1945.

THE PARLIAMENT OF THE COMMONWEALTH OF AUSTRALIA.

EIGHTH INTERIM REPORT

FROM THE

JOINT COMMITTEE ON SOCIAL SECURITY,

DATED

27TH JUNE, 1945.

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Senator COOPER, Deputy Chairman, -

I bring up the Eighth Interim Report

from the

Joint Committee on Social Security

and move - That the Paper be printed.

Entry, please

Aug 2.

MEMBERS OF THE COMMONWEALTH PARLIAMENTARY JOINT COMMITTEE ON SOCIAL SECURITY.

(The Seventeenth Parliament.)

First Session.

(*Appointed 14th October*, 1943.)

Herbert Claude Barnard, Esquire, M.P., Chairman.

Senate.	*House of Representatives.*
Senator Walter Jackson Cooper, M.B.E.*	Frederick Michael Daly, Esquire, M.P.
Senator Dorothy Margaret Tangney.	Leslie Clement Haylen, Esquire, M.P.
	Rupert Sumner Ryan, Esquire, C.M.G., D.S.O., M.P.*
	The Honorable Sir Frederick Harold Stewart, M.P.*

* Discharged from attendance 30th March, 1944.

Second Session and Third Session.

(*Appointed 20th July*, 1944.) (*Appointed 10th May*, 1945.)

Herbert Claude Barnard, Esquire, M.P., Chairman.

Senate.	*House of Representatives.*
Senator Walter Jackson Cooper, M.B.E.	Frederick Michael Daly, Esquire, M.P.
The Honorable Hattil Spencer Foll.	Leslie Clement Haylen, Esquire, M.P.
Senator Dorothy Margaret Tangney.	Rupert Sumner Ryan, Esquire, C.M.G., D.S.O., M.P.

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JOINT COMMITTEE ON SOCIAL SECURITY.

EIGHTH INTERIM REPORT.

INTRODUCTORY.

1. The Joint Committee on Social Security, in its Sixth Interim Report presented to Parliament on the 1st July, 1943, dealt with the nature and extent of health services necessary and adequate for the Australian people, and submitted various proposals to provide these services. However, owing to unforseen parliamentary developments—which led to an early dissolution of the House of Representatives and later to a general election—the Committee indicated that its deliberations and proposals were unavoidably inconclusive and needed further consideration and development. Moreover, the Committee was convinced that a complete outline of health services for Australia should be discussed by it with interested parties, such as the medical profession and the National Health and Medical Research Council. As a matter of fact, such a conference had been arranged when these political developments rendered its assembling impracticable.

2. When the Joint Committee on Social Security was re-appointed by the Seventeenth Parliament, it resolved to proceed with this proposed conference and to invite thereto representatives of the British Medical Association, the National Health and Medical Research Council, and the Directors-General of the Defence Medical Services, as well as the medical members of the Medical Survey Committee. This conference was held in Canberra on the 8th and 9th December, 1943, immediately following meetings of the National Health and Medical Research Council and of the Ministers for Health; it was attended by—

Joint Committee on Social Security—
Mr. H. C. Barnard, M.P. (Chairman).
Senator W. J. Cooper (Deputy Chairman).
Senator D. M. Tangney.
Mr. F. M. Daly, M.P.
Mr. L. O. Haylen, M.P.
Mr. R. S. Ryan, M.P.
The Honorable Sir F. H. Stewart, M.P.

British Medical Association—
Sir Henry Newland (President of the Federal Council of the British Medical Association.
Sir Charles B. Blackburn (College of Physicians).
Dr. W. F. Simmons (New South Wales).
Dr. F. W. Carter (Western Australia).
Dr. F. L. Davies (Victoria).
Dr. T. E. V. Hurley (College of Surgeons) accompanied by Dr. J. G. Hunter, General Secretary.

National Health and Medical Research Council—
Dr. J. H. L. Cumpston (Chairman of the Council, and Commonwealth Director-General of Health).

Directors-General of Defence Medical Services—
Major-General R. S. Burston (Director-General of Medical Services, Army).
Air Vice-Marshal T. E. V. Hurley (Director-General of Medical Services, Air).
Surgeon Captain W. J. Carr (Director-General of Medical Services, Navy).

Social Security Medical Survey Committee (Medical members)—
Dr. Allan B. Lilley (Chairman).
Dr. F. McCallum (Deputy Chairman).
Dr. Arthur E. Brown.
Sir Raphael Cilento.

3. An invitation to be represented at the conference by six members had previously been extended to and accepted by the National Health and Medical Research Council, but, when the arrangements were completed, the Chairman of the Council, Dr. Cumpston, intimated that the Council had decided not to be represented by six delegates, but instead had directed him as Chairman, to represent it and present a prepared statement.

4. After discussions, during which the conference concurred in many of the recommendations of the Joint Committee in its Sixth Interim Report, it was resolved that—

> Conference agrees that consideration be given to the provision of a general medical service through a system of group clinics, staffed by private medical practitioners, on a part-time or per session basis, subject to adequate trial being made by the establishment of an experimental clinic in each State under conditions to be considered by a representative sub-committee of this conference and later considered by the conference.

The appointment of the sub-committee was left in the hands of Mr. Barnard, Sir Henry Newland and Major-General Burston. This sub-committee comprised—

Mr. H. C. Barnard, M.P.
Senator W. J. Cooper
Hon. Sir F. H. Stewart, M.P. } Representing the Joint Committee on Social Security.

Sir Henry S. Newland
Sir Charles B. Blackburn
Dr. W. F. Simmons } Representing the British Medical Association in Australia.

Dr. F. McCallum—Representing the Commonwealth Director-General of Health.

Dr. Allan B. Lilley
Sir Raphael Cilento } Representing the Social Security Medical Survey Committee.

(Dr. J. G. Hunter, General Secretary of the British Medical Association was also in attendance),

and under the title of "Medical Planning Committee" met in Sydney on 24th January, 1944, and compiled a comprehensive and unanimous report, copies of which, dated 1st March, 1944, were made available to all members of the conference.

5. In June, 1944, the Minister for Health (Senator Fraser), on the recommendation of the National Health and Medical Research Council, invited the Federal Council of the British Medical Association and representatives of the Royal Australasian Colleges of Physicians and Surgeons to meet, in conference with the Federal Treasurer and himself, together with the members of the National Health and Medical Research Council, "with the object, if possible, of arriving at agreement as to the form which improved medical services to the people might take". Arising from this conference, a committee of six members of the Federal Council of the British Medical Association was to be appointed to confer with officers of the Government to consider details of a scheme that would be acceptable to all parties. This meeting took place in September last, and was attended by the Commonwealth Minister for Health, the Commonwealth Director-General of Health, and six members of the Federal Council of the British Medical Association who had been nominated as representing each State. No reports of either of these meetings have been issued; no formal resolutions

were adopted, but informal discussions, it is understood, covered the range of the Government's proposals and alternative proposals of the British Medical Association for improved health and medical services. There the matter now rests.

6. In the meantime the Joint Committee, having considered the report of the Medical Planning Committee, is of the opinion that, as that report is comprehensive and informative, and carries with it the approval of the Federal Council of the British Medical Association of Australia, its contents should be made available to Parliament. It is accordingly attached hereto as an Appendix. Moreover many of the subjects referred to in the Sixth Interim Report of the Joint Committee on Social Security (paragraph 165) as requiring further consideration have been covered by this report of the Medical Planning Committee.

HEALTH CENTRES.

7. In its Sixth Interim Report, the Joint Committee made the following observation in paragraph 144:—

> Having regard to all the circumstances and to the need for early and substantial reorganization of, and improvement in, health services generally as indicated herein, we consider that . . . such services should now be planned, for introduction as and when the war situation permits
>
> (1) For remote areas . . . a voluntary full-time salaried medical service. . . .
>
> (2) For all other areas . . . a part-time salaried medical service . . . Such service should be provided at out-patient and consulting clinics located in the centres of population in urban areas and country towns.

Subsequently, the Medical Planning Committee considered the general question of health centres in conjunction with the Medical Survey Committee's recommendation that experimental health centres should be established.

8. We do not feel that it is necessary in this report to traverse or recount the whole of the reasons upon which the Committee formed the conclusion that these experimental health centres should be established in certain selected areas in Australia. The position is summarized in the unanimous report of the Medical Planning Committee which investigated this question, and is expressed in the following terms:—

203. Having regard to all the circumstances and to the need for early and substantial re-organization of, and improvement in, health services generally as indicated herein, we consider that a Comprehensive Health Service should be one directed to the achievement of Positive Health and the prevention of disease, no less than to the relief of sickness; and should be available to every individual in the community.

204. It should normally provide the services of any necessary consultants and specialists, laboratory services, and all ancillary services, together with institutional provision when required. The several parts of this Comprehensive Health Scheme should be closely co-ordinated and developed by the application of a planned national health policy.

205. We believe that, in the setting up of any Comprehensive Health Service, the preservation of the doctor-patient relationship of the family doctor and of the principle of free choice of doctor is essential.

206. For the provision of such a service it is necessary to sub-divide the populated areas into—remote areas, country areas, and metropolitan or city areas. Each of these will now be dealt with in turn.

Remote Areas.

207. For Remote Areas a voluntary full-time salaried or subsidized 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 is essential; such services to be established and extended as necessary.

209 In all such appointments, the emolument and conditions of service should be such as to make the post attractive to a good type of competent medical practitioner; in particular they should include specific facilities for adequate post graduate study.

Country Areas.

213 Country Areas fall naturally into the divisions—Minor and Major Country Centres. Country Centres are larger country towns often situated at rail junctions, ports, roads or rail heads where they act as natural centres for areas varying in population. According to their size they show a more or less complete sufficiency for general medical purposes other than the most highly specialized. The larger centres are the towns suited to be key towns in any plan for districting or regionalization of medical and hospital services. It has been generally accepted, and this Committee agrees, that it is desirable that there should be a regionalization of the populated area into medical and hospital districts.

214. Medical practice (as at present provided by a private practitioner or governmental service) in these, or in any area, may include—

> (a) consulting-room practice,
> (b) domiciliary practice,
> (c) institutional practice,
> (d) preventive practice in respect to health, and
> (e) specialist practice.

These various types of practice are discussed at length in paragraphs 215 to 229 of the Medical Planning Committee Report.—*See* Appendix.

Metropolitan or City Areas.

230. Medical practice in metropolitan or city areas comprises all these activities mentioned under paragraph 214, Country Areas, in an intensified form and, moreover, includes the university teaching centres, where such exist, and the governmental departments controlling the various aspects of health and medical services financed from government revenue.

231. In metropolitan and city and certain industrialized areas of low-income level, there is an obvious inequality of distribution of medical services, and particularly of medical personnel. This is undoubtedly related to economic causes.

232. In such areas patients cannot pay for a full medical service, and doctors must, to obtain an adequate income, work at the expense of their professional efficiency. This is neither satisfactory nor equitable to doctor or to patient.

233. Increasing numbers of persons seek treatment at the out-patient departments of public hospitals, often travelling miles to secure it and wasting many hours of working time in the process and in waiting time. In cities this has of late years become a serious feature of administrative medical disability.

234. The services such patients require could, under a better organized scheme, and should be secured from medical practitioners available within reasonable distances of the homes of the patients.

235. Moreover, the efficiency of hospitals should not be handicapped by the out-patient problem, and the care of out-patients should be returned to the general medical practitioner, by correction of the economic disability that at present intervenes, to detach such patients from him.

236. Obviously, any such change must be made in a way that suggests no discrimination or inequality of benefit to particular sections of the public and also in such a way as to use the public funds required to correct the situation strictly in accordance with the principles of economic administrative procedure.

> Regionalization of activity and the modern trend to specialization and differentiation of institutional provision, and the best means for providing for the needs of the public in the most convenient manner are referred to in paragraphs 238 to 249 of the Medical Planning Committee Report.—*See* Appendix.

250. In conformity with what has been said about the desirability of group-practice centres, particular attention has been paid to the tentative recommendation of the Joint Committee on Social Security in its Sixth Interim Report as to the establishment of services at "out-patient and consulting clinics" located in centres of population in urban areas and country towns, equipped with all modern diagnostic aids and treatment facilities, supervised by a salaried medical liaison officer responsible to the central health administration and controlled generally by the medical personnel of each clinic.

251. It was further recommended by the Joint Committee that under such a system of voluntary participation, general practitioners 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 what would in effect be a part-time salaried basis.

252. Further discussions of this scheme indicated the desirability not only of testing it experimentally, but also of extending the investigation to other schemes, differing in detail but essentially based upon group practice.

253. We therefore recommend that experimental group-practice centres be set up at carefully selected places in Australia where different sets of conditions, differing types of practice and different methods of payment for services

might be tested fully for practicability—careful records being made of every aspect of each situation, in order that an ideal scheme might ultimately be formulated, sufficiently elastic to be applicable to the varying circumstances and conditions that operate in different parts of Australia.

9. It is essential that medical service should be available to all who need it, and the Joint Committee supports the views and the general proposals of the Medical Planning Committee regarding the provision of medical services for remote areas, as well as for the country and metropolitan districts. It unanimously endorses the recommendation that experimental group-practice centres should be established, and is of opinion that early action should be taken to give effect to this recommendation. Around these centres or in close proximity thereto, there could with advantage be grouped other proposed health services, such as, maternal, infant and child welfare activities, physiotherapy and occupational therapy departments, dental and optical clinics, and so forth.

10. In an article on Social Medicine recently published in the *Medical Journal of Australia*, Sir Raphael Cilento, Director-General of Health and Medical Services in Queensland, says—

> I have for some years consistently advocated the correlation of protective and corrective measures for health. Social medicine not only provides in its research aspects the basis upon which health may be protected, and, indeed, disease attacked, but acts as the link between "government medicine", university medical training and general practice. I believe that it is best located for actual practice in consultative health clinics in the cities and large towns, and that, through co-operative effort, and on a somewhat smaller scale, it is best established in association with the hospitals and the public health offices (including baby clinics, school health services, &c.) in small towns.
>
> The establishment of a complete consultative health centre, as I see it, is an attempt to fulfil the following functions:—
>
> (a) to correct the undue increase at large general hospitals, of out-patient work of a kind that is essentially general practice work, and to return it to the general practitioners who are established near these patients' homes;
>
> (b) to keep the local general practitioner in touch with his patient, even when the patient requires specialist care, and to provide him readily with that care;
>
> (c) to aid diagnosis without cost to the patient;
>
> (d) to minimize the overlapping and the overhead costs of professional competition, and to pool professional knowledge in the interests of the patient;
>
> (e) to safeguard the "doctor-patient relationship" so rapidly disappearing, and to preserve and extend what free choice of doctor there is;
>
> (f) to provide better and more complete records of disease incidence and aetiology and thus better facilities for productive research into common diseases;
>
> (g) to co-ordinate the personal aspects of protective and corrective medical care; and finally
>
> (h) to ensure the medical practitioner himself—
>
> (i) adequate remuneration for his services, including sources from which at present he gets nothing;
>
> (ii) reasonable opportunities for the maintenance and improvement of his knowledge, his skill and his desire for ultimate specialization;
>
> (iii) relief from the present handicap of his "24-hours-a-day accessibility".

In return, the who'e of the medical men in a district (with any additions necessary if they are short-handed) are asked to charge themselves with the complete care of the health of their district—the promotion of its health positively, the prevention of disease, and the correction of established illness.

Consultative health centres of full status (that is, including all personal protective and corrective care short of specialization) require for their justification a minimal population of 15,000, and become unwieldy if they attempt to serve more than 50,000; the ideal provision is for 30,000 people. What a saving of overhead costs to the doctors and of discomfort and inconvenience to the patient would result if a joint consultative health centre for protective and corrective care, or even a polyclinic for corrective care alone, was set up in every town of 15,000 or more people, and in every suburb of from 15,000 to 50,000 at appropriate spots where population density was greatest, where transport and traffic routes converged conveniently, and where there would be easy access, if necessary, to a subsidiary or base hospital!

In his views on group practice, Dr. L. J. Jarvis Nye, of the Brisbane Clinic, uses these words—

> In conclusion, it is our belief that group practice, by ethical, responsible individuals imbued with a proper sense of duty to the patient and properly co-ordinated and controlled, offers great advantages to both the patient and the medical practitioner. To the patient it offers the most honest, most efficient and most economical service obtainable. It minimizes mistakes that are otherwise inevitable in the choice of a medical attendant and supplies a method by which the technical and educational advantages of specialism may become available.
>
> At the same time, by close co-operation with other members, the outlook of the specialist becomes less limited and there is a much less tendency to regard a of foremost importance any disorder which the specialist consulted is competent to treat. To the medical man it offers the educational advantages of the study of a limited field, while the constant and intimate association with specialists in other fields offsets the narrowing influence of such a study. It enables him to provide adequate technical aid and equipment. It reduces the worry and anxiety of individual practice by the group's sharing of each other's difficulties, while it simplifies satisfactory arrangements for holidays, sickness and study leave in a way impossible to the individual practitioner without disconsolation of his professional life. Finally, it offers him a stabilized income, with the economic security of partnership practice

HOSPITAL SERVICES.

11. There is a wide field open for the extension and improvement of hospitals, for the establishment of facilities for specialized treatment, and for research centres. Such work demands early attention. Plans should be dominated by the concept of "social medicine", and stress should be laid on the maintenance of health and not so much on disease. This necessitates regular supervision and advice by medical men familiar with the family environment and with the living and working conditions of the patients.

12. The Joint Committee has already reported that very few hospitals in Australia measure up to the standards laid down as ideal by world experience and has recommended the establishment of an expert body to advise on hospital planning, equipment and standardization; it has further urged a process of regionalization of hospitals in co-operation with State hospital authorities; improvement in facilities for the transport of the sick; and classification of hospitals. (Paragraphs 145 to 149 of Sixth Interim Report of the Joint Committee on Social Security.)

These recommendations were accepted by the Health Services Conference at Canberra on 8th December, 1943, and by the Medical Planning Committee. They are discussed at length in the Report of the Committee —*see* paragraphs 156 to 198 of Appendix.

These recommendations are now urged by the Joint Committee for adoption in a long-range planning of hospitalization for the Commonwealth.

13. This long-range planning, as recommended by the Joint Committee in its Seventh Report (paragraph 46), should be carried out by an advisory body consisting of a medical hospital expert, an architect experienced in modern hospital design, and a layman experienced in hospital finance.

It has since been urged that, as Catholic and other denominational hospitals have pioneered the care of the sick and provide a good proportion of the present hospital services, representation on such a body should be given to these institutions. The Committee has had many opportunities of seeing the splendid work performed by these institutions and agrees that the request is a reasonable one and might well be granted.

14. In the Seventh Interim Report of the Joint Committee mention was made that regionalization of hospitals would be discussed more fully in a later report.

The objective, so far as the medical health service in Australia is concerned, is to make available to every member of the community the best possible protective and corrective medical care; two further essentials are that the services within the area selected as a unit in the scheme must be properly correlated with others within and outside the area, and that the personnel of the service must be adequate and available. None of these three essentials is at present satisfied in any State of Australia.

For the commencement of organized health services the local authority unit has been accepted as the essential unit, and a scheme for regionalization naturally looks primarily to existing local government areas (of which there are nearly 1,000 separately established in this country). It would appear, however, that a complete personal and environmental programme for health in the modern sense is beyond their individual powers.

Apart from the general problem, therefore, there is a twofold aspect; the cities, densely peopled, present the metropolitan aspect—they need regionalization by subdivision and correction of duplicated or overlapping facilities; the rural areas, sparsely peopled and sprinkled with many small towns, villages, and railway sidings or outpost camps, call for regionalization by combination of facilities, the grouping of isolated units, and the provision of supplementary occasional services and betterment of transport services.

In all areas the actual organization and co-ordination of services which is, in the true sense, regionalization, will depend upon the basis accepted for control and the legislative steps taken to implement it.

It is considered that, even including the metropolitan areas, this could be achieved within a few months for some, and in ten years as a measure of planned economy throughout all Australia.

15. The Joint Committee concurs with the recommendations of the Medical Planning Committee regarding the plan for regionalization—paragraphs 161-179 of Appendix—and recommends their adoption as the basis for further detailed study and consideration by an expert body.

16. So far as hospital accommodation is concerned, the Joint Committee is of opinion—

(*a*) that every patient in Australia who, in the opinion of his medical attendant, needs hospitalization, should be assured of immediate admission to a hospital suitably equipped for the treatment of his disability;

(*b*) that every medical practitioner should have facilities for treating his patients in his local cottage or district hospital for such illnesses and injuries as do not require transfer to a base hospital for specialized treatment; and

(*c*) that it is the duty of those charged with the medical care of the people to ensure that sufficient hospital beds adequately equipped and staffed are available to meet the requirements for immediate admission to hospital of all the sick and injured.

17. While the Medical Survey Committee report clearly indicates that there is urgent need for many more hospital beds, it also makes it clear that it would be more efficient and economical if all hospital beds were concentrated into larger units with adequate transport facilities and a resultant decrease in the present large number of minor hospitals. Evidence suggests that the smallest size unit which can give proper efficiency and be conducted economically is a 200-bed hospital and in those areas which will support such a number of beds this should be the minimum unit of construction.

At the same time it is the opinion of the Joint Committee that some hospitals in Australia are too large and because of their size it is not possible for the patients to obtain the personal and close attention desired in the case of illness. The maximum size hospital to be erected in Australia should not, it is considered, exceed 500 beds capacity.

18. The position of maternity hospitals in the Commonwealth has received the close attention of the Committee, and it is of opinion that this section of our hospital services requires the most urgent attention of the Government. In addition to the shortage of beds, attention is directed to the following grave deficiencies in many hospitals, and which are all too common:—

(*a*) Lack of provision of hostels for expectant mothers awaiting admission;

(*b*) Low standard of accommodation and equipment;

(*c*) Lack of attention to the accommodation and care of the baby, and in the vast majority of hospitals, the entire absence of any provision for the care of the premature or sick baby;

(*d*) Limitation of stay of patients to ten days (largely influenced by the shortage of beds);

(*e*) Lack of convalescent accommodation;

(*f*) Inadequate provision in the home of nursing and domestic help, both pre-natal and post-natal; and

(*g*) Inadequate pre-natal supervision of the expectant mother.

19. The Joint Committee repeats that it is useless making grants to patients of moneys for hospital accommodation benefits, free medicines, &c., if there is no provision for patients to utilize these benefits by being able to gain admission to hospital when needed. The Committee feels that the first and most urgent call on any fund should be the making good of all deficiencies in accommodation in hospitals, that the immediate and cheapest solution lies in overcoming the glaring deficiencies in accommodation for sub-acute and chronic diseases, and for the evacuation of these patients from acute hospitals with resultant lowering 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 of these patients.

SPECIALIST SERVICES.

