Chapter 10

HEALTH

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The desire to attain good health is universal. Throughout history man has always endeavoured to protect his health, at first by devising techniques and selecting special individuals to ward off 'evil spirits'. Observation and experience gradually identified ways for keeping well. Laws were developed to govern health and, as large communities developed, methods of sanitation were devised. But it was not until the 1800s with the discovery that germs caused disease, that significant advances in man's understanding of, and ability to successfully treat, illness were made.

Yet, for all the knowledge and resources now directed towards attaining good health, disease, injury and illness are still part of everyday life, present everywhere and touching all of us.

10.1 MORBIDITY

In a two week period during 1983, just under two thirds of Tasmanians took some positive action in relation to their health. This is the finding of a national survey of people conducted by the Australian Bureau of Statistics. The survey found that 63 per cent of Tasmanians had a stay in hospital, used a medication, had a consultation with a medical doctor, dentist or other health professional, had either a day off work or school or experienced a day of reduced activity due to health reasons. This compared with 71 per cent for Australia as a whole.

Males indicated having more injury and were more likely to take time off work for health reasons than were females; overall males took action relating to their health less frequently than did females. They also reported less illness than did females.

The survey found that just over half the population had recently experienced an illness condition. For both males and females the most prominent illness condition reported was associated with the respiratory system.

The highest rate occurred among children under the age of 5 years (11 per cent) who experienced acute nasopharyngitis (the common cold). The corresponding figure for children aged 5–14 years was also a relatively high 7.2 per cent. The rate recorded for individuals in other age groups was about half this figure.

10.1 Proportion of Tasmanians with an Illness Condition, 1983, (%)

Condition	*Males*	*Females*	*Persons*
Endocrine nutritional and metabolic diseases	2.2	2.3	2.2
Mental disorders	1.7	4.2	2.9
Nervous system and sense organs	3.5	4.1	3.8
Circulatory system	8.3	11.2	9.8
Respiratory system	15.0	14.8	14.9
Digestive system	7.0	8.7	7.8
Genito-urinary system	*	3.6	2.1
Skin and subcutaneous tissue	6.3	6.6	6.4
Musculoskeletal system	6.6	10.2	8.4
Other specified conditions	4.8	4.6	4.7
Symptoms and ill-defined conditions	10.5	19.3	14.9
All conditions	47.4	56.5	52.0

Equally high was the incidence of symptoms of illness and ill-defined conditions (14.9 per cent). This was particularly prevalent among people aged 65 years and over who experienced insomnia (14.5 per cent). A high rate was also recorded for individuals in the 25–64 years age group suffering from headache (due to unspecified or trivial causes). Females tended to experience more headaches (10.4 per cent) than males (5 per cent).

Conditions associated with the respiratory system, and symptoms and ill-defined complaints were the two most frequent cause of illness among both males and females. The third most common source of complaint was associated

with the circulatory system with females reporting a substantially higher rate of illness than males (11.2 per cent and 8.3 per cent). Hypertension was prominent among people 65 years and over (27.9 per cent), with females experiencing a higher rate than males. High blood pressure among people aged 45–64 years (15.6 per cent), and heart disease among the 65 and over age group (16 per cent) were other high rates of conditions associated with the circulatory system.

Relative to males, females experienced a higher rate of illness associated with the musculoskeletal system, particularly in regard to arthritis. The higher rates of persons experiencing arthritis were found in the 65 years and over age group, and to a lesser degree, in the 45–64 year age group.

The survey showed that most of those who reported an illness condition, experienced one illness only. However, a higher proportion of females than males reported having two or more illness conditions.

10.2 Proportion of Males and Females Reporting Illness Condition, Tasmania, 1983

	Number of different illness conditions			
	1	*2*	*3 or more*	*Total*
Males (% of total males)	33.0	9.0	4.5	47.4
Females (% of total females)	33.1	14.2	9.2	56.5
Total (% of total pop.)	33.1	12.0	6.9	52.0

Taking Medications

Almost 60 per cent of Tasmanians reported taking one or more medications in the two weeks of the survey reference period. This compares with just over 65 per cent of Australians. Again females outnumbered males, and with respect to almost all types of medications, but particularly in taking pain relievers, heart, blood pressure and fluid tablets, sleeping pills and vitamin or mineral supplements. The survey showed that pain relievers were the most frequently taken form of medication, closely followed by vitamins and mineral supplements. Other relatively frequently taken medications were skin medications, and heart, blood pressure or fluid tablets.

10.3 Frequency of Tasmanians Taking Medications, 1983 (%)

Medication	*Males*	*Females*	*Persons*
Pain relievers	19.8	30.9	25.4
Vitamins or mineral supplements	17.8	23.6	20.7
Heart, blood pressure or fluid tablets	7.6	11.1	9.4
Skin medications (*a*)	6.8	6.5	6.7
Cough medicines	5.8	6.4	6.1
Sleeping pills	2.2	4.9	3.6
Tranquillisers	2.1	4.2	3.1
Birth control pills (*b*)	—	30.3	30.3 (*c*)
Other medications	9.2	8.9	9.0
Total persons taking medications (*d*)	48.8	66.1	57.5

(*a*) Excludes cosmetic creams and preparations.
(*b*) Includes only females aged 18 to 50 years.
(*c*) Per cent of females aged 18–50.
(*d*) Each person may have taken more than one type of medication and, therefore, components do not add to totals.

Medical Consultations

Over 75 per cent of Tasmanians had consulted a medical practitioner at least once in the 12 months prior to the survey. In all age groups except the 5–14 year olds, the proportion consulting a doctor was higher for females than for males.

10.4 Proportion of Tasmanians Reporting Doctor Consultations in Twelve Month Period, 1983 (%)

Age group (years)	*Males*	*Females*	*Persons*
Under 5	81.2	93.9	87.4
5–14	71.7	67.2	69.0
15–24	57.5	84.0	70.8
25–44	66.9	85.1	76.0
45–64	73.2	78.6	75.9
65 and over	86.3	93.1	90.1
All ages	70.1	82.2	76.2

10.2 MORTALITY

In 1984 more resident Tasmanians died than in any previous year. A total of 3596 people died, 1971 males and 1625 females, which was an increase of 8.3 per cent on the number of deaths registered in 1983. It was also the highest rate of deaths (number per 1000 of mean population) since 1976.

