1943-44.

THE PARLIAMENT OF THE COMMONWEALTH OF AUSTRALIA.

SEVENTH INTERIM REPORT

FROM THE

JOINT COMMITTEE ON SOCIAL SECURITY,

DATED

15TH FEBRUARY, 1944.

By Authority:
L. F. JOHNSTON, Commonwealth Government Printer, Canberra.
(Printed in Australia.)

F.1112.

MEMBERS OF THE COMMONWEALTH PARLIAMENTARY JOINT COMMITTEE ON SOCIAL SECURITY.
(THE SEVENTEENTH PARLIAMENT.)

(*Appointed 14th October*, 1943.)

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	THE HONORABLE SIR FREDERICK HAROLD STEWART, M.P.

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JOINT COMMITTEE ON SOCIAL SECURITY.

SEVENTH INTERIM REPORT.

A COMMONWEALTH HOSPITAL BENEFIT SCHEME; HOSPITALIZATION; CONSOLIDATION OF SOCIAL LEGISLATION.

1. The Committee has given consideration to the request of the Government for early advice concerning a Commonwealth hospital benefit scheme and hospitalization generally.

RECOMMENDATIONS.

2. Subject to the report which follows, we recommend—

A COMMONWEALTH HOSPITAL BENEFIT.

I. Payment by the Commonwealth from a fund raised by taxation for the purpose of a subsidy of 6s. 6d. per daily occupied hospital bed, for general medical, surgical and obstetric cases, conditional upon (paragraphs 18 and 30)—

(*a*) provision of public bed accommodation without additional charge to a patient (paragraphs 9, 20 and 30); or

(*b*) an allowance, equal to the rate of subsidy towards the cost of an intermediate or private bed in a public or private hospital of an approved standard (paragraphs 9, 17 and 30);

(*c*) payment into a trust account for the extension and improvement of hospital services of any savings resulting to a State from the payment of this Commonwealth hospital benefit subsidy (paragraphs 18 and 44).

II. Payment of differential rates of subsidy per daily occupied bed in respect of mental, chronic diseases, tuberculosis, infectious diseases, subacute and convalescent patients, having regard to the varying amounts now received in patients' fees from each of these categories (paragraph 31).

HOSPITALIZATION.

III. Deferment for one year of the above hospital benefit and payment for that period of the total amount of the subsidies into a trust account for the extension and improvement of hospital services throughout Australia; the planning of such services to be undertaken by an expert advisory body consisting of—

(*a*) a medical-hospital expert;

(*b*) an architect with special up-to-date knowledge and experience of hospital design and services; and

(*c*) a layman experienced in hospital finance and administration to represent the public, and chosen by the Commonwealth and States conjointly (paragraphs 43-47).

ADMINISTRATION.

IV. (*a*) The Commonwealth hospital benefit fund to be administered by the Department of Social Services;

(*b*) The planning of hospital services and the control of funds to be administered by the Commonwealth Department of Health in co-operation with the State Departments concerned (paragraph 48).

CONSOLIDATION OF SOCIAL LEGISLATION AND FINANCE.

V. Consolidation of all social legislation, and inclusion of future measures, in an appropriate Commonwealth Act, financed from a fund raised for the purpose by a graduated tax on income (paragraphs 50-53).

COMMONWEALTH HOSPITAL BENEFIT.

3. Any proposal for a Commonwealth hospital benefit scheme is complicated, *firstly*, by the fact that control of health is vested chiefly in the States and only to a very minor degree in the Commonwealth, and, *secondly*, by the almost complete absence of uniform hospital provision and standards, and great variation in the cost of hospitalization in and between the States, and in hospital revenue from patients' fees, government subsidies, and charitable and other sources. Details of these differentials are attached as Appendix "A".

4. The restricted powers of the Commonwealth, particularly regarding health, limit its activities in respect of the two matters upon which our advice is sought, and doubt has been expressed by law officers as to any health or other power possessed by the Commonwealth, which would enable it to grant financial assistance in either case.

5. The report of the Social Security Medical Survey Committee, in this regard, states—

> The Government of the Commonwealth has no power to intervene in respect of hospital care within the States of Australia, except insofar as its activities are covered by the term "insurance" (*Commonwealth Constitution Act* 1901 S.51, XIV.) or with the consent of the States concerned (*loc. cit.* S.51, XXXVII.). No benefit may be distributed to the undue or unequal advantage of a State as against other States (*loc. cit.* S.99, *et al.*).

We agree with this statement of the Medical Survey Committee.

6. Unless the powers of the Commonwealth in regard to health are extended by an alteration of the Constitution, it would appear that the only method by which the Commonwealth can provide financial assistance to inmates of hospitals, other than under section 51 of the Constitution, is by way of financial assistance to the States under section 96 of the Constitution, or by agreement with the States. It is probable that, under section 96 of the Constitution, assistance could only be granted to reimburse payments made by the States to hospitals or inmates, or to cover payments for which the States are liable. It would be necessary, therefore, for the Commonwealth and the States to agree upon the basis upon which the assistance should be given. The States would then grant the assistance, and the Commonwealth would grant financial assistance to the States to cover such payments.

