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HEALTH AND MEDICAL RESEARCH

GOVERNMENT HEALTH SERVICES

Commonwealth Government

Commonwealth Department of Health

The Commonwealth Department of Health is concerned with development, planning, and administration in the fields of public health, hospitals, community health and dental services, hospital, medical, and pharmaceutical benefits, therapeutic goods, quarantine, and grants for medical research. To carry out its many roles, the Department has numerous divisions, namely, the Quarantine, Public Health, Medical Services, Health Services, Therapeutics, National Health and Medical Research Council, Policy and Planning, Management Services, Medical Insurance Services, and the Hospital Insurance and Nursing Homes Divisions. Other areas within the Department are the National Biological Standards Laboratory, the School of Public Health and Tropical Medicine, and the Institute of Child Health.

The Commonwealth Minister for Health is responsible for the administration of the Department and three statutory authorities—the Capital Territory Health Commission, the Commonwealth Serum Laboratories Commission (see pages 642–3), and the Health Insurance Commission (see pages 616–19).

The Commonwealth Department of Health is administered, subject to the Minister, by a Director-General of Health situated in Canberra. In Victoria, as in the other States, there is a Commonwealth Director of Health responsible to the Director-General. As such, he and his officers represent the Department in any Central Office activities in Victoria.

Social Welfare Policy Secretariat

On 19 December 1977, the Commonwealth Government announced the establishment of the Social Welfare Policy Secretariat and that it would work through a Committee of Permanent Heads to the Social Welfare Policy Committee of Cabinet.

The functions of the Secretariat are to:

(1) Be responsible to the Permanent Heads Commmittee on Social Welfare for the provision of advice on, and the integrated development of, plans and policies and programmes in the broad field of health and welfare;

(2) provide, or ensure the provision of, support to the Social Welfare Policy Committee of Cabinet on matters in the broad field of health and welfare;

(3) assist the Permanent Heads Committee on Social Welfare to carry out its functions, including those of any sub-committee it might establish; and

(4) ensure the co-ordinated development and review of health and welfare policy and ensure that appropriate research activities are directed to these ends.

Community Health Program

The Community Health Program was introduced in 1973–74, to encourage the provision of comprehensive and integrated community-based health care and support services. Its objectives emphasise prevention, education, rehabilitation, and domiciliary services as an alternative to institutional care. Although by no means all community health services are supported under this one programme, it is seen as a major source of support for new

initiatives in community health services. There is a clear preference for proposals in which the community itself has been involved in the planning of programmes, together with the relevant State health authorities.

In previous years, grants to projects in the States were approved on an individual project basis, but at the outset of 1976–77 this approach was changed. Financial allocations to the States now take the form of annual block grants for each State's total approved programme, including projects conducted by non-government organisations operating at State or local levels. Under these arrangements, the States have responsibility for determining the allocations to individual projects from their respective block grants, and have flexibility in the movement of funds from one approved project to another, to meet changing circumstances. The block grant system involves the Commonwealth Government in broad policy issues; in seeking agreement with the States on the inclusion of projects in annual programmes and the broad priorities therein; and, in conjunction with the States, in evaluation and progress reporting. The States have primary responsibility for detailed administration of their annual programmes. Commonwealth Government funding to projects conducted by the States or by non-government organisations funded through the States has been made on the basis of 50 per cent of capital and operating costs since 1978. In addition to funds provided to the States for projects at State or local levels, the Commonwealth Government provides funds, generally on a 100 per cent basis, direct to approved national projects conducted by non-government organisations.

An amount of $6.0m has been provided to cover the cost of projects conducted by national organisations including the Family Medicine Program and the National Alcohol and Industry Program.

The Commonwealth Government is concerned that assistance should be available to women and children in crisis situations and regards the financing of women's refuges as a matter of importance. An amount of $3.6m has been provided for 1979–80 to meet up to 75 per cent of operating costs and up to 50 per cent of the capital costs of women's refuges approved under the Community Health Program.

During 1979–80, the Commonwealth Government intended to make $59.3m available for allocation under the Community Health Program. Of this $59.3m, $53.3m will be available to the States in the form of block grants, of which Victoria expects to receive $14.07m. The remaining $6.0m will be absorbed by national projects financed directly by the Commonwealth Government.