20. Advancement in medical science, concentration on definite lines of study, and the development of special methods and technique have tended to the growth of specialist services. The Joint Committee is of opinion that in any national medical service provision must be made for specialist services. In this connexion the Joint Committee endorses the views of the Medical Planning Committee, which has expressed them as follows:—

Dealing with medical services in remote areas—

210. With regard to the provision of specialist and consultant services, circumstances may dictate one of three solutions, namely—

(*a*) the building up at the nearest base of specialists of general practitioner standing; or

(*b*) the provision at regular intervals of service through visiting specialists as required; or

(*c*) the transfer of patients needing specialist service to the nearest base centre or capital city.

In country areas—

227. In respect to specialist facilities there should be a considerable planned extension of diagnostic provision. This should extend to every major country centre which is or becomes the basic centre for any regional service. Such aids should include—

(*a*) complete laboratory diagnostic facilities, and

(*b*) radiological diagnostic facilities.

228. With regard to other specialist services we have already expressed three alternatives in paragraph 210 above relating to Remote Areas. The particular provision in any minor or major country centre would be determined in each case by the local circumstances.

229. The natural evolution of medical practice has led to the development of specialist service in the major country centres. Such development has been assisted to a great extent by the opportunities afforded to Australian graduates to obtain higher qualifications through the agency of the Universities and the Royal Australasian Colleges of Surgeons and Physicians. The facilities for such post-graduate medical training should be advanced in every possible way.

Regarding the availability of specialist services generally, the report continues—

254. We agree with the British Medical Association in Australia that 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 treatment, the successful employment of which involves specialized knowledge and experience, and, in many cases, complex and expensive apparatus. 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.

255. Having regard to geographical conditions and the proposed hospital distribution, the future development and organization of special investigational centres should be in connexion with the main metropolitan and base hospitals in the country. Private consultative and specialist practice should continue within and without the hospitals.

256. The payment for specialist services (where payment is made) will vary according to the circumstances and might accordingly be upon a fee-for-service, a sessional, a subsidized, or a salaried basis.

21. Concerning the qualifications of specialists, Queensland alone among the States has recently instituted, by statute, a "Register of Specialists", in an endeavour to define the conditions under which medical men may set themselves up as specialists.

The Joint Committee considers that it is advisable in the interests of the public and of the medical profession generally that medical men should satisfy a certain standard of eligibility for the qualification of specialist. It is therefore recommended that the principle applied in Queensland should be adopted throughout the Commonwealth.

MATERNAL AND INFANT WELFARE.

22. No comprehensive scheme of medical service for the people of Australia would be complete without ample provision being made for maternal and infant welfare. The evidence presented to the Joint Committee has been marked by its unanimity of opinion. It is a truism that the child precedes the man. It is therefore of paramount importance that provision should be made for this section of the community, and it was put very strongly to the Committee that maternal and infant welfare has an important place in any comprehensive health scheme, not only because it is obviously desirable that the loss of a mother should be as rare an event as possible, but also because of the psychological value of a mother approaching what is really a natural incident with a minimum degree of anxiety about the outcome.

Much is being done by the Commonwealth and State Governments and by semi governmental and voluntary organizations. Better maternity services are being planned for the time when more doctors and nurses are available; housing schemes are being developed and the convenience of the housewife studied; organizations are being formed to raise the status and convenience of domestic work and to provide help for mothers. There is, however, much need for some central co-ordinating authority to accept the real responsibility for the many agencies now functioning, such as clinics, nurseries, and kindergartens.

The preventive side of maternity work rests very largely on the education of the expectant mother to seek early and regular ante natal care and supervision. A corollary is the education of the medical student, the doctor and the midwife-nurse in this vital phase of midwifery. Important as the work of the nurse may be in advising the expectant mother in many aspects of personal hygiene and regulated living, ante-natal supervision, in practice, is essentially a matter for a medical man.

Ante-natal supervision by experienced medical men is accepted as one of the essential features of the campaign to reduce the maternal and infant death rates, and to eliminate the dangers and difficulties which may complicate pregnancy.

A wide range of organizations, official and voluntary, is responsible in each State for the care of the infant and child. Infant welfare activities are based on the consideration that the health of the infant depends primarily upon the efficiency of the mother, and that, as the majority of babies are born healthy, mothers should be taught how to keep them well and how to prevent unnecessary sickness by employing sound methods of infant management. The basic function of the infant welfare centres or baby clinics is the care of the child through the education of the mother in mothercraft.

The infant welfare centre is concerned with the baby during the first year of its life. A gap hitherto existed in medical supervision of the child from the time when attendance at the clinic ceases until school life begins. Medical care of the toddler and of the child to his fifth year and the school days is now becoming an integral part of the work of day nurseries (which provide for children whose mothers are obliged to go to work) and the kindergartens (which give training in the beginnings of education).

23. This subject is discussed at length in the Report of the Medical Planning Committee—*see* paragraphs 40 to 61 of Appendix. Briefly its recommendations are—

(*a*) that in any provision for maternity hospital plans, staffing, equipment and maintenance, adequate facilities should be provided for an effective ante-natal service to every expectant mother;

(*b*) that every opportunity be taken for educating expectant mothers in benefits of ante-natal care; and

(*c*) that home nursing services and home aids be developed on a local basis.

24. The Medical Planning Committee also endorsed the emphasis placed on the importance of maternal care by the National Health and Medical Research Council in its reports over several years, and commended the recommendations of the Federal Health Council in 1935, which, it considered, still represented a model plan for the betterment of maternal welfare, and the practice of midwifery.

Briefly, these recommendations were—

(*a*) establishing a model maternity centre in each capital city, either by expanding existing institutions or erecting new institutions;
(*b*) establishing a consultant service of senior obstetricians wherever possible;
(*c*) expanding infant welfare centres where possible to include an ante-natal clinic; or alternatively, associating the infant welfare centres with newly established ante-natal clinics in properly equipped institutions;
(*d*) providing maternity wards with separate staffs for every metropolitan hospital where such a ward is possible;
(*e*) increasing the accommodation provided in convalescent and after-care homes;
(*f*) subsidizing and extending the Bush Nursing and other approved organizations;
(*g*) making provision for the investigation of maternity deaths;
(*h*) a system of notification of deaths from (i) abortion, (ii) still-birth, (iii) any cause within three months after childbirth, is very desirable.

Certain of these recommendations have meantime been implemented, whilst others have been adopted in part.

25. Quite recently, at its session at Canberra in November last, the National Health and Medical Research Council had placed before it a plan for a national programme of maternal and child welfare submitted by Miss Constance Duncan, of the Commonwealth Department of Health, who had conducted an Australia-wide inquiry into these problems. This programme is designed to guarantee to mothers and children, regardless of State boundaries, certain minimum Australian standards of services and facilities.

26. What has been accomplished in the saving of child life since the advent of baby clinics is significantly told in the following paragraphs from the report of the Medical Planning Committee:—

59. The infant welfare centre is concerned with the baby during the first year of its life. The development of these clinics over the past 30 years has coincided with one of the greatest achievements of modern times—the saving of child life during that first year which is statistically registered by the infantile mortality rate (deaths of infants under one year of age per 1,000 live births). The experience of Victoria may be taken as typical of Australia—in every 1,000 children born during the years 1900-04, Victoria lost 98 infants each year before their first birthday, 74 infants during the years 1910-14, 65 during the years 1920-24, and 43 each year during the years 1930-34. In 1940, the deaths per 1,000 births numbered 39; in 1941, 36.2; in 1942, 41.7; and in 1943, 35.8.

60. In that decline, there has been a significant variation in the annual causes of deaths per 1,000 births. Over the years, the mortality of infants from diarrhoeal diseases has been reduced by 93 per cent; the main respiratory diseases by 38 per cent., and the infectious diseases by 72 per cent. Variations in classification in earlier years of the pre-natal causes of death prevent an exact comparison, but on detailed analysis of causes of death under this heading, no appreciable decline is evident (that is, in deaths recorded as due to such causes as malformations, congenital debility and prematurity, &c.).

For the whole of Australia since 1911, infantile mortality has shown a marked decline, as the following figures indicate:—

Period	Rate per 1,000.	Period	Rate per 1,000.
1911-15	70.32	1926-30	51.99
1916-20	64.67	1931-35	41 27
1921-25	57 88	1936-40	38.81

27. The Joint Committee is unanimously of opinion that the adoption of the proposals in the preceding paragraphs will go a long way towards meeting the problems associated with this most important need of the times. Combined with the activit es of the community health centres recommended in this report even greater achievements may be possible. The Committee's own observations have also shown the great need for the establishment of some place where the other young children of a family can be cared for whilst the mother is in hospital. Excellent examples of this are to be found in Brisbane at the Head-quarters of the Maternal and Child Welfare Department and at the Mothercraft Hostel.

CHILD WELFARE.

28. The pre-school movement as yet covers only a numerically small proportion of Australian children, but the movement is receiving active support and interest; it is attracting a good type of instructor for whom scientific training is now available, and it is therefore an activity of educational and health progress which should be developed and encouraged along sound lines of advancement.

For many years little has been done to bridge the gap between health supervision given at infant welfare centres and that provided by the school medical services. There is now, however, a general realization of the important health work which can be done at child centres, such as crèches, day nurseries, and kindergarten schools, and which should be done to reach this group of growing children.

29. The co-ordination of the kindergarten and day nursery movements has assisted in bringing the health aspect into an important place in the objective of the societies. When the Kindergarten Unions formed the Australian Association for Pre-school Child Development, the Commonwealth Government erected in each capital city demonstration units known as the Lady Gowrie Child Centres, where collaboration was arranged between the Commonwealth Department of Health and the Association to ensure a correlated study of physical and mental health, child growth and nutrition.

The Joint Committee was impressed by the complete personal records compiled at the Lady Gowrie Child Centres regarding the physical and mental conditions and development of the children; these records form an important basis for the child's future well-being, and when he proceeds to school they should be maintained to assist in his future physical and mental development.

This need for continuity of records forms the basis of a resolution adopted by the Conference of Commonwealth and State Ministers for Health in June, 1943, in the following terms:—

This conference is of the opinion that, in order to secure continuity of record, supervision of child from birth to end of school life be a function of the Health Department in each State; and that further attention be given by school medical officers and other medical practitioners to the pre-school child through the well organized system under the Health Department.

30. The Joint Committee has had opportunities of visiting Lady Gowrie Child Centres in different States, and is unanimously of opinion that many more such centres should be established as soon as trained staff is available, and that they should be extended to selected industrial and country centres throughout the Commonwealth. These centres have now been operating for five years, and in a recent review of the work accomplished at the Melbourne centre these words were used—

Perhaps the finest tribute has come from the parents themselves. They fully realize the worth of what is being done for the physical, mental and emotional welfare of their children, and feel so strongly that these advantages should be provided for every pre-school child in the neighbourhood—not just the 100 admitted to the centre—that they convened a meeting to express these views and discuss what means could be adopted to extend the work of "The Lady Gowrie Child Centre".

31. The latest statistics indicate that there are in Australia some 750,000 pre-school-age children who need kindergarten training and only about 10,000 have kindergartens to which they can go.

The benefit of the kindergarten is that they offer a centre for training children in personality development, for good physical health and, above all, for good social adjustment. It is said that children learn these things more successfully from each other than by having elders preach to them. The kindergarten also is a service to the community because it carries a programme of education for parenthood which is taught nowhere in the schools.

Moreover, it is claimed that children having attended kindergartens have seldom gone before a court for misbehaviour. If this be true, not only has the child been given an opportunity to develop himself along wholesome lines, but the influence of the kindergarten on the home life has been a good thing indeed.

In considering the extension of kindergartens, the advice and assistance of the Kindergarten Union and other similar organizations should be sought and their assistance and interest solicited, in view of the excellent work they have performed in a voluntary way for many years.

The Joint Committee is also impressed with the need for provision of community playgrounds as an essential service for children, especially in inner suburban and industrial areas. No health service is comprehensive which does not include an open playground accessible to every toddler and child in the community.

32. The Medical Planning Committee stresses the importance of pre-school child work in its report—*see* paragraphs 62 to 72 of Appendix, from which the following are quoted:—

68. We commend the action of those State Health Departments which have appointed special pre-school officers to the departmental divisions of maternal and infant welfare. Under their inspiration and guidance, and in collaboration with local organizations, it would appear to be a sound line of advancement where kindergarten principles are being adopted for pre-school children who attend with their mothers at infant welfare centres and who are accommodated in the special "waiting places" provided.

71. We are convinced that, with the development of a system of crèches and day nurseries, and of home "minders" the lot of the mother with young children could be greatly eased. There would be a restored encouragement of family and happier home life if the mother could be assured of regular relief at home for shopping or visiting excursions, and the young married couple could be released together for an occasional evening at the pictures or a dance.

72. The Country Women's Association, with the great-hearted kindliness of the outback, can arrange such help at distant homesteads. We suggest that other women's organizations in city, suburbs or rural areas might well serve their fellow-women in a work which has implications of national importance.

33. The Joint Committee emphasizes the pressing need for an extension of school medical services. During 1939, only 23.7 per cent. of the children attending State schools were examined by school medical officers and a further 6 per cent. were examined by school nurses. As an indication of the small importance attached to this matter, it is pointed out that the cost of school medical services is a very minor item in the education vote, representing approximately between 2d. and 3d. per head of population in the total expenditure on education of between £1 15s. and £2 per head of population.

In the opinion of the Committee there should be—

(*a*) more adequate medical examination of all school children, with provision for the necessary medical treatment to be made available; where no provision now exists, all subsidized hospitals should be required, as a condition of that subsidy, to provide for the treatment of children suffering from defects notified by the school medical services;
(*b*) miniature X-ray photography for detecting physical defects;
(*c*) a continuity of the personal record card system as compiled at the Lady Gowrie Child Centres to follow the child through to the school-leaving age;
(*d*) arrangements made for a regular supply of milk to growing children along the lines of the "free and cheap milk" scheme of Great Britain.

34. School medical services are reviewed at length in the Report of the Medical Planning Committee, paragraphs 73 to 95 of Appendix, and the report concludes by saying—

In all this work, we reiterate our opinion that the growing child is the national asset most worth preserving, and that any comprehensive health plan should aim primarily at ensuring the best physical and mental development of the child.

MENTAL HEALTH.

35. The attitude of the general public towards the mentally afflicted needs correction. Too many persons are prone to regard insanity as a crime and the insane as criminals. Insanity is an illness of the mind, just as fever is an illness of the body, equally deserving of the very best that scientific skill can give in the hope of making the sufferer once more a valuable member of society.

No report on national health would be complete without reference to mental health when one realizes that there are more than 20,000 patients in the mental institutions of Australia and that a very much larger number of the population has at some time or other been treated for a serious mental breakdown; it will be seen that this section of medicine cannot be ignored in a comprehensive health policy. Apart from very severe cases, it has become increasingly apparent to the medical profession that a considerable percentage of what was formerly believed to be physical illness is really of nervous origin. Over the last twenty years the treatment of mental disorders in the early stages at least has become much more effective. A number of procedures has been developed which have made the outlook in these disorders much more hopeful. Institutions for the reception of nerve cases and the early treatment of nervous disorders have had very good results—only 20 per cent. of patients having to be sent on to mental hospitals. Admittedly a number of the 80 per cent. who are discharged as the result of treatment are not restored to complete health and relapses must be expected. However, exactly the same limitations apply to many patients discharged from general hospitals. In 1943, an investigation was made in Western Australia of the results obtained in 135 cases of severe mental disorder due to war service, and of those admitted to Heathcote hospital, 61 cases were discharged recovered from their symptoms, 59 were discharged as improved, and only fifteen, or 11 per cent., had not improved. Only one returned serviceman in Western Australia has been transferred to the Mental Hospital—which is in marked contrast to the last war and is indicative of the improvement in methods of treatment which have been evolved in the interim.

36. There is little doubt that the standard of amenities in the mental institutions of Australia as a whole, are a good deal below what they should be. The average rate of maintenance of a patient in a mental hospital is considerably below that of an inmate of

a general hospital. In Western Australia the weekly cost per head in the mental hospital was £1 12s. 9d. per week, while in Heathcote reception home it was £3 14s. 2d. per week.

Throughout Australia less than 20 per cent. of the amount spent on mental institutions is recoverable from patients.

If the standard of amenities is to be raised and all forms of treatment used to their maximum extent, it would seem that the States will require financial assistance from the Commonwealth. Mental institutions, such as reception homes, should receive the proposed hospital subsidy of 6s. per day. The cost is high in cases of recent origin and the results definitely worth while. In institutions where chronic cases are maintained, a smaller subsidy of, say, 3s. per day would be reasonable.

37. The tendency in Australia is for mental hospitals to be large institutions. Experiments in England have proved very successful in the cottage system whereby patients are more readily rehabilitated into normal life through more homelike surroundings.

38. *Treatment of Mentally Deficient Children.*—Subnormal children fall into three categories.

(*a*) Dull or Backward Children.—In these the degree of mental sub-normality is relatively mild and they are best dealt with by the opportunity classes of the various State Education Departments. This is at present being done on a limited scale in some of the larger metropolitan schools throughout the Commonwealth. In Tasmania the area schools with their modified curriculum make it possible for mentally backward children of both sexes to advance in practical work in spite of their being academically weak. An extension of the area school system to other States would go far towards solving the problems of the educationally backward child.

(*b*) Feebleminded Children.—In these the mental subnormality is more pronounced so that they cannot be handled by the Education Department. Speaking generally the facilities for the care of this group are not good. In many cases there is no provision at all. Residential schools providing for training in handicrafts, domestic and manual work are necessary.

(*c*) Imbeciles and Idiots.—In these the mental deficiency is pronounced and this is the only group catered for by Mental Hospitals Department. These children are generally accommodated in mental asylums, whereas farm colonies would yield better results.

In addition to the facilities offered by the opportunity classes, residential schools for the feebleminded and farm colonies for the insane, psychological clinics are of the utmost importance in the diagnosis of the mental condition. In some States these already exist, but their development and closer co-operation with other departments, e.g., Child Welfare, are necessary, as child delinquency is often associated with mental deficiency.

Finally to control these various activities it will be necessary to have uniform mental deficiency legislation so that legislative authority will be given for the control of mentally defective children in the various categories.

39. The views of the Joint Committee on the question of mental hygiene have already been expressed in paragraphs 114 and 115 of its Sixth Interim Report and these views have been endorsed by the Medical Planning Committee. Briefly stated, 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.

It is essential too that provision be made for mental patients suffering from tuberculosis. At the present time most sanatoriums refuse to accept mental patients whose recovery from their tubercular condition is thus retarded.

ALMONERS AND TRAINED SOCIAL WORKERS.

40. A Commonwealth plan for medical and health services cannot be fully effective unless it is based upon a recognition of close relationship between health and social well-being. Such a plan should provide for the medical-social care of individuals by appropriately trained personnel, and for co-operation between hospitals, health services, and other social services. The growing recognition of the link between social maladjustment and ill health has led to a greatly increased demand for the services of trained almoners in Great Britain and America as well as in Australia.

Co-operation between hospitals and other health and social services in the medical and social care of individuals may prevent unnecessary use of hospital services, save the patient from needless hardship and expense. An almoner's training equips her with a knowledge of the nature and function of other health and social services so that she can ensure effective co-operation between them and the hospital.

41. Almoners departments were introduced into public hospitals because medical men thought that social factors had an important bearing on the medical care of hospital patients, and that efficiency in dealing with these factors could best be achieved by the appointment of trained almoners.

Trained almoners on the staffs of hospitals and health centres, clinics, sanatoriums, convalescent homes and such like institutions could work with the medical staff in investigating social problems causing or aggravating ill health, help patients in their recovery, act as liaison between health units and the Government and private agencies in arranging for the care of the children when the parents are disabled, plan after-care and convalescence, and arrange for vocational guidance and occupational training.

42. The Australian Association of Hospital Almoners submitted that the principle should be adopted that all hospitals with 100 or more beds, should establish almoners departments, that almoners should be attached to health centres, and that the Commonwealth Government should support the training of almoners and other social workers by declaring training for social work to be a reserved occupation, by making grants-in-aid to students, and by helping to develop the teaching of sociology and social science in the universities.

43. Whilst recognizing the help given by the Commonwealth Department of Labour and National Service and the State Department of Labour and Industry in an endeavour to find suitable jobs for disabled persons, more adequate provision should be made for the vocational guidance and placement of disabled persons, many of whom need skilful help in selecting a job and adjusting themselves to it, if they are to be encouraged to achieve a maximum degree of health and usefulness. The association therefore recommended that there should be a special section of the Department of Labour and National Service to deal with physically and mentally handicapped people, staffed by specially trained officers with a wide knowledge of industry who would work in co-operation with employers, medical men, vocational guidance officers, almoners and other social workers.

44. The Joint Committee has been impressed by the evidence placed before it regarding the increasing and valuable use being made of the services of almoners and trained social workers and considers that the importance of their work justifies the employment of more almoners at hospitals and that additional trained social workers should be added to the staff of the Department of Social Services, as recommended in the First Report of the Joint Committee on Social Security.

FLYING DOCTOR AND AIR AMBULANCE SERVICES.

45. The Flying Doctor Service was originally introduced by Reverend Dr. Flynn, in 1928, at the experimental base of Cloncurry (Queensland), to foster and safeguard the health, morale and physical well-being of residents in the sparsely settled areas of the Commonwealth, its dependencies and mandated territories, by ensuring that there shall be readily available to these residents the benefits offered by modern medical and nursing facilities, aviation, radio, libraries and other such developments of our civilization.

On this basis, the Flying Doctor Service has developed, through the agencies of a central Federal Council located in Melbourne, with separate State sections throughout the several States of Australia, until it has reached very substantial proportions and has, during the years it has been established, rendered very fine service to the people it was originally designed to serve.

It is claimed that the Flying Doctor Service has pioneered, not only medical service to the people of the isolated outposts, but has established a service which deals with matters concerning health, aerial transport, radio, and hospital problems. The welfare of the womenfolk is also provided for by international women's associations, and over the years that it has operated has proved to be an unqualified success.

It serves pioneer settlers at their outposts throughout over half of our continent. It takes account of neither State or political boundaries, favours no party, creed, pursuit or industry, and helps rich and poor, black as well as white.

It has six Flying Doctor bases, and covers practically the whole of the sparsely settled areas of Australia. At each of these six base stations powerful wireless transmitters and receivers are installed.

46. In evidence presented to the Committee, it has been made abundantly clear that the Flying Doctor Service has now passed the experimental stage and in the post-war years should be expanded and considerably developed. The help that has been rendered in past years had been limited only to the extent of the facilities at its disposal. Moreover, the Committee had ample first-hand evidence of the work being done at the centre at Broken Hill, which it visited in 1943.

As an example of the coverage of this service it might be mentioned that the radius served from Broken Hill is 500 miles toward the far interior of Australia.