10.5 Deaths in Tasmania, 1984

Age group (years)	*Males*	*Females*	*Persons*
0–4	58	40	98
5–14	13	5	18
15–24	51	15	66
25–44	116	53	169
45–54	124	77	201
55–64	349	190	539
65–74	599	334	933
75 and over	661	910	1571
Total	1971	1625	3596

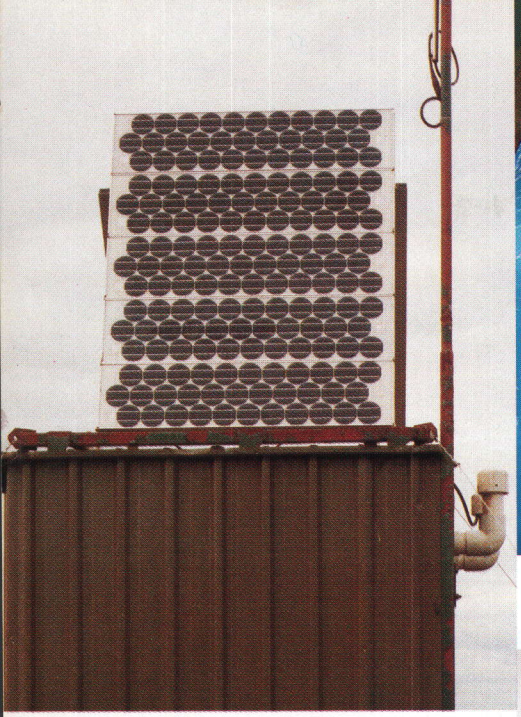
Teacher training in Tasmania is provided by the Tasmanian State Institute of Technology in Launceston.

The Australian Maritime College in Northern Tasmania is Australia's national educator of seafarers. The photo shows the College's three main vessels, the Stephen Brown, Bluefin and the Wyuna moored at Beauty Point.

In 1966 Tasmania became the first Australian State to develop a School of Dental Therapy.
(Government Stills Photographic Section)

Home nursing and home care services care for over 6 000 patients in their own homes.
(Government Stills Photographic Section)

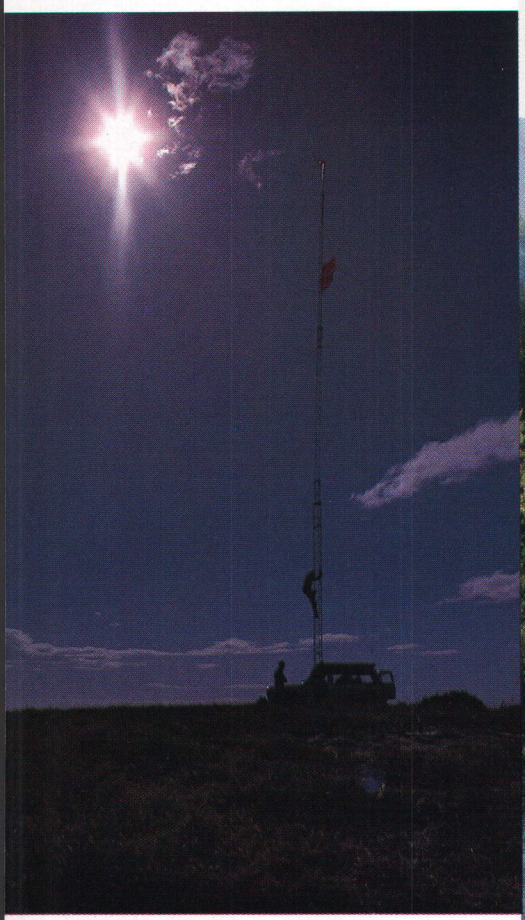
St John's Hospital, Hobart.



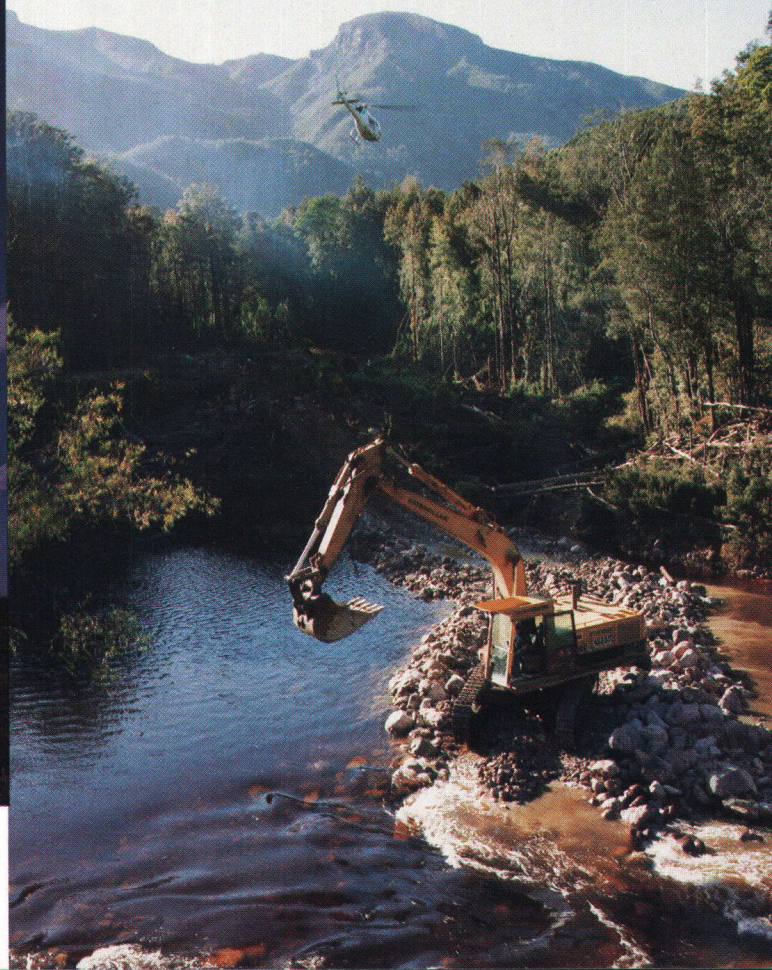
A solar collector is used to power the radio base station at Mt. Huxley. (Hydro-Electric Commission)

Drilling for oil offshore from Burnie. (Fred Kohl, Mercury)

Construction activity near the site of the King River Power Station. (Hydro-Electric Commission)



Erecting wind monitoring equipment in the North East of the State. (Hydro-Electric Commission)



Coal from the Fingal Valley mines is transported by train to bulk consumers such as the newsprint mill at Boyer. (Michael Dix)

Up until age 75 male deaths outnumbered female deaths. However, the reversal in the 75 and over age group, occurred only because of the higher number of females of that age in the population; in all age groups the death rate of males was higher than for females. And for most age groups the male rate is almost twice the female rate. Only the 0–4 age group provides a rate for females somewhere close to the male rate, and then only among children aged between one and four; the death rate among infants, children aged less than one year, is considerably higher for males than for females.

