnancy, labour, and the puerperium being under the continuous supervision of her general practitioner.

41. Institutional Services:
Hospital service should be included in a comprehensive medical service. The public hospital, which at one time was primarily the place in which the poor could obtain the treatment they needed, is to-day providing a highly efficient service to the great majority of the population, comprising not only the poor but those who can and do pay, in part or in whole, for the care they receive. In such a service it is desirable that whenever practicable, the patient should be attended by a practitioner of his own choice.

42. The Association envisages the evolution of a hospital system on a regional basis. In each region all the hospitals would be grouped around a central or base hospital, either associated with a medical school or possessing outstanding advantages in regard to staff and equipment for undertaking the more specialized methods of treatment. Around such a base hospital or hospitals would be grouped all other hospitals in the area. These, which would include both special and district hospitals, would provide such services as were within their competence, patients being passed on where necessary to the central or base hospital. The services of such a region or area would be developed as an integrated whole, and a patient would be directed to one or other of the institutions according to the conditions from which he suffers and not because of individual prejudice or preference.

43. The Staffing of Hospitals -
Certain general principles underlie the Association's policy in this matter. When a hospital is devoting itself entirely to consultant and specialist work, only those practitioners who are equipped with the necessary knowledge and experience should undertake the responsibility for the medical work. On the other hand, where the conditions for which provision is made include those falling within the sphere and competence of the general practitioner, it is highly desirable that he should be freely admitted for the treatment of patients suffering from these conditions. In practice, the larger hospital devoting itself to specialist work is staffed by selected medical practitioners, while the smaller hospital to which the latter type of case is admitted is staffed on an unrestricted basis by general practitioners. Both kinds of hospital accommodation are necessary. There is, however, a growing need for a more extensive provision of a type of hospital or accommodation in which the general practitioner can treat cases falling within his sphere of competence. It commonly happens to-day that, for a social reason such as unsatisfactory home surroundings, a patient is admitted to hospital for a condition which, in a patient in more fortunate circumstances, would be treated at home by the patient's own doctor. It is contrary to the interest of the patient and damaging to the efficiency of general practice if social conditions lead to a discontinuity of medical treatment.

44. The importance to a general practitioner, and to the efficiency of his service to the community, of an association with a hospital is

44. (contd.)
difficult to exaggerate. The contacts it affords with fellow practitioners and the team work it involves stimulate him to a higher standard of efficiency, with consequent benefit to the community.

45. Further, in the case of those patients who are rightly transferred to the general wards of a hospital for specialist treatment unobtainable from the general practitioner, the transfer to hospital is often marked by an unnecessarily complete break between the patient and his family doctor. A much closer co-operation should be secured by more effective methods of communication and exchange of information between the hospital and the general practitioner.

46. Hospitals should, as a general rule, be staffed on a part-time basis - that is, by a visiting medical staff of practitioners who are also engaged in private practice. In this way the hospital benefits by the wider experience gained in hospital and private practice by members of its staff, and the general public, whether it seeks its consultant and specialist service at hospital or privately, can avail itself of the best service in the area.

47. Payment of Hospital Staffs -
Consideration of the change in clientele and of the change in the law leads inevitably to certain conclusions. The strictly charitable basis of the public hospital now exists only to the extent that some of the poor are still treated gratuitously; the majority of persons obtaining treatment are those who can pay, desire to pay, and do in fact pay, directly or indirectly, towards their maintenance and treatment. Although the medical profession will gladly give, as always, its services gratuitously to those who cannot afford to pay for them, it is inequitable to require it to give its services without remuneration in public hospitals which treat persons able to pay and which, in practice, collect payments from a large number of their patients. The field of private practice has inevitably contracted, with the result that consultants, and in particular the younger consultants, are finding it increasingly difficult to secure and maintain a standard of living which represents a reasonable reward for their services and which enables them to maintain the highest possible standard of professional efficiency. In the view of the Association there should be remuneration of the medical staff in respect of all medical services in hospital for which payment is made, directly or indirectly, by contributory scheme, by staff authority, by employer or by patient.