It is possible that assistance to hospital patients could be granted under the appropriation power, as has been done in the case of the maternity allowance, but this would involve the setting up of Commonwealth machinery as has been done in relation to maternity

allowances, and it is thought that it would be necessary to obtain the advice of the Attorney-General's Department before deciding to adopt such a scheme.

7. As regards the object of such assistance, the Medical Survey Committee report states—

> Reference has already been made to the fact that the presumed object of a Commonwealth hospital benefit scheme is to confer a direct financial benefit on hospital patients themselves, thus ensuring to them relief from part or all of their actual hospital expenses.

8. In support of this, conclusive evidence was submitted by medical and other witnesses to us concerning the very high proportion of the cost of sickness represented by hospital expenses and this, at present, falls particularly heavy on the middle income group.

9. In an endeavour to arrive at an equitable and uniform basis upon which such assistance might be granted, we have investigated the existing systems and conditions of hospital finance, but, the differentials referred to are so complex as to make it extremely difficult to find a basis which is likely to establish complete uniformity among all the States or be acceptable to them. The Commonwealth, however, is in no way responsible for the present lack of uniformity which arises, chiefly, because each State administers its health laws and services in its own way, without the aid or existence of any Commonwealth-wide co-ordinating authority. It remains, therefore, to devise a system which, while recognizing the right of the States to impose these varying conditions upon the people, enables the Commonwealth to confer an equal benefit upon all without discrimination against any State or individual. There is much to commend any system which will bring this about and, at the same time, provide a direct individual benefit upon taxpayers. The benefit would consist of the provision, in return for a tax payment, of hospital in-patient accommodation and care up to public bed standard, without additional charge to the patient, or a corresponding allowance towards the cost of an intermediate or private bed; and, in association with such a scheme, to establish approved standards of hospitalization generally to meet community needs. Thus, whatever method be adopted, an equal benefit would be conferred on all taxpayers.

10. The introduction of such a scheme would be a recognition of a national responsibility to relieve the individual taxpayer of the cost of necessary hospital care, as a charge to Commonwealth funds raised by taxation for the purpose.

11. Three alternative methods for conferring these benefits, as distinct from improved hospitalization generally, have been considered. These are for payment by the Commonwealth of—

(i) a flat rate subsidy per daily occupied bed, based upon the average amount now received from patients' fees.

(ii) a *per capita* of population grant to the States for hospital purposes, and

(iii) a contribution to the States approximating 50 per cent. of the present bed cost per day of hospital public bed accommodation.

12. We set out hereunder what appear to us to be the relative merits of these three methods:—

1 Subsidy Per Occupied Bed.

13. While the amount of patients' fees is not particularly related to the cost factor in providing hospital care, to confer a benefit directly upon patients themselves the most equitable and practicable means is to relieve patients of payment for hospital accommodation and care up to a prescribed minimum standard. The method of payment might be for the Commonwealth to make a payment of a flat-rate subsidy per daily occupied hospital bed. This payment would be made to the State and credited to the constituted State authority for providing public hospital services, and to individual hospitals where these are privately owned, subject to approved standards.

14. To adopt, for this purpose, a varying rate of subsidy based on the existing varying amounts received from patients' fees in the different States (from 3s. 9½d. in Victoria to 5s. 9d. in New South Wales), would be contrary to the Commonwealth obligation to provide an equal benefit. Moreover, the funds for this purpose, being collected on a uniform basis, distribution should be made on a similar basis.

15. Any Commonwealth subsidy under this proposal, therefore, would need to be at a flat-rate to all States and should be sufficient to cover the return from patients' fees in that State in which the highest average exists, in this case, 5s. 9d. in New South Wales. It should be understood, however, that this represents the average fees of patients in public hospitals including public, intermediate and private beds, the amount of fees from patients in private hospitals being unavailable.

16. While it has not been possible to secure details of fees paid by each of the three categories of public hospital patients, there is probably a steep increase in the proportion paid by public, intermediate and private patients respectively, and, if the rate of subsidy were related to the average of fees from "public" patients only, it would, obviously, be considerably lower than if related to the average of all patients' fees. Adoption of this proposal would represent the nearest practicable approach to the nation-wide extension of the benefits now provided by voluntary hospital benefit funds, though its introduction would seriously affect the stability of such funds.