Health Services Planning and Research Program

Through this Program, research activities concerned with the planning, organisation, staffing, financing, management, operation, and use of health services are supported. An amount of $1.35m was made available in 1979–80 for all States to develop and expand their health planning agencies. Also, $460,000 was allocated to State health authorities on a dollar for dollar basis.

The Commonwealth Department of Health is involved in research activities concerned with the planning, organisation, staffing, financing, management, operation, and use of health services.

Further references: Hospital and Health Services Commission, *Victorian Year Book* 1976, pp. 675–6; 1978, pp. 658–61

Health Insurance Commission

From 1 November 1978, the role of the Health Insurance Commission has been reduced to that of a private registered organisation (while still a statutory authority) with its former functions having been taken over by the Commonwealth Department of Health.

Further references: *Victorian Year Book* 1977, pp. 755–6; 1978, p. 661

Victorian Government

Health Commission of Victoria

The Health Commission of Victoria commenced operations in December 1978. Its structure is based upon three line divisions — the Public Health Division, Hospitals Division, and Mental Health Division.

Public Health Division

The main functions of the Public Health Division of the Health Commission of Victoria lie in the fields of dental health, medical assessment, food and drugs, general health, pre-school child development, maternal and child health, tuberculosis, and community services.

The Medical Assessment Services Section is responsible for the medical examination and assessment of applicants for appointment to the Victorian Public Service and semi-governmental bodies. It also advises Victorian Government departments, the Public Service Board, and the Superannuation Board on matters relating to the ill health or retirement of officers.

The Food and Drugs Section of the Division supervises the production of foodstuffs to meet the prescribed standards of wholesomeness and purity. Such food regulations apply to manufacture, preparation, storage, wholesale and retail sale, and use by the consumer. The production of drugs, as proprietary medicines or as therapeutic substances, also lies within the jurisdiction of the Section. Products are required to conform to the prescribed standards of efficacy and safety in manufacture, storage, wholesale distribution, sale by retail outlets, and in their use by consumers. The Section also controls the margins of safety that apply in the manufacture, storage, and distribution of poisons and deleterious substances.

The General Health Section of the Division encompasses a wide range of responsibilities, as the following paragraphs indicate.

The Prison Medical Service provides medical and dental treatment for all prisoners in Victoria. In country institutions, treatment is provided through local general practitioners and hospitals. At Pentridge, there are three clinics in the remand prison, a psychiatric service, and the Pentridge Clinic. The treatment service will be expanded with the new prison hospital which is expected to be in operation in 1980. Other programmes include tuberculosis screening at Pentridge, Prison Dental Service, Optometry Service, and Prison Psychiatric Service.

The Public Service Medical Centre provides an occupational health service to protect, promote, and improve the health of all Crown employees.

The Cemeteries Section exercises responsibility over 758 private burial grounds in Victoria. The Cemeteries Act provides for a variety of duties, including the establishment and discontinuance of cemeteries, appointment of cemetery trustees, approval of scales and fees and rules and regulations, expenditure of funds, acquisition of land, maintenance of monuments, and inspection of cemeteries. The Section also deals with the allocation of grants to country cemeteries in May and September of each year, for various maintenance works.

The Industrial Hygiene Section carries out investigations into lead poisoning; occupational asthma; the provision of chest X-rays for suspected occupational lung disease; surveillance of manufacturing plants in relation to cadmium pigments; the prevalence of carbon monoxide in factories; and the occurrence of organo-phosphates and other pesticides. There has been considerable investigation of the dangers of asbestos, and the information gained has been made available to the Victorian Department of Labour and Industry for the drafting of asbestos regulations. Work is continuing in the field of radiation monitoring and particular testing has been done on micro-wave ovens and the level of X-ray emissions from video display units. The Section is currently undertaking audiometric testing for noise level assessment in relation to the legislation required in this area.

In late 1979, the Communicable Diseases Centre was opened to deal with sexually transmitted diseases — the only area of disease control with its own statute. A high standard of diagnostic, therapeutic, and epidemiological service is now available to patients.

Medical officers with qualifications in public health together with health surveyors have defined geographical areas of responsibility for their role in superintending and advising local government in matters of public health.