48. Out-Patient Departments:
The responsibility for the examination and treatment at the out-patient department of persons who could obtain what they require from their own practitioners, or from a consultant in his private capacity, rests mainly with the hospital authorities. The desire to maintain or to increase the statistics for out-patient attendances and so to intensify their appeal to the public for financial support plays in some instances a significant part in determining the policy of hospital authorities. Not only does the abuse of out-patient departments constitute an encroachment upon the sphere of the private practitioner, but it damages the efficiency of the hospital itself and the machinery of its out-patient department by the retention of persons who never needed hospital attention or whose condition has reached a stage when they could properly be transferred to other agencies. In the view of the Association the one way of dealing with this problem is to insist that, except in emergency, all patients should, upon presenting themselves at hospital, produce an introductory letter from their own practitioner. Practitioners should help hospitals by sending to hospital only those patients who need the specialized service available there.

49. The chief use of out-patient departments should be for the following classes of case -

(1) casualty cases (mainly accidents and sudden emergencies);
(2) cases bringing recommendation and letter from a medical practitioner for the purpose of consultative opinion;

49. (contd.)
(3) cases which as a result of such consultation are found to require special treatment which can be given conveniently only at the hospital;
(4) discharged in-patients who for a further period require special supervision and treatment.

50. Existing Public Health Services:
Environmental Services - The adoption of the Association's principles for a general medical service for the nation would in no way diminish the need for the maintenance and development of the environmental and impersonal protective services such as those directed to sanitation, pure water and food supply, good housing, and the control of infectious disease. Little has been done to deal with the evil of atmospheric pollution by smoke. The noise of our towns increases, and there is practically no attempt by statutory bodies to abate this evil. Water-borne and milk-borne epidemics still occur, and too little attention is paid to the safety of such an important food as milk. The problems of nutrition and physical education are just beginning to receive the official attention which they deserve.

51. Personal Health Services.
It is believed that the adoption of the principles set out in this document will add greatly to the national health. But they cannot and will not yield their greatest value until greater attention is paid to the economic, social and environmental factors upon which a healthy life depends. Their adoption would, however, involve a re-examination of the existing health provision for individuals. Such specialist services as these dealing with tuberculosis and venereal disease should continue much in their present form; such services as those provided for mothers and infants and for school children will need substantial modification if overlapping with the general medical service is to be avoided.

52. Reference has already been made to a national maternity service. The utilization of the services of the general practitioner for the ante-natal, natal, and post-natal care of the normal mother would render unnecessary the establishment of ante-natal and post-natal clinics. When there are available to the mother the services of a midwife, a general practitioner, an obstetric specialist, and the necessary auxiliary facilities, the need for institutional accommodation for normal cases will be greatly lessened. On the other hand, the need for consultant and specialist facilities in the home and in the clinic or out-patient department, and for institutional accommodation for difficult cases, will be increased rather than diminished.

53. The provision of a family doctor for every family would secure for infants and young children the service which the general practitioner is capable of rendering. While this would render unnecessary any other provision for their general medical care, the system of child welfare centres at which mothers can obtain advice and guidance in the care and nurture of their children would continue to be of the greatest value. Instruction in mothercraft and the general care and hygiene of infants, hints on nursing, dressing, and bathing, and regular weighing, are of the greatest possible value and can be efficiently undertaken in infant welfare centres. The centres should continue their educational and social work in collaboration with the family doctor. The provision of a family doctor for every child would enable the clinics to increase the value of their work by concentrating on the more positive aspects of health.

54. One of the most valuable developments in our educational system during the past generation has been the medical inspection of school children and the provision made for securing the treatment of the defects discovered on inspection. The work of regular medical inspection, particularly of those children found to be suffering from serious or persistent defects, should of course continue and develop. It would not, however, be necessary to provide treatment facilities for those conditions normally treated by the family

54. (contd.)
doctor. Through his agency the necessary specialist facilities would be available, and the treatment facilities given by the school medical service should be limited to those conditions which can be more effectively dealt with in the clinic or the hospital out-patient department. As a result the school medical doctor, like the infant welfare doctor, would be enabled to concentrate his attention on a field of great potentiality, that of the positive prosecution of mental and physical health.