10.6 Age-Specific Death Rates, Tasmania, 1984

Age group (years)	*Males*	*Females*
0–4	3.25	2.33
5–14	0.35	0.14
15–24	1.34	0.40
25–44	1.82	0.85
45–54	5.91	3.80
55–64	17.79	9.40
65–74	45.24	21.15
75 and over	106.12	86.08
All ages	9.08	7.38

Infant Deaths

Just under two thirds of all infant deaths are males, and just over half occur at less than four weeks of age.

10.7 Infant Deaths, Tasmania, 1984

Age	*Males*		*Females*	
	No.	*Rate (a)*	*No.*	*Rate (a)*
Under 1 day	20	5.6	6	1.7
1 day and under 1 week	6	1.7	5	1.4
1 week and under 4 weeks	5	1.4	3	0.9
4 weeks and under 12 months	20	5.6	16	4.5
Total	51	14.3	30	8.5

(*a*) Deaths per 1000 live births.

10.2.1 Causes of Death

In 1984, five causes accounted for over 72 per cent of all deaths registered. These were heart disease (28.9 per cent), cancer (23.4 per cent), strokes (10.7 per cent), bronchitis, emphysema and asthma (5.1 per cent), accidents, suicides, poisonings and violence (4.6 per cent).

10.8 Principal Causes of Death, Tasmania, 1984

Cause	*Proportion of all deaths*	*Number*	
		Males	*Females*
Ischaemic heart disease	28.9	612	428
Malignant neoplasm	23.4	481	361
Cerebrovascular diseases	10.7	150	235
Bronchitis, emphasema and asthma	5.1	137	48
Accidents, suicides and violence	4.6	116	48

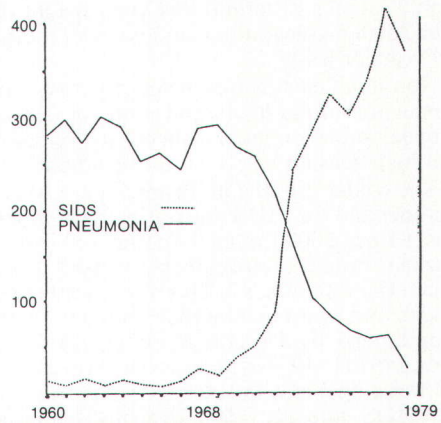
Cot Deaths

Sudden Infant Death Syndrome, variously called Cot Death, Crib Death or SIDS, is the most common cause of death in infants between one week and one year of life in many Western countries. The syndrome actually accounts for more deaths than all other causes combined during this period.

10.9 Main Causes of Death at Ages Under 1 Year, Tasmania, 1984

Cause	*Male*	*Female*
Congenital anomalies	14	13
Conditions originating in the perinatal period	20	5
'Cot death'	15	11
All causes	51	33

Defined as 'the sudden death of any infant or young child which is unexpected by history and in which a thorough post-mortem examination fails to demonstrate an adequate cause of death' (Beckwith 1970), SIDS was not commonly recognised before the 1970s. Until 1979, most cases of sudden infant death, even those coming to autopsy, were labelled as pneumonia, broncho-pneumonia or interstitial pneumonia.



Infant Deaths: Diagnosis of SIDS and Pneumonia, Australia.

The graph comparing the number of diagnoses of SIDS and pneumonia in infants under twelve months of age in Australia between 1960 and 1979 suggests that those cases diagnosed as pneumonia may in actual fact be considered as SIDS.

Since most cot deaths occur during the infants' sleeping hours, the bulk of research has been aimed at explaining the apparent link between sleep and SIDS. It has been suggested that this could be due to the depression of many protective respiratory reflexes during sleep. In this state vulnerability to asphyxia is increased because the lung volume and oxygen gas stores are reduced, intercostal muscles are inhibited and breathing is sustained primarily by the diaphragm. Thus, reflex arousal from sleep in response to asphyxia is delayed.

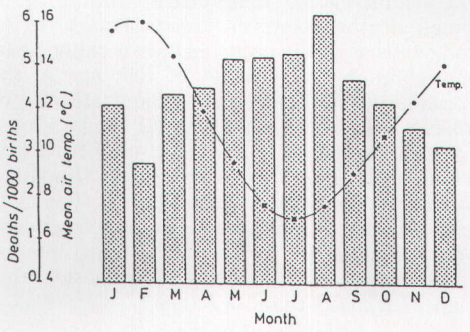
This alone, however, does not explain SIDS as evidence suggests there may be subtle neuropathological abnormalities and possible biochemical aberrations. Although the apnoea theory is accepted by a large number of research groups around the world and has substantial supportive data, proof of the hypothesis is still lacking.

A study of 213 infants dying of SIDS in Tasmania during the years 1975 to 1981 has indicated that the incidence for the seven years was 4.4 per 1 000 live births compared with a national average of 1.6 per 1 000. Other world figures range from a low of 0.49 in Sweden to a high of 4.37 in parts of England.

The peak incidence of death was in the 3 month age group with 24.9 per cent of deaths occurring in this group. There would also appear to be a preponderance of male deaths from SIDS, the male to female ratio being 142:100 whereas the male to female ratio for births over this period in Tasmania was 106:100. Other significant factors were pre-term delivery (less than 37 weeks gestation) low birth weight (less than 2500gm) illegitimacy and younger mothers (24 years or less).

Non significant factors included parity, urban versus non-urban habitation mode of delivery, surgical induction and augmentation of labour, and hypertension before or during labour.

The colder months in Tasmania are May to October and the SIDS rate during these months was 5.1 per 1 000 live births compared with the warmer months, November to April during which the rate was 3.7. This variation between colder and warmer months is similar to that propounded by Deacon *et al* (1979) for the period 1973 to 1977 in Melbourne. Also comparing these figures with those of South Australia the SIDS rate per 1 000 live births are very similar in the months when the mean daily temperature is 10°–16°C; 3.8 per 1 000 in



Cases of SIDS, Tasmania 1975–81

Tasmania and 3.2 in South Australia. In the remaining colder months in Tasmania it is 5.0 per 1 000 live births and 1.4 in the warmer months in South Australia.