The Land Waste Management Section administers the powers and functions delegated to the Health Commission by the Environment Protection Authority. The Commission is

responsible for the transport and discharge of all wastes, including solids, liquids, and sludges to land, i.e., the control of soil pollution. It receives licence applications, issues and amends licences, checks licence conditions, and investigates breaches of the Act.

The Pest Control Section supervises general pest control and investigates a variety of complaints. These include insect infestation of foods, fly and rat breeding in garbage depots, poultry farms, and abattoirs. A mosquito vector monitoring programme is conducted throughout Victoria and the Murray Valley to control the breeding of the mosquito *Culex annulirostris,* thereby reducing the possibility of transmission of Australian arbo-encephalitis.

The Sanitation Section exercises responsibility for the installation of safe water supplies; the sanitary handling and disposal of excreta; the provision of fluoridation of water supply; and the standards of cleanliness in swimming pools. Other activities include approval of septic tanks installed by councils; public buildings assessment; supervision of sewage treatment processes; approval of council-owned cattle saleyards and other offensive trade premises; and licensing of waste water re-use.

The Health Education Centre offers resources to enable members of the community to make better informed choices concerning their health and well-being. Resources for schools and community groups include a consultancy service for planning health education programmes, advice on films and other materials, and speakers on various health-related subjects.

The aim of the audiological service is to provide a State-wide testing service to detect hearing impairments in infants before the age of twelve months, and a consultancy service within the early childhood development programme to test for conductive deafness, particularly middle-ear problems. The service fosters a greater awareness of the importance of normal hearing for infants and young children in the development of speech.

The physiotherapy service provides a programme designed to maintain the independence of poliomyelitis sufferers in the domestic environment; to augment current services for persons suffering from multiple sclerosis; to develop preventive programmes for children in community physiotherapy and to communicate the role of the community physiotherapist by health promotion and educational programmes to the parents.

Other paramedical services which have been developed and expanded as part of the early childhood development programme include dietetics, occupational therapy, social work, psychology, and speech therapy.

The Special Health Services Section aims to promote the well-being of Aboriginal persons in Victoria, with particular reference to regions outside the Melbourne metropolitan area. The service is family-based, and each community health aide has a number of families for whom she is responsible. Within the field of preventive medicine, the aim of the Section is to satisfy the needs and wants of Aboriginals so that they have a level of health and general well-being equal to that of the general Australian population.

Hospitals Division

On 7 December 1978, the Hospitals Division, as one of the main line divisions of the new Health Commission, became generally responsible for the day to day administration of most areas formerly governed by the Hospitals and Charities Commission.

The Hospitals and Charities Act provides for the registration of "institutions" and "benevolent societies" as defined in the Act. The main requirements for registration are suitable objectives and a constitution, and, if not incorporated, provision to appoint personal trustees to be responsible for the accumulated assets, etc., of the organisation.

Registration makes such organisations eligible to share in the Hospitals and Charities Fund for maintenance (operating) subsidies. The great proportion of financial assistance is allocated to hospitals and hospitals for the aged. The awarding of grants is dependent upon the availability of funds and the purposes for which they are to be used. Close scrutiny is maintained over hospital budgets and each institution is required to submit for approval budgets covering the succeeding year's operations.

The cost of operating the public hospital system has increased substantially. The average cost per bed per day was $19.35 in 1968, compared with $115.03 in 1978.

The Health Commission of Victoria, through the Hospitals Division, exercises control of State funds for capital works, where Commission approval is required at all stages of a building project from the original narrative, through the preliminary sketches to documentation, tendering, and supervision of the project. Capital expenditure undertaken was $15.2m in 1968, compared with $66.5m in 1978.

The Division co-ordinates hospital and institutional activities, and it has the power to inquire into the administration of institutions and societies.

The Division has various responsibilities for nursing in Victoria, deciding in consultation with the Victorian Nursing Council whether any particular hospital will participate in approved basic or post-basic registered general nursing courses; it determines the establishment of nursing staff for hospitals; advises intending applicants for basic courses in nursing on the educational standard required and subjects preferred for entry into the various branches of nursing; produces publicity information including films and other advice; offers scholarships for recommended registered general nurses to attend tertiary institutions to undertake postgraduate courses; directs a staff of nurses to relieve matrons in country hospitals when they are on leave and assists when urgent shortages of nursing staff occur; and helps generally in nursing matters in hospitals and community health services.