55. Rehabilitation Services -
The phase of after care is the one most commonly neglected to-day. Excellent primary treatment is of little value in many cases unless it is followed by a phase of active exercise directed to a complete restoration of function. The Association therefore urges the establishment of rehabilitation centres where physical and mental development can be achieved by games, by activities in the gymnasium and the swimming pool and by graduated work.

56. Administration.
A fair criticism of health insurance schemes as established previously both in this and other countries, is that it has not been preventive in practice and but little in outlook. This in the main is due to the fact that the financial aspects of schemes have assumed overwhelming importance and the preventive side has been crowded out in the welter of complex administrative difficulties. As previously stated, the Royal Commission on National Insurance in its report published in 1926 states that, after reviewing the reports of the experience of other countries, it is not desirable to include medical benefit in any scheme for financial benefits but they should be dealt with under a national health scheme.

The Association believes that the organized preventive and curative medical services should be fully co-ordinated.

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APPENDIX "E"

Extract from Report of the Federal Health Council of Australia, Third Session, 25-28th February and 1st March, 1929.

APPENDIX I. TUBERCULOSIS.

Report on the control of Tuberculosis in Australia

by

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SUMMARY OF PROPOSALS.

Legislation.

1. Notification of Cases.- In view of the dependence of the control system upon notification of cases, State Governments are urged to make the necessary amendments to legislation as early as possible, in order to give effect to that portion of Resolution No.11 of the second session of the Federal Health Council, March, 1928, recommending that all forms of tuberculosis should be made notifiable in all portions of the State.

It is recommended that the Form of Notification should include information as to -

(a) whether the disease is pulmonary or non-pulmonary.

(b) the site of the lesion.

2. Where legislation does not already exist for the purpose, legislation should be enacted to provide that notification should be made by the medical man who examines a person who is suffering from tuberculosis or from any sickness, the symptoms of which raise a reasonable suspicion that it may be tuberculosis.

3. Cases of tuberculosis should be notified direct to the State Health Department as well as to the local health authority.

4. Notification of Deaths.- Deaths from tuberculosis should be notified direct to the State Health Department.

5. Fees for Notification.- Fees for notification should be paid automatically. A doctor notifying a case should not be required to forward an application for the notification fee.

6. Compulsory Isolation.- Legislation should include power to cover compulsory isolation of persons who are negligent or deliberately careless in the matter of precautionary measures, or who neglect to follow instructions as to precautionary measures issued by an officer of a central or local health authority.

7. Change of Address.- Legislation should, where necessary, be amended to provide that a patient suffering from tuberculosis must not change his address without giving notice to the medical officer of health of his district, and that both the patient and the local council of the district must notify the council of the district to which the patient proposes to move.

GENERAL ADMINISTRATION AND CO-ORDINATION OF ACTIVITIES.

8. General Administration.- It is considered that for the efficient working of any scheme of tuberculosis control, a responsible full time officer of the State Department of Health should be detailed in each State to co-ordinate all the activities, departmental, municipal, medical and voluntary bearing upon the prevention and control of the disease and to guide and supervise the work of the clinics and of the institutions. Such an officer might in addition personally conduct the operations of a central departmental chest clinic.

9. Co-operation with Local Health Authorities.- The establishment of clinics should not be permitted to relieve local health authorities of any portion of their responsibilities under the Health Act and Regulations, but should be made a means of stimulating the local health authorities to carry out their duties more efficiently and in close accordance with the principles laid down in the scheme of control adopted by the State Department of Health.