17. The proposed benefit is related to the incidence of sickness. In this respect, in principle, the scheme does not differ materially from other Commonwealth measures, for example widows' pensions, where the benefit is conditional upon individual need. It does not seem possible to devise any system which can properly disregard this basic condition, if the benefit is to be to the individual and not to the State. Moreover, the benefit would be uniform if, in return for the subsidy, all public hospitals provided public ward accommodation free of charge to patients, and public and private hospitals granted an allowance, equal to the amount of Commonwealth subsidy, for all intermediate and private bed accommodation. This would, no doubt, stimulate the finances of private hospitals but it would also assist substantially in the development of public hospitals on "community" hospital lines—a desirable improvement which has been strongly recommended in evidence before this Committee.

18. For such a purpose, based on figures for the year 1941-42, a flat-rate subsidy of 6s. per daily occupied bed for general medical, surgical and obstetric cases, would be adequate. Having regard, however, to the subsequent general increase of approximately 10 per cent. in hospital maintenance costs and an increase in patients' fees, details of which for all States are not yet available, we consider it would be necessary to increase the rate of subsidy to 6s. 6d. per daily occupied bed. From such an amount, the States would benefit by certain savings representing the difference between the present revenue from "public" patients' fees and the amount of the Commonwealth subsidy. These we consider should be specially set aside for improving and extending hospital services as referred to later under the section of this report dealing with hospitalization.

19. The following table indicates the position in respect of public hospital and private hospital beds in the various States, based on figures for the year 1941-42, if a subsidy of 6s. per daily occupied bed were paid:—

State.	Daily Occupied Beds.			Total Annual Subsidy at Daily Rate			Present Income from Public Hospital Patients only.		Surplus over Public Hospital Patients' Fees
	Public Hospitals.	Private Hospitals.	Total.	Public Hospitals.	Private Hospitals.	Total	Per Day	Per Year	
				£	£	£	s. d.	£	£
New South Wales	11,650	3,800	15,450	1,276,000	416,000	1,692,000	5 9	1,234,000	42,000
Victoria	6,300	4,200	10,500	690,000	460,000	1,150,000	3 9½	434,000	256,000
Queensland	4,730	1,200	5,930	518,000	131,000	649,000	4 0½	350,000	168,000
South Australia	2,023	1,400	3,420	221,000	153,000	374,000	4 6	165,000	60,000
Western Australia	1,850	800	2,650	203,000	88,000	291,000	5 8	192,000	11,000
Tasmania	1,030	200	1,230	113,000	22,000	135,000	5 1¼	96,000	17,000
Total	27,580	11,600	39,180	3,021,000	1,270,000	4,291,000	4 11 (average)	2,471,000	550,000

20. While there appears to be no existing common basis for complete uniformity of hospitalization due to the differing conditions and nature and extent of hospital services in the States and the varying means tests, the payment of a flat-rate subsidy as suggested would in itself very largely achieve this. We believe that the payment of a subsidy, as proposed, justifies abolition of the means test. If agreement with the State concerning this cannot be reached, an endeavour might be made to reconcile the major differences in the means tests now imposed by the States on public hospital patients, by defining "public" bed accommodation, and applying this generally throughout the Commonwealth. A real measure of uniformity would be established by the payment of the subsidy only to hospitals of an approved standard. The fact that debits against public-bed patients, varying from 0s. to 9s. in Queensland to as high as 15s. in parts of Western Australia, demonstrates the need for greater uniformity in this regard and also the risk that the object of a Commonwealth benefit might be defeated were these differential debits continued and patients required to pay any balance over and above the amount of the subsidy. This would be overcome by the firm condition that in return for the subsidy all public beds would be provided without further charge to patients.

Per Capita of Population Payment.

21. Assuming that the object would be to relieve the patient of the whole or portion of the cost of hospitalization, as in the former proposal, the logical basis for a per capita payment would be an aggregate amount equal to the total annual revenue now received from patients' fees for all States. This was £2,471,000 for the year 1941-42 for all classes of public hospital patients, excluding those in mental and benevolent institutions.

22. As indicated in the following Treasury Table, a per capita payment of £.345 or 6s. 11d. per head of population would produce £2,460,000. Under this method grants to the States would be—

—	Population.	Grant.	Public Hospitals Patients' Fees.
	('000).	£	£
New South Wales	2,820	975,000	1,234,000
Victoria	1,960	676,000	434,000
Queensland	1,010	355,000	350,000
South Australia	610	210,000	165,000
Western Australia	465	160,000	192,000
Tasmania	240	85,000	96,000
	..	2,460,000	2,471,000

23. This method has the merit of relating benefit to population needs and this is in accord with recognized world practice in calculating community hospital requirements on a population basis. It does not, however, assist in reconciling differentials in hospital finance, but, on the contrary, appears to aggravate the position. An analysis of the effect of such a payment upon hospital finance discloses other anomalies which probably would make this method unacceptable to a majority of the States. For example, on this basis Western Australia, New South Wales and Tasmania would receive, respectively, £32,000, £259,000 and £11,000 *less* than they now receive from patients' fees, while by comparison, Victoria would receive £241,000, and South Australia £55,000 *more*, without taking into account amounts received from donations from charitable and other non governmental sources. The effect, therefore, would be to penalize the former States which have the highest return from patients' fees by requiring them to make good the deficiency, while benefiting the latter States whose revenue from patients' fees is the lowest and third lowest, respectively.