Mental Health Division

The Mental Health Division of the Health Commission of Victoria plans and directs Victoria's treatment and preventive services in the fields of mental illness, mental retardation, alcoholism, and drug dependence.

The Division, which until December 1978 was controlled by the Mental Health Authority, is administered by a director and secretary and has three service sub-divisions—psychiatric services, mental retardation services, and alcohol and drug services. These services are provided by some 9,000 staff.

At January 1980, the Division was operating with 270 medical practitioners, of whom almost half were specialists. Other professionals included 60 pharmacists, 75 psychologists, 113 social workers (including part-timers), 103 occupational therapists, approximately 1,250 mental health nurses, and approximately 600 student nurses.

Further references: History of the Victorian Department of Health, *Victorian Year Book* 1961, pp. 215-17; Health of the Victorian Community, 1962, pp. 243-6; Hospital Regional Planning, 1962, pp. 261-2; Historical Outline, 1965, pp. 253-5; Hospital Architecture, 1966, 241-2; Charities in Victoria, 1968, pp., 514-15; Rationalised Medical Services, 1971, pp. 511-12; Committee of Inquiry into Hospital and Health Services in Victoria, 1976, pp. 671-5; Victorian Department of Health, 1978, pp. 662-4; Local Government Authorities, 1978, p. 665

HEALTH INSURANCE IN AUSTRALIA

Introduction

The current health insurance arrangements in Australia were further modified on 1 September 1979. The basic feature of these arrangements is the provision of a primary level of coverage against health costs by the Commonwealth Government with additional coverage being offered by private health insurance organisations.

The coverage provided by the Commonwealth Government is universal and automatic. The Commonwealth Government now finances the coverage it provides from consolidated revenue. The element of compulsory insurance existing under the modified Medibank scheme has also been removed.

Medical coverage

General features

Excepting pensioners holding Pensioner Health Benefit Cards, disadvantaged persons, and uninsured persons receiving medical treatment from hospital doctors while accommodated in a recognised hospital, all of whom are covered by special arrangements, all Australian residents are entitled to receive a Commonwealth medical benefit for schedule fees in excess of $20, such that the maximum patient contribution for any one service where the schedule fee is charged is $20. When the schedule fee exceeds this amount, the Commonwealth benefit progressively increases. All fees were increased from 1 November 1979.

The Commonwealth benefit is payable through the registered health insurance organisations. Services attracting benefits include most medical practitioner services, certain optometrical services, and certain medical services performed by approved dentists and dental surgeons in recognised hospitals.

Additional medical coverage is available on a voluntary basis, from private health insurance organisations. As a condition of registration, private health insurance organisations must offer, separately, a basic medical benefit table which, when combined with the Commonwealth benefit, provides coverage for 75 per cent of the schedule fee, with a maximum patient payment of $10 for any one service where the schedule fee is charged.

In addition to the basic table, private health insurance organisations offer supplementary tables which include benefits for schedule services up to the schedule fee (i.e., a maximum fund benefit of 60 per cent), optional deductibles arrangements, and benefits for allied and ancillary health services.

The Commonwealth Department of Health allocates each medical practitioner a unique number called the provider number. Payment of medical benefits is facilitated if doctors include their provider number on their accounts and receipts. Private medical practitioners normally charge for treatment provided on a fee-for-service basis. Each medical service which attracts a medical benefit has a schedule fee which is set by an independent tribunal. The fees are set for medical benefit payment purposes only and doctors are not compelled to charge them.

The Australian Medical Association (A.M.A.) publishes its own list of medical services and fees which in the opinion of the Association are fair, reasonable, and appropriate for the services listed. While there is some variation between individual items, generally speaking the A.M.A. fees are in excess of the schedule fees (e.g., G.P. standard surgery consultation: $10.40 A.M.A. and $9.50 schedule).

Since 1970, a feature of the Australian medical benefits arrangements has been the payment of higher rate of benefit for medical services performed by recognised specialists and consultant physicians. Thus, for medical benefit payment purposes, Specialist Recognition Advisory Committees were established in each State to consider applications for recognition from medical practitioners. At 1 December 1979, there were 1,894 recognised specialists and 809 recognised consultant physicians in Victoria.