With this object in view, the medical officer in charge of a clinic should maintain close touch with local health authorities, and the forms used by health inspectors and nurses of the local health authority in making their reports in connection with domiciliary supervision should be identical with those used by the nurses on the staff of the chest clinics. A copy of each domiciliary supervision report completed by the health inspector or nurse of a local health authority should be sent to the medical officer in charge of the district chest clinic, or to the State Director of Tuberculosis or other officer appointed to co-ordinate the work of tuberculosis control in the State.

10. When a patient is sent from a local health district to an institution for treatment, on return to his local health district after discharge from the institution, the local health authority should be advised and informed as to whether or not the patient is still infective.

11. All possible means should be taken by co-operation with local health authorities, medical practitioners and otherwise, to secure early notification and the supply of essential information on notification.

12. Co-operation with Medical Practitioners.- The clinics should not encroach on the relationship between the private practitioner and his patient, but the principle of utilizing the general practitioner to the fullest possible extent in connection with the scheme of control should be aimed at.

Routine treatment at clinics should be discouraged. Private practitioners should be encouraged to continue to treat cases in their own homes, and definite cases of tuberculosis detected at clinics should, wherever possible, be referred to their own doctor for treatment at home if the home environment is suitable and the patient educated as to mode of life and precautionary measures.

Cases on discharge from sanatorium or other institution, although remaining under the supervision of a clinic, should be referred back to their own doctor for continuation of treatment, and this doctor should be furnished with a copy of the patient's discharge sheet showing treatment given in the sanatorium and the present condition of the patient as regards physical signs, general health, and indications for treatment.

The private practitioner treating a case should be encouraged to utilize the clinic fully for consultation and for advice in diagnosis and treatment and in the precautionary measures to be taken in the home.

It is considered that the line of action indicated above is likely to result in the co-operation of the medical profession and in improvement in the standard of care and treatment given by the medical practitioner to the patient, whereas undue interference between doctor and private patient is likely to have the opposite effect and to militate against the early recognition and notification of cases.

Exceptions to the practice of referring a patient to his own doctor for treatment at home should be made in the case of -

(a) Patients who should be sent at once to an institution. This includes patients who require a short period of close observation in a hospital.

(b) Patients requiring special treatment which cannot be effectively or readily administered in the patient's home.

(c) Patients who cannot afford to pay a private doctor.

13. The medical officer in charge of a clinic should maintain the closest possible touch with medical practitioners in his district, and should be available to them for consultation, and should encourage them to make free and full use of the clinic.

14. In order to facilitate co-operation with medical practitioners, the State Branch of the British Medical Association should be asked to circularize its members advising them as to the system adopted for prevention and control of tuberculosis, and asking medical practitioners to co-operate by making full use of the facilities offered at clinics, and by making notification at the earliest possible date.

15. Medical Attention for Indigent Persons.- For persons who do not require to be sent to an institution, and who cannot afford to pay a private doctor, provision should be made by Government to supply necessary medical attention in the home free of cost to the patient. The medical practitioners employed for this purpose should be remunerated by the Government according to a scale agreed upon.

16. Tuberculosis in Pregnancy.- Arrangements should be made for information as to pregnant mothers suffering from tuberculosis to be forwarded to the Infant and Child Welfare Department, or other appropriate department, so that necessary precautions may be taken on the birth of the child to remove it from the risk of infection, as for example, by sending it to an institution or boarding it out in a suitable home.

17. Boarded-out Children.- Care should be taken by co-operation with the appropriate authorities to ensure that careful investigation is made into the conditions of a home as regards tuberculosis before a boarded-out child is permitted to be accommodated in the home.

CLINICS.

18. Administration.- The "chest clinic" should be the foundation on which the system for the prevention and control of tuberculosis should be built and each clinic should act as:-

(a) A centre for the careful investigation of doubtful cases,

(b) a clearing house for the classification of cases of tuberculosis and for making arrangements where necessary for the disposal of cases to suitable institutions,

(c) a centre for the examination and continued observation of contacts,

(d) a centre for the supervision and aftercare of domiciliary cases, including a comprehensive system of home visitation for the regulation of the life and environment of the patient and his contacts,

(e) a centre for the investigation of the financial position of patients by trained nurse inspector, with the object of making such arrangements as are necessary for relief,

(f) a centre for the continued supervision of cases discharged from sanatorium or other institutions,

(g) a centre which will be available at all times to the general practitioners of the district for advice and assistance in connection with the diagnosis or treatment of any case of the disease, and precautionary measures to be taken,

(h) a centre for the collection of information and records regarding tuberculosis,

(i) a centre for the education of the patient and the public,

(j) a centre at which certain forms of curative treatment are available for special cases.