47. The Joint Committee is quite satisfied that the Flying Doctor Service, through its base stations, can form the centre co-ordinating the needs of the pioneer with what already exists and can be extended to supply his further needs.

Throughout the years the Flying Doctor Service has been considerably helped and strengthened by the co-operation of the various civil aviation services, which will no doubt form a feature of a strengthened service in the future.

The Committee is convinced that this service should be augmented by additional units in some areas, by the use of faster and more adequately equipped planes, and the provision of a pilot-mechanic in addition to the doctor-pilot.

Any extension of the service should provide for periodical visits to the outback by an eye-specialist and by a dentist to care for the needs of children, and, where necessary, of the adult population. The addition of a visiting nurse would also prove valuable. The nurse could be taken by air to urgent cases and remain in attendance under instruction over the air by the doctor. Consideration might also be given to the appointment of a suitable woman to the staff at certain bases to look after matters of interest to the womenfolk through the area; the provision of rest homes for women and children and their transport to and from their homes; and, as the number of children increases, the service might offer means for assisting in their education and in their transport.

To provide the additional and strengthened services envisaged by the Committee, there should be substantial aid provided by the Commonwealth Government in addition to that already provided by the States.

48. The Joint Committee concurs with the views expressed by the Medical Planning Committee in the following terms:—

257. The aerial transport of patients, which was beginning to play a very important part in the service to persons in remote areas prior to the present war, has assumed infinitely greater importance during it. We are of the opinion that in many instances ambulance transport by air is speedier, more comfortable and less damaging to patients than road transport for distances of 50 miles and upwards.

258. The accommodation as to specialist services and the establishment of regionalized areas based on central towns indicate the related necessity for a considerable development, not only for routine medical service in areas of sparse population at considerable distances, but also for rapid transport of patients to specialized hospitals and facilities.

259. We consider there should be a post-war development of a series of aerial bases properly distributed in relation to selected major and minor centres, both city and rural, and providing—

(*a*) "flying doctor" services, including specialist services, to the most remote and otherwise unstaffed areas; and

(*b*) air ambulance services from any area to the centre appropriate for specialized treatment in individual cases.

260. The "flying doctors" appointed to routine service in respect of (*a*) above and nursing and ancillary personnel should be employed under terms and conditions providing adequate salary and living conditions and with a degree of comfort somewhat greater than the provision of the bare amenities of life, and with either short-term appointments or regular opportunities for "refresher" and post graduate study courses.

261. The development of transceiver facilities should proceed equally in all areas thus serviced.

DENTAL HEALTH SERVICE.

49. The need for dental research and treatment as essential in a comprehensive health scheme is well expressed in the evidence of a practising dentist of 40 years' experience—

Dental disease is so prevalent that it has been accepted in the minds of the public as a normal state of affairs. This disease affects 95 per cent of the people, and its ill effects are so far reaching that it must be regarded as the most serious menace we have in Australia. Unless this menace is removed a great deal of the proposed medical care of the people will be nullified. If the mouth is diseased, then the rest of the body cannot be healthy. Not only is the diseased condition transmitted to the rest of the body, but the painful conditions of the diseased mouth render mastication inefficient, and then various digestive troubles arise and finally result in malnutrition. Dental disease is

a diet deficiency disease, and costs the community an enormous amount in pain and distress as well as in money and loss of personal efficiency. Although it is a diet-deficiency disease it has not, in the past, been treated as such. This is due to the fatal system of treating results instead of finding the cause.

50. Recognizing that a comprehensive health service would be incomplete without adequate provision for dental treatment, the Australian Dental Association was invited to submit its views to the Joint Committee and the federal officers of the Association prepared an informative memorandum on the problems affecting the introduction of any form of national dental health service.

Dental health contributes greatly to national efficiency, but this ideal state can only be achieved by the elimination or adequate control of dental diseases. The full extent and scope of this field can be imagined when it is realized that dental disorders affect 95 per cent. of the population, and 75 per cent. of the community is unconcerned with, if not ignorant of, the clearly defined importance of prevention.

51. On behalf of the federal officers of the Australian Dental Association it was stated that—

> The members of the profession approach the question of a national dental health scheme with varying degrees of scepticism, with an attitude of full co-operative support for a plan that will advance with standards of dental fitness, particularly among children, and with strongly pronounced convictions against the introduction of any scheme that might jeopardize the present standard of dental science or abolish the right of private practice. The public must not be deprived of the right to select their own dental surgeon and obtain the private treatment they have sought and secured for so many years.
>
> The profession attaches great significance to child welfare. The education of the child in the importance of the care of the teeth in conjunction with the periodic examination and treatment of these young citizens would be a health safeguard to the nation's greatest asset.
>
> The child of to-day, whose dental treatment is a serious economic liability to the family on the basic wage, is the adult of to-morrow: a self-supporting person, able to meet the expense of maintenance of dental health if the ravages of disease have been controlled and cured in childhood.

The statement proceeds—

> Complete nationalization of the dental profession has no prospect of support, except in the isolated cases of practitioners, who favour institutional practice or have joined the Forces and hesitate to face the post-war financial responsibilities of establishing themselves in private practice.
>
> The establishment of any national dental service is fraught with difficulties and dangers, the main danger being the provision of some scheme which reduces the standard of practice to the lowest common denominator instead of, to continue the mathematical metaphor, raising it to the highest common factor. Undoubtedly, the main cause of the reduction is the loss of incentive to the individual to improve his own standards, both in regard to the quality and quantity of work done, which is inherent in any organization where promotion and salary levels are relatively "fixed" factors. There are many motives for self-improvement—keenness for work, sense of public duty, &c. However, human nature being what it is, the most potent incentive is financial security. Dentistry is an arduous profession, involving physical fatigue and nervous strain, as well as a high degree of skill and concentration. The number of years at the zenith of practice is not great. From 45 years onward, dentists have to conserve their energy output; therefore, the incentive to maintain a high standard and volume of work is closely related to the prospect of ensuring future security.

52. The Association was emphatic, however, that any dental health service should be established under the authority of representatives of the dental profession, and it is suggested that administrative control should be by a commission comprising—

(*a*) A chairman and two other dental members selected from a small panel nominated by the dental profession; one of them should have had administrative experience of dental hospitals, clinics or organizations.

(*b*) The Commonwealth Director-General of Health.

(*c*) A lay representative with special qualifications and experience in finance.

To indicate the magnitude of the treatment problem the Association pointed out that there are 982,123 children aged from two to ten years inclusive in Australia, and it may be fairly assumed 860,000 are in need of treatment. The average number of fillings required is ten. The colossal figure of 8,500,000 fillings at least is required for this age group. Without subsequent regular treatment the recurrence of dental caries would be overwhelming.

For this reason the Association recommended that any national service should start with a small age group, two to four years inclusive, when the incidence is much lower, and another age group should be added each year until all children of school age are included.

In the two to four years group there are 345,150 children. Allowing for 15 per cent. receiving treatment, approximately 300,000 children require initial treatment. This number represents the concentrated attention of 600 dentists for one year, for the inception of such a plan.

The Association asserted that there is no possibility of combating or overtaking the widespread disease of every dentally crippled adult, however tempting it might be to contemplate such a prospect theoretically.

53. The population of Australia was 7,229,864 on 30th June, 1943, and it has been estimated that approximately 25 per cent. of this number have been seeking dental treatment with any regularity.

Recent registration reveals that the total number of dental surgeons in the Services and in civil practice is 3,330, including some who have retired or who are partly incapacitated. On present information the ratio of dentists to population is 1:2,171.

A calculation made from the volume of work carried out in the Children's Clinic at the Sydney Dental Hospital indicated that it would take 2,000 dentists at least one year to render the 860,000 children in the age group from two to ten years dentally fit.

54. The Association then directed attention to the problem of meeting demands—

> The overwhelming incidence of dental disease and the marked shortage of qualified dentists to meet any increased demands for dental service, compels attention to the problem of dental education and training of additional personnel.
>
> Existing facilities are quite inadequate to meet additional dental demands of the population. Dental personnel must be increased if any significant improvement in the number of persons receiving dental treatment is contemplated. This expansion of personnel must be derived from two sources, by increasing (*a*) the number of qualified dental surgeons, and (*b*) the number of assistants who would relieve the former of work which does not require the exercise of full professional knowledge and skill. . . .
>
> Any plan at its inception must be operated on the basis of limiting the treatment to certain restricted age groups of children for whom sufficient personnel is available. In each successive year the groups could be increased in accordance with the number of additional dentists available over and above maintenance requirements.

55. The Australian Dental Association is of opinion that a federal dental act, providing for uniform Commonwealth registration of dentists, should precede the planning of any national dental service and so ensure standard requirements and conditions of practice in all States. The establishment of reciprocal rights of practice in all States and the proper legal control of auxiliary services such as dental hygienists, dental nurses, dental technicians, would be essential; the present Dental Boards, with their wide experience, should be responsible for the administration in each State.

56. The Dean of Faculty of Dentistry at the University of Sydney, in an informative account of the development of the faculty from its original establishment as a department of the Faculty of Medicine, also emphasized the pressing need for increased facilities and finance to meet the demand for dentists. In his opinion the importance of the faculty called for the establishment of two additional chairs—professors of operative dentistry and of prosthetic dentistry.

Much more time, he considered, could be profitably spent in the teaching of those aspects of dental treatment having most bearing upon prevention.

Trained technicians could handle the laboratory work and the processing of dentures, thus giving the dentist more time for preventive treatment and actual chairside work. The constitution of research work on an active basis would be an incentive to progress.

57. In placing before the Joint Committee some observations on the prospective establishment of a national dental health service, the Director of Dental Services in the Army (Brigadier J. E. Down) stressed the fact that at least 1,000 more dentists would be required to meet Australia's needs. Some hundreds of dental officers with adequate equipment and all facilities for having patients made available have not succeeded in making the Australian Military Forces more than 60 per cent. fit in four years. He indicated that any proposed dental health scheme must be based on the following:—

(1) An efficient administrative body controlled by a dentist.
(2) An adequate supply of trained personnel.
(3) An adequate supply of first-class equipment and expendable material.
(4) Concentration of initial effort on children of school age.
(5) Efficient propaganda.
(6) Adequate scale of remuneration and pensions for dental personnel.
(7) Complete elimination of any suggestion of institutional organization.

He did not consider it was practicable at this juncture to embark on a comprehensive scheme because—

(*a*) There was not a sufficient number of registered dentists in Australia.
(*b*) The lack of reciprocity between States would circumvent free interchange of dentists, other than university graduates.
(*c*) The public are unprepared to take advantage of full dental service. It would not be a sound proposition to set up a supply which exceeded the demand.
(*d*) The obvious solution would be to especially train a given number of young graduates in children's dentistry, and, by propaganda, encourage parents to taken advantage of the service supplied.
(*e*) Although not generally approved of by dentists, it might become a national necessity to employ female dental hygienists to work only in the company of a registered dentist, in which case State laws might need to be reconciled with the scheme.

58. In the section of its report dealing with School Medical Services, the Medical Planning Committee expressed its views—

> 86. Dental supervision has become an essential part of the work of the school medical service; dental caries represent the highest total of all defects found in children (in up to and over 30 per cent. of all children examined).
>
> 87. We urge far greater attention to the problems of dental hygiene and the provision of necessary clinics, stationary and travelling, to ensure that no child is deprived of the opportunity of dental attention.

At this point it might be indicated that mobile dental units now being used for dental treatment in the Services could with advantage be utilized later for implementing dental services in outlying areas.

59. The Australian Dental Association pointed out that the School Dental Service in New Zealand offers a method of supplementing trained personnel. There the treatment and extraction of children's teeth and instruction in dental hygiene is carried out by school dental nurses who have received two years intensive training in this restricted field of work at a college especially established for that purpose.

60. The Joint Committee is of opinion that no comprehensive health service would be complete without adequate control of dental diseases and that the inauguration of a national dental service should form part of the complete plan. Such a service covering the problems of research, prevention, treatment and personnel should be planned by representatives of the dental profession and the Government, and be administered by the profession itself. Uniform registration of dentists throughout Australia will be a necessary step, too, before such a service can be satisfactorily established.

At its inception the dental service should provide for all children commencing with the two to four age group, and, as more trained professional staff become available, the service should be extended to the older age groups.

OPTICAL SERVICES.

61. An important feature in any comprehensive health service should be the rectification of visual defects. In some States special attention is given to the eyesight of school children, whilst in Queensland there is an optometrical service for the inland people. The unique Ophthalmic School Hostel in Brisbane, conducted by the Queensland Department of Health, provides specialist treatment and specialized education for children sent in from the country. Generally speaking, however, visual service to school children throughout Australia is grossly inadequate.

Evidence was unanimous that, as in other professions, the number of trained men available cannot meet demands, and that the intake of trainees is insufficient.

62. In New South Wales and Victoria there are intermediate clinics known as the Medical Eye Service of New South Wales and Victoria conducted by legally qualified medical practitioners with special qualifications in ophthalmic work.

At each medical school of the universities of Australia there are lectureships in ophthalmology for the benefit of the medical students, but, as with all sections of medical practice, there is a deficiency of practitioners.

The Ophthalmological Society of Australia, which embraces most of the practising ophthalmic surgeons of Australia, and during normal times conducts scientific meetings, is of opinion that in order to obviate the necessity for medical practitioners desiring special knowledge of eye work to go abroad, a post-graduate ophthalmic school and hospital should be established in conjunction with one of the Australian universities.

The expressed opinion of the spokesman of the Ophthalmological Society of Australia was that "group practice clinics at which all medical services would be made available, including the ophthalmologist and optometrist, would provide an adequate health service for the community". He added, "in order to reduce cases of blindness, we require to do more than just make treatment more readily available to the public. We need a group of practitioners to concentrate on preventive medicine. By their research they

would be able to inform ophthalmic practitioners generally, and advise measures to be taken. Their advice could also form a basis of legislation to combat eye diseases."

63. On behalf of the Australasian Optometrical Association there was submitted to the Committee an outline of a salaried optometrical service to apply to all persons regardless of income, but providing for the right of private practice to be retained by optometrists not wishing to join the scheme, for which the public would pay the usual fee.

It was suggested that an advisory council of optometrists be appointed to administrate the scheme—the administrator to be an optometrist.

To provide for uniform standards of education and training throughout the States, Commonwealth registration *was recommended, and it was strongly* advocated that in a national medical service optometry be not considered a part of the medical practitioner's work; ophthalmology should be covered in any salaried medical service, but ophthalmologists should be relieved entirely of refraction, thus enabling them to concentrate on the important work of dealing with diseases of the eye.

The need to ensure sufficient lighting in factories to conserve the eyesight of industrial workers was emphasized by the association. Whilst adequate provision is being made in modern factories, much improvement is needed in the older types of buildings to provide adequate lighting facilities.

64. On the other hand, the Opticians and Optometrists Association of New South Wales submitted to the Committee a scheme whereby eye examination should be carried out on the premises of optometrists. Under this plan optometrists already registered under the State laws would pay a small annual registration fee to be affiliated with the scheme and would then receive fees for eye examination and refraction and also for the optical appliances or spectacles supplied. This plan, it is claimed, would allow individuals to select the optometrist he desired at his own home town and would permit optometrists to retain the right of private practice to prescribe for members of the public who did not wish to take advantage of any *government scheme.*

65. The Joint Committee is of opinion that eye treatment should form part of a comprehensive health service. Many problems will undoubtedly arise in the establishment of ophthalmic and optometrical services, such as, the field of service of the medical practitioner and of the optometrist, uniform standard of qualifications, provision of spectacles and the type of frame, breakages and renewals, &c., and the Committee considers that the details of any proposed scheme should be planned at a conference between representative *medical men, optometrists and the Government.* In the main, the administration and control should be in the hands of the ophthmalogist, whilst much useful service can be rendered by the optometrist and the optician.

EFFECT OF WAR SERVICE ON DOCTORS AND NURSES.

66. The necessity for special consideration being extended to medical practitioners and nurses returning to the practice of their professions after long periods *on service has been stressed in evidence before the* Joint Committee.

Many members of these professions enlisted or were called up as soon as they completed their training courses. Years spent on service, whilst giving them good experience in some directions, may have unfitted them to some degree for civilian requirements, as much as their professional work with the forces would be of a nature not required on resuming their normal vocation.

As was stated recently in an address by the president *of the Queensland branch of the British Medical* Association—

> Successful rehabilitation demands not merely a few short post-graduate lectures and demonstrations, or a brief period of watchful attendance in hospital. A young man needs reteaching in the practical aspects of these subjects—he will *welcome demonstration, but he must be permitted, and should* be required, to effect many techniques under expert direction, if he is to be fitted to take his place amongst his colleagues with reasonable proficiency and in reasonable time.

67. The Joint Committee is of opinion that such doctors and nurses before being discharged from the *Services should be given ample opportunity for* rehabilitation without expense to themselves. Medical practitioners should be given post-graduate or refresher courses, and nurses should be given time and training to enable them to resume their rightful places in ministering to the needs of the civilian population.

APPRECIATION.

68. During the course of its inquiries members of the Joint Committee have visited many public, private and denominational hospitals, as well as military hospitals, and Royal Australian Air Force medical rehabilitation units. Lady Gowrie Child Centres, maternal and infant welfare homes and clinics, free kindergartens and homes for the aged have also been inspected.

Throughout its inspections and inquiries all members of the Committee have been impressed by the capacity and sincerity of those responsible for the conduct of these institutions and with the excellent work being performed, notwithstanding that in most cases they are hampered by lack of staff and inadequate space.

CONSTITUTIONAL POSITION.

69. The Joint Committee has already indicated in earlier reports that constitutional difficulties are likely to be encountered in implementing an Australia-wide comprehensive health service. The successful introduction of any such scheme can be accomplished only after discussions between the Commonwealth and State *authorities, the medical profession and other interested* parties have resulted in mutual agreement.

This problem was discussed in the Sixth Interim Report of the Joint Committee in these terms—

> 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 constitu*tional 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.

INTERNATIONAL LABOUR ORGANIZATION.

70. Medical care formed the subject of special world-wide consideration at the International Labour Conference at its Twenty-sixth Session, held in Philadelphia in 1944, which the then Minister for Supply and Shipping (Hon. J. A. Beasley) and the Chairman of the Joint Committee on Social Security (Mr. H. C. Barnard) attended as Commonwealth Government delegates.

The question of preventive and curative medicine was an important item on the agenda and, as recom*mendations relating* to this matter had been fully considered and later adopted by an overwhelming majority of the nations participating, the Joint Committee feels that the opinions of that Conference are of sufficient importance and interest to be included as an Appendix to this Report, particularly as they support to a marked degree the evidence and conclusions of the Joint Committee on Social Security, which has been investigating this problem in Australia for some years.

The Recommendation of the International Labour *Conference concerning medical care, being an* extract from the *Official Bulletin of the International Labour Office*, dated 1st June, 1944, Vol. XXVI., No. 1, is printed as Appendix "B" to this Report.

CONCLUSION.

71. In conclusion, the Joint Committee desires to state that it cannot but regard the action of the Minister for Health in calling in June last the conference of representatives of the British Medical Association and Royal Australasian Colleges of Physicians and Surgeons "with the object, if possible, of arriving at agreement as to the form which improved medical service to the people might take" as being otherwise than discourteous to the Committee and unfortunate in its results. Amongst the specific proposals referred to the Committee by the Government on the 21st July, 1941, was "*A Comprehensive Health Scheme*", which comprised, amongst other proposals, a "Community Medical Service". Under these terms of reference it has been carrying on discussions with the medical profession with a view to determining the best form which a comprehensive medical and hospital service for Australia should take and has presented to Parliament two reports containing such recommendations as its investigations have enabled it to make.

The Joint Committee desires to record its deep appreciation of the cordial and helpful co-operation which it has received from the *governing bodies and* members of the medical and nursing professions and which, it believes, has resulted in valuable progress being made towards laying the foundations of a national medical service.

The action of the Minister for Health in convening the conference referred to above, was taken without prior consultation with the Committee and, indeed, without even informing it of what was taking place. The action has side-tracked the work of the Com*mittee and it is now evident that no useful purpose* can be served by further investigation on the part of the Committee, while the matter is being handled by the Government directly with the medical profession. It is clearly impossible for the profession to carry on discussion concurrently with the Committee and a department of the Government. In fact, the direct intervention of the Minister for Health, at a time when the question was at a decisive stage of discussion between the Committee and the medical profession, has resulted in creating the feeling in that *profession that its discussions with the Committee have* been wasted, although the Committee does not entirely subscribe to this view. The Committee, for its part, is of opinion that, in the present position, no further investigation by it in regard to the national medical service can serve any useful purpose. The present Report, therefore, transmits to Parliament its final, and necessarily incomplete, recommendations in regard to a national medical service.

72. In submitting this Report, the Joint Committee strongly recommends the acceptance of the following principles as a basis when the future national health service is under consideration:—

(1) Preventive medicine should have priority over remedial medicine in any scheme of national service.

(2) The *construction* and servicing of appropriately placed hospitals and sanatoriums should be regarded as of first priority.

(3) Planning of medical services should proceed, but no general change should be made until after the war.

(4) Co-operation and goodwill should prevail between the Government and the medical profession.

H. C. BARNARD, Chairman.
W. J. COOPER, Deputy Chairman.
F. M. DALY, Member.
H. S. FOLL, Member.
L. C. HAYLEN, Member.
R. S. RYAN, Member.
D. M. TANGNEY, Member.

Canberra, 27th June, 1945.

APPENDIX "A"

TO THE

EIGHTH INTERIM REPORT

FROM THE

COMMONWEALTH PARLIAMENTARY JOINT COMMITTEE ON SOCIAL SECURITY

BEING

INTERIM REPORT

OF THE

MEDICAL PLANNING COMMITTEE.

Dated Canberra, 1st March, 1944.

INTERIM REPORT OF THE MEDICAL PLANNING COMMITTEE.

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COMMONWEALTH PARLIAMENTARY JOINT COMMITTEE ON SOCIAL SECURITY.

INTERIM REPORT OF THE MEDICAL PLANNING COMMITTEE.

1. *Personnel of Committee.*—

Mr. H. C. Barnard, M.P. (Chairman), Senator W. J. Cooper, M.B.E., and Hon. Sir F. H. Stewart, M.P., representing the Joint Committee on Social Security.

Sir Henry S. Newland, C.B.E., D.S.O., Sir Charles B. Blackburn, O.B.E., and Dr. W. F. Simmons, representing the British Medical Association in Australia.

Dr. F. McCallum, representing the Commonwealth Director-General of Health.

Dr. Alan B. Lilley and Sir Raphael Cilento, representing the Social Security Medical Survey Committee.

2. Also in attendance were Dr. John G. Hunter, general secretary, British Medical Association in Australia, and Mr. Roy Rowe, research officer, Joint Committee on Social Security, and secretary, Medical Planning Committee.