Optometrical arrangements

Underpinning the provision of optometrical consultation benefits is a Participating Optometrists Scheme, whereby optometrists, or if applicable, their employees, must undertake to charge consultation fees no higher than those set out in the Schedule to the Commonwealth Health Insurance Act and that consultations will be provided generally at no direct cost to eligible pensioners and their dependants by means of assignment of Commonwealth medical benefits.

Most optometrists in Victoria are participating in the Scheme. At 1 December 1979, 140 undertakings were in effect in respect of 244 practice locations. These undertakings covered a total of 228 optometrists.

Before the introduction of the Participating Optometrists Scheme, optometrists who made their services available to isolated areas recouped the additional costs incurred by raising a surcharge. The current arrangements preclude such additional charges. To ensure that an adequate optometrical service is available in isolated areas, the Commonwealth Government covers the approved costs incurred by making per capita grants directly related to the number of patients seen in these isolated areas. This assistance is in addition to the optometrical consultation benefits.

At 1 September 1979, eight Victorian optometrists were receiving such assistance with the per capita grants ranging from $1.50 to $4.50.

Pathology arrangements

Following the consideration of the Final Report by the Pathology Services Working Party, the Commonwealth Government introduced, on 1 August 1977, a number of measures intended to eliminate abuses and contain the escalating costs of medical benefits for pathology services.

A new pathology services and fees section of the medical benefits schedule was introduced which reduced the number of pathology items and fee levels, adjusted fees to stimulate the use of cost saving technology, and generally improved the rules on multiple testing of pathology specimens. The new section also contains a division of pathology items into two groups. The first group of items applies only where the pathology services are rendered by approved pathology practitioners. The second group of items applies where the services are performed by medical practitioners who are not approved pathology practitioners. Approval as a pathology practitioner is obtained from the Commonwealth Minister for Health through the Approved Pathology Practitioner Scheme. This approval is conditional on the signing of an undertaking to observe a code of conduct. Such observance is to be monitored by the Medical Services Committee of Inquiry.

The items in the first group attract fees and benefits at either the "SP" or "OP" rate. The "SP" rate applies only where the service is performed by an approved pathology practitioner who is a recognised specialist pathologist or by a recognised specialist pathologist employed by an approved pathology practitioner. Also, certain other conditions have to be met. The "OP" rate applies where the service is performed by an approved pathology practitioner who is not a recognised specialist pathologist, and who does not employ a recognised specialist pathologist. This "OP" rate also applies to services performed by an approved pathology practioner who is, or employs, a recognised specialist pathologist but where all the other "SP" rate conditions have not been met.

Bulk billing facilities were withdrawn for pathology services other than those provided to eligible pensioners and their dependants. Also "pay doctor cheques" can no longer be sent by private health benefits organisations direct to medical practitioners or to patients at the doctor's address (even if requested by the patient to do so). "Pay doctor cheques" are now forwarded to the contributor's normal address.

The Health Insurance Act has been amended so that medical benefits are not payable in respect of pathology services unless a practitioner has determined that the service is reasonably necessary for the adequate medical care of the patient concerned, whether he performs the service or requests another practitioner to perform the pathology tests. It is also a requirement that requests for pathology services within the above mentioned first group of items must be in the requesting practitioner's own handwriting unless these services are self-determined. A request in writing is required within a partnership or group of practitioners. Approved pathology practitioners must retain requests in writing for eighteen months. Requests in writing are not required for services listed in the second group of items.

Medical practitioners who request pathology services must be identified on the patient's account so that they can be made accountable to the Medical Services Committee of Inquiry which will be able to ask them to show that the services requested were reasonably necessary for the adequate medical care of their patients.

Since 1 November 1977, a further "HP" fee and benefit rate was introduced and applies to pathology services in respect of private inpatients of recognised hospitals where recognised hospital or government laboratory equipment and/or staff is used. At the same time, the range of pathology services attracting the "OP" fee and benefit rate was extended to include services where government (including university) laboratories staff or equipment is used. This brings these laboratories into line with recognised hospitals' laboratories.