3 Contribution to the States Approximating 50 per cent. of Hospital "Public" Bed Costs.

24. It has been suggested that bed cost is a more logical and equitable basis upon which to grant Commonwealth assistance for hospital purposes, particularly for a hospital benefit scheme, and that the Commonwealth should be prepared to contribute 50 per cent. of the cost of providing "public" bed accommodation. Such a payment would be a recognition by the Commonwealth—in the absence of Commonwealth health powers—of a joint responsibility with the States for hospitalization, as a major portion of health services, by sharing equally the maintenance cost of public beds. It is assumed that, in return for such a Commonwealth payment, the States would be required to provide a benefit to individual patients similar to that of the two former proposals.

25. A major difficulty encountered in developing this proposal has been the unavailability, in most States, of separate costs of maintaining "public", as distinct from "intermediate" and "private" beds in public hospitals, such costs only being recorded in Tasmania and partly in Victoria, under existing hospital accounting systems. To make a special dissection of such costs would occupy time, labour and expense which would not appear to be justified in the present circumstances, unless it were first decided to adopt this method. For the purpose of consideration, however, it would appear from such facts as are available, that the cost of "public" beds throughout Australia would be little

less than that of all beds in public hospitals. The difference in cost probably would be from 6d. to 9d. per bed per day only because, in the great majority of cases, private and intermediate beds represent only a small proportion of the total beds, and the difference in service is in the greater privacy of a small or private ward, the treatment and food being the same generally for all patients.

26. The Medical Survey Report, Part IV. (4), Table 18, disclosed an average daily bed cost of 12s. 10½d. for all patients for all States for the year 1941-42, the varying State averages being New South Wales 12s. 10½d., Victoria 11s. 10½d., Queensland 13s. 8d., South Australia 14s. 6d., Western Australia 13s. 6d. and Tasmania 11s. 5d. More recent official figures indicate an average cost of 12s. 6d. in Tasmania—an increase of 1s. 1d. per daily bed cost, and for portion only of Victoria an average of 15s. 1d. The latter figure is not comparable with the cost in 1941-42 for that State, each being compiled on a different basis, but it does confirm the fact that an increase in cost is occurring in all States. Efforts to obtain the actual public bed cost for other States have failed. At the Royal Prince Alfred Hospital, Sydney, separate costs are kept for public, intermediate, private and out-patients' services, but the present figures cannot be used as a basis for calculation because the hospital has not been static for several years and portion of its beds have been used for Allied Army personnel. Also, it is a teaching hospital with resultant extra costs. In the case of such hospitals as Sydney Public and Royal North Shore, for each of which the daily bed costs exceeds £1, this is complicated by the inclusion in the former of the cost of out-patient and teaching services, and in the latter by the inclusion of out-patient, intermediate and private charges. The Tasmanian figure is probably a reasonable guide to present costs in other States, and this suggests an increase since 1941-42 of approximately 10 per cent. Calculated on this basis, the present average daily bed cost for all public hospital beds for all States would be 14s. 2d., and the probable cost of public beds about 13s. 6d.

27. For the Commonwealth to contribute 50 per cent. of the cost of public beds would involve a subsidy at the rate of 6s. 9d. per occupied bed per day or a total annual sum of £3,397,000, based on the total of beds in public hospitals in 1941-42; limited to public beds only, this would be reduced to £3,035,000. If such a payment is, as stated, conditional upon provision by the States of free public bed accommodation or an equivalent allowance for an intermediate or private bed, patients desiring the latter would be denied this benefit unless the subsidy were paid in respect of all occupied beds, including intermediate and private beds in private hospitals of which there are 11,600. This would increase the annual payment of the Commonwealth by £1,429,000 and bring the total annual amount to £4,826,000.

28. From the viewpoint of national expenditure this system has the weakness that the Commonwealth, in having accepted the obligation to make a 50 per cent. daily bed cost contribution, would have no control whatever over the expenditure, the sole responsibility for all factors relating to the bed cost being under the control of the States. Also, to police the measure adequately, a special system of accounting would need to be established involving continuous internal checking of costs, and of the items contributing to them which would appear to provide numerous grounds for disagreement between the Commonwealth and the States.

29. Should this method be adopted, law officers advise that it would be in order for the Commonwealth to pay a differential rate representing 50 per cent. of the average public bed cost in each State. Payment at a flat rate, based on the average cost for all States, would be less than 50 per cent. in those States where the average for the State exceeds the average for all States. The latter is inequitable and the former no check on inefficiency or extravagance.