3. Having considered the matters referred to it by the Social Security Health Services Conference at Canberra on the 9th December, 1943, the Medical Planning Committee submits an Interim Report on *the general principles of a Comprehensive Health* Service in three sections, viz.—

I. Public health;
II. Hospital and ancillary services, and research; and
III. Medical services.

A COMPREHENSIVE HEALTH SERVICE.

SECTION I.—PUBLIC HEALTH.

4. In its Sixth Interim Report, the Social Security Committee reviewed at some length the concept of "positive health." The recommendations of that report, for a Comprehensive Health Scheme, envisaged the integration of the practice of preventive and of curative medicine, directed to the achievement of "positive health," for the individual as for the community.

5. As a result of further deliberations, the necessity of that integration of practice is again emphasized. As the Federal Council of the British Medical Association in Australia has stated: "Medicine . . . now approaches the problems of health and disease from the stand-point 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."

6. There are three essential principles which emerge from all the evidence taken, from the reports and projects studied by us, from our deliberations and from the consultations with representatives of the practising medical profession and of the health services, military and civil.

7. These three principles may be expressed in clear terms.—

(*a*) As, in our present need, the growing child is our most important asset, the foremost consideration in any plan for social security should be the adoption of measures to encourage the birth of an increasing number of healthy children and to ensure the mental and physical health of the growing child.

(*b*) Whatever we may do administratively, and however large the sums we spend officially the environmental and economic status of *the individual is, in the last analysis, the* determinant factor in health.

(*c*) The successful introduction of any comprehensive scheme for health services implies inevitably complete co-operation between the Commonwealth and the States, the medical profession, and the general public.

8. These three essential principles constitute the basis of the considerations here set forth. These principles have determined the recommendations made under each relevant head.

9. This section of the report deals with the following items of public health in more particular detail. Appended (at paragraphs 140-155) is a summary of essential aspects embodied in this section:—

Health powers and Commonwealth-States co-operation.
Health aspects of the population problem.
Economic conditions and public health.
Medical survey of the population.
Maternal welfare.
Infant welfare.
The pre-school child.
School medical services.
National fitness.
Nutrition.
Industrial hygiene.
Infectious diseases.
Tuberculosis.
Venereal diseases.
Mental hygiene.
Tropical medicine and hygiene.
The toll of accidents.
Administration.
Uniform legislation for food, drugs and poisons.
Health education.

(I) Health Powers and Commonwealth-States Co-operation.

10. In the Sixth Interim Report the Social Security Committee noted the limitation of Commonwealth powers under the Constitution to "quarantine" but recorded the far wider fields of activity in public health of Commonwealth agencies, expanded by mutual agreement with the States.

11. It was obviously the view of the founders of the Commonwealth over 40 years ago that the sole

province of the proposed Commonwealth Government should be that of "quarantine," that is, the defence of the whole area against invasion by infection from abroad.

12. The care of the health of the public was envisaged as a local responsibility of the individual self-governing States, as a matter of domestic welfare. In 1900, both Commonwealth and States regarded "health as comprising (*a*) the sanitation of environment, and (*b*) the control thereby of infectious and contagious or epidemic diseases". Even in these fields, when in 1900 plague passed the quarantine barrier, the common danger found no Federal provisions to secure co-ordinated action between States. Later came the rapid growth of medical knowledge and "the new public health" which in turn has now given place to the newer concept of "positive health." At the outset, therefore, the Commonwealth was deprived inadvertently of important powers for co-ordination and co-operative action among the States.

13. From time to time in seeking uniformity of standards or of action, and on occasions of public health emergency, and in respect of progressive research or other activities of national rather than local significance, the effects of this initial defect have been very apparent.

14. The decisions of the Convention of Canberra in November, 1942, included as one desirable extension of Commonwealth legislative power the clause: "National health in co-operation with the States."

15. Following reference to the State legislatures, the constitutional position remains as yet unchanged. No competent legal opinion has been given whether the words "in co-operation with the States" do not also, in effect, leave the constitutional position unchanged, since legislative power in respect of public health will not then be exclusively vested in the Commonwealth as apparently necessary under the Constitution itself.

16. The Conference of Commonwealth and State Ministers of Health which met in Canberra in 1943, could only agree:—

> "That the Commonwealth 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 in health services and hospital standards may be established generally throughout the whole Commonwealth."

17. In these circumstances, it is thus quite impossible at the present time to define clearly the administrative picture of Commonwealth and States relationship in matters of public health.

18. The Social Security Committee has, however, repeatedly emphasized that, wherever lies the constitutional power, public health can only advance through the co-operative efforts of the Commonwealth and State authorities, the practising medical profession, and the general public.

19. We would, however, reiterate our belief, as expressed in three especially significant subparagraphs of the Sixth Interim Report of the Social Security Committee, that—

> "21. The deficiencies in the public health provision may be summarized as being—
>
> (*a*) The restricted powers of the Commonwealth in respect of health;
>
> (*b*) A lack of uniformity in the legislation for health and the organization of health (including hospital) services in six self-governing States;
>
> (*c*) A needless separation of the health problem into unrelated parts under separate controls by failure to recognize their unity in essence;
>
> . . . . . ."

(II) Health Aspects of the Population Problem.

20. The Social Security Committee in its earlier inquiries into the basic principles of social security was told in evidence by an expert economist that "there is no population policy in Australia," the need for which he stressed, as well as "the importance of considering all security measures from the angle of their effects on the quantity and quality of the population, and of framing all measures in fact with the most careful regard for their possible effect on the future quantity and quality of population."

21. Much of the evidence subsequently heard from medical men has proved the truth of this; personal and community health is very intimately related to every aspect of the population problem.

22. We have been concerned, as is every intelligent Australian, with all the implications of the modern phenomena of a falling birth-rate and a fast ageing population. We have no ready-made solution for the manifold problems inherent in these phenomena.

23. The Social Security Committee has, however, heard much evidence which clearly indicates certain steps which Governments, with the support of the people, must take—

> (*a*) To foster by every means early marriage and the natural development of family life, for it is realized that economic circumstances play an undefined part in delaying marriage and in the refusal of parenthood. That economic factor should, however, be fully considered in relation, for example, to—
>
> marriage loans,
>
> child endowment, and
>
> housing.
>
> (*b*) To foster means for making maternity safer, and less difficult from the social and domestic side.
>
> (*c*) To ensure child care, and opportunity of development, education and employment, so that no parent can claim doubts for his child's future.

24. The Social Security Committee has taken no direct evidence on the question of birth control. We feel, however, that we cannot ignore this feature of the population problem because it is controversial. We feel that the decision as to the practice of birth control must be decided by Australian married folk as an individual responsibility according to the dictates of their conscience. We deprecate, however, any ready availability of contraceptives. The National Security (Venereal Disease and Contraceptives) Regulations which prohibit the advertising of contraceptives have achieved the elimination of an objectionable feature. We urge that similar legislation should if possible be secured, possibly by agreement between the States, to ensure a maintenance of this prohibition of advertisement when the National Security Act is no longer operative.

25. Similarly, no special evidence was taken on the question of abortion which over recent years, either self-induced or criminally procured, has contributed a quota of deaths and of grave illnesses to an increasing number of Australian women. We have it on the authority of the National Health and Medical Research Council that economic considerations play a large part but that other factors or

motives operate. In present circumstances, we feel that this problem should continue to be very closely watched by health and hospital authorities so that those other motives and factors might be located and if possible corrected.

26. We subscribe to the ideal that "Australia's best immigrants are its babies." We recognize, however, that in post-war planning, immigration must play an integral part in the development of the nation. We commend a thoughtful report on "Medical Aspects of Migration," included in the report of the tenth session of the National Health and Medical Research Council. That report advocated an intelligent application of medical principles in maintaining a certain degree of restrictive control on immigration into Australia, and we agree that whatever may be the background of future migration the health and medical aspects should be regarded as a fundamental part of the administrative machinery.

27. In particular, we are impressed with the potentialities of child migration, which was the vision of Kingsley Fairbridge, founder of the great system of child migration named in his honour; he saw "little children shedding the bondage of bitter circumstances, and stretching their legs and minds amid the thousand interests of the farm . . . the waste of unneeded humanity converted to the husbandry of unpeopled acres."

28. The policy and ideal of a White Australia cannot be ignored in relation to our population problems of the post-war era. We believe that Sir John Latham well expressed Australian feeling when he wrote in a foreword to "The Peopling of Australia" that—

> "It is firmly and, in my opinion, reasonably believed by Australians that Australia can do most to secure what the Greeks would have called 'a good life' for her people by maintaining the present social composition of the community. This is not a selfish ideal for it is, we believe, as a free white democracy that Australia can make her best contribution to the peace and well-being of the world as a whole."

29. We are impressed with the need for continued scientific observation and record of Australian population movements as the basis of all social studies. We have in another section of this report (*see* paragraph 44) advocated a development of the statistical services for the betterment of demographic and vital statistics. We have been interested in the department of sociological medicine initiated and maintained by the New South Wales branch of the British Medical Association. This activity recognizes that the medical profession and the health services are very vitally concerned in population problems and we urge close collaboraton in this field between doctors, economists and statisticians whether they work in the government services of Commonwealth or States, or in the universities, or in private practice or voluntary agencies.

(III) Economic Conditions and Public Health.

30. We have been impressed by the difficulty of obtaining adequate data concerning the relationship of economic conditions and health in Australia. There are English and Scottish records which very clearly show gross differences in physical development between children of different social classes, and between distressed and prosperous areas. Sir John Orr has clearly shown the lower consumption of the important "protective" foodstuffs by people on the lower income levels. Infantile mortality rates and tuberculosis incidence have been correlated with economic status.

31. In Australia it is very difficult to show such significant and constant variations. The Commonwealth Advisory Council on Nutrition found that an undetermined proportion of the children in Australia did not get enough to eat because of the economic conditions of the family, but ignorance of dietary values caused malnutrition amongst children at every economic level. Infantile mortality rates do not vary constantly between towns or between suburbs according to the economic level of the inhabitants. With regard to tuberculosis, evidence was heard of the incidence of infection amongst such selected groups as nurses and medical students.

32. In no way do we underrate the necessity of maintaining high standards of living to secure individual and community health. We recognize only too well how complex are the factors involved in practically every phase of public health. We are agreed that for the development of a full community life of health and happiness, the economic aspect and freedom from want are essential considerations. We are, however, very much in agreement with Sir William Beveridge in his pronouncement on his plan of social security as "one part only of an attack upon five giant evils: Upon the physical Want with which it is directly concerned, upon Disease which often causes that want and brings many other troubles in its train, upon Ignorance which no democracy can afford among its citizens, upon the Squalor which arises mainly through haphazard distribution of industry and population, and upon the Idleness which destroys health and corrupts men, whether they are well fed or not, when they are idle." No planning for a social policy can succeed unless it aims to combat these five giant evils, in all the complexity of their manifestations and effects.

(IV) Medical Survey of the Population.

33. It has been suggested that we should advocate the compulsory annual medical examination of the whole community as a health measure.

34. The plan of periodical medical examination of the community has been much publicized in the United States of America and by such agencies as the Peckham Health Centre in England. As an ideal, or as implemented by individual or local arrangement, periodical medical examination is to be advocated as a sound measure of individual health. We agree that as a national or state scheme, however, the practical difficulties are varied and considerable, especially if an attempt at universal compulsory enforcement were made in peace-time.

35. Similar objection, on the score of practicability and acceptability, might be raised to the adoption of an individual health record in its complete form as a personal dossier of the citizen from the cradle to the grave. Little has been heard of the individual "Carnet sanitaire" advocated in certain Continental countries before the war.

36. Compulsory medical examination before marriage, another theoretical ideal, has been adopted in certain American states; reports have varied widely in praising and condemning the results of the legislation. It is unlikely that Australia is yet ready for the adoption of such a measure.

37. We feel, however, that every facility should be afforded the individual who desires to avail himself of the opportunity of a regular medical inspection, or to undergo pre-marital examination and tests. In

the development of the community health centre, such provision might be established as a service to citizens and to educate the community in the value of such examinations. It is emphasized that any such examination should be made with a background of health and physical fitness rather than of disease; the examination should be that of the athlete rather than of the invalid.

38. One related aspect concerns the maintenance of health of those in the higher age groups who in our ageing population will increasingly be asked to carry on responsible tasks beyond what is now accepted as the retiring age. As Sir William Beveridge has said: "A people ageing in years need not be old in spirit." Regular medical examination will undoubtedly do much to bring to notice and attention the "risks of middle age"—those heart and arterial conditions, early arthritic, malignant or degenerative changes which may mean a shortened or a crippled life over years which could be fully employed for the good of the citizen and of society.

39. In the more specialized fields of health surveys, the Social Security Committee has heard evidence which has stressed especially the importance of regular school medical examinations, tuberculosis surveys by the newer technique of mass radiography, and such health surveys as that carried out amongst children in the Adelaide Hills district. Rheumatism, goitre and mental hygiene are other fields in which specialized surveys offer promise of attack against problems which affect certain quotas of the community.

40. Such surveys represent an opportunity to obtain specific inspection over a defined cross-section of the community at any given time. On the other hand, an established system of vital statistics records certain features of population movement and of happenings within a community through the periodical censuses, the registration of births, deaths and marriages, and the notification of infectious diseases. These vital statistics relate to statutory requirements, administered by Government Departments, other vital and social statistics of importance are collected by hospitals, friendly societies, insurance companies, and industrial organisations.

41. Such vital statistics constitute an essential part of any public health and medical plan. "Health accountancy can teach us many lessons," and only through accurate statistics is it possible to have a stocktaking of the health and welfare of the community.

42. Birth statistics in Australia are complete and accurate, but still-births are not legally recorded in all States. It would appear that there are social and public health advantages in the legislative requirement of notification of still-births and we recommend that this should be done.

43. While there has been substantial progress in recent years in the field of mortality statistics—that of the classification of causes of death—little or no advance has been made in the collection and collation of data concerning sickness. Accurate information about the prevalence, course, geographical and occupational distribution of sickness, properly classified, is essential for the development of social hygiene and preventive medicine. Without a reliable statistical basis, clinical research is seriously hampered. There is no international list of causes of morbidity as there is for mortality. Infectious diseases, notifiable under the several State health Acts, are a special category, as all Health Departments compile and publish relatively complete statistics of notified cases of these diseases If any social scheme, involving the recording of sicknesses, is introduced on an Australia-wide scale, expert statistical and medical opinion should be sought to initiate a code system along scientific and sound lines. Any such code should be adaptable for conversion to an international model after the war. (Prior to the war, the International Institute of Statistics and the Health Section of the League of Nations were collaborating in the preparation of such a list for international adoption.)

44. The development of the machine system of recording and analysing statistical data makes possible a fully detailed classification of statistical material. With the extension of social services in Australia large new fields for scientific investigation are likely to be opened. Opportunities will be presented such as never before existed for making statistical contact with original sources of information. We strongly urge that these opportunities be seized. For that purpose, it is further recommended that—

(*a*) Definite and formal co-operation should be established between the statistical and health agencies of Commonwealth and States.

(*b*) Legislation, where necessary, should be enacted to provide that such statistics as are required, shall be furnished by Government departments, friendly societies, industrial and other bodies, such as public hospitals, and by medical practitioners.

(*c*) A competent medical officer with special aptitude and qualifications such as university training in statistical method, should be seconded from the Commonwealth Department of Health for service with the Commonwealth Statistician, to organize, under the direction of the Statistician, the development of morbidity statistics in Australia.

45. In the more specialized field of hospital statistics, the inquiries of the Social Security Committee have indicated that there is considerable room for improvement and uniformity in the compilation and classification of such statistics as those covering admissions, bed states, daily occupied beds, &c. Similarly, hospital case records are too often regarded as no more than a temporary clinical record. Professor F. Wood Jones, on the other hand, emphasised that "accurately kept, case records containing all facts relevant to the condition and progress of the patient, are the bricks and mortar from which the edifice of real clinical knowledge must be built." Hospital authorities and governmental agencies concerned with the administration of hospitals, should make it possible that accurate case records are secured and maintained for the study which they provide for an increased knowledge of the incidence and prognosis of disability and disease throughout Australia.

(V) Maternal Welfare.

46. We have been impressed by the unanimity of opinion, in one matter, of those who have given evidence before the Social Security Committee, namely, with regard to the importance of maternal and child welfare in any comprehensive health scheme. It was inevitable that, in recording the Minutes of Evidence, the larger questions of medical and hospital services should have been more featured at some length; actually, of individual indexed items of public health importance, references to maternal welfare and to infant welfare appear more often than to any other subject. Few phases of public health

can be discussed intelligently without some reference to the essential services rendered to the mother and the child.

47. We endorse the emphasis placed on this importance of maternal care by the National Health and Medical Research Council. In separate reports over recent years this council has stated that:—

> "Many mothers die during childbirth because they do not receive adequate or sufficiently early treatment . . . obstetric emergencies often occur because the woman has not had in time proper ante-natal advice, and many emergencies could be prevented by such advice.
>
> "It would not be right for this council to convey the impression that even with the use of every means available at present every maternal death can be prevented. But knowledge of the underlying causes is improving all the time and everything which can be done should be done both to utilize and apply the knowledge at present available and to acquire new knowledge from experience and research.
>
> "The employment of women in industry must be particularly safeguarded, with special provision in respect of pregnant women. A concerted programme of measures for the care of the greatest industry of all—the mothers engaged on home duties—is urgently necessary in the interests of health. The matter presents difficulties but also offers opportunities now recognizably obvious."

48. Evidence given before the Social Security Committee has emphasized that the "preventive" aspects of maternity work depend very largely upon recognition by the expectant mother of the need for her to seek early and regular ante-natal care and supervision. It has also been stressed that whilst the work of a nurse may be important in advising the expectant mother upon many aspects of personal hygiene and regulated living, ante-natal supervision is, in practice, essentially a matter for the medical attendant. A corollary is the education of the medical student, the doctor and the midwife-nurse in this important phase of midwifery practice.

49. In private medical practice, it is happily becoming a recognized custom for women to "book" their confinement ahead with their doctor upon his confirmation of their condition; they then attend at stated intervals for regular ante-natal examination and advice.

50. In hospital practice, the demand for maternity beds in a popular hospital has made it essential for the expectant mother "to book early." It is now customary for maternity hospitals to insist that "booked" cases attend once a month, and every fortnight over the last two months of pregnancy; early booking therefore ensures more effective supervision throughout the period of pregnancy.

51. Representations have been made that independent ante-natal supervision is ineffective and discontinuous when carried out at baby welfare or other clinics which are not directly associated with the maternity hospital at which the mother will be confined. In some centres, however, outlying districts have been afforded a service by arranging for supervision at local clinics but in association with the hospital itself.

52. Significant figures, confirming the saving of life of mother and baby which ante-natal supervision ensures, have been recorded by a large hospital in Melbourne; during the year ended 30th June, 1941, in 2581 cases which had attended for ante-natal care only five mothers died (or two per 1,000 cases); in 509 "emergency" cases admitted to the hospital, 12 died (or 23 per 1,000 cases).

53. We urge that in any provision for maternity hospital plans, staffing, equipment and maintenance, adequate facilities should be provided for an effective ante-natal service to every expectant mother.

54. We further recommend that every opportunity be taken for educating expectant mothers in the benefits of ante-natal care.

55. There are admittedly administrative difficulties in arranging a maternity allowance otherwise than in a lump sum. Particularly in the case of working mothers, however, there is much to be said for some such principle as that advocated in the Beveridge plan whereby the mother who is gainfully employed is paid benefit over a period of thirteen weeks in addition to the usual maternity allowance; such measure ensures relief from the stress of employment and frees her for the care of herself and her baby over that all-important period which may so materially affect the course of their future lives and health.

56. There are very clear responsibilities involved in relation to maternity hospital provision and midwifery services because, as an Australian authority has said:—

> "Maternal mortality, and especially maternal morbidity, varies in direct proportion to the inefficiency or inadequacy of the professional care and supervision during the ante-natal and post-natal periods."

57. Our attention was drawn to a series of recommendations of the Federal Health Council in 1935, which still represents a model plan for the betterment of maternal welfare and the practice of midwifery. Certain of these recommendations have been implemented, others have been adopted in part. We commend full maintenance of these items, and the development of the other items, for an adequate service throughout Australia, as advocated by the Federal Health Council:—

"(*a*) Establishing a model maternity centre in each capital city either by expanding existing institutions (the preferable course) or erecting new institutions. These would be centres for:—
  (i) Demonstrating proper technique;
  (ii) Post graduate courses for doctors and nurses, and
  (iii) Clinical research and trying new methods,
  and would be training schools for midwifery nurses and medical students.
  In order to secure the full use of such a centre a Professor of Midwifery should be appointed at each State university whether a medical school exists or not. (It would not be essential that the person so appointed should be entitled "professor"). This professor would have a sufficiently attractive salary with the right of consulting practice and should be the person in charge of the activities of the model maternity care.

(*b*) Establishing a consultant service of senior obstetricians wherever possible.

(*c*) Expanding infant welfare centres where possible to include an ante-natal clinic; or alternatively, associating the infant welfare centres with newly established ante-natal clinics in properly equipped

institutions. This would probably mean in many cases, reorganization of existing centres, perhaps new buildings; where possible the ante-natal course should be given by medical practitioners.

(*d*) Providing maternity wards for every metropolitan hospital where such a ward is possible. It is important that the maternity wards should be staffed with a staff separate from the general staff of the general wards.

(*e*) Increasing the accommodation provided in convalescent and after-care homes.

(*f*) Subsidizing and extending the Bush Nursing and other approved organizations.

(*g*) Making provision for the investigation of all (so far as is possible) maternity deaths. Any such investigation should be made confidentially and discreetly by a permanent medical officer of the Health Department of the State concerned.

(*h*) A system of notification to the Registrar-General of deaths from (i) abortion; (ii) still-birth; (iii) any cause within three months after childbirth is very desirable".

Home nursing service and home aids have a special value in the case of the housewife during the period of her confinement. This enlistment of organized aid for the purpose of assisting women with their domestic responsibilities might well be developed on a local basis analogous to the many organizations now created for patriotic purposes. We feel that this is a service which women themselves should inaugurate and organize, but that Governments should give generous support in providing such funds as are necessary to stabilize any responsible organization on an acceptable basis.

(VI) Infant Welfare.

58. A wide range of organizations, official and voluntary, are responsible in each State for the care of the infant and child. Infant welfare activities are based on the consideration "that the health of the infant depends primarily upon the efficiency of the mother, and that, as the majority of babies are born healthy, mothers should be taught how to keep them well and how to prevent unnecessary sickness by employing sound methods of infant management." The basic function of the infant welfare centre (or baby clinic) is the care of the child through the education of the mother in mothercraft.