19. Designation of Clinics.- Clinics associated with the system for the prevention and control of tuberculosis should be designated "chest clinics" and no reference should be made to tuberculosis in the designation of these clinics.

20. Functions of Clinics.- The functions of the clinic should be directed towards prevention rather than treatment. Clinics should dissociate themselves from being looked upon as treatment centres. Routine treatment at clinics should be discouraged, and as far as possible, treatment of patients on the clinic list should be referred to the patient's private doctor, with whom the medical officer in charge of the clinic should endeavour to maintain close co-operation. Treatment at clinics should, as far as practicable, be limited to special treatment, which cannot readily or suitably be given to the patient by his doctor in his own home.

21. Co-operation with Hospital.- Each clinic should have automatic access to, and be run in close co-operation with the several special and general departments of a well-equipped hospital, including the pathological, X-ray, nose and throat, dental, orthopaedic and general medical and surgical departments, so as to provide for expert consultation and team work in diagnosis.

22. Departmental and Branch Clinics.- It is desirable that the clinic system should consist of one central departmental clinic in each State conducted by a full-time officer of the State Department of Health, either in conjunction with a large hospital or as a separate establishment with access to a hospital, and in addition a sufficient number of branch clinics, adequately subsidized, situated at strategic points, and each operating in association with a hospital. The work of these branch clinics should be co-ordinated and supervised by the officer-in-charge of the central clinic, or some other officer of the State Department of Health, appointed for that purpose.

23. Continuous Clinics.- Clinics should be continuous, and for this and other reasons separate accommodation should be provided from that used for the ordinary out-patient activities of the hospital.

24. Services Free.- All the services of a clinic, including X-ray and laboratory examinations, should be free of charge.

25. Number of Clinics Required.- In the metropolitan areas of large cities the basis should be adopted of one fully-developed chest clinic for at least every 300,000 of population, and in smaller cities or extra metropolitan areas, fully-developed clinics should be established at strategic points to cover large districts.

26. Accommodation at Clinics.- Accommodation at subsidized clinics, including waiting room accommodation, should be adequate and suitable and to the satisfaction of the State Department of Health.

27. Hospital Beds for Clinics.- In association with each clinic there should be a sufficient number of hospital beds specially provided for the use of the clinic for (a) the observation of doubtful cases, (b) the temporary accommodation of acute cases requiring hospital attention before removal to a sanatorium, and of dangerously infective cases requiring isolation, (c) the administration of special treatment, (d) teaching purposes.

These hospital beds should, preferably, in the case of large clinics, be provided in a special block with one ward for male and one ward for female cases. The number of beds provided will be governed by the size of the clinic, but in the case of a metropolitan clinic, covering a population of 300,000 not less than ten beds for males and ten beds for females should be provided.

28. Staff.- Each clinic should be definitely in charge of a full-time medical officer, whose duty and responsibility it should be to organise the work of the clinic generally, supervise and control the work of visiting nurses, the proper keeping of records, and the collection and preparation of statistical data, to visit domiciliary cases where necessary and to maintain the closest possible co-operation with medical practitioners, local health authorities, and others concerned in his district.

29. The nursing staff should be adequately trained in their special duties.

30. The number of nurses employed in a clinic should be sufficient to enable effective domiciliary visitation to be maintained, and in a clinic covering a population of 300,000 the number should not be less than three.

31. A records clerk should be definitely attached to each clinic, either in a full time or part time capacity, according to the volume of the work, who should be held responsible under the medical officer in charge of the clinic for the accurate keeping of records on the lines laid down.