The contribution of temperature to SIDS is represented in the comparison between mean monthly temperature in Tasmania and the monthly incidence of SIDS. As the temperature falls the cot death rate rises. Furthermore, the regions of Tasmania which have a higher incidence of SIDS, the southern and western areas, average 1°C colder than the remainder.

Mild respiratory tract infection accompanies death in 40–75 per cent of SIDS cases (Beckwith 1970). This suggests that a lowering of ambient temperature in combination with mild hypoxia from partial upper airway obstruction, infections, or from some other cause may disrupt the sleep pattern causing a reduction of time for active sleep, placing the infant at greater risk. Moreover an increased incidence of infections in winter and a possible association of infections with SIDS has been previously recognised (Naeye *et al*, 1976).

Several disproven theories still result in anxiety and parental recrimination. The idea that neglect, or smothering by inappropriate bed clothing can cause SIDS still results in unnecessary parental grief even though this has been negated. The incidence of SIDS is not linked to breast or bottle feeding, allergies or house dust. Vitamin C levels have been measured in SIDS infants and found to be normal.

The final physiological mechanisms for SIDS are still speculative. However, the syndrome appears to result from failure to arouse under adverse respiratory circumstances, and to be associated with predisposing factors. It is suggested that cold, hypoxia and respiratory infection play a major role in the onset of SIDS.

Acknowledgement: This article is based primarily on an unpublished paper by Neville M. Newman, Department of Obstetrics and Gynaecology, University of Tasmania.

10.10 Sudden Infant Death Syndrome (SIDS) Rates (per 1 000 live births), Australia, 1975–1981

Year	*NSW*	*Vic.*	*Qld*	*SA*	*WA*	*Tas*	*NT*	*ACT*	*Total*
1975	0.8	1.5	1.4	1.9	1.6	3.6	0.9	3.4	1.4
1976	0.9	1.1	1.0	1.5	2.0	3.6	—	3.3	1.3
1977	1.1	1.4	1.1	1.5	2.3	5.5	1.5	3.9	1.5
1978	1.6	1.9	1.7	2.9	1.5	4.1	0.4	1.6	1.8
1979	1.4	2.2	1.1	1.9	1.8	4.5	0.7	1.3	1.7
1980	1.4	1.9	1.8	1.8	1.7	4.0	1.5	1.8	2.0
1981	1.7	1.8	1.6	1.8	1.9	4.6	1.6	2.2	1.8
Mean	1.3	1.7	1.4	1.9	1.8	4.4	0.9	2.5	1.6

Deaths from Age 1

Most deaths among people up to age 34 result from the first two categories, motor vehicle traffic accidents and, suicide and self-inflected injuries. These two causes account for about 50 per cent of all male deaths, and about 30 per cent of all female deaths in the age group 1–34 years.

10.11 Main Causes of Death at Selected Ages (Number), Tasmania, 1984

Cause	*Male*	*Female*
1–34 Age group		
Motor vehicle traffic accidents	41	8
Suicide and self-inflicted injuries	18	7
Other accidents and violence	25	8
Other causes	31	25
All causes	115	48
35–44 Age group		
Accidents and violence	22	2
Diseases of the circulatory system including heart disease	24	8
Neoplasm	17	17
Other causes	9	5
All causes	72	32
45–64 Age group		
Diseases of the circulatory system including heart disease	367	160
Neoplasms	165	116
Accidents and violence	33	13
Diseases of the respiratory system	21	16
Other causes	53	27
All causes	473	267
65 and over age group		
Diseases of the circulatory system including heart disease	1 201	1 222
Neoplasms	290	219
Diseases of the respiratory system	140	67
Accidents and violence	22	30
Other causes	113	162
All causes	1 260	1 244

Around the ages 35–40 for both males and females a change in the pattern of deaths takes place. For males, diseases of the circulatory system, heart disease and strokes, emerge as the main causes of death for age groups 35 years and upwards. Cancers also become increasingly significant. Two broad groups, malignant neoplasms of the digestive organs and peritoneum (which include 'stomach' and 'bowel' cancers) and lung cancer account for most cancer deaths. For ages 65 and over, diseases associated with the respiratory system are also significant.

While the predominant causes of death among women are similar, the pattern differs in that initially cancers are more important than diseases associated with the circulatory system. About 12 per cent of female deaths in the 55–64 age group are from breast cancer. From about the mid-60 ages, diseases of the circulatory system (heart and cerebrovascular diseases) become the predominant causes of death. Diseases of the respiratory system account for fewer female than male deaths.

10.3 CARING FOR THE SICK

The treatment of illness is the major function of the health care system. In Australia the most visible, and the most expensive, part of the system is the hospital. But although some form of institution for the care of the sick has probably always existed, hospitals in their current form are a relatively modern concept.

Originally hospitals were established for sick or weary travellers and for the poor, the blind and the crippled. Usually operated by religious orders, hospitals served as institutions to care for persons too poor or too sick to be treated at home. Even up to the 1700s they were still operated as charity institutions, with the well-to-do being treated in their own homes.

It wasn't until the 1800s, when hospitals underwent considerable improvement in cleanliness, that the trend of caring for patients in hospitals instead of in their own homes began.

Perhaps ironically the escalating costs of treating patients in modern hospitals has forced a new move back to home based nursing care. Increasingly, efforts are being made to significantly reduce the length of time patients are kept in hospitals. More and more admissions are being delayed and patients are being discharged early to be cared for by teams of Home Nurses and people providing 'home help' or 'handyman' services.

10.3.1 Hospitals

In 1983 an estimated 12 per cent of Tasmanians had had one or more episodes in a hospital during the previous twelve months. For most, the stay in hospital was of a relatively short duration; for 70 per cent, one week or less. Less than four per cent of the population was hospitalised for more than a month, and only 20 per cent underwent more than one period in hospital during the 12 month period.

In most age groups, more females than males had been hospitalised; only among infants and children up to 14 years of age were females outnumbered by males.

Tasmania has 28 hospitals of which six are operated privately. In Hobart, the Medical Benefits owns and operates St Johns Hospital and Australian Hospital Care Pty Ltd own St Helen's Hospital. Both provide medical and surgical facilities. The Roman Catholic Church own Calvary Hospital in Hobart and St Vincents in Launceston. St Lukes Health Insurance own and operate St Lukes Hospital in Launceston. The sixth is a psychiatric hospital, the Hobart Clinic.

At the end of June 1985, a total of 2532 approved beds were being provided in Tasmania; 6.0 beds for every 1 000 people, a rate equal to Western Australia but below the 6.8 for Queensland and 6.4 in South Australia.