59 The infant welfare centre is concerned with the baby during the first year of its life. The development of these clinics over the past 30 years has coincided with one of the greatest achievements of modern times—the saving of child life during that first year which is statistically registered by the infantile mortality rate (deaths of infants under one year of age per 1,000 live births). The experience of Victoria may be taken as typical of Australia—in every 1,000 children born, during the years 1900-04, Victoria lost 98 infants each year before their first birthday; 74 infants during the years 1910-14, 65 during the years 1920-24 and 43 each year during the years 1930-34. In 1940, the deaths per 1,000 births numbered 39.

60. In that decline, there has been a significant variation in the annual causes of deaths per 1,000 births. Over the years, the mortality of infants from diarrhoeal diseases has been reduced by 93 per cent.; the main respiratory diseases by 38 per cent., and the infectious diseases by 72 per cent. Variations in classification in earlier years of the pre-natal causes of death prevent an exact comparison, but on detailed analysis of causes of death under this heading, no appreciable decline is evident (that is, in deaths recorded as due to such causes as malformations, congenital debility and prematurity, &c.).

61. In modern life, the infant welfare movement, mothercraft, and (in those centres where it has been developed) fathercraft, constitute an essential social service. We commend what has been achieved, and believe that with the integration of the movement in the community health centres recommended by this Medical Planning Committee (paragraph 242), even greater achievement may be possible.

(VII) The Pre-School Child.

62. Health authorities have pointed out for more than twenty years that little has been done to bridge the gap which exists between the health supervision given at infant welfare centres and that provided by the school medical services.

63. As Dame Janet Campbell pointed out in her report in 1929 on *Maternal and Child Welfare in Australia*, in Australia, as in England, during the age period of 2 to 5 years "the child is only too often subject to no effective health supervision at all, yet it is a time when good care and watchfulness are needed to prevent or deal with infectious or constitutional disease which, if neglected, may lead to considerable physical disability, and when special attention is called for in regard to matters of dietary, hygiene and training."

64 There have been for many years kindergarten, day nursery and Montessori schools in Australia. The Committee has watched with interest and its members have themselves seen the results of the co-ordination of the kindergarten and day-nursery movements in bringing the health aspects of their work into an important place in the objectives of the societies.

65 When the kindergarten unions of the several States joined in a Commonwealth-wide organization —the Australian Association for Pre-School Child Development — the Commonwealth Government erected the Lady Gowrie Child Health Centres as demonstration units in each capital city. Collaboration was arranged between the Commonwealth Department of Health and the association to ensure a correlated study of physical and mental health, child growth and nutrition.

66. Statistics are not complete but in 1940 there were 78 free kindergartens in Australia with an average attendance of 3,570. Training colleges now function in all the mainland capital cities and only partly meet the demand for highly trained instructors in a system which requires a high proportion of instructors per centre. This indicates that a beginning has been made.

67. We stress the importance of this work. Here again, the community health centre offers scope for development in correlation with the kindergarten movement.

68. We commend the action of those State Health Departments which have appointed special pre-school officers to the departmental divisions of maternal and infant welfare. Under their inspiration and guidance, and in collaboration with local organizations, it would appear to be a sound line of advancement where kindergarten principles are being adopted for pre-school children who attend

with their mothers at infant welfare centres and who are accommodated in the special "waiting places" provided.

69. The provision of community play grounds is an essential service for children, especially in inner suburban and industrial areas. We believe that no health service is comprehensive, which does not include an open playground accessible to every toddler and child in the community.

70. There is another aspect in relation of the home life and care of children at this age. We have already referred to the importance of some system of "home help" as part of a complete system of maternal welfare.

71. We are convinced that with the development of a system of creches and day nurseries, and of home "minders," the lot of the mother with young children could be greatly eased. There would be a restored encouragement of family and happier home life if the mother could be assured of regular relief at home for shopping or visiting excursions, and the young married couple could be released together for an occasional evening at the pictures or a dance.

72. The Country Women's Association, with the great-hearted kindliness of the out-back, can arrange such help at distant homesteads. We suggest that other women's organizations in city, suburbs or rural areas might well serve their fellow-women in a work which has implications of national importance.

(VIII) School Medical Services.

73. According to the Commonwealth *Year-Book*, during the year 1939, the average daily attendance at State schools in Australia numbered 744,706, and of these 176,136 or 23.7 per cent. were examined by school medical officers; another 45,189 children were examined by school nurses. The cost of school medical services is a very minor item in the education vote (approximately between 2d. and 3d. per head of population in a total expenditure on education of between £1 15s. to £2 per head of population).

74. In New South Wales 36 per cent. of the children attending are examined under a system which provides—

> "In country districts the medical examination of every child at least twice during the usual period of school attendance (6-14 years). In the metropolitan area . . . the full medical examination of all children in first and sixth classes and the review of children in other classes who have been found defective in previous years."

75. We endorse authoritative opinion that this provision should be the minimum for an effective system of school medical service.

76. The question has remained open whether the school medical service can function most efficiently under the administration of the Education or the Health Department. In four States the service is now part of the Health Department; in two States the service is still included in the Department of Education.

77. To those who advocate in modern education the trend towards a psychological basis of training, especially in the earlier years of schooling, the school medical service appears as an integral part of that training. The co-ordination of mind and body, the cultural achievement, the vocational guidance and ultimately the vocational training of this new education links the teacher and the doctor in a very close collaboration. Especially is this so with that quota of children who are retarded by mental or physical disability, in selection of such children and their later training, the team of doctor-psychologist-teacher must work together. The educationalist views with some misgiving what he regards as a divorce of the doctor from this team, with the administration of school medical services by the Health Department

78. From a wider viewpoint, the school life of the child can only be regarded as one episode only, however important, in his life. In the newer public health, there is a direct sequence of health guidance of the individual from birth through infancy and the pre-school years to school life and the early adolescent years of technical training and entrance to industry.

79. The Health Department is becoming more and more a co-ordinating centre of many activities devoted to many phases of social responsibility; in that concept the school medical service takes its natural place, as part of this social responsibility within the ambit of the Health Department

80. The conference of Commonwealth and State Ministers for Health on 15th and 16th June, 1943, adopted a resolution in the following terms:—

> "This conference is of the opinion that, in order to secure continuity of record, supervision of child from birth to end of school life be a function of the Health Department in each State; and that further attention be given by school medical officers and other medical practitioners to the pre-school child through the well-organized system under the Health Department."

81. The system of community health centres and the part which the general practitioner can play in supervising the health of the school child are referred to later in this report.

82. The success of any such development will be gauged largely by the proportion of children found with some disability who are successfully treated or who receive remedial or preventive measures.

83. At present, in the exceptional circumstances which exist at Canberra, with personal follow up by nurses, 88 per cent. of children receive treatment recommended. In the cities it is reported that there is a reasonable response by parents to notifications of remedial defects and the available facilities at hospitals and through their own doctors are utilised. In country districts the proximity of the nearest base hospital is often the determining factor whether anything is done, especially in securing treatment for nose and throat conditions.

84. We recommend that where no provision now exists, all subsidized hospitals should be required, as a condition of that subsidy, to provide for the treatment of children suffering from defects notified by the school medical service and whose parents establish their inability to pay normal fees.

85. Although the provisions of child welfare and other legislation make a parent or guardian responsible for obtaining adequate medical care for a child, Western Australia is the only State which requires (under Section 317 of the Health Act) that a parent should secure medical or surgical attention for a physical defect in a child notified by a medical officer.

86. Dental supervision has become an essential part of the work of the school medical service; dental caries represent the highest total of all defects found in children (in up to and over 30 per cent. of all children examined).

87. We urge far greater attention to the problems of dental hygiene and the provision of necessary clinics, stationary and travelling, to ensure that no child is deprived of the opportunity of dental attention.

88. The rectification of visual defects is receiving increasing attention. In New South Wales there are special arrangements for obtaining spectacles at contract rates even when a child is referred by the oculist medical officer to a private oculist. A beginning has been made with the establishment of special "eyesight saving" school classes—an admirable innovation.

89. Trachoma is now a problem only of the Far West, but still engages the attention of the school medical service—local practitioners as local ophthalmic medical officers have co-operated in attending cases of what was once the scourge of country children in Australia, and in Queensland the special Ophthalmic School Hostel in Brisbane provides specialist treatment and specialized education for children sent in from the country. These are achievements of the service but governments must recognize that such specialized service is not cheap, but pays good dividends in the prevention of blindness and of the handicap of defective vision.

90. The school medical service provides primarily for the child attending school from home. There were in Australia, however, in 1939, a total of 54,627 children under State control or supervision. At the last census (in 1933) there were enumerated 183 blind children (under the age of 14 years) and 500 deaf and dumb children. The orphan and neglected children, the under privileged, the crippled, blind and deaf and dumb children, the mentally deficient, the mentally diseased and the epileptic, all await what we can offer to minimize their handicaps and to restore them as far as possible to a happy and useful community life.

91. We are familiar with much of the work done in their fields by voluntary agencies, both religious and lay, and by State departments. Devotion and skill of staff are too often hampered by inadequate buildings and poor equipment. We urge that governments should look generously towards these activities. As a sum in social economics, there is clear profit in the child who is trained to a craft or some useful employment, and so saved from the dead-end hopelessness of the invalid pension.

92. In another section of this report we refer to the mentally handicapped child. Here we would note the useful co-operation which is maintained in some States between the school medical services, the child guidance clinics, the opportunity classes and special classes for backward children. There has been a praiseworthy development in Victoria; a war-time evacuation unit, appointed to decide "billetability" of city children, has so established its usefulness that it now constitutes a permanent children's clinic for preventive psychiatry.

93. We urge that governments should accept a very full responsibility for the under privileged child who becomes a ward of the State. Much has been accomplished and in some States the work of the Child Welfare Department, or equivalent agency, is worthy of all praise. There is, however, food for thought in a table of venereal disease statistics recently recorded in a capital city; of 28 girls detained under National Security Regulations as suffering from venereal diseases, 15 were single girls between the ages of 18 and 25, 13 were married. Of the 15 single girls, 13 were ex-wards of the State; of the 13 married women, 2 at least were ex-wards.

94. This experience does not in itself prove that the State is a bad parent, and in another State the results of "opportunity class" work, under trained State supervision, is revealing. A series of 390 children completed their schooling from these classes at the age of 14 and remain under after-care supervision until they are 18. Of this 390, 281 are gainfully employed, 8 are in institutions, 29 girls are helping at home, 21 are permanent invalids or too low grade to work and 51 remain under the Children's Welfare Department or have gone to the country. The majority of these children were of "slow mental development," the recruiting ground for the young delinquent and the prostitute.

95. In all this work, we reiterate our opinion that the growing child is the national asset most worth preserving, and that any comprehensive health plan should aim primarily at ensuring the best physical and mental development of the child.

(IX) National Fitness.

96. It is significant that, just after Munich, the National Health and Medical Research Council submitted a resolution to the Commonwealth Government through the Minister for Health, which included the following comment and recommendations:—

> "In the constant struggle for economic survival, progress is determined, other resources being equal, by the relative proportions of the fit and the unfit, that is to say, in effect, the percentage of the population ineffective towards national life and survival, by physical infirmity or lack of training . . .
>
> "The council is convinced of the urgency and importance, in any case, of establishing a national organization which shall have as its main objective a standard of physical fitness such as this country, with its racial heritages, natural environment and economic opportunities, should show.
>
> "It is recognized that this is particularly a field of endeavour in which instead of looking passively to governments to do all the work and provide money (which may or may not be well spent), the people of Australia should help themselves."

97. Two months later, in January, 1939, the Commonwealth Government convened the first meeting of a National Co-ordinating Council for Physical Fitness (now the Commonwealth Council for National Fitness).

98. The movement has grown despite the pre-occupations of war-time, and we commend what has b en done, especially in the recognition of the principles noted above. An essential achievement is the provision made for the development of physical education and the training of those who must teach and lead, including the provisions for a university diploma course in physical education.

99. We endorse especially a recommendation which was made to the seventh session of the Commonwealth Council at Canberra in September, 1943—

> "The foundations of national fitness are laid in childhood, and the schools play a major part in its promotion. Moreover, the schools have the machinery in established curriculums and trained staff through which sound principles of national fitness can be developed. The habits and attitudes established during childhood inevitably determine the attitudes of the adult."

100. We are convinced of the significant truth of that last sentence if Australia is to be peopled by a fit community and survive.

(X) Nutrition.

101. A member of this Medical Planning Committee, who was the Australian Government delegate to the International Labour Conference at Geneva in June, 1935, aroused international interest and concern when he pointed out the paradox that existed in a world of ample food supply where there was still a large proportion of the world's population inadequately fed, and—in the aggregate—a vast number of people were actually unnourished.

102. Having inspired a world-wide movement, the Commonwealth Government accepted a challenge and opportunity of examining the nutritional state of its own people and of rectifying whatever evils might exist.

103. The surveys and investigations of the Commonwealth Advisory Council on Nutrition continued from February, 1936, until a sixth and final report was presented in July, 1938. That final report recorded in detail findings which the council observed might not be "conclusive or dramatic but are very suggestive."

104. The report of the council continued—

> "It may reasonably be assumed from the evidence reviewed that the Australian people are on the whole well-fed, but that a minority is not obtaining and may not be in a position to obtain enough food. The numerical size of this minority cannot be stated as a result of this inquiry, but within the limits of this survey it has been stated to be represented by some 6 per cent. of the dietaries recorded by housewives."
>
> "Also, two things are very clear—
>
> (1) that there is much ignorance in the community as to the proper balance of food items;
>
> (2) that some people in both town and country are unable for various reasons to obtain the essential fresh foods.
>
> "It is also clear that for these reasons a considerable mass of minor departures from normal health (describable generally as malnutrition) exists amongst the young children in both town and country.
>
> "Thus the evidence points to faulty selection of diets as the main cause of malnutrition, a selection sometimes necessitated by poverty, but more often the result of ignorance.
>
> ". . . It must be emphasized that the degree of ill health indicated in this report are of a minor character. The medium or severe types of malnutrition were not found. No comparison should be made, therefore, between the figures given for Australia in this report and the figures given for any other country.
>
> "But if we are to face facts in Australia, we must realize that—
>
> "Milk, cheese, fruit, vegetables, fish, are not always or everywhere available to the public in sufficient quantities and at prices low enough."

105. These findings and observations hold true to-day. War-time rationing measures have but served to emphasize the importance of an appreciation of dietary balance and values—whether as the basis of national policy or of household budgeting.

106. We are assured that in war-time rationing the responsible authorities will ensure for the normal consumer a sufficiency of food to maintain health and working efficiency. We urge, however, that full consideration be given to the maintenance of adequate supplies of essential foodstuffs for the "vulnerable groups" of infants, children, expectant and nursing women and (in a special category) invalids. In war-time, as in the peace to come, we are convinced of the essential need of meeting the full nutritional requirements of these groups. We have already insisted that the economic status of the individual is, in the last analysis, the determinant factor in health. Given that status, and education in dietary needs and values, the Australian people should be amongst the world's best-fed people. But, insofar as that status is not achieved, or essential foodstuffs are not available through failure of production or distribution (or war-time diversions) Governments must accept in principle responsibility for the nutritional condition of the mothers and children of the nation. This principle has been accepted in Great Britain by the Ministry of Food in its "free and cheap milk scheme."

107. We urge an administrative realism which will accept this principle, and which will follow expert advice upon the nutritional needs in detail of these all-important "vulnerable groups."

(XI) Industrial Hygiene.

108. There was a Division of Industrial Hygiene in the Commonwealth Department of Health from 1924 until 1932 when the division was abolished during the staff retrenchment of that period of economic depression. With war-time responsibilities of the Commonwealth for the health of munition workers, a Munitions Medical Service has been established and functions effectively under the administration of the Commonwealth Department of Health, on behalf of the Department of Munitions. Associated also is the Industrial Welfare Division of the Department of Labour and National Service. A Committee on Industrial Hygiene in Munition Establishments, appointed by the National Health and Medical Research Council serves to co-ordinate aspects of work in this field.

109. In New South Wales, Victoria and Queensland, divisions of industrial hygiene exist in the State Departments of Health. Specialist medical officers carry out investigations and research, advising upon and co-ordinating health aspects of other State activities in the industrial field. Administratively, in all States, separate departments of Labour and Industry, Mines and other agencies control conditions of work in industry.

110. The objectives of industrial hygiene have been concisely stated in relation to the industrial war effort in England in the following terms, which are applicable both in peace and war in Australia:—

> "To suggest problems for investigation and to advise or carry out schemes of research . . . undertaken to promote better knowledge of the relations of methods and conditions of work to functions of the human body, having regard both to the preservation of health among the workers and to industrial efficiency; and to take steps to secure the co-operation of industries in making widely known such results of this research work as are capable of useful application to practical needs."

111. We consider that there is a great need for effective maintenance and development, along scientific lines, of industrial hygiene activities of

Commonwealth and State Health Departments. We feel that in the reconstruction and maintenance of industry in Australia after this war, the Commonwealth should ensure that organized industrial hygiene will guide especially—

(a) Scientific inquiries into the health conditions and hazards of labour;

(b) Co-ordination of legislation and of the enforcement of relevant regulations;

(c) Collection and compilation of uniform statistics of occupational morbidity, &c., and

(d) Education and propaganda.

112. There are two matters directly related to industry but of health concern to the whole community, although both are mainly city problems. We urge that civic authorities should protect their citizens by scientific attack upon the problems of noise and of smoke pollution of the atmosphere.

113. We assume that as an integral part of Australia's international co-operation in the post-war period, there will be active participation in the work of the International Labour Office.

114. In relation to post-war development in Australia, and in the planning of industrial changes and developments, we desire to emphasize four matters which we consider of importance—

(i) The primary industries should share with the secondary industries the care and supervision of the expert services of industrial hygiene.

(ii) Full provision must be made to safeguard the health of women in industry, and especially to protect the expectant mother who is in any industrial employment.

(iii) Industrial hygiene should include a full service for the conservation of health. The more dramatic industrial risks are apt to divert attention from the more continuous and more prevalent, if less forceful, industrial hazards.

(iv) Industrial hygiene, especially in war-time, aims to keep the worker fit to serve his machine for a maximum production and the problems of industrial hygiene demand the specialized services of highly skilled technical experts. These facts tend to obscure the outlook of industrial hygiene, which should be correlated with the concept of "positive health". Whilst the industrial hygiene service protects the artisan or miner from the special hazards of his trade, the service should primarily serve the men and women of industry as citizens who have a life and leisure, in which their industrial occupation is but a part.

(XII) Infectious Diseases.

115. We call attention to three matters of importance, with regard to infectious diseases—

(a) The co-operation of medical officer of health with general practitioner in the scheme envisaged by this Committee offers an opportunity for prevention and control of infectious diseases not hitherto possible in Australia.

(b) The Social Security Committee, in its Sixth Interim Report (paragraph 21 (g)), has called attention to "the lack of standardization with regard to infectious diseases hospitals and technique; and the need for the establishment of infectious diseases hospitals on a basic plan throughout the Commonwealth in accordance with population distribution and infection risk".

(c) Diphtheria immunization offers a tried and now accepted method which should be extended for the elimination of diphtheria as a health problem in Australia. (During 1943, 7,045 cases of diphtheria were notified in Australia.)

(XIII) Tuberculosis.

116. The Social Security Committee reported at some length in its Sixth Interim Report on the problems of tuberculosis, with the recommendations of which we wholeheartedly concur. We welcome the decisions of the conference of Ministers of Health of Commonwealth and States (December, 1943), which promises a co-ordinated plan of activity in every State. We reaffirm the recommendations of the Social Security Committee as essential principles of the campaign—

"(1) An increase in special rate pensions to the tuberculous and allowances to dependants (but to be not less than repatriation payments in similar cases*);

(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 sanatoriums, by the most modern methods and technique; and

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

(XIV) Venereal Disease.

117. We cannot do better than repeat the comment and recommendations of the Social Security Committee in its Sixth Interim Report on this subject.

118. Special venereal disease legislation has been in force in every State (excepting South Australia) 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, only in Queensland was there 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

* The Social Security Committee rates approximated the basic wage.

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. Wartime experience shows 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 utilized 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 organizations 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 becoming a general police power.

119. The Social Security Committee was very concerned with this problem of venereal disease as a matter which concerns the social life of the Australian community, and took evidence on many aspects of the problem. We endorse its recommendation of 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" patient 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.

(XV) Mental Hygiene.

120. We again endorse what the Social Security Committee has stated on this subject.

121. Evidence has been adduced that much more might be done for the prevention and treatment of nervous and mental illness and for the specialized education and social utilization 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.

122. 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 these problems of modern life in which mental deficiency, character maladjustment and neurosis enter so largely—for example, child delinquency and crime; prostitution and venereal disease; and a quota of the unemployable. We are of opinion that—

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

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

(c) 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; and

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

(XVI) Tropical Medicine and Hygiene.

123. The Social Security Committee has taken no evidence with special reference to health and disease in the tropical areas of Australia and its territories. At the present time, however, every Australian, as never before, appreciates the task and achievement of medical services in these tropical areas. We urge, therefore, that in medical planning for the future, full recognition should be afforded for the provision and maintenance of adequate health and medical services for these areas.

124. The services should have all the scientific resources necessary for effective advancement of the health of our own people and of those native peoples entrusted to our care, either under our direct administration or in our wider international responsibilities in the Pacific.

125. The Sydney School of Public Health and Tropical Medicine has already played a notable part in relation to our own territories and in international co-operation in the Austral-Pacific zone. Many medical officers and other personnel have been trained at the school in the special problems of these areas. These activities will be increased greatly in scope and magnitude as our comprehensive Pacific responsibilities develop. We recommend that the school should be enlarged to provide the additional accommodation which will be necessary to discharge fully its functions as a centre for training and scientific investigation and inspiration. Since these problems in the Pacific are of immediate, as well as of post-war importance, any possible development should be afforded a high priority as an essential service.

(XVII) The Toll of Accidents.

126. Deaths from accidents rank fifth or sixth amongst the principle causes of death. In 1942, in the total deaths in Australia of 75,191 persons, deaths from accidents ranked sixth, preceded by diseases of the heart (21,006), cancer (8,491), intra-cranial lesions of vascular origin (6,750), pneumonia

(4,471) and nephritis (3,893). The 3,611 deaths from accidents or violence far exceeded those from tuberculosis (2,564).

127. Automobile accidents—what the Americans significantly call "vehicide"—caused 961 deaths in 1942, compared with an annual average of 1,394 deaths over the three years before the war. The Melbourne City Coroner, commenting recently on a 50 per cent. decline in road deaths in that city, has attributed this to: (1) the lifting of black-out restrictions; (2) the introduction of 30 miles per hour speed limit, and (3) petrol restrictions.

128. During 1942, accidents on railways caused 189 deaths, "other" road deaths (tramways, &c.) 211, motor transport 30, civil air accidents 15, mines and quarries 68, agricultural and forestry 48 and accidents caused by machinery 46.