30. After careful investigation of these three alternative proposals, we consider that the payment of a flat rate subsidy based on the highest State average of revenue from patients' fees is the most equitable and desirable basis for a Commonwealth hospital benefit scheme, to confer the benefit of free public bed hospitalization or an equivalent allowance towards the cost of an intermediate or private bed in a public or private hospital of an approved standard, and that the rate of subsidy be 6s. 6d. per daily occupied bed, subject to the conditions herein stated.

31. It is assumed that a Commonwealth scheme of hospital benefits would cover all classes of patients, and, therefore, that mental, chronic diseases, tuberculosis, infectious diseases, subacute and convalescent patients would be included. Medical Survey Table 20, Part IV. (4), *vide* Appendix "B" herewith, gives details as to occupancy and maintenance expenditure and contributions of mental patients' fees, representing an average for Australia of 8d. per day as against a government contribution of 3s. 8d. per day. Patients' fees are highest in South Australia (1s. 4d.) and lowest in Queensland (5½d.), and government contributions highest in Tasmania (5s. 1½d.) and lowest in Victoria (3s. 8d). Comparable figures for the other diseases mentioned are not supplied, but these should be procurable and would be an essential basis upon which differential rates of subsidy could be established.

32. In view of the special assistance now granted by the Commonwealth in cases of maternity, it is not considered that any special provision be made in a Commonwealth hospital benefit scheme for such patients other than the general provision of public ward accommodation in accordance with these proposals.

33. As all workers' compensation cases are already provided for in respect of hospital and medical care, no provision for them, as such, is necessary and none is therefore included in these proposals.

34. The effect of a Commonwealth hospital benefit scheme upon the voluntary hospital benefit funds in all States, providing hospitalization for their members, will be considerable. This should not affect State commitments generally as hospitals would receive the Commonwealth subsidy instead of, as formerly, an equivalent amount from the funds of the voluntary organization. It is considered likely that a proportion of existing subscribers to these funds will continue as such in order to become entitled to benefits in excess of the public bed standard. Appendix "C" attached summarizes the scope of existing voluntary funds throughout Australia. Such funds contribute in hospital fees £599,500 out of a total from all public hospital patients of £2,342,000. The percentage of voluntary fund contributions is highest in New South Wales at 35.6 per cent. and Queensland at 27.1 per cent. where the effects of a Commonwealth scheme upon voluntary funds will be the most severe—the average for Australia being 23.6 per cent. While at present the benefits provided by these voluntary funds supply a most valuable community service, the need for such benefits being extended to cover the whole community is paramount and this can only be done by a nation-wide benefit scheme.

35. An important consideration is bed classification. The payment from a Commonwealth subsidy of an allowance, equal to public ward rate, towards the cost of intermediate and private beds, will increase the demand for the latter. The tendency also, will be for doctors to encourage this, as under existing conditions, public ward patients pay no medical fees, whereas other patients generally pay fees somewhat related to the type of hospital bed occupied. This trend is illustrated by the fact that the payment of increased maternity benefits has resulted in an increased demand for intermediate and private beds. While public hospitals would receive the same rate of subsidy for all patients, it would be in the interests of the hospital to decrease public beds which now make a loss and increase other types of beds which provide a small profit. This would have the effect of reducing State expenditure on public hospitals and of increasing the income of private hospitals. It would be necessary, therefore, to definitely establish the bed classification for all public hospitals as at the commencement of a Commonwealth subsidy, and to permit variation of this only by approval. Also, with the anticipated increased demand for intermediate and private bed accommodation following the introduction of a Commonwealth hospital benefit scheme, the tendency would be for hospitals to increase charges for these beds. Action should be taken, therefore, to obtain the bed classification and charges of all private and community hospitals with the object of authorizing increased charges only when justification for an increase has been fully established.

Out-patients.

36. The provision of a benefit for out-patients differs from that for in-patients. The fees paid by out-patients—of which it has not been possible to secure separate details for all States—must be related to the number of attendances, and these differ substantially in each State, indicating a higher standard of out-patient treatment in some States than in others. The out-patient problem has a direct relation to a general medical service, if and when provided. It may be considered that any hospital benefit scheme must include out-patients, but, in the event of a general medical service being instituted, out-patients would be provided for automatically at the suggested group clinics or health centres and hospitals; the only difference would be that they would be treated by general practitioners and not, as at present, by specialists, who waste a great deal of valuable time treating minor ailments. Existing out-patient facilities are grossly inadequate and unsatisfactory to all parties concerned, and reorganization of the service is urgently needed. The medical profession desire that the out-patient be returned to the general practitioner, and this is exactly what would happen under the group clinic system for providing a general medical service. Under it, the general practitioner would refer to a specialist any case requiring his attendance or treatment.

37. The proposal, later referred to, for deferment of hospital benefit for one year, has a direct bearing on the out-patient problem. The planning of a general medical service is now being undertaken in association with the medical profession and consideration of an out-patient benefit might be deferred for the present, as it is expected this position will be clarified within the next few months. The estimated cost of out-patient treatment is 2s. 4d. a visit or a total sum of £500,000 (rising) per annum, covering 1,276,000 out-patients and 4,159,000 attendances.