St Johns Hospital — A Brief History

In 1901 George Stanton Crouch, Joshua Tavell Soundy, William Lord, Charles Duncan Hayward, Harry Kingston Fysh, and Albert Edward Richardson purchased from the Estate of John Fisher the buildings, on approximately 3 acres of land, in which the Hobart Homeopathic Hospital had earlier been established.

In 1930 the Board of Management of the Hobart Homeopathic Hospital was faced with the prospect of closing it's hospital through lack of support. The Board negotiated with the Church of England, and it was agreed that the Church would pay off the current debts and then take over the assets and liabilities without further consideration.

On April 20, 1931, the hospital was officially opened by the Bishop of Tasmania, Bishop Hay, and it became known as St John's Hospital (Church of England) incorporating the Hobart Homeopathic Hospital. Fund-raising auxiliaries were formed in Hobart parishes to raise the necessary finance to pay off the debts and furnish the wards of the twenty-bed hospital.

A new wing was completed in 1935, and in 1939 a lift was installed and a further eight single rooms were added. By 1941 the hospital had sixty-four beds.

In 1942, as an emergency wartime measure, and with the concurrence of the Nurses' Registration Board, St John's decided to accept trainees for a three year training period after the completion of a satisfactory probationary period. It was the beginning of the hospital's record as a training school.

By 1949 a new kitchen block and a second storey for the nurses' home had been constructed, and in 1953 new accommodation for an X-ray plant and a room for pathological work were added. Further extensions to the hospital by 1959 increased the total number of beds by fourteen to eighty-two. The Maud and Robert Snowden Hay Memorial Chapel was also completed and furnished.

A disastrous fire necessitated the construction of a new theatre complex of three theatres, a recovery ward, and a central sterilizing department; it was opened on May 18, 1969.

During 1972–73 all wards in the hospital were extensively renovated. On December 12, 1972 a new pathology block was completed, and the old pathology block was renovated to provide sitting rooms and toilet facilities for staff.

In 1976 tenders were called for extensions that included sixteen private 'motel-type' single rooms, a new reception and administration area, and a basement area for lease. The work was completed in early 1978.

The extension is attached to the original stone building standing on this site in 1824 and then named 'Wellington Grange'. On account of this historical link and because Mt. Wellington stands sentinel over Hobart it was appropriate that the extension be named 'Wellington Wing'.

More recent improvements have included a new traffic entrance landscaped with lawn and shrubs.

On August 17, 1984 the hospital was purchased by the MBF.

10.12 Approved Hospital Beds, Tasmania, 30 June 1985

Beds in —	
Public hospitals	2016
Private hospitals —	
Category 1	142
Category 2	362
Category 3	12
Total private hospitals	516
Total hospitals	2532

Four general hospitals, 14 district hospitals, 11 hospital annexes and district nursing centres with bed accommodation, six centres without accommodation, one mental hospital, two maternity hospitals and three nursing homes for the aged are provided by the State. A total of 2016 public hospital beds are available.

10.13 Public Hospital Beds, Tasmania, 1985

General Hospitals —	
Royal Hobart	497
Launceston General	386
Mersey General	187
North-Western General	236
Maternity Hospitals —	
Queen Alexandra	68
Queen Victoria	117
District Hospitals —	
Huon	48
Beaconsfield	26
Campbell Town	18
King Island	24
New Norfolk	42
North-Eastern Soldiers' Memorial	49
Ouse	10
Roseberry	15
Smithton	40
St Helens	9
St Marys	19
Toosey	33
Ulverstone	48
West Coast	43
District Nursing Centres	58
Miscellaneous	43
Total	2016

The four general hospitals, the Royal Hobart, Launceston General, Mersey General (at Latrobe and Devonport) and the North-Western General (with divisions at Burnie and Wynyard) provide all facilities. Specialist treatment is available in obstetrics, gynaecology, orthopaedics, uro-genital surgery, plastic and reconstructional surgery, neuro-surgery and neurology, radiology, pathology, radiotherapy, psychiatry and ophthalmology. Skin diseases and venereal diseases are also treated and clinics operate in thoracic medicine and surgery. An emergency obstetric service, with specialists based in Hobart and Launceston, provides a free service to the smaller public hospitals, district nursing hospitals and district medical officers outside Hobart and Launceston.

During 1984–85 a total of 60 288 in-patients were treated in the State's hospitals.

10.14 In-patients Treated Tasmanian Public Hospitals, 1984–85

Hospital	*General*	*Maternity*
General hospitals	41 372	2217
District hospitals	7239	786
Maternity hospitals	2342	5473
District nursing centres	859	—
Other (*a*)	774	—
Total	51 812	8476

(*a*) Mothercraft Home and Peacock Convalescent Home

10.3.2 Home Nursing

The Home Nursing Service, provided by the Department of Health Services, provides patient care at home to some 6000 persons statewide at any one time. This is about three times as many patients as provided for by the State's public hospitals at any one time.

Patients are cared for by 300 nurses who in 1984–85 made 445 685 home visits. In extreme cases some of the patients require visits as much as five times a day, but on average patients are visited twice a week.

The type of patient varies. The majority are elderly people but 20 per cent belong to younger age groups and are a cross-section, from children with rare chronic diseases to severely multiply handicapped people requiring varied levels of support.

By providing an alternative to hospital or institutional care, caring for patients in their own homes gives individuals the opportunity to remain independent and close to their family and friends. As well as the psychological benefits of this to the patient it is cost effective. Hospitals are very expensive to run, costing about $170 a day to keep a patient in hospital. Certain types of patients can receive the same quality of care at home for a fraction of that cost.

The Home Nursing Service is staffed by Registered General Nurses (some with further community health training) supported by trained auxiliary nurses and backed-up by home help staff who provide domestic aid to the family.

Home nursing projects are administered from 22 hospitals around the State. The scheme was structured in this way partly to encourage hospital boards to see their role in a broader community context rather than in isolation. Patients are referred by various agencies, including general practitioners, social workers, welfare officers, and other health professionals in the community.

The Home Nursing Service offers a wide range of aid and advice according to need. The services include:

- equipment in the form of wheelchairs, commodes, bed pans, and sheepskins;
- linen service;
- day care centres for the patient to take the pressure off families;
- respite holiday admissions, taking the pressure off the family caring for a nursing patient by providing information and criteria for this scheme.