129. The toll of accidents is too often of the young and strong. We urge support of all "safety first" movements in industry and on the road. The speed restrictions in built-up areas and more recent war-time regulations appear to have influenced a declining death rate from automobile accidents. There is general agreement with stronger measures to curb the irresponsible and drunken driver. From the health and medical aspects, there is a threefold interest in measures to reduce this toll of accidents; (1) in the unnecessary deaths; (2) in crippled and disabled citizens, often in the full strength of youth; and (3) in the heavy demand upon hospital accommodation and attendance which accident cases involve.

(XVIII) Administration.

130. The Medical Planning Committee has envisaged, in the medical services section of the comprehensive health scheme recorded later, a service which is "directed to the achievement of positive health and the prevention of disease, no less than to the relief of sickness". That scheme envisages an integration of preventive and curative medicine, a system of district and local medical officers of health in close collaboration with general practitioners, on a basis of health districts and served by local community health centres.

131. We are of opinion that an effective administrative machinery can be devised whether that scheme is to function under present constitutional arrangements, or whether it may be serviced by any of the projected schemes which have been discussed, but until the constitutional issue is determined as to the allocation of powers between Commonwealth and States, no clear administrative picture can be demonstrated.

(XIX) Uniform Legislation for Food, Drugs and Poisons.

132. The Social Security Committee, in its Sixth Interim Report, noted that Commonwealth powers in respect of foods, 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. We concur with this decision and urge that it should be put into effect.

(XX) Health Education.

133. We have been interested in the methods adopted throughout Australia to educate the public in matters of public health. Much more might be done, were the means available, but much is being well done through the publicity programmes of Commonwealth and State Health Departments and of voluntary societies. Broadcast talks prepared under the auspices of the British Medical Association have covered admirably the "health front" and the "kitchen front."

134. In Western Australia the Social Security Committee heard in evidence a country practitioner who gives a weekly lecture to the local school; an excellent syllabus covers a wide field and, as he stated, he is "even allowed to tell the children how to prepare their bodies for parenthood."

135. That subject of sex biology raises perhaps the most contentious question in popular health education. We have been impressed with, and endorse a resolution of the fifteenth session (May, 1943) of the National Health and Medical Research Council, with special reference to the prevention of venereal diseases. The relevant recommendations of this resolution were as follows:—

> "The council appreciates the necessity for commencing biological education at as early an age as possible.
>
> "In the primary schools, general biological education and nature study are desirable, but the council believes that specific sex education should not commence at the primary school age.
>
> "Parental responsibility in relation to general social conduct and self-discipline should be upheld and encouraged, but the council appreciates the real difficulties in the way of parental education of sex biology on an accurate basis because of the ignorance and diffidence of many parents.
>
> "As the children pass to the secondary school age, the need for intelligent education in the main features of sex biology becomes more pressing.
>
> "This council is of the opinion that the educational authorities should very carefully consider the introduction of instruction in sex biology and in the dangers of venereal disease by properly trained teachers.
>
> "Newspapers offer a desirable medium for education of the public in relation to venereal diseases, provided that the letterpress consists of statements issued by the Commonwealth or State Health Departments or by official medical bodies, such as the British Medical Association, the College of Surgeons or the College of Physicians. This applies whether the statements appear as paid advertisements or as news items.
>
> "Radio broadcasting is open to the objection that all members of the family of all ages hear these broadcasts without notice.
>
> "This form of education would need to be very carefully safeguarded.

> "Perhaps the British Medical Association might consider extending its admirable series of health talks through the Australian Broadcasting Commission to cover a series of plain talks on venereal diseases.
>
> "The Health Department also might consider the preparation of broadcast talks on this subject when possible.
>
> "Pamphlets are a recognized method of education and should be widely used—a number of pamphlets issued by official departments and other responsible agencies are now available.
>
> "Cinema films can be used with advantage, but these should always be approved by the Department of Health.
>
> "Posters have a definite value, but these should always be issued by official departments."

136. Whilst we support full and frank discussion in all matters of social concern, we deplore the recent popular exposition of a so-called "sexology." We regret that some medical men should have been associated with articles in popular magazines and addresses in public lecture halls which concentrate attention upon an exaggeration of anatomical and physiological detail, with a discussion of intimate matters which belong to the consulting room or the psychiatric clinic. We are assured by competent medical opinion that this perverted specialism and its popular expositions are both unscientific and unhealthy.

137. We urge that governments should recognize the necessity of sound principles of popular education in matters of public health. Unfortunately, much of this health education and propaganda must compete with all the wealth and artistry which modern commerce can command to advertise its products. Governments must be prepared to make available adequate financial resources to meet that competition.

138. We agree, however, that much unscientific and quasi-scientific advertisement should be controlled in the interests of the public health. We believe that good has been achieved, without undue loss of freedom of expression and commercial enterprise, by the censorship of broadcast medical talks by the Director-General of Health under the provisions of the Broadcasting Act.

139. We wish to emphasize that popular education in health can only succeed if it secures sustained personal interest and the acceptance of personal responsibility by the individual. In this whole issue we are convinced of a cardinal rule—the achievement of "positive health" resolves itself largely into the inculcation of essential principles in childhood. No comprehensive health scheme can secure continuity unless it so insures itself with the coming generation.

(XXI) Summary of Essential Aspects.

140. There are essential features of this section which the Committee cannot too strongly emphasize. We have stressed throughout that the welfare of the child is the matter of paramount importance in public health.

141. Since nothing could more surely enhance the security and prosperity of the Australian Commonwealth than a rapid and progressive increase in the indigenous population, we strongly urge that everything possible should be done to encourage people to marry earlier and have larger families. We believe that this natural increase in population would result if the Government gave a clear lead and showed its appreciation of the vital importance of the problem by providing better housing facilities, by undertaking to financially assist those prepared to undertake parenthood, and by making provision to improve the amenities and lessen the drudgery of family life. Such provision would entail better care of expectant mothers and the establishment of very large numbers of day nurseries, crèches and kindergartens so that all mothers with young families would have close at hand an establishment where their children could be cared for while they themselves attended to their household duties and shopping.

142. It would also be necessary to provide groups of home helpers who could assist in times of sickness and other emergencies and on a regular roster take charge of homes to enable parents to go out together.

143. We would greatly stress, also, the importance of better supervision of the mental and physical health of every child from birth to adult life. A great improvement in the general well-being of children of the pre-school age would result from the greater availability and much wider use of the day nurseries, crèches and kindergartens not only as a result of the care and training they would receive there but also through the contacts the mothers would make with the trained personnel in charge. During the school period we believe that a much higher standard of health would be achieved if a greatly increased number of playgrounds were provided and if the children were more closely watched for evidence of under-nutrition, lack of parental care, nervous instability and other minor departures from health, and if all schools had attached to them nurses or trained social workers empowered to visit the children's homes whenever it appeared likely that they were suffering as a result of an unsatisfactory environment.

144. We regard the above-mentioned matters as the most urgent social problem facing the Commonwealth at the present time, and would stress the need for taking immediate steps to deal with them. We realize that the implementation of the programme we have outlined would involve the expenditure of a very large sum of money but we feel confident that any public funds available for social security could not be devoted to a better purpose.

145. On such a basis, public health in Australia would be developed on a sure and sound foundation. We believe that in every other field of health the accent must be upon youth. The need, the interpretation and the impact of each phase of preventive medicine must be considered primarily in relation to the children of this country.

146. We reiterate certain recommendations which we have made in this Report, as matters of some special importance.

147. We urge that industrial hygiene should be an active function of Commonwealth and State Health Departments, in close collaboration with Labour, Mines and similar departments. There should be vigorous research into health conditions and hazards of industry, correlation of legislation and statistics, and above all an application of the concept of positive health to the citizen in industry, whether in the factory, the office or on the farm.

148. With regard to tuberculosis, we have recommended as essential principles of the campaign:—

> (*a*) An increase in special rate pensions to the tuberculous and allowances to dependants (but to be not less than repatriation payments in similar cases*);

* The Social Security Committee rate approximated the basic wage.

(b) 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;

(c) Adequate follow-up of contacts and examination by these facilities;

(d) Improved accommodation and facilities for treatment, especially of early cases, in hospitals and sanitoriums, by the most modern methods and technique; and

(e) Greater development of after-care and of rehabilitation including occupational therapy and village settlement of "arrested" cases.

149. We again urge the practical adoption of those measures necessary for an adequate campaign against the menace of venereal disease—

(a) A continued improvement and extension of clinic facilities;

(b) Provision of more bed accommodation for "in-patient" treatment of cases of venereal disease;

(c) Provision of prophylactic facilities for civilians as well as servicemen;

(d) Continued education of the public, provided that such education remains in the hands of responsible medical and health authorities;

(e) Provision for all forms of sports and for recreational and social contacts during hours of leisure; and

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

150. In the field of mental hygiene, we are of the opinion that—

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

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

(c) In any future development, it is very desirable that collaboration in the field of mental hygiene should embrace all medical and health services, since pathological and mental aspects enter into every field of health; and

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

151. We realize the immediate concern to Australia of tropical medicine and hygiene—in the war as in the peace to come. We urge full recognition of the medical and health needs of all those island-groups for which we have a direct—or indirect—responsibility. The Sydney School of Public Health and Tropical Medicine will have increasingly important functions, and we recommend that the school should be enlarged to provide the additional accommodation which will be necessary if it is to discharge fully these functions.

152. We express the hope that early opportunity will be taken, as more normal times return, to convene a conference, representative of governmental, professional and trade interests, to formulate greater uniformity in State legislation and administration relating to food, drugs and poisons.

153. We recommend that all Governments should increasingly recognize the need for health education and propaganda on a basis of sound principles. We believe that sex biology should be taught to children of secondary school age by competent teachers but that parental responsibility for general social conduct and self-discipline must be more widely stressed.

154. We are of the opinion that popular education in regard to venereal disease should be conducted only by health departments or officially recognized medical bodies, and, further, that much unscientific and quasi-scientific advertisement should be controlled in the interests of the public health.

155. For better "health accountancy" throughout the Commonwealth, we recommend that—

(a) Definite and formal co-operation should be established between the statistical and health agencies of Commonwealth and States;

(b) Legislation, where necessary, should be enacted to provide that such statistics as are required shall be furnished by Government departments, friendly societies, industrial and other bodies—such as public hospitals—and by medical practitioners; and

(c) A competent medical officer, with special aptitude and qualifications, such as a university training in statistical method, should be seconded from the Commonwealth Department of Health for service with the Commonwealth Statistician, to organize under the direction of the Statistician, the development of morbidity statistics in Australia.

SECTION II.—HOSPITAL AND ANCILLARY SERVICES AND RESEARCH.

(I) Hospital Services.

(i) *Uniform Hospital Standards and Services, Planning and Administration.*

156. It is evident that at this stage of hospital construction there must be an optimum plan for building each type of hospital that is needed, minor modifications for the differing climatic conditions that occur in the Commonwealth of Australia being the only necessary modifying factor.

157. The existing system of building hospitals in Australia calls for a multiplicity of planning committees, architects, &c., many of whom are approaching the problem for the first time in their careers. Few of the people concerned have had an opportunity to study the problem widely, frequently they have no knowledge of conditions outside the confines of their own small district. The rapid advances in hospital construction, both overseas and in this country, are not known to many who, under our present system, are charged with the responsibility of erecting with public funds hospital accommodation of all types.

158. Of the hospitals in Australia, few, if any, are of a similar type of construction. Such a position obviously calls for the provision of expert advice in all cases in which hospital construction is undertaken, so that every district in the community shall be assured that it will get the best value for the money expended. Hospital construction and equipment is an expert study, and great economies

can be effected by standardization (due regard, of course, being paid to the necessity for the advising body being given adequate opportunity to study all advances in planning and equipment and from time to time modifying its standards to meet any advances in knowledge).

159. We are of opinion that there should be established a Commonwealth expert advisory body charged with the responsibility of studying and giving advice to hospitals throughout Australia on their planning, construction and equipment; that this body should work out uniform standards of planning, construction and equipment suitable for the different climatic localities of Australia; and that all problems of new construction or modifications of existing constructions should be referred to this body for its advice and approval. All new constructions should as far as circumstances permit conform to the standard plan for that size and type of construction regarded as the optimum plan at the date of the projected new construction; the advisory body should be given opportunities of keeping abreast of world development and knowledge in hospital planning, construction and equipment; and it should be a specified condition of Commonwealth subsidy that every subsidized hospital will accept and implement the advice of this advisory body.

160. This body could delegate its authority to a similarly constituted body in each State to carry out the details of administration.

(ii) *Regionalization Plan and Functions.*

161. The objective, so far as a medical health service in Australia is concerned, is to make available to every member of the community the best possible protective and corrective medical care; two further essentials are that the services within the area selected as a unit in the scheme must be properly correlated with others within and outside the area, and that the personnel of the service must be adequate and available. None of these three postulates is at present satisfied in any State of Australia.

162. From the commencement of organized health services the local authority unit has been accepted as the essential unit, and a scheme for regionalization naturally looks primarily to existing local government areas (of which there are nearly 1,000 separately established in this country). It would appear, however, that a complete personal and environmental programme for health in the modern sense, is beyond their individual powers.

163. Studies in other countries indicate that few, if any, local authority areas of 20,000 people or less are equal to the administrative, financial, or specialized professional functions of a complete scheme; that the provision of (say) specialist services or full general and special hospital facilities is beyond a community of less than 100,000 people—doubtless having in mind closely settled areas of that size; and that (say) provision for tuberculosis may conveniently cover 250,000 people; and that provision for mental sickness including all psychiatric aspects should cover 500,000 people.

164. As a generalization it seems that units of 50,000 to 100,000 people can provide both environmental and personal health and medical services within their areas, if specialists are supplied to them as needed, from without, and the largest of their problems dealt with on a "regional" basis or from a national standpoint. In Australia this last category might conveniently include such matters as mental illness, the prevention and care of tuberculosis, of venereal disease, of cancer, &c.

165. From another viewpoint the provision and the need for health and medical services are materially affected by population density, the frequency or specific nature of health hazards, the ease or difficulty of transport services in any area, and the availability of medical men and hospital or other facilities.

166. The first of these considerations, population, introduces a problem in which Australia is almost, if not actually, unique: approximately one-half of the total population is in or about the six State capitals, and the whole remainder of the population is spread very thinly over the populated area of the continent with a relative sprinkling only of large towns. Moreover, more than one-third of the continent is uninhabited because of its arid nature; five-thirteenths of it lies within the tropics; and the early settlement of Sydney, Hobart, Launceston, Melbourne and Adelaide gave an impetus to the south-eastern coastal edge of Australia that still is obvious, in terms of population and facilities.

167. Apart from the general problem, therefore, there is a two-fold aspect: The cities, densely peopled, present the metropolitan aspect—they need regionalization by subdivision and correction of duplicated or overlapping facilities; the rural areas, sparsely peopled and sprinkled with many small towns, villages, and railway sidings or outpost camps, call for regionalization by combination of facilities, the grouping of isolated units, and the provision of supplementary occasional services and betterment of transport services.

168. The maps prepared by the Medical Survey Committee* and associated with their report show the distribution of all hospitals and indicate (if compared with population distribution) their relation to density of population, transport services (rail and road) are also shown though not completely; the distribution of medical practitioners has been determined by lists compiled as carefully as possible by authorities in each State; and the subdividing lines have been drawn subject to these considerations and others. It is noted that, for other purposes (electoral, statistical, police, educational, physiographical, &c.) there are already several existing schemes of subdivision and advantage has also been taken of these in elaborating the series.

169. The subdivision does not show the proposals for regionalization in metropolitan areas. There is already a rough subdivision of activities and facilities in these great city areas, but it has been the accidental result of a multiplicity of private, incidental and governmental interests and influences. To correct it would require the closest and most meticulous activity for an agreed measure of co-operation and would undoubtedly require to be achieved in stages over a period of years. For this reason the Medical Survey Committee has not specified any proposals in detail.

170. In all areas, the actual organization and co-ordination of services which is, in the true sense, regionalization, will depend upon the basis accepted for control and the legislative steps taken to implement it.

171. Both in metropolitan and rural areas, these linkages and correlations are matters for intensive local study by the parties concerned. They may be suggested, as they are in the maps, but they can only be efficiently established in operation after close and frequent discussions between the local (State) authorities and the medical profession.

* Refers to Medical Survey Committee of the Commonwealth Parliamentary Committee on Social Security.

172. It is considered that, even including the *metropolitan areas, this could be achieved within a* few months for some, and in ten years as a measure of planned economy throughout all Australia.

173. The maps prepared to illustrate this section of the Medical Survey Committee's report are, in their order, regionalized plans for—

(*a*) New South Wales;
(*b*) Victoria;
(*c*) Queensland;
(*d*) South Australia;
(*e*) Western Australia;
(*f*) Tasmania; and
(*g*) Population chart, illustrating density of population throughout each of the States, as listed, and for Australia as a whole.

174. The recommendations of the Medical Survey Committee envisage each region in the country, *outlying cottage and district hospitals draining to* a base hospital, which should be fully equipped with all necessary aids to diagnosis and full facilities for treatment, and adequately staffed with specialists to provide every service required in the community. In some regions this need may be met by specialists being allocated to a number of regions which they *visit in turn and periodically.*

175. *The function of the base hospital should thus* be that it is the end point in the region of a series of lesser hospitals from which the general practitioners in the outlying district can refer their patients for further elucidation of the diagnosis, or for surgical or medical treatment by specialists, in those cases with which they themselves do not feel *competent to deal.*

176. Such base hospitals would, of course, need an efficient transport system and the services of an adequate resident medical and nursing staff and a staff for the ancillary services, i.e., physiotherapy, *dietetics, occupational therapy, laboratory and X-ray* techniques, &c., and each self-contained district would also include within its confines adequate *evacuation facilities for sub-acute, chronic and con*valescent patients, so that these patients would not have to leave their own district. These sub-acute and chronic facilities should be completely divorced *from the homes for the aged and infirm, which* should each have its own sick bay to deal with minor illnesses, but whose patients, when they suffer from *more serious maladies, should pass out from the* home and into the care of the hospital organization of the district.

177. Flying doctor services and hospital services in outlying districts should also be extended and *organized to provide lines of evacuation to country* base hospitals.

178. In the cities the teaching hospitals and large metropolitan hospitals correspond to the base hospitals of the country districts. They should be surrounded by a ring of district hospitals suitably located according to density of population and transport facilities, and draining their more difficult and serious cases to the city base hospitals which would also receive cases evacuated from the country base hospitals for elucidation of the diagnosis or treatment *by more highly skilled specialists. The city of* Sydney is reasonably well planned on this basis, but no other city of the Commonwealth meets these needs fully at present.

179. This Committee concurs with the recommendations of the Medical Survey Committee regarding the plan of regionalization, and recommends their adoption as the basis for further detailed study and *recommendation by an expert body. This body* might be the expert advisory body recommended in paragraph 159 of this Report.

(iii) *Teaching Hospitals.*

180. Four cities in Australia, viz., Sydney, Melbourne, Adelaide and Brisbane, conduct teaching *hospitals for medical students. General hospitals* which are medical schools must be regarded in a category distinct from all other types of hospitals. They are the centres on which depend the standard of medical, nursing and ancillary services and research practice throughout the whole Commonwealth. The standard of these services throughout *Australia rises and falls with the standard set by* the teaching hospitals. Because of their teaching function they are necessarily more expensive to *maintain than all other types of hospitals* and their adequate financing is vital to the maintenance of medical, &c., standards and progress in medical science.

181. *Medical schools must be located in close* proximity to a university. The scientific, therapeutic, economic and social advantages of such a liaison are obvious, and such a location conserves the time of teachers and students.

182. The whole trend of world opinion has therefore been towards centralization in a medical centre closely attached to a university, of all the *hospital facilities necessary for the training of the* student. We must show vision in these projects by taking immediate steps to plan such a medical *centre in all the cities concerned, and to ensure that* sufficient land is available at reasonable cost to provide for the ultimate expansion of these centres to the projected maximum needs of the future population of the States. *Such a scheme has been* tentatively planned in Sydney and there are great possibilities in Melbourne and Brisbane to do *similarly. We cannot too strongly stress the need* for immediate attention being directed to this problem so that posterity will not be faced with prohibitive costs of the expansion, which is inevitable as population increases.

(iv) *Out-Patients.*

183. We *believe that there is a need for decentra*lization of out-patient services. Where, in any district, there are not at present reasonable *facilities available for patients to reach the out*patients' departments of hospitals, we recommend that decentralized clinics should be erected, to which patients could be sent for investigation and specialist treatment.

(v) *Hospital Administrators' Course of Training.*

184. We are of opinion that there is an urgent need in this country for the provision of facilities for training of personnel undertaking hospital administration. For too long we have followed the haphazard *method of appointing to these positions,* in most cases, men without previous experience of this specialty. Such a system is not in the best *interests of hospitals, and we therefore recommend* that a specified course of training and apprenticeship should be established to provide better trained personnel for this purpose. Such a system, of which full details are *available to the Social Security Com*mittee, operates in America, and we strongly recommend that a similar type of training be *organized here on a Commonwealth-wide* basis, as the demand is too small for each State to undertake it separately.

(vi) *Hospital Accommodation.*

185. We would preface our remarks on this subject by stating that it is our opinion—

(*a*) That every patient in Australia who, in the opinion of his medical attendant, *needs hospitalization, should be assured* of immediate admission to a hospital suitably equipped for the treatment of his disability;
(*b*) That every medical practitioner should have facilities for treating his patients in his local cottage or district hospital for *such illnesses and injuries as do not* require transfer to a base hospital for specialized treatment; and
(*c*) That it is the duty of those charged with the medical care of the people to ensure that sufficient hospital beds adequately equipped and staffed are available to *meet the requirements for immediate* admission to hospital of all the sick and injured.

186. Hospital accommodation can be considered from two points of view. The first is that of quantity. The report of the Medical Survey Committee shows that, based on world standard requirements, the present estimated population of Australia is 6,690 *beds short in its general hospitals (including* provision for general medicine and surgery, maternity, children, infectious diseases and convalescent patients); 2,963 beds short in hospitals for tuberculosis patients; and 6,994 beds short of the standard accommodation required for mental diseases; a total shortage of all types of beds of 16,647.

187. Proper care of the sick and injured cannot be *achieved in the face of such a desperate lack of* provision for accommodation. This situation should be remedied immediately.