Hospital Standards.

38. The present varying conditions in the States apply not only to the various aspects of finance, but, also, to the great variety of hospital standards and

services in both public and private hospitals throughout Australia. Dealing with this, the Medical Survey Committee, Part IV. (4), reported—

> "The haphazard growth of hospital provision both in public and private, has led to marked disparities in distribution and to a great variation in efficiency. . . . Requirements differ in detail in each State and there are grave deficiencies in certain respects in all States."

39. We stress the necessity for insistence upon approved hospital standards of accommodation, medical and surgical equipment, staffing, records and accessory services, under a system of regular inspection particulars of private hospitals participating in a Commonwealth hospital benefit. We consider that only hospitals which conform to an approved standard should be entitled to receive the subsidy, and that this condition should be effectively policed, as a protection to patients and as a means of raising the deplorably low standard of a large number of private hospitals in Australia. Non insistence upon such standards would permit these conditions to continue, thus depriving patients of adequate health safeguards and proper hospital care

HOSPITALIZATION.

40. This section deals with the most urgent aspects of the present hospital problem in Australia. In our final report on comprehensive health services, we will deal further with the regionalization of the hospital system in its relation to health services generally.

41. The introduction of a Commonwealth hospital benefit scheme would undoubtedly increase demands upon the already seriously inadequate hospital accommodation. The existing private hospital accommodation also would subject to approved standards being maintained—have to be used to meet public requirements. The Social Security Medical Survey revealed a bed shortage of 6,774 general, 2,963 tuberculosis and 6,994 mental, or a total of 16,731. Of these, the most pressing need is beds to accommodate chronic and sub-acute cases.

42. We are of opinion that it is useless making grants to patients of moneys for hospital accommodation benefit, free medicine, &c., if there is no provision for patients to utilize these benefits by being able to gain admission to hospital when needed. We feel that the first and most urgent call on any fund should be the making good of all deficiencies in hospital accommodation, that the immediate and cheapest solution lies in overcoming the glaring deficiencies in accommodation for subacute and chronic diseases, and for the evacuation of these patients from acute hospitals with resultant lowering of maintenance costs. The accommodation provided for such sub-acute and chronic hospitals should be of the best possible type, and adequately equipped and staffed to secure the restoration to health and rehabilitation of these patients.

43. The Chairman of the Medical Survey Committee (Dr. Lilley) stated in evidence that the provision of accommodation for such cases would immediately relieve the congestion in all large hospitals and would enable them to provide adequate beds for acute cases. He estimates that hospitals to accommodate chronic and sub-acute cases would cost very much less than for acute cases and could be provided at an overall cost of £600 per bed. On this basis the whole of the existing bed shortage could be made good for the sum of £10,000,000. It has been urged, and we endorse the view, that action to relieve this situation is urgently necessary. We consider it expedient and desirable, therefore, to associate with these proposals a recommendation that the payment of a Commonwealth hospital benefit be deferred for one year and that the

whole amount of the subsidy for that period be paid into a trust account to provide extended and improved hospital accommodation. This is estimated to provide approximately £4,250,000.

44. Further, we recommend that it be a condition of any Commonwealth subsidy that any savings resulting to a State—such as referred to in paragraph 18—be set aside for the extension and improvement of hospital facilities on agreed-upon conditions. While an assessment of such savings can only be made, following expert calculations having regard to all relevant items of expenditure and revenue, it is estimated that this may produce £1,000,000 per annum. Such an amount, together with the initial contribution of the Commonwealth, would enable an early commencement to be made on this urgent and important work, as soon as war-time priorities permitted.

45. Before a commencement can be made on construction, however, much expert planning needs to be undertaken. In this regard, while visualizing a still more comprehensive plan of hospitalization, our recommendation (*vide* paragraph 145, Sixth Interim Report), as endorsed by the Health Services Conference at Canberra on the 8th December, 1943, was for—

(i) an expert body to advise on hospital planning, location, construction and equipment for the whole of the Commonwealth:

(ii) uniform standards for hospitals of various types and bed capacity; and

(iii) regionalization of hospitals in co-operation with State hospital authorities, to improve hospital standards and services generally.

46. The planning involved in the present proposals contemplates an expenditure of £10,000,000 on hospital services and would be an integral part of any long-range hospitalization plan. It should, therefore, be controlled by the expert body referred to above, rather than by any particular department. Moreover, it is a job for experts who are probably not, at present, within either the Commonwealth or State Services. But, as the States are concerned equally with the Commonwealth in such planning, mutual agreement would be essential. It is considered that, pending the introduction of a comprehensive health scheme, or, at least, at this stage, the expert body to prepare a plan and to advise on hospitalization generally, in the terms of the Committee's recommendation above, should be an advisory body, and might consist of—

(*a*) a medical-hospital expert;

(*b*) an architect with special up-to-date knowledge and experience of hospital design and services; and

(*c*) a layman experienced in hospital finance to represent the public and chosen by the Commonwealth and the States conjointly.