An effective home nursing service prevents people occupying hospital beds that may be needed for patients suffering from more acute illnesses. In the case of the elderly, it prevents nursing home beds being taken up by persons who could cope at home, while someone in real need cannot get a place. The effective use of accommodation for the elderly is particularly important. Although Tasmania has more than the national average number of nursing home beds for the elderly, it is unlikely that any more will be provided in the near future, because of funding restraints.

To meet the needs of an increasing aged population the best possible use of existing facilities must be made. To achieve this the Department of Health Services launched a unique scheme. Three professional geriatric assessment teams were set up to cover the three major geographic regions of the State, the South, North East, and North West. Each team has a senior nurse, social worker, occupational therapist and receptionist and their role is to ensure that every elderly person in need of help receives the most appropriate services available.

The object of the teams is to help all elderly people make contact with appropriate home care, elderly persons' units, hostel and nursing home accommodation. The teams are also able to assist the providers of accommodation for the elderly to fill that accommodation with the most appropriate applicants. In practice each team maintains a list of all people known to the caring agencies in the team's area. The team then visits these people and assesses their needs and what their priorities are. In this way, those with the greatest need receive the earliest attention.

One of the aims of the geriatric assessment teams is to remove the fear among many that accommodation for the elderly will not be available when it is needed. That fear has been responsible for people entering nursing homes before necessary and thereby denying those in greater need.

Pilot testing of the scheme showed its worth. In a trial a list of 1 500 names of elderly persons said to be in need of accommodation was provided as being in need of accommodation. A senior nursing sister set out to interview all those on the list. After eliminating from the list those who had moved, died, found accommodation already, and were unknowingly put on the list by relatives, the sister found 20 people in immediate need of accommodation.

One of the points this test proved was that many people did not know that home care services were available as an alternative to nursing homes.

After its first decade, the picture for home nursing is certainly not one of total satisfaction or complete success. But more remains to be done, particularly in the area of educating the public about what the service has to offer, and a change in community attitudes.

10.4 HEALTH MAINTENANCE

Increasingly it is being argued that preventing illness is not only the best, but the cheapest, form of health care provision. This move is evident in an increasing emphasis on health education for adults in particular. But it is also part of the rationale for such measures as fluoridating public water supplies and introducing a range of screening and monitoring services for children especially. Examples are the Child Health Clinics, mobile dental units, school nurses, dental therapists and medical officers.

10.4.1 Child Health

The Child Health Service commenced in 1917 under the auspices of two voluntary organisations, the Hobart and the Launceston Child Welfare Associations. Since then, the Tasmanian Government, through the Department of Health Services, has increasingly assumed responsibility and now provides the staff and the majority of the buildings. However, the voluntary organisation which has become the Child Health Association of Tasmania, still owns a number of the Child Health Centres and the Association's committees continue to support and to meet the running costs of the majority of the Child Health Centres.

In 1985 there were 118 Child Health Centres and 15 travelling units. Triple certificated child health nurses attached to these Centres advise mothers on all aspects of caring for babies and young children. Mothers are advised on infant feeding, child development and other health and social problems that occur in the family. The registered nurses screen children's growth and development to detect, as early as possible, a deviation from the normal pattern of development and refer these to the family doctor or the appropriate agency for investigation and/or early treatment. Child health nurses visit new born babies at home and continue the supervision and

'Curative Medicine' or Prevention

An article contributed by the Tasmanian Department of Health Services

The Tasmanian Department of Health Services spends in excess of $130 million a year on the health care system for the State. By far the largest amount is spent on running public hospitals, $105 million. The rest of the budget is divided up to be spent on public health, maintaining food and water hygiene standards and community health — taking care to people in their homes.

The figures illustrate the distinct bias towards 'curative medicine'; that is curing those who are sick in institutions such as hospitals. But the irony is that even with such huge amounts of money being spent, and with technological advances in health care, in some respects we are not as healthy as our turn-of-the century forebears.

Today we do less exercise, eat a less balanced diet, smoke more and consume more alcohol. The result is 'the new epidemics' of our society, heart disease, cancer and alcoholism.

The figures tell the story: In 1905 heart disease caused just over three per cent of all deaths. Currently it causes some 36 per cent of deaths. Similarly, cancer has tripled as a cause of death in the last 80 years.

The modern lifestyle is the major health problem of today. A lifestyle that places us at risk from motor vehicle accidents, from heart disease, cancer, alcohol-related problems, and stress-related illnesses of anxiety, neurosis and depression.

The 'new epidemics' call for a fundamental rethink in the way the public regards personal health and health services. They cannot be cured in hospitals by 'hi-tech' medicine, or by wonder drugs. Curative medicine can only alleviate the symptoms. Cigarette smoking is a case in point.

Some 40 per cent of the male and 30 per cent of the female population smoke (and the figure among women is increasing). This is despite the fact that smoking has been declared a man-made epidemic by the World Health Organisation, is condemned as harmful by all leading medical bodies, the existence of 30 000 articles published since 1962 on the health risks, and the 16 000 smoking-related deaths each year in Australia.

Tasmania has proportionately the highest death rate from some tobacco-related diseases of any State. More than 500 Tasmanians die each year from diseases associated with smoking. This habit is the major cause of preventable death and disease in Tasmania and as such is a priority target for the Department of Health Services.

Yet curative medicine cannot provide a cure for smoking, it can only treat the results; heart disease, lung cancer, emphysema, bronchitis, and a host of other complications. The real cure lies in prevention, in not taking up smoking in the first place, and in encouraging smokers to give up. The preventive health answer to smoking is an integrated approach which tackles the causes rooted in complex social, economic and political conditions.

The *Quit. For Life* anti-smoking campaign which the Department ran tackled the social myths surrounding smoking. Based around mass-reach techniques using the media this was a campaign first to alert smokers to the dangers of tobacco and then to offer them help in quitting. Smokers were warned of the dangers of their habit in two newspaper supplements delivered to every home in the State. This was followed up with television advertisements.

The helping hand came in the form of *Quit Kits* which were specially designed packages containing an explanatory booklet, an audio tape and cards to monitor progress. These were distributed through all the State's pharmacies. Working in co-operation with voluntary groups, stop-smoking courses were encouraged and promoted.

At the same time fiscal and legislative measures are being taken by the Tasmanian Government which affect smoking rates. Increases in taxation have an effect on consumption, and there are moves to tighten enforcement of laws governing the sale of cigarettes to minors and toughen and make more informative health warnings on tobacco products.

This is an example of preventive medicine tackling underlying causes on many fronts, and is worlds away from high technology medicine.