188. While the Medical Survey Committee report *clearly indicates that there is urgent need for many* more hospital beds, it also makes it clear that it would be more efficient and economical if all hospital beds were concentrated into larger units with adequate transport facilities and a resultant decrease in the present large number of minor hospitals. Evidence suggests that the smallest size unit which *can give proper efficiency and be conducted* economically is a 200-bed hospital and in those areas which will support such a number of beds this should *be the minimum unit of construction.*

189. *Detailed consideration of the shortage in* general hospitals reveals that the lack of provision exists chiefly in that for sub-acute and chronic diseases, and that the greatest deficiencies occur in the States of New South Wales and Victoria. The Medical Survey Committee draws urgent attention to the large number of patients suffering from sub*acute and chronic diseases occupying beds at high* maintenance costs in acute general hospitals. The ever-increasing economic loss of this system is disturbing, and *should be remedied at once.*

190. This Committee is of opinion that it is useless making grants to patients of monies for hospital accommodation benefits, free medicines, *&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 sub-acute 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 they should be adequately equipped and staffed* to secure the restoration to health and rehabilitation of these patients.

191. The chronic and sub-acute hospitals serving *metropolitan areas should be located in close relation* to the universities and the teaching hospitals.

192. We are of opinion also that such sub-acute and chronic accommodation should be de-centralized into *regionalized districts, so that these patients are within* reasonable distance of their homes, and that such hospital accommodation should be entirely divorced from that provided as homes for the aged and infirm. If, because of financial stringency, this involves the deferment of any monetary benefit to patients, we are strongly of opinion that this is the only states*manlike view to take, and that it will make an* infinitely greater contribution to the health of the community than any monetary benefit to individuals.

193. The average quality of hospital accommoda*tion leaves, according to the report of the Medical* Survey Committee, much to be desired. We agree with the opinion expressed by that committee that closer supervision of hospitals is urgently necessary, and it is our opinion that no hospital should be registered or permitted to function which fails to measure up to standards of construction, main*tenance, administration, equipment, clinical care of* the patients, and the keeping of standard statistics, as laid down by such an expert Commonwealth body *as has* been recommended previously in this Report.

194. *In maternity hospitals particularly, we draw* urgent attention to the following grave deficiencies in very many hospitals, and which are all too common:—

(*a*) Lack of provision of hostels for expectant mothers awaiting admission;
(*b*) Low standard of accommodation and equipment;
(*c*) Lack of attention to the accommodation and care of the baby, and in the vast majority of hospitals, the entire absence of any provision for the care of the premature or sick baby;
(*d*) Limitation of stay of patients to ten days (*largely influenced by the shortage of* beds);
(*e*) Lack of convalescent accommodation;
(*f*) Inadequate provision in the home of nursing and domestic help, both pre-natal and post-natal; and
(*g*) Inadequate pre-natal supervision of the *expectant mother.*

195. In some hospitals pre natal supervision is provided in the out-patients' department for some expectant mothers In other hospitals and even in *those conducting pre natal clinics, there is need for* a closer liaison between the medical attendant conducting the pre natal care and the hospital.

196. We also recommend that it should be a fixed *condition of subsidy or grant of capital expenditure* to any hospital that such financially assisted hospital must not refuse admission to any patient requiring treatment, except on the ground that every bed in the hospital is occupied at the time of the patients' application.

197. We are also of opinion that ambulance services should be placed under the direct control of hospitals.

(vii) *Admission of Patients to Hospitals.*

198. We recommend that in all metropolitan areas there should be established a central hospital admission depot. This depot would assume control of the admission of all patients to subsidized hospitals which would be responsible for keeping the depot informed of their bed states. Each such depot should be under the control of a medical officer.

(II) Ancillary Services (Nursing, Physiotherapy, Technicians, Almoners, &c).

(i) *Nursing Services.*

199. We are of opinion that there should be a standard course of training, standard conditions (subject to basic wage variations), and uniform registration for all nurses in Australia. We believe that the details of such a scheme should be worked out by a conference of representative medical men and nurses appointed for that purpose.

200. We recommend also that all nurses should undergo a course of preliminary training; that such courses should, as far as possible, be centralized into a college of nursing, and that, exclusive of the preliminary training course, a nurse's training should extend to four years, three years being spent in general training, nine months in obstetric training, and three months in specialist training. We further recommend that the three years general training should include periods in which nurses are seconded to special hospitals for instruction and training in infectious diseases and also in any other specialty which the general hospital does not provide in sufficient amount.

(ii) *Other Ancillary Services; Technicians, Physiotherapy, Laboratory and X-ray, Dieticians, Almoners, &c.*

201. All these services are now an integral and important section of hospital service, and should extend as far at least as district hospitals in the city and base hospitals in the country. Properly organized courses of training exist for some, and need establishment or improvement for others. These defects should be made good to ensure a steady flow of skilled staff to conduct these important aids to efficient diagnosis and treatment.

(III) Research and Powers of the National Health and Medical Research Council.

202. Consideration of this matter by the Medical Planning Committee was deferred.

SECTION III.—MEDICAL SERVICES.

(I) Medical and Health Services.

203. Having regard to all the circumstances and to the need for early and substantial reorganization of, and improvement in, health services generally as indicated herein, we consider that a Comprehensive Health Service should be one directed to the achievement of positive health and the prevention of disease, no less than to the relief of sickness; and should be available to every individual in the community.

204. It should normally provide the services of any necessary consultants and specialists, laboratory services, and all ancillary services, together with institutional provision when required. The several parts of this Comprehensive Health Service should be closely co-ordinated and developed by the application of a planned national health policy.

205. We believe that, in the setting up of any comprehensive health service, the preservation of the doctor-patient relationship of the family doctor and of the principle of free choice of doctor is essential.

206. For the provision of such a service it is necessary to subdivide the populated areas into: (i) remote areas; (ii) country areas; and (iii) metropolitan or city areas. Each of these will now be dealt with in turn.

(i) *Remote Areas.*

207. For remote areas a voluntary full-time salaried or subsidized 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 is essential; such services to be established and extended as necessary.

208. We consider a "remote area" in this sense to be—

(a) An area with 1,000 people* or more resident within a radius of 25 miles and unprovided with a doctor; and/or

(b) Any area in which the medical necessities of the whole area can be met by a hospital provision of twenty beds or less.

209. In all such appointments, the emolument and conditions of service should be such as to make the post attractive to a good type of competent medical practitioner; in particular, they should include specific facilities for adequate post graduate study.

210. With regard to the provision of specialist and consultant services, circumstances may dictate one of three solutions, namely—

(a) The building up at the nearest base of specialists of general practitioner standing; or

(b) The provision at regular intervals of service through visiting specialists as required; or

(c) The transfer of patients needing specialist service to the nearest base centre or capital city.

211. Such specialist services might, in accordance with circumstances, be paid on a fee-for-service, sessional or salaried basis.

212. To ensure co-ordination between the practice of preventive and curative medicine, the medical practitioners should also be the medical officers of health for their respective areas and, as such, should be specifically responsible to the regional or district health officer.

(ii) *Country Areas.*

213. Country areas fall naturally into the divisions—*minor and major country centres.* Country centres are larger country towns often situated at rail junctions, ports, road or rail heads where they act as natural centres for areas varying in population. According to their size they show a more or less complete sufficiency for general medical purposes other than the most highly specialized. The larger centres are the towns suited to be key towns in any plan for districting or regionalization of medical and hospital services. It has been generally accepted, and this Committee agrees, that it is desirable that there should be a regionalization of the populated area into medical and hospital districts. *(See also paragraphs 161 to 173.)*

214. Medical practice (as at present provided by a private practitioner or governmental service) in these, or in any area, may include—

(a) Consulting room practice;

(b) Domiciliary practice;

(c) Institutional practice;

* In even less populated districts, the flying doctor service operates and will be mentioned later.

(d) Preventive practice in respect to health; and

(e) Specialist practice.

215. *Consulting Room Practice.*—Patients may consult a medical practitioner either at the rooms of a practitioner privately or, in certain circumstances, at general hospitals or at institutional or at group centres either private or governmental, in which several practitioners collaborate.

216. The essential advantage of individual consultative practice is its privacy and its maintenance, at the highest level, of the confidential patient-doctor relationship. In a great proportion of cases such consultations can immediately meet the patient's requirements, but in a lesser proportion of cases some consultation with medical colleagues is desirable. As a matter of traditional practice there has grown up for convenience a tendency to concentrate medical activities in certain streets and, indeed, in certain blocks of buildings where doctors, while preserving their individuality, nevertheless have access to the assistance of their fellows, as desired. In some instances this has resulted in the establishment of group centres and group practice Such group centres, definitely organized, might materially assist to complete the medical provision available to the patient.

217. *Domiciliary Practice.*—The viewpoint as to domiciliary visiting has materially changed in recent years owing to modern economic trends, life in flats and apartments, difficulties in respect of domestic service, improved facilities and availability of hospitals, &c. The essential purpose of domiciliary visiting is the diagnosis and assessment of severity of the case, and this may obviously require more visits than one. Whilst the great advances that have been made in medicine in recent years have resulted in a greater proportion of patients being admitted to hospitals, there will always be a considerable proportion of patients who, by reason of the nature of the illness from which they are suffering, will require medical care in their own home. Obviously domiciliary visiting will, therefore, remain a considerable part of medical practice.

218. *Institutional Practice.*—In minor and major country centres institutional activities may include—

(a) A public hospital partly or wholly financed by the Government;

(b) Voluntary hospitals partly or wholly financed by subscriptions; and

(c) Private hospitals which may or may not be denominational.

219. In many instances, but not in all, every locally practising medical practitioner has the right to follow his patient into any one of these hospitals. Insofar as this is to the interest of the patient, this policy should be maintained. 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. 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. *(See* also paragraphs 174 to 176.)

220. The growing out-patient problem in certain of the larger country centres is dealt with later in the discussion of this problem in city or metropolitan areas, and also in paragraph 183.

221. *Preventive Practice in Respect of Health.*—Preventive services which, at one time, included only the sanitation of environment, have grown with increasing recognition of the objective of positive health and with increasing governmental participation to comprise a considerable range of activities, of which routine sanitation is now a minor aspect only

222. Preventive health procedures find expression in many ways, from maternal and child welfare centres, pre-school clinics and school health services to, for example, physical education and national fitness activities.

223. These are at present inadequately co-ordinated and they insufficiently utilize and correlate the special facilities the private practitioner can provide in that regard.

224. Preventive health work, moreover, has assumed the dimensions of a specialty and should be regarded as such.

225. In country towns acting as major or minor centres, such activities should be collected, where possible, into one building which should function as a community health centre under the direction of a district medical officer of health for the area concerned, to whom the medical officers of health in subsidiary areas should be responsible.

226. The activities thus co-ordinated should be carried out by the medical, nursing and ancillary personnel trained for these specialized works, in co-operation with the practising profession and in pursuance of the policy of correlating preventive and curative medicine.

227. *Specialist Practice.*—In respect of specialist facilities there should be a considerable planned extension of diagnostic provision. This should extend to every major country centre which is or becomes the basic centre for any regional service. Such aids should include—

(a) Complete laboratory diagnostic facilities; and

(b) Radiological diagnostic facilities.

228. With regard to other specialist services we have already expressed three alternatives in paragraph 210 above relating to remote areas. The particular provision in any minor or major country centre would be determined in each case by the local circumstances.

229. The natural evolution of medical practice has led to the development of specialist service in the major country centres. Such development has been assisted to a great extent by the opportunities afforded to Australian graduates to obtain higher qualifications through the agency of the universities and the Royal Australasian Colleges of Surgeons and Physicians. The facilities for such post-graduate medical training should be advanced in every possible way.

(iii) *Metropolitan or City Areas.*

230. Medical practice in metropolitan or city areas comprises all those activities mentioned under paragraph 214 *(country areas)* in an intensified form and, moreover, includes the university teaching centres, where such exist, and the governmental departments controlling the various aspects of health and medical services financed from government revenue.

231. In metropolitan and city and certain industrialized areas of low income level, there is an obvious inequality of distribution of medical services, and particularly of medical personnel. This is undoubtedly related to economic causes.

232. In such areas patients cannot pay for a full medical service, and doctors must, to obtain an adequate income, work at the expense of their professional efficiency. This is neither satisfactory nor equitable to doctor or to patient.

233. Increasing numbers of persons seek treatment at the out-patient departments of public hospitals, often travelling miles to secure it and wasting many hours of working time in the process and in waiting time. In cities this has of late years become a serious feature of administrative medical disability.

234. The services such patients require could, under a better organized scheme, and should, be secured from medical practitioners available within reasonable distances of the homes of the patients.

235. Moreover, the efficiency of hospitals should not be handicapped by the out-patient problem, and the care of out-patients should be returned to the general medical practitioner, by correction of the economic disability that at present intervenes, to detach such patients from him.

236. Obviously, any such change must be made in a way that suggests no discrimination or inequality of benefit to particular sections of the public and also in such a way as to use the public funds required to correct the situation strictly in accordance with the principles of economic administrative procedure.

237. The British Medical Association has requested that it be charged and entrusted with the care of the health of the public and has agreed that regionalization of activity is the ideal method of decentralizing control in this regard.

238. In respect of institutional provision it has laid it down that it "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 condition from which he suffers and not because of individual prejudice or preference".

(Medical schools exist only at Sydney, Melbourne, Brisbane and Adelaide, but similar considerations apply in other metropolitan or city areas).

239. In such areas the actual process of growth of the city has often provided a regionalization into wards, or local government areas, or actual geographical or industrial subdivisions that lend themselves readily to the proposal for decentralized control of medical care. Such subdivisions usually have their own hospital provision, preventive service centres and local specialist groups.

240. The tendency of the day is to emphasize the trend to specialization and differentiation of institutional provision, pointed out by the British Medical Association.

241. In conformity with it there should be in each such metropolitan or city area a subdivision into proper medical wards or districts, each self-contained for medical and health services other than the most specialized, and, with a central institution or series of institutions (available to all subdivisions), to provide these highly specialized services for the whole area.

242. Within each subdivision the medical and health needs of the community concerned should be the responsibility of the medical profession. The preventive health services should, as in country centres, be aggregated at a community health centre under the direction of the district medical officer of health. The institutional services should be organized about a base or district hospital with such public or private subsidiaries as may be required. The general practice (including what is now out-patient practice) should return to the general practitioner as his admitted field, and should relieve the undue and inappropriate burden upon hospitals. Such adjustment should be made economically so as to ensure that no injustice is suffered by patient or doctor and that governmental funds are applied with equality and economy.

243. Payment for these services will be discussed later. It might be made by fee for service, by capitation fee, by salary, or by a combination of any or all of these methods. Whatever scheme is adopted, a regional service of administrative supervision will be necessary to prevent abuses. In respect of professional matters, this should be entirely in the hands of the medical personnel concerned acting as a whole; and in respect of administrative and economic matters, should be in the hands of an appropriate body upon which the medical personnel of the area should have adequate representation.

244. It may be added at this stage that, insofar as the public is concerned, the Government in power is already levying a graduated income tax upon all but those unable to pay anything whatever, and of this sum of £30,000,000 annually collected for social services, part has been set apart as a prepayment of medical care to the extent to which the Government is prepared to provide medical and health services and benefits from revenue. To that extent the whole population has already purchased an interest in the proposals for the care of its health and welfare and will continue to do so from year to year.

245. Provision for the needs of the public should obviously be made in the most convenient manner. For hospital and institutional services the method is stated in the proposals of the British Medical Association quoted above; for preventive measures a community health centre in each district is advised; for domiciliary and minor medical care the services of individual general medical practitioners within the district, at the choice of the patient, are necessary.

246. These should be provided from the consulting rooms of the practitioner concerned, which may either be at his home, at a central group-practice centre, or partly at one and partly at the other. For convenience it would appear undoubted that group-practice centres, located where population density and transport facilities indicate ideal sites, would materially assist the convenience both of the public and the practitioner for general consultative purposes. For domiciliary visiting and emergency work, night work and regulation of hours of work, arrangements might readily be made through a system of group-practice in the case of those medical men willing to join such groups and to profit by the joint clerical, telephonic, administrative and record systems available at the group centres.

247. The British Medical Association has in this connexion appropriately said that "greater efficiency and economy would be secured and less expense incurred if groups of practitioners would co-operate to conduct a single centre at which all of them would see their own patients and share equipment and the services of secretarial, domestic and dispensing staff. The value of the practitioner to his patients would gain immeasurably from his close and constant contact with his colleagues."

248. No medical practitioner, however, within the district should be compelled to enter any scheme. We are of the opinion that adherence to any scheme should be purely voluntary. The essential principle should be that the medical and health services of the area are adequately available at need to every resident member of the community concerned.

249. The function of the Government should be to provide that where this is not the case, adequate provision is made to meet the deficiency by appropriate means.

(II) Experimental Group-Practice Centres.

250. In conformity with what has been said about the desirability of group-practice centres, particular attention has been paid to the tentative recommendation of the Joint Committee on Social Security in its Sixth Interim Report as to the establishment of services at "out-patient and consulting clinics" located in the centres of population in urban areas and country towns, equipped with all modern diagnostic aids and treatment facilities, supervised by a salaried medical liaison officer responsible to the central health administration and controlled generally by the medical personnel of each clinic.

251. It was further recommended by the Joint Committee that under such a system of voluntary participation, general practitioners 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 what would in effect be a part-time salaried basis.

252. Further discussion of this scheme indicated the desirability not only of testing it experimentally, but also of extending the investigation to other schemes, differing in detail but essentially based upon group practice.

253. We therefore recommend that experimental group-practice centres be set up at carefully selected places in Australia where different sets of conditions, different types of practice and different methods of payment for services might be tested fully for practicability—careful records being made of every aspect of each situation, in order that an ideal scheme might ultimately be formulated, sufficiently elastic to be applicable to the varying circumstances and conditions that operate in different parts of Australia.

(III) Availability of Specialist Services.

254. We agree with the British Medical Association in Australia that 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 treatment, the successful employment of which involves specialized knowledge and experience, and, in many cases, complex and expensive apparatus. 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.

255. Having regard to geographical conditions and the proposed hospital distribution, the future development and organization of special investigational centres should be in connexion with the main metropolitan and base hospitals in the country Private consultative and specialist practice should continue within and without the hospitals.

256. The payment for specialist services (where payment is made) will vary according to the circumstances and might accordingly be upon a fee-for-service, a sessional, a subsidized, or a salaried basis.

(IV) Flying Doctor Services and Air Ambulance Transport.

257. The aerial transport of patients, which was beginning to play a very important part in the service to persons in remote areas prior to the present war, has assumed infinitely greater importance during it. We are of the opinion that in many instances ambulance transport by air is speedier, more comfortable and less damaging to patients than road transport for distances of 50 miles and upwards

258. The accommodation as to specialist services and the establishment of regionalized areas based on central towns indicate the related necessity for a considerable development, not only for routine medical service in areas of sparse population at considerable distances, but also for rapid transport of patients to specialized hospitals and facilities.

259. We consider there should be a post-war development of a series of aerial bases properly distributed in relation to selected major and minor centres, both city and rural, and providing—

(*a*) "Flying doctor" services, including specialist services to the most remote and otherwise unstaffed areas; and

(*b*) Air ambulance services from any area to the centre appropriate for specialized treatment in individual cases.

260. The "flying doctors" appointed to routine service in respect of (*a*) above, and nursing and ancillary personnel, should be employed under terms and conditions providing adequate salary and living conditions and with a degree of comfort somewhat greater than the provision of the bare amenities of life, and with either short term appointments or regular opportunities for "refresher" and post-graduate study courses.

261. The development of transceiver facilities should proceed equally in all areas thus serviced.

(V) Medical Education and Post-Graduate Study.

262. A deficiency in the education of medical students at present is the fact that their education has been directed almost exclusively to medical and surgical procedures of a curative nature.

263. More and more the aspects of positive health are gaining recognition. More than twenty years ago it was strongly urged by members of the medical profession that those aspects which are included within the term "social medicine," i.e., preventive

medicine, public health technique, hygiene and sanitation, industrial hygiene and similar activities leading to positive health, must be recognized as being not only essential aspects of medical education but must be presented to the student in a practical form in order that he may subsequently apply them in practice as a medical practitioner.

264. It is in our opinion advisable that there should be in each university a chair of social medicine, deliberately directed to this objective and embracing those activities and related activities in the medical and all other faculties. The national importance of this objective suggests that the Commonwealth Government might legitimately endow or sustain such chairs.

265. It has consistently been advocated that the preventive side of medicine should be stressed throughout the whole of the medical course and it is in our opinion advisable that specific attention should be given to this aspect in each year of the medical course in a progressive manner, and that the lectures should be associated with practical work in connexion with those outside activities including Commonwealth and State Departments, industrial organizations and related services which make these their function.

266. Moreover, in respect of general training, the curriculum of the medical student is governed to a great degree by the fact that it is bound to set aspects of hospital practice in special teaching hospitals. The student learns in city hospitals the grossly abnormal, but to some extent fails to familiarize himself with the minor ailments and incipient indications of disease which form a considerable and a very important part of general medical practice.

267. It is recommended that in the last two of his three years' clinical course there should be an improvement upon the present provision of a closer association of the student with the work of out-patients departments and the suggested group-practice centres. This combination of major and minor, or externe and interne medical experience, has manifest advantages.

268. Specific reference is made elsewhere in this *report to the desirability of establishing a chair* of midwifery at each State university, whether a faculty of medicine exists at that university or not. We strongly endorse this view as an improved aspect of medical education.

269. *At the conclusion of* his *medical* course, and before being permitted to undertake general practice, it is our opinion that there should be a compulsory period of hospital experience for all medical graduands. This period might profitably be not less than twelve months. Subsequent to the satisfactory performance of this period of hospital work, medical graduands should be registered for general medical practice.

270. Subsequent to registration, it is desirable in the interests of the patient that medical men should from time to time have opportunities to familiarize themselves with advances in scientific knowledge for application to general practice. It is only necessary in this connexion to mention the advantages that would accrue from special provision for medical men of post-graduate training at the times of such discoveries as those of insulin, drugs of the sulphanilamide group and, to quote a most recent instance, their application to the correction of venereal diseases, bacillary, dysentery, pneumonia, &c.

271. Economic circumstances frequently prevent medical practitioners benefiting in this way, though *they may earnestly desire so to do. Since the matter* is one obviously directed towards the improvement of general practice in the interests of the patient, it is advocated that provision should be made to put such post-graduate facilities within the reach of every medical practitioner, both urban and rural, at appropriate intervals.

MEDICAL REGISTRATION.

272. We are agreed that there would be many advantages in a Commonwealth system of medical registration. Such a system would ensure uniformity of qualification and the maintenance of high ethical standards throughout the medical profession in Australia. We believe that this could be best achieved by Commonwealth legislation with such decentralized administration as is necessary. If constitutional *difficulties still persist, a uniform* legislative code should be agreed upon for adoption in all States and the Commonwealth territories.

For and on behalf of the Committee,

H. C. BARNARD, Chairman, Joint Committee on Social Security.

H. S. NEWLAND, President, Federal Council, British Medical Association in Australia.

Canberra, 1st March, 1944.