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49. Agreement between the Commonwealth and the States would be a condition precedent to the successful introduction of these proposals. It is assumed, therefore, that the matter would be the subject of discussions between Commonwealth and State government representatives. Mutual agreement, also, would be necessary regarding the important matter of inspections to ensure approved hospital standards.

CONSOLIDATION OF SOCIAL LEGISLATION AND FINANCE.

50. In previous reports we have urged the need for consolidation of all social legislation, and that piecemeal legislation should give place to a properly integrated long-range plan of social security, of which health services would form an important part. If this principle is accepted, it means that all new legislation affecting social security must be based on one financial principle running through legislation on social security as a whole, and so designed as to integrate efficiently and satisfactorily with the legislation now in force or to be adopted at a later date.

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52. The Committee believes that all social security measures should be financed by personal contributions from those for whom the benefits under the scheme will be provided. In this connexion attention is directed to paragraph 12 of the Committee's Second Report, paragraph 28 (7) of its Third Report, and paragraph 124 of its Sixth Report, in which the principle of a graduated tax on income for social security is recommended. We are, therefore, of opinion that this financial principle should be incorporated in this, as well as in all future measures dealing with social security.

53. Basing its opinion on the above principle, the Committee believes it to be necessary that early provision be made for the consolidation of the existing social legislation in an appropriate Commonwealth Act in which all future legislation of a similar nature shall be included.

H. C. BARNARD, Chairman.

Canberra,

15th February, 1944.

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TABLE 16.—AUSTRALIA—BED OCCUPANCY—ALL HOSPITALS 1941–42.

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	Daily Average Occupied Beds.	Beds per 1,000 of Population.	Daily Average Occupied Beds.	Beds per 1,000 of Population.	Daily Average Occupied Beds.	Beds per 1,000 of Population.
New South Wales	11,650	4.13	3,800	1.35	15,450	5.5
Victoria	6,300	3.21	4,200	2.14	10,500	5.4
Queensland	4,730	4.60	1,200	1.17	5,930	5.8
South Australia	2,020	3.32	1,400	2.30	3,420	5.6
Western Australia	1,850	3.94	800	1.70	2,650	5.6
Tasmania	1,030	4.29	200	0.83	1,230	5.1
Commonwealth	27,580	3.86	11,600	1.63	39,180	5.5

(Exclusive of Australian Capital Territory and Northern Territory.)

TABLE 17.—SOURCES OF MAINTENANCE COSTS, 1941–42. FIGURES IN THOUSANDS OF POUNDS.

State.	Government Aid.			Patients' Payments.			Donations and Entertainments.	Other	Total Maintenance Cost.	Daily Average Occupied Beds.
	State.	Local.	Total.	Fees.	Systematic Payments.	Total.				
New South Wales	1,233	..	1,233	801	433	1,234	177	93	2,737	11,650
Victoria	533	81	614	386	48	434	217.5	95.5	1,361	6,300
Queensland	516	272	788	262	88	350	29.5	9.5	1,177	4,730
South Australia	277	52	329	146.5	18.5	165	33	8	535	2,020
Western Australia	246	..	246	177	15	192	8.5	7.5	454	1,850
Tasmania	97	..	97	90	6	96	14	7	214	1,030
Total	..	..	3,307	1,862.5	608.5	2,471	479.5	220.5	6,478	27,580

TABLE 18.—PUBLIC HOSPITALS 1941–42—SOURCES OF DAILY MAINTENANCE COST: IN-PATIENTS.

State.	Government.			Patients.			Donations and Entertainments.	Other	Total
	State.	Local.	Total.	Fees.	Systematic.	Total.			
	s. d.	*s. d.*	*s. d.*	*s. d.*	*s. d.*	*s. d.*	*s. d.*	*s. d.*	*s. d.*
New South Wales	5 10	..	5 10	3 9	2 0	5 9	0 10½	0 5	12 10½
Victoria	4 8	0 3	5 4	3 4½	0 5	3 9½	1 11	0 10½	11 10½
Queensland	6 0	3 2	9 2	3 0½	1 0	4 0½	0 4	0 1½	13 8
South Australia	7 6	1 5	8 11	4 0	0 6	4 6	0 10½	0 2½	14 8
Western Australia	7 3½	..	7 3½	5 3	0 5	5 8	0 3	0 3	13 6
Tasmania	5 2	..	5 2	4 0½	0 4	5 1½	0 0	0 4½	11 5
Average	..	..	6 7	3 8½	1 2½	4 11	0 11½	0 5	12 10½

Towards daily maintenance costs, State and local authorities in *Queensland* contribute 9s. 2d. of the total cost of 13s. 8d.; the State Government provides 6s. and the local authorities, 3s. 2d. of this amount. In *Victoria*, the contribution of State and local governments is only 5s. 4d. out of a total of 11s. 10½d. (These differences are compensated for by complementary difference in the average daily contributions of patients towards their maintenance, plus charitable contributions, &c.)