The paradox here is that on the one hand, medical technology has transformed the treatment of a wide range of illnesses and diseases. Yet on the other hand despite the huge expenditure on curative medicine it can do little to cure smoking, and there are no medical cures for lifestyle diseases such as heart disease brought on by obesity, or the drink driver involved in a smash. The cure lies in prevention, by the individual.

It is therefore the Department of Health Services' objective to promote preventive medicine in the hope that attitude change will take place in the community and that a balanced lifestyle becomes the accepted route to better health. The community can no longer afford to believe we can abuse our bodies with the expectation that a miracle cure exists in a sparkling new hospital.

support either at home or, more commonly, in the Child Health Centre where individual records are maintained. Nurses also arrange for examinations to be carried out by family doctors under the Pre-School Medical Scheme. Departmental medical officers carry out examinations in Child Health Centres.

Mothercraft Home

The Mothercraft Home admits babies and toddlers up to the age of 6 years for the assessment and management of such problems as failure to thrive, establishment of breast feeding, dietary intolerance as well as for adoption.

The Mothercraft Home also caters for emotionally deprived and physically abused children, or children whose parents are unable to cope with them at home — 'babies at risk'. The mother is usually admitted with the child and offered help and support with a plan of management designed to help them cope with and accept the child.

Accommodation for mentally handicapped children from birth to three years is also available at the Home, after which they are usually transferred to the Royal Derwent Hospital, New Norfolk.

The original Mothercraft Home was located in Pirie Street, New Town, but due to deterioration of the building over the years, the Home was moved from New Town to Gore Street, South Hobart, in March, 1982.

The old stone home called 'Flint House' was built in 1856, and was purchased by the Hobart Child Welfare Association with the aid of a government grant of £250. It was officially opened on 13th August, 1925. The building was to be used in a similar way to the Dr. Truby King Karitane Homes in New Zealand, 'for the help and care of mothers and babies with breast feeding difficulties, for the adjustment of dietary problems, nursing of premature babies until they were able to thrive under ordinary conditions and care of boarder babies whilst their mothers were in hospital'. Referrals come mainly from General Practitioners, Paediatricians, Child Health Clinics, the Community Welfare Department, maternity units, and the Child Protection Board.

The basic aim of the Mothercraft Home is to restore the child to its natural environment within the family unit as soon as possible. Mothers are encouraged to live in wherever possible, and for this, no cost is incurred by the mother except for her meals. Tea and coffee making facilities, sitting rooms with TV, magazines and electric organ and laundry facilities are all available free of charge.

The Mothercraft Home is also a training school, the only one of its kind in Tasmania, where Mothercraft Nurses can undergo a 15 month course in the care of mothers and babies. Registered nurses already holding general and midwifery certificates can also undertake a six month course in Child Health.

At any one time there are 18 Mothercraft and eight Child Health nurses in training at the Home.

Registered nurses are also employed by the State Health Department to supervise the health and general well being of children in schools. Monitoring of children's health is carried out through co-operation between school nurses, parents, teachers, guidance officers, welfare officers and other ancillary services.

The main role of the School Health Service is that of screening and referral. Each child receives an examination by a school medical officer at 5 years of age or during the first year of attendance, with reviews as necessary. Some children may also be seen by the medical officer again at the ages of 11 and 15. 11 year old children not causing concern have a full health assessment by the School Nurse. Routinely, all children have vision screening, hearing tests, and checks of height, weight, thyroid, posture and skin. Where necessary, checks are made for infestation and hygiene.

Frequency of the visits of the school nurse varies, depending on the size of the school and the age and needs of the pupils. Weekly visits are made to the larger suburban primary and high schools. Frequency of visits to country schools and smaller schools vary according to needs.

When any medical defect is found it is either observed for later review, or the parents are notified by telephone, home visit or letter. After notification, arrangements are made, either by the parent or the nurse, for the child to receive treatment. Medical reports are sent back to the School Health Service, to keep the nurse informed of any present and future management of the problem.

The nurse informs the school staff or the referring agency of any relevant information which may affect the child in the school situation. This communication between the nurse and school staff ensures that they are mutually aware of the continuing management or resolution of the problem. As well, informal discussion often increases awareness of family pressures which may be causing health and personal problems affecting the child's education.

10.4.2 Dental Health

Free dental treatment is available each year for every child up to the school leaving age from the School Dental Health Service. At the end of June 1985, 41 clinics had been established and 57 mobile dental units were visiting schools. The service had a staff of the equivalent of 65 full-time Dental Therapists and 14 District Dental Officers.

In 1966 Tasmania became the first Australian State to develop a School of Dental Therapy. As well as training Tasmanian students in a two year course for service IN clinics throughout the State the Tasmanian School also trains students on behalf of the Australian Capital Territory Health Commission and the Australian Development Assistance Bureau.

The School is located in Hobart and has residential hostel accommodation for up to 28 students.

During 1984–85, a total of 64 574 school children and 1 526 pre-school age children were treated.

10.4.3 Health Education

Traditionally health education has relied upon taking messages to groups of individuals, or working through institutions such as schools. But it is becoming more cost effective to use mass-reach techniques to spread the desired message.

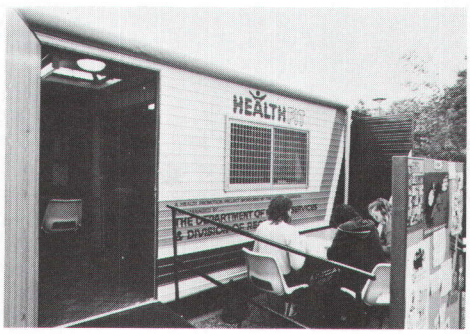
The Department of Health Services has therefore begun to use the mass media extensively in its health education. It has published its own "newspapers" as supplements within the daily and weekly print media. Television and radio advertising have played a big part in specific campaigns. The Department has even co-produced films using such identities as Robert de Castella. It is also a sports sponsor. But in a media-saturated world, the health message must battle against all-comers who often have more money to spend on the medium and whose message is more superficially appealing. To sell its message, the Department must substitute attractive virtues, for the so-called attractive vices, smoking, drinking, sedentary lifestyle. One of the initiatives recently started is the Healthfit unit.

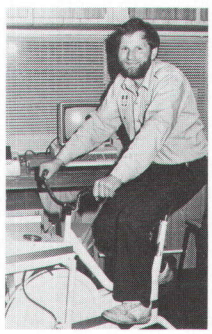
The Healthfit unit is a specially-built caravan which houses a computer and test equipment. Its role is to tour the State delivering health and fitness tests and preaching the healthy lifestyle message in a direct manner. Individuals are given a computerised health assessment, which, linked with basic physical measurements, taken at the time, give a clue to their health. A counsellor then discusses the test results and suggests improvements that can be made. Five basic lifestyle subjects are examined; exercise, or lack of it, nutrition, smoking, alcohol, and stress.