APPENDIX "B"

TO THE

EIGHTH INTERIM REPORT

FROM THE

COMMONWEALTH PARLIAMENTARY JOINT COMMITTEE ON SOCIAL SECURITY

BEING

RECOMMENDATION CONCERNING MEDICAL CARE

ADOPTED BY THE

INTERNATIONAL LABOUR CONFERENCE.

AT ITS

Twenty-sixth Session, Philadelphia, 1944.

RECOMMENDATION (No. 69) CONCERNING MEDICAL CARE.

The General Conference of the International Labour Organization—

Having been convened at Philadelphia by the Governing Body of the International Labour Office, and having met in its Twenty-sixth Session on 20th April, 1944; and

Having decided upon the adoption of certain proposals with regard to the question of medical care services which is included in the fourth item on the agenda of the Session; and

Having determined that these proposals shall take the form of a recommendation,

adopts, this twelfth day of May, 1944, the following recommendation which may be cited as the Medical Care Recommendation, 1944:—

Whereas the Atlantic Charter contemplates "the fullest collaboration between all nations in the economic field with the object of securing for all improved labour standards, economic advancement and social security"; and

Whereas the Conference of the International Labour Organization, by a resolution adopted on 5th November, 1941, endorsed this principle of the Atlantic Charter and pledged the full co-operation of the International Labour Organization in its implementation; and

Whereas the availability of adequate medical care is an essential element in social security; and

Whereas the International Labour Organization has promoted the development of medical care services—

by the inclusion of requirements relating to medical care in the Workmen's Compensation (Accidents) Convention, 1925, and the Sickness Insurance (Industry, &c.) and (Agriculture) Conventions, 1927,

by the communication to the Members of the Organization by the Governing Body of the conclusions of meetings of experts relating to public health and health insurance in periods of economic depression, the economical administration of medical and pharmaceutical benefits under sickness insurance schemes, and guiding principles for curative and preventive action by invalidity, old-age and widows' and orphans' insurance,

by the adoption by the First and Second Labour Conferences of American States of the resolutions constituting the Inter-American Social Insurance Code, by the participation of a delegation of the Governing Body in the First Inter-American Conference on Social Security which adopted the Declaration of Santiago de Chile, and by the approval by the Governing Body of the Statute of the Inter-American Conference on Social Security, established as a permanent agency of co-operation between social security administrations and institutions acting in concert with the International Labour Office, and

by the participation of the International Labour Office in an advisory capacity in the framing of social insurance schemes in a number of countries and by other measures; and

Whereas some Members have not taken such steps as are within their competence to improve the health of the people by the extension of medical facilities, the development of public health programmes, the spread of health education, and the improvement of nutrition and housing, although their need in that respect is greatest, and it is highly desirable that such Members take all steps as soon as possible to reach the international minimum standards and to develop these standards; and

Whereas it is now desirable to take further steps for the improvement and unification of medical care services, the extension of such services to all workers and their families, including rural populations and the self-employed, and the elimination of inequitable anomalies, without prejudice to the right of any beneficiary of the medical care service who so desires to arrange privately at his own expense for medical care; and

Whereas the formulation of certain general principles which should be followed by Members of the Organization in developing their medical care services along these lines will contribute to this end:

The Conference recommends the Members of the Organization to apply the following principles, as rapidly as national conditions allow, in developing their medical care services with a view to the implementation of the fifth principle of the Atlantic Charter, and to report to the International Labour Office, as requested by the Governing Body, concerning the measures taken to give effect to these principles.

I.—General.

Essential Features of a Medical Care Service.

1. A medical care service should meet the need of the individual for care by members of the medical and allied professions and for such other facilities as are provided at medical institutions—

(*a*) With a view to restoring the individual's health, preventing the further development of disease and alleviating suffering, when he is afflicted by ill health (curative care); and

(*b*) With a view to protecting and improving his health (preventive care).

2. The nature and extent of the care provided by the service should be defined by law.

3. The authorities or bodies responsible for the administration of the service should provide medical care for its beneficiaries by securing the services of members of the medical and allied professions and by arranging for hospital and other institutional services.

4. The cost of the service should be met collectively by regular periodical payments which may take the form of social insurance contributions or of taxes, or of both.

Forms of Medical Care Service.

5. Medical care should be provided either through a social insurance medical care service with supplementary provision by way of social assistance to meet the requirements of needy persons not yet covered by social insurance, or through a public medical care service.

6. Where medical care is provided through a social insurance medical care service—

(*a*) Every insured contributor, the dependent wife or husband and dependent children of every such contributor, such other dependants as may be prescribed by national laws or regulations, and every other person insured by virtue of contributions paid on his behalf, should be entitled to all care provided by the service;

(*b*) Care for persons not yet insured should be provided by way of social assistance if they are unable to obtain it at their own expense; and

(*c*) The service should be financed by contributions from insured persons, from their employers, and by subsidies from public funds.

7. Where medical care is provided through a public medical care service—

(a) Every member of the community should be entitled to all care provided by the service;

(b) The service should be financed out of funds raised either by a progressive tax specifically imposed for the purpose of financing *the medical care service or of financing* all health services, or from general revenue.

II.—Persons Covered.

Complete Coverage.

8. The medical care service should cover all members of the community, *whether* or not *they are gainfully* occupied.

9. Where the service is limited to a section of the population or to a specified area, or where the contributory mechanism already exists for other branches of social insurance and it is possible ultimately to bring under the insurance scheme the whole or the majority of the population, social insurance may be appropriate.

10. Where the whole of the population is to be covered by the service and it is desired to integrate medical care with general health services, a public service *may* be appropriate.

Coverage through a Social Insurance Medical Care Service.

11. Where medical care is provided through a social insurance medical care service, all members of the community should have the right to care as insured persons, or, pending their inclusion in the scope of insurance, should have the right to receive care at the expense of the competent authority when unable to provide it for themselves.

12. All adult members of the community (that is to *say, all persons* other than children as defined in paragraph 15) should be required to pay insurance contributions if their income is not below the subsistence *level. The dependent wife or husband of a contributor* should be insured in virtue of the contribution of her or his breadwinner, without any addition on that account.

13. Other adults who prove that their income is below the subsistence level, including indigents, should be entitled to care as insured persons, the contribution being paid on their behalf by the competent authority. Rules defining the subsistence level in each country should be laid down by the competent authority.

14. If and so long as adults unable to pay a contribution are not insured as provided for in paragraph 13, they should receive care at the expense of the competent authority.

15. All children (that is to say, all persons who are under the age of sixteen years, or such higher age as may be prescribed, or who are dependent on others for *regular support while continuing their general* or vocational education) should be insured in virtue of the contributions paid by or on behalf of adult insured persons in general, *and no additional* contribution should be payable on their behalf by their parents or guardians.

16. If and so long as children *are not insured as* provided for in paragraph 15, because the service does not yet extend to the whole population, they should be insured in virtue of the contribution paid by or on behalf of their father or mother without any additional contribution being payable on their behalf. Children for whom medical care is not so provided should, in case of need, receive it at the expense of the competent authority.

17. Where any person is insured under a scheme of social insurance for cash benefits or is receiving benefit *under such a scheme*, he and his qualified dependants as defined in paragraph 6, should also be insured under the medical care service.

Coverage through a Public Medical Care Service.

18. Where medical care is provided through a public medical care service, the provision of care should not depend on any qualifying conditions, such as payment *of taxes or compliance with a means* test and all beneficiaries should have an equal right to the care provided.

III.—The Provision of Medical Care and its Co-ordination with General Health Services.

Range of Service.

19. Complete preventive and curative care should be constantly available, rationally organized and, so far as possible, co-ordinated with general health services.

Constant Availability of Complete Care.

20. Complete preventive and curative care should be available at any time and place to all members of the community covered by the service, on the same conditions, without any hindrance or barrier of an *administrative, financial or political nature*, or otherwise unrelated to their health.

21. The care afforded should comprise both general-practitioner and specialist out- and in-patient care, including domiciliary visiting; dental care; nursing care at home or in hospital or other medical institutions; the care given by qualified midwives and other maternity services at home or in hospital; maintenance in hospitals, convalescent homes, sanatoria or other medical institutions; so far as possible, the requisite dental, pharmaceutical and other medical or surgical *supplies, including artificial limbs;* and the care furnished by such other professions as may at any time be legally recognized as belonging to the allied *professions.*

22. All care and supplies should be available at any time and without time limit, when and as long as they are needed, subject only to the doctor's judgment and to such reasonable limitations as may be imposed by the technical organization of the service.

23. Beneficiaries should be able to obtain care at the centres or offices provided, wherever they happen to be *when the need arises, whether at their place* of residence or elsewhere within the total area in which the service is available, irrespective of their membership in any particular *insurance institution, arrears in* contributions or of other factors unrelated to health.

24. The administration of the medical care service should be unified for appropriate health areas sufficiently large for a self-contained and well-balanced service, and should be centrally supervised.

25. Where the medical care service covers only a section of the population or is at present administered by different types of *insurance institutions* and authorities, the institutions and authorities concerned should provide care for their beneficiaries by securing collectively the services of members of the medical and allied professions, and by the joint establishment or maintenance of health centres and other medical institutions, pending the regional and national unification of the services.

26. *Arrangements* should be made by the administration of the service for securing adequate hospital and other residential accommodation and care, either by *contracts with existing public and* approved private institutions, or by the establishment and maintenance of appropriate institutions.

Rational Organization of Medical Care Service.

27. The optimum of medical care should be made readily available through an organization that ensures the greatest possible economy and efficiency by the pooling of knowledge, staff, equipment and other resources and by close contact and collaboration among *all participating members of the medical and allied* professions and agencies.

28. The wholehearted participation of the greatest possible number of members of the medical and allied professions is essential for the success of any national medical care service. The numbers of general practitioners, specialists, dentists, nurses and members of other professions within the service should be adapted to the distribution and the needs of the beneficiaries.

29. Complete diagnostic and treatment facilities, including laboratory and X-ray services, should be available to the general practitioner, and all specialist advice and care, as well as nursing, maternity, pharmaceutical and other auxiliary services, and residential accommodation, should be at the disposal of the general practitioner for the use of his patients.

30. *Complete and up-to-date technical equipment* for all branches of specialist treatment, including dental care, should be available, and specialists should have at *their disposal all necessary hospital and research facilities*, and auxiliary out-patient services such as nursing, through the agency of the general practitioner.

31. To achieve these aims, care should preferably be furnished by group practice at centres of various kinds working in effective relation with hospitals.

32. Pending the establishment of, and experiments with, group practice at medical or health centres, it would be appropriate to obtain care for beneficiaries from members of the medical and allied professions practising at their own offices.

33. Where the medical care service covers the majority of the population, medical or health centres *may appropriately be built, equipped and operated* by the authority administering the service in the health area, in one of the forms indicated in paragraphs 34, *35* and *36*.

34. Where no adequate facilities exist or where a system of hospitals with out-patient departments for general-practitioner and specialist treatment already obtains in the health area at the time when the medical care service is introduced, hospitals may appropriately be established as, or developed into, centres providing all kinds of in- and out-patient care and complemented by *local outposts for* general-practitioner care and for auxiliary services.

35. Where general practice is well developed outside the hospital system while specialists are mainly consultants and working at hospitals, it may be appropriate to establish medical or health centres for non-residential general-practitioner care and auxiliary services, and to centralize specialist in-patient and out-patient care at hospitals.

36. Where general and specialist practice are well developed outside the hospital system, it may be appropriate to *establish medical or health centres* for all non-residential treatment, general-practitioner and specialist, and all auxiliary services, while cases needing residential care are directed *from the centres to the* hospitals.

37. Where the medical care service does not cover the majority of the population but has a substantial number of beneficiaries, and existing hospital and other *medical facilities are inadequate*, the insurance institution, or insurance institutions jointly, should establish a system of medical or health centres which affords all care, *including hospital accommodation* at the main centres, and, so far as possible, transport arrangements; such centres may be required more particularly in sparsely settled areas *with a scattered insured* population.

38. Where the medical care service covers too small a section for complete health centres to be an economical *means of serving its beneficiaries, and existing* facilities for specialist treatment in the area are inadequate, it may be appropriate for the insurance institution, or the institutions jointly, to maintain posts at which specialists attend beneficiaries as required.

39. Where the medical care service covers a relatively small section of the population concentrated in an area with extensive private practice, it may be appropriate for the members of the medical and allied professions participating in the service to collaborate at centres rented, equipped and administered by the *members, at which both* beneficiaries of the service and private patients receive care.

40. Where the medical care service covers only a small number of beneficiaries who are scattered over a populated area with adequate existing facilities, and voluntary group practice as provided for in paragraph 39 is not feasible, beneficiaries may appropriately receive care from members of the medical and allied professions practising at their own offices, and at public and approved private hospitals and other medical institutions.

41. *Travelling clinics in motor vans or aircraft*, equipped for first-aid, dental treatment, general examination and possibly other health services such as maternal and infant health services, should be provided for serving areas with a scattered population and remote from towns or cities, and arrangements should be made for the free conveyance of patients to centres and hospitals.

Collaboration with General Health Services.

42. There should be available to the beneficiaries of the medical care service all general health services, being services providing means for the whole community and or groups of individuals to promote and protect their health while it is not yet threatened or known to be threatened, whether such services be given by members of the medical and allied professions or otherwise.

43. The medical care service should be provided in close co-ordination with general health services, either by means of close collaboration of the social insurance institutions providing medical care and the authorities administering the general health services, or by combining medical care and general health services in one public service.

44. Local co-ordination of medical care and general health services should be aimed at either by establish*ing medical care centres in proximity to* the headquarters for general health services, or by establishing common centres as head-quarters for all or most health services.

45. The members of the medical and allied professions participating in the medical care service and working at health centres may appropriately undertake such general health care as can with advantage be given by the same staff, including immunization, examination of school children and other groups, advice to expectant mothers and mothers with infants, and *other* care of a like nature.

IV.—The Quality of Service.

Optimum Standard.

46. The medical care service should aim at providing the highest possible standard of care, due regard being paid to the importance of the doctor-patient relationship and the professional and personal responsibility of the doctor, while safeguarding both the interests of the beneficiaries and those of the professions participating.

Choice of Doctor and Continuity of Care.

47. The beneficiary should have the right to make an initial choice, among the general practitioners at the disposal of the service within a reasonable distance from his home, of the doctor by whom he wishes to be attended in a permanent capacity (family doctor); he should have the same right of choice for his children. These principles should also apply to the choice of a dentist as family dentist.

48. When care is provided at or from health centres, the beneficiary should have the right to choose his centre within a reasonable distance from his home and to select for himself or his children a doctor and a dentist among the general practitioners and dentists working at this centre.

49. Where there is no centre, the beneficiary should have the right to select his family doctor and dentist among the participating general practitioners and dentists whose office is within a reasonable distance from his home.

50. The beneficiary should have the right subsequently to change his family doctor or dentist, subject to giving notice within a prescribed time, for good reasons, such as lack of personal contact and confidence.

51. The general practitioner or the dentist participating in the service should have the right to accept or refuse a client, but may not accept a number in excess of a prescribed maximum nor refuse such clients as have not made their own choice and are assigned to him by the service through impartial methods.

52. The care given by specialists and members of allied professions, such as nurses, midwives, masseurs and others, should be available on the recommendation, and through the agency, of the beneficiary's family doctor who should take reasonable account of the patient's wishes if several members of the specialty or other profession are available at the centre or within a reasonable distance of the patient's home. Special provision should be made for the availability of the specialist when requested by the patient though not recommended by the family doctor.

53. Residential care should be made available on the recommendation of the beneficiary's family doctor, or on the advice of the specialist, if any, who has been consulted.

54. If residential care is provided at the centre to which the family doctor or specialist is attached, the patient should preferably be attended in the hospital by his own family doctor or the specialist to whom he was referred.

55. Arrangements for the general practitioners or dentists at a centre to be consulted by appointment should be made whenever practicable.

Working Conditions and Status of Doctors and Members of Allied Professions.

56. The working conditions of doctors and members of allied professions participating in the service should be designed to relieve the doctor or member from financial anxiety by providing adequate income during work, leave and illness and in retirement, and pensions to his survivors, without restricting his professional discretion otherwise than by professional supervision, and should not be such as to distract his attention from the maintenance and improvement of the health of the beneficiaries.

57. General practitioners, specialists and dentists, working for a medical care service covering the whole or a large majority of the population, may appropriately be employed whole time for a salary, with adequate provision for leave, sickness, old age and death, if the medical profession is adequately represented on the body employing them.

58. Where general practitioners or dentists, engaged in private practice, undertake part-time work for a medical care service with a sufficient number of beneficiaries, it may be appropriate to pay them a fixed basic amount per year, including provision for leave, sickness, old age and death, and increased if desired by a capitation fee for each person or family in the doctor's or dentist's charge.

59. Specialists engaged in private practice who work part time for a medical care service with a considerable number of beneficiaries may appropriately be paid an amount proportionate to the time devoted to such service (part-time salary).

60. Doctors and dentists engaged in private practice who work part time for a medical care service with few beneficiaries only may appropriately be paid fees for services rendered.

61. Among the members of allied professions participating in the service, those rendering personal care may appropriately be employed whole time for salary, with adequate provision for leave, sickness, old age and death, while members furnishing supplies should be paid in accordance with adequate tariffs.

62. Working conditions for members of the medical and allied professions participating in the service should be uniform throughout the country or for all sections covered by the service, and agreed on with the representative bodies of the profession, subject only to such variations as may be necessitated by differences in the exigencies of the service.

63. Provision should be made for the submission of complaints by beneficiaries, concerning the care received and by members of the medical or allied professions concerning their relations with the administration of the service, to appropriate arbitration bodies under conditions affording adequate guarantees to all parties concerned.

64. The professional supervision of the members of the medical and allied professions working for the service should be entrusted to bodies predominantly composed of representatives of the professions participating with adequate provision for disciplinary measures.

65. Where, in the proceedings referred to in paragraph 63, a member of the medical or allied professions working for the service is deemed to have neglected his professional duties, the arbitration body should refer the matter to the supervisory body referred to in paragraph 64.

Standard of Professional Skill and Knowledge.

66. The highest possible standard of skill and knowledge should be achieved and maintained for the professions participating both by requiring high standards of education, training and licensing and by keeping up to date and developing the skill and knowledge of those engaged in the service.

67. Doctors participating in the service should be required to have an adequate training in social medicine.

68. Students of the medical and dental professions should, before being admitted as fully qualified doctors or dentists to the service, be required to work as assistants at health centres or offices, especially in rural areas, under the supervision and direction of more experienced practitioners.

69. A minimum period as hospital assistant should be prescribed among the qualifications for every doctor entering the service.

70. Doctors wishing to furnish specialist service should be required to have certificates of competence for their specialty.

71. Doctors and dentists participating should be required periodically to attend post-graduate courses organized or approved for this purpose.

72. Adequate periods of apprenticeship at hospitals or health centres should be prescribed for members of allied professions, and post-graduate courses should be organized and attendance periodically required for those participating in the service.

73. Adequate facilities for teaching and research should be made available at the hospitals administered by or working with the medical care service.

74. Professional education and research should be promoted with the financial and legal support of the State.

V.—Financing of Medical Care Service.

Raising of Funds under Social Insurance Service.

75. The maximum contribution that may be charged to an insured person should not exceed such proportion of his income as, applied to the income of all insured persons, would yield an income equal to the probable total cost of the medical care service, including the cost of care given to qualified dependants as defined in paragraph 6.

76. The contribution paid by an insured person should be such part of the maximum contribution as can be borne without hardship.

77. Employers should be required to pay part of the maximum contribution on behalf of persons employed by them.

78. Persons whose income does not exceed the subsistence level should not be required to pay an insurance contribution. Equitable contributions should be paid by the public authority on their behalf: Provided that in the case of employed persons, such contributions may be paid wholly or partly by their employers.

79. The cost of the medical care service not covered by contributions should be borne by taxpayers.

80. Contributions in respect of employed persons may appropriately be collected by their employers.

81. Where membership of an occupational association or the possession of a licence is compulsory for any class of self-employed persons, the association or the licensing authority may be made responsible for collecting contributions from the persons concerned.

82. The national or local authority may be made responsible for collecting contributions from self-employed persons registered for the purpose of taxation.

83. Where a scheme of social insurance for cash benefits is in operation, contributions both under such scheme and under the medical care service may appropriately be collected together.

Raising of Funds under Public Medical Care Service.

84. The cost of the medical care service should be met out of public funds.

85. Where the whole population is covered by the medical care service and all health services are under unified central and area administration, the medical care service may appropriately be financed out of general revenue.

86. Where the administration of the medical care service is separate from that of general health services, it may be appropriate to finance the medical care service by a special tax.

87. The special tax should be paid into a separate fund reserved for the purpose of financing the medical care service.

88. The special tax should be progressively graded and should be designed to yield a return sufficient for financing the medical care service.

89. Persons whose income does not exceed the subsistence level should not be required to pay the tax.

90. The special tax may appropriately be collected by the national income tax authorities or, where there is no national income tax, by authorities responsible for collecting local taxes.

Raising of Capital Funds.

91. In addition to providing the normal resources for financing the medical care service, measures should be taken to utilize the assets of social insurance institutions, or funds raised by other means, for financing the extraordinary expenditure necessitated by the extension and improvement of the service, more particularly by the building or equipment of hospitals and medical centres.

VI.—Supervision and Administration of Medical Care Service.

Unity of Health Services and Democratic Control.

92. All medical care and general health services should be centrally supervised and should be administered by health areas as defined in paragraph 24, and the beneficiaries of the medical care service, as well as the medical and allied professions concerned, should have a voice in the administration of the service.

Unification of Central Administration.

93. A central authority, representative of the community, should be responsible for formulating the health policy or policies and for supervising all medical care and general health services, subject to consultation of, and collaboration with, the medical and allied professions on all professional matters, and to consultation of the beneficiaries on matters of policy and administration affecting the medical care service.

94. Where the medical care service covers the whole or the majority of the population and a central Government agency supervises or administers all medical care and general health services, beneficiaries may appropriately be deemed to be represented by the head of the agency.

95. The central Government agency should keep in touch with the beneficiaries through advisory bodies comprising representatives of organizations of the different sections of the population, such as trade unions, employers' associations, chambers of commerce, farmers' associations, women's associations and child protection societies.

96. Where the medical care service covers only a section of the population, and a central Government agency supervises all medical care and general health services, representatives of the insured persons should participate in the supervision, preferably through advisory committees, as regards all matters of policy affecting the medical care service.

97. The central Government agency should consult the representatives of the medical and allied professions, preferably through advisory committees, on all questions relating to the working conditions of the members of the professions participating, and on all other matters primarily of a professional nature, more particularly on the preparation of laws and regulations concerning the nature, extent and provision of the care furnished under the service.

98. Where the medical care service covers the whole or the majority of the population and a representative body supervises or administers all medical care and general health services, beneficiaries should be represented on such body, either directly or indirectly.