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State.	Average Inmates.	Annual Maintenance Expenditure.	Sources of Maintenance Expenditure.			Daily Maintenance Costs.				Daily Inmates per 1,000 Population.
			Government.	Patients.	Other.	Government.	Patients.	Other	Total	
		£'000.	£'000.	£'000.	£'000.	*s. d.*	*s. d.*	*s. d.*	*s. d.*	
New South Wales ..	11,270	843	699	134	10	3 4½	0 8	0 0½	4 1	3.65
Victoria	7,000	353	265	88	..	3 8	0 8	..	4 4	3.6
Queensland	3,540	270	239	30	1	3 8½	0 5½	..	4 2	3.35
South Australia	1,880	186	140	46	..	4 1	1 4	..	5 5	3.15
Western Australia	1,530	137	116	21	..	4 2	0 9	..	4 11	3.2
Tasmania	680	72	64	8	..	5 2	0 8	..	5 10	2.9
Commonwealth ..	25,900	2,061	1,723	327	11	3 8 (average)	0 8 (average)	..	4 4 (average)	3.62 (average)

As the Table shows, the total maintenance expenditure on Mental Institutions in 1941–42 was £2,061,000, to which Governments contributed £1,723,000 and patients £327,000. The daily cost was 4s. 4d., of which Government contributions represent 3s. 8d. and patients' contributions, 8d.

whole amount of the subsidy for that period be paid into a trust account to provide extended and improved hospital accommodation. This is estimated to provide approximately £4,250,000.

44. Further, we recommend that it be a condition of any Commonwealth subsidy that any savings resulting to a State—such as referred to in paragraph 18—be set aside for the extension and improvement of hospital facilities on agreed-upon conditions. While an assessment of such savings can only be made, following expert calculations having regard to all relevant items of expenditure and revenue, it is estimated that this may produce £1,000,000 per annum. Such an amount, together with the initial contribution of the Commonwealth, would enable an early commencement to be made on this urgent and important work, as soon as war-time priorities permitted.

45. Before a commencement can be made on construction, however, much expert planning needs to be undertaken. In this regard, while visualizing a still more comprehensive plan of hospitalization, our recommendation (*vide* paragraph 145, Sixth Interim Report), as endorsed by the Health Services Conference at Canberra on the 8th December, 1943, was for—

(i) an expert body to advise on hospital planning, location, construction and equipment for the whole of the Commonwealth:

(ii) uniform standards for hospitals of various types and bed capacity; and

(iii) regionalization of hospitals in co-operation with State hospital authorities, to improve hospital standards and services generally.

46. The planning involved in the present proposals contemplates an expenditure of £10,000,000 on hospital services and would be an integral part of any long-range hospitalization plan. It should, therefore, be controlled by the expert body referred to above, rather than by any particular department. Moreover, it is a job for experts who are probably not, at present, within either the Commonwealth or State Services. But, as the States are concerned equally with the Commonwealth in such planning, mutual agreement would be essential. It is considered that, pending the introduction of a comprehensive health scheme, or, at least, at this stage, the expert body to prepare a plan and to advise on hospitalization generally, in the terms of the Committee's recommendation above, should be an advisory body, and might consist of—

(*a*) a medical-hospital expert;

(*b*) an architect with special up-to-date knowledge and experience of hospital design and services; and

(*c*) a layman experienced in hospital finance to represent the public and chosen by the Commonwealth and the States conjointly.

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TABLE 22.—HOSPITAL BENEFIT CONTRIBUTORY SCHEMES.

State.	Number of Contributors.	Annual Contributions.	Fees Paid to Hospitals.	Total Patients' Fees Received by Hospitals from all Sources.	Percentage of Fees Received from Schemes to Total Patients' Fees Received by Hospitals from all Sources.
		£	£	£	
New South Wales, 1941–42	*	*	433,000	1,215,000	35.6
Victoria, 1941–42	61,710	45,000‡	48,000	422,400	12.3
Queensland, 1941–42	65,628	*	88,000	350,000	27.1
South Australia, 1941–42	29,892	24,000	18,500	164,000	11.3
Western Australia, 1942–43§	13,000†	16,500†	12,000†	191,000 (1941–42)	6.3
Tasmania	*	*	*	*	..
	..	..	599,500	2,342,400	25.6

* Not available.
† Estimated.
‡ In Victoria, 1941–42, contributors fell short of payments to hospitals by £3,000.
§ Includes Metropolitan Hospital Benefit Fund only; Miners' Contribution Funds are excluded.

By Authority: L. F. JOHNSTON, Commonwealth Government Printer, Canberra.