The rationale behind the scheme is three-pronged:

- to motivate the individual to improve his/her lifestyle in specific areas like fitness, stress, diet, and weight, based on the person's specific needs and interests at that time;
- to help analyse specific problems and inter-relationships between lifestyle factors (e.g. stress may be related to excessive smoking or alcohol consumption) and to recommend to the person specific programs, often based upon fact sheets specially prepared for use in the unit;
- to provide baseline data for research. The data may be used to obtain descriptive statistics on the health status of different groups in the community or to measure changes that may occur over time with specific groups who have participated in the assessment previously.

The Healthfit unit is a joint venture managed by the Department of Health Services and the Division of Recreation, and funded by the Menzies Foundation and the Commonwealth Department of Sport and Recreation. The unit is a practical reminder to the community of the need to rethink lifestyles, and raises the very issues at the core of changes to the health system in a way that is relevant to the individual.





10.5 MENTAL HEALTH

Significant advances have been made in the field of clinical psychiatry and in the treatment of mental illness during the past three decades. The development of psychotropic drugs, new therapeutic techniques and improved methods of clinical practice have revolutionised the mental hospital from an institution for the incarceration of lunatics to a modern hospital geared to the care and rehabilitation of the sufferers of psychiatric disorders. In Tasmania a range of services for the mentally ill and the intellectually handicapped are provided by the Mental Health Services Commission, a statutory authority established in 1967.

10.5.1 Adult Psychiatric Services

Adult psychiatric services are provided from the Royal Derwent Hospital, psychiatric units within general hospitals and various community based clinics located throughout the State.

The Royal Derwent Hospital at New Norfolk in the south is the State's principal centre for treatment of patients suffering severe and chronic psychiatric illness. Approximately 300 beds comprising nine wards, cater for medium to long-term management, acute close management and rehabilitation, with active and individualized programmes replacing custodial care wherever possible. Residential accommodation is also supplied for long-term psychotic patients. A psychiatric unit, located at the Royal Hobart Hospital has 23 beds available for acute cases presented to Casualty as well as from general referral sources. This unit also has a major teaching function at undergraduate and post-graduate levels. As well, two Community Centres providing general community access in addition to dealing entirely with many patients who need no hospital intervention, provide an alternative to hospital admission. From these Centres, a team approach comprising a psychiatrist, a welfare officer and a nursing sister, has been developed. The Centres in Hobart City and Bellerive are to be complemented with a Glenorchy Centre when accommodation is located. A Day Centre for elderly brain failure patients is located in South Hobart where specialist consultation, respite care and assessment are provided.

The north of the State is serviced by the Lindsay Miller Clinic attached to the Launceston General Hospital, and the north-west by the Spencer Psychiatric Clinic and the Devon Clinic located at the North-Western and Mersey General Hospitals respectively. The Lindsay Miller Clinic provides acute psychiatric management on an in-patient, day-patient and out-patient basis. The unit has 16 beds with nursing services being provided by the hospital.

The Spencer Psychiatric Clinic has 17 in-patient beds and out-patient facilities. The unit is also recognised as an Alcohol and Drug Dependency Treatment Centre and provides comprehensive medical treatment for all psychiatric disorders. At the Devon Clinic clients are dealt with on an out-patient basis, with referral to hospital when necessary. Psychiatric assessment, medical treatment, counselling and psychotherapy using a team approach are available.

10.15 Adult Psychiatric Patients, Tasmania, 1984–85

Hospital/Clinic	*In-patients*	*Out-patients/ Day-patients*
Royal Derwent	259	49
Royal Hobart	290	678
Lindsay Miller Clinic	235	681
Spencer Clinic	257	478
Devon Clinic	240	98
Total	1 281	1 984
Community Centres	—	2 086

10.5.2 Child and Adolescent Psychiatric Services

Services for young people are located in Hobart and Launceston. Operating from Clare Street, New Town, the Southern service provides a multi-disciplinary approach to the management of a range of problems from temper tantrums in the pre-school child to delinquency in older children. There is a strong emphasis on a family centred approach, and on consultation with other agencies who may also be involved with the young person or his family. Staff in the South hold regular clinics in outlying and suburban areas such as Rokeby/Bridgewater, the Huon Valley and Kingborough.

In the North, the Wellington Street Clinic provides a similar style of service, although there are fewer staff. Consultations with other departments have included collaboration with the Education Department in a task force on early school leavers or 'drop outs'.

10.16 Child and Adolescent Out-Patients, Tasmania, 1984–85

Region	*Out-patients*
North	985
South	312
Total	1 297

10.5.3 Intellectual Handicap Services

In the south, services for adults are centred at the Willow Court Residential Training Centre located within the Royal Derwent Hospital at New Norfolk. The Centre manages a residential population of some 320 clients whose disabilities range from moderate to severe. The gradual reorganisation of the Centre's traditional departmental structure toward a programmatic system of service delivery has enabled an increasing emphasis on habilitation and other training for a less dependent lifestyle. The Quindalup Respite Care Centre in Hobart provides a residential respite service for children under 16 years of age as well as a limited day care service.

In the north, the Rocherlea Training Centre in Launceston provides a residential respite care service to intellectually disabled people of all ages and levels of disability. It also provides a range of social and vocational training programs to adults who live within commuting distance.

10.17 Intellectually Handicapped Patients, Tasmania, 1984–85

Patients	*Number*
Residential	38
Out-patients	41
Respite care	148
Day training	120

10.5.4 Alcohol and Drug Dependency Services

Treatment of alcohol and drug dependency in Tasmania is provided at two centres, the John Edis Hospital in Hobart and the Launceston and Northern Tasmanian Alcohol and Drug Dependency Centre at the Launceston General Hospital. The John Edis Hospital has facilities for outpatient, day-patient, and in-patient care as well as a 10 bed detoxification unit. The northern centre provides medical assessment and treatment combined with individual counselling and group work. Beds are provided at the Lindsay Miller Clinic for medical treatment of short duration while detoxification is managed at the hospital. In the south the service is planning to commence locally based clinics at health centres.

10.18 Alcohol and Drug Dependent Patients, Tasmania, 1984–85

Patients	*Number*
In-patients	417
Out-patients	1 015
Day-patients	54

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