32. Salaries of Staff.- The salaries and allowances paid to the medical officer in charge of the clinic, the nursing staff and records clerk should be paid by the State Department of Health, and this Department should maintain close and constant supervision over every subsidized clinic.

Maintenance of Nutrition in the Families of Tuberculous Persons.

33. The maintenance of the nutrition of the families of persons suffering from tuberculosis is an essential factor in the prevention and control of tuberculosis. Money provided for this purpose should be definitely directed towards the prevention of further cases of tuberculosis in the family.

It is recommended that in order to ensure that the money is properly applied, a fund should be established by each State Government to be administered by the Minister for Health on the recommendation and advice of the State Health Department, which,

through the clinics, will be in a position to assess the relief required by each family and to apply the relief granted in the most efficient way.

Institutional Accommodation.

34. Beds required.- It is considered that for the purposes of computing the number of beds required for the treatment of tuberculosis the basis that the number of institutional beds to be provided in sanatoria and hospitals should equal the average number of deaths per annum should prove amply sufficient.

35. Treatment at Home.- Under an effective system of domiciliary supervision, many cases of tuberculosis can be quite safely and adequately treated in their own homes, and where such is the case these patients should, after a short period of institutional treatment for educative purposes, be discharged to their homes.

36. Before further expenditure in providing institutional accommodation is embarked upon, the effect of careful weeding out of unsuitable cases from sanatoria and hospitals, thus setting free accommodation for suitable cases, should receive careful consideration.

37. Non-pulmonary Tuberculosis.- In considering institutional accommodation, care should be taken that sufficient and suitable accommodation is provided to enable adequate treatment to be given for a sufficient length of time to cases of spine, bone and joint tuberculosis under suitable open-air conditions.

38. Beds in country hospitals.- The practice of sending country cases to sanatoria in the metropolitan area, without making full investigation as to their suitability for sanatorium treatment, should be discouraged.

Country hospitals should provide a small number of beds to which patients can be sent for observation pending decision as to suitability for sanatorium treatment, or in which cases unsuitable for sanatorium treatment or for treatment at home can be cared for. Two or three beds on the hospital verandah would usually be sufficient.

39. Transfer of Cases.- Provision should be made for ready transfer from sanatorium to hospital, or vice versa, of cases in which it is considered that such transfer is desirable. For this purpose all accommodation in institutions should be at the disposal of an officer controlling the tuberculosis activities of the State.

40. Selection of Cases.- Sanatoria should be reserved for hopeful cases. Cases with little prospect of arrest should, if practicable, be accommodated elsewhere, or if accommodation is not available elsewhere, should be placed in a separate section of the sanatorium.

41. It is desirable that separate institutions should be provided for -

(a) Cases with reasonable prospect of arrest;

(b) intermediate cases;

(c) late and hopeless cases.

42. Separation of Sexes.- It is desirable that the sexes should be accommodated in separate sanatoria.

43. Hospital Beds in Sanatoria.- It is considered that sanatoria should have a small separate section with suitable facilities for

hospital treatment of acute and emergency conditions to which cases requiring special care can be removed temporarily until they improve; or if found unsuitable for sanatorium, can be transferred elsewhere.

44. Duration of stay in Sanatorium.- It is considered that for curative purposes the duration of stay in sanatorium should not be less than six months and preferably longer. For educative purposes the duration of stay may be considerably reduced.

No case should remain in a sanatorium for longer than twelve months without reference, with special medical recommendation, to the officer of the State Health Service who has control of the disposal of cases to institutions.

45. Staff.- There should be a resident medical officer in charge of each sanatorium, who should be invested with adequate disciplinary authority.

46. Equipment.- Before additional sanatoria are erected, full consideration should be given to the advantages from the point of view of economy and efficiency of increasing accommodation at existing sanatoria, so that it may be economically possible to provide laboratory X-ray and special treatment at each sanatorium.

47. Dental Treatment.- Patients before admission to sanatorium should be made, as far as possible, dentally fit, and adequate arrangements should be made for dental attention to be continued while in sanatorium.

48. Diet.- The question of diet in sanatoria should be carefully considered from the point of view of suitability and economy.

49. Standardisation of Equipment, etc.- The functions, equipment and management of sanatoria should be standardised.

50. Procedure on Discharge.- Every case on discharge from a sanatorium or other institution should be referred to a clinic for subsequent supervision, and information should be given to the local health authority of the district in which the patient will be living.

PREVENTORIA.

51. The provision of suitable homes or "preventoria" to which pretubercular children or children showing any evidence suspicious of incipient tuberculosis can be sent for suitable periods for recuperation, should be a definite part of the control system.

52. It is also recommended that arrangements should be made for the provision of camps at suitable times of the year to which children can be sent who, though poorly nourished or weedy, have not suffered in health to the same extent as those requiring more specialised care in preventoria, or who have been in a preventorium but require further attention.

RECORDS.

53. The keeping of a complete and accurate system of records is essential in every clinic and institution for treatment, and the system of records adopted, including all forms, charts, history sheets, cards and leaflets, should be uniform throughout the State.

54. It is very desirable that the records system should, as far as possible, be uniform throughout the Commonwealth, and it is recommended that the Commonwealth Department of Health should consult with the State Health Departments in order to arrive at a uniform system.

55. It is suggested that the records system at present in use in connection with the Central Tuberculosis Bureau in Melbourne should be taken as the basis for discussion with suitable modifications for branch clinics.

LABORATORY FACILITIES.

56. In association with each clinic there should be laboratory facilities readily available, either at the clinic itself or at the hospital or other recognised laboratory, for the examination of sputum and for other diagnostic examinations.

57. Sputum outfits should be made available free to all medical practitioners through the medical officer of health at the Town Hall, who should arrange, if desired, to forward the specimens to the nearest authorised laboratory. The local health authorities should be asked to circularize medical practitioners in their districts as to the facilities provided.

58. When sputum examination is carried out at an authorised laboratory for a private practitioner, or local health authority, etc. a copy of the laboratory report should be forwarded to the clinic or to the State Department of Health.

EDUCATION.

59. Arrangements should be made, if possible, with the appropriate authorities at the University for the inclusion in the curriculum of the medical course of a set number of hours to be devoted by each undergraduate to clinical work in tuberculosis, and the sanatoria and the hospital beds operated in conjunction with clinics should be utilised for teaching purposes.

60. The undergraduate, during his medical course, should be trained to a full understanding and close acquaintance with the tuberculosis clinic system, and with the measures adopted for the prevention and control of tuberculosis.

61. Facilities should be provided for post-graduate instruction in tuberculosis and clinics, sanatoria and hospitals should be utilized for this purpose.

62. Private practitioners should be encouraged to visit the clinics, and to make free use of them for consultation and advice, and for the purpose of keeping in touch with advances in treatment and preventive measures.

63. In connection with the course for the diploma of public health, set hours for lectures and for practical instruction in tuberculosis should be included, and provision should be made for each candidate to be fully instructed in the scheme in operation for the prevention and control of this disease.

64. A special course of instruction and training for nurses appointed to clinics should be arranged, and these nurses should be required to pass an examination before they become eligible for increased remuneration.

65. Nurses who have qualified by special examination should be eligible for automatic increments rising to at least £260 p.a.

STATISTICS.

66. Early action should be taken to prepare from existing records in Commonwealth and State a comprehensive compilation of such statistical data regarding tuberculosis as is available.

RESEARCH.

67. Active research should be prosecuted into the question of the incidence and geographical distribution of bovine infections in humans in Australia, and into other problems in connection with which accurate data are required in order that the subject of prevention and control may be dealt with on sound scientific lines.

Note.- The question of animal tuberculosis and milk supplies is the subject of separate consideration as indicated in Resolutions No.5 and No.5 of the Federal Health Council, passed at its second session in March, 1928.