Commonwealth Health Laboratories undertake pathology work for hospitals and private practitioners, and since 1 November 1977, charges equal to the appropriate medical benefits have been introduced for pathology services provided on behalf of privately insured patients. These patients are able to recover the incurred costs from their medical insurance funds. The new charging policy is in line with the Commonwealth Government's belief that those who can afford to pay for health services should do so. There is one Commonwealth Health Laboratory in Victoria, situated at Bendigo.

Currently there are 539 medical practitioners approved as pathology practitioners in Victoria.

Bulk billing arrangements

Bulk billing arrangements exist for pensioners (plus dependants) who hold Pensioner Health Benefit Cards, excepting those with private medical insurance. The pensioner is

able to assign his/her benefits to the doctor who claims the full amount from the Commonwealth Department of Health. The rate of benefit is equal to 85 per cent of the schedule fee with a maximum patient payment of $5 where the schedule fee is charged.

A similar bulk billing arrangement exists for persons identified by the doctor concerned as disadvantaged except that the rate of Commonwealth benefit for bulk billed services in this case is equal to 75 per cent of the schedule fee. Also there is the requirement that doctors accept the benefit in full satisfaction for their services.

Uninsured persons

Uninsured persons while accommodated in a recognised hospital, in a standard ward unless their condition necessitates otherwise, are not charged for medical treatment rendered by a doctor engaged by the hospital. Recognised hospitals must also not raise charges when providing outpatient treatment to uninsured persons. Insured persons who receive outpatient treatment are charged an amount, currently $6 per attendance, though benefits from their private health insurance organisation are available to cover this fee. The provision of medical treatment to uninsured persons in a recognised hospital and outpatient arrangements for insured and uninsured persons are all conditions under which the Commonwealth Government makes payments to the State Governments to help cover the net operating costs of recognised hospitals.

Statistical data

As part of the existing medical benefits arrangements, a comprehensive range of statistics on medical services and payments is being maintained under the health insurance medical statistical system. Data is obtained from all registered health benefits organisations operating medical funds and from within the Commonwealth Department of Health. Through the use of computers this data is being used for effective monitoring of the overall operation and costs of the medical benefits scheme; analysis for use in fee and benefit negotiations and inquiries; providing information as a basis for reviewing and restructuring the medical benefits schedule, and for assessing the effects and cost of such review and restructuring; and analysing medical practitioner servicing patterns and providing basic data for Medical Services Committees of Inquiry.

Medical Services Committees of Inquiry

In August 1977, a further Medical Services Committee of Inquiry was established in Victoria, in common with other States, under the Health Insurance Act (there already is a Committee under the National Health Act).

The Committees are concerned with monitoring and making recommendations to the Commonwealth Minister for Health in regard to, among other matters, the rendering of excessive medical services, the excessive initiation of pathology services, and the adherence to the conditions which are part of a pathology services undertaking. These Committees do not examine cases of fraud, which are covered by other sections of the Health Insurance Act.

Each Committee has five members, one of whom is the Commonwealth Director of Health in Victoria. The other members comprise two general practitioners, a specialist surgeon, and a physician. These other members are selected by the Minister from nominations by various medical associations.

An Optometrical Services Committee of Inquiry was appointed in 1979.

Health programme grants scheme

Health programme grants were introduced as part of the Medibank arrangements with effect from 1 July 1975, primarily to provide an alternative source of financing to the payment of medical benefits for services provided outside of hospitals by medical practitioners employed on a salaried or sessional basis. It was believed that meeting the cost of these services by means of a grant would result in savings to the Commonwealth Government as under the then existing arrangements that Government would have had to meet under Medibank the rest of the medical benefits for services rendered. The grants were also used to assist organisations in the provision of appropriate health type services.

Since 1 October 1976, and as a general principle, organisations receiving grants are required to raise fees for services rendered to privately insured persons. Therefore, grants

are now generally restricted to meeting the cost of services provided to persons who are uninsured, and to meeting the cost of services which do not attract medical benefits.

Commonwealth Government concern about the serious cost escalation being experienced by Australia's health care delivery system has led to the introduction of health programme grants for development projects and associated evaluative research which consider new and different forms of health care, quality assurance processes, and cost containment in health services.

Hospital coverage

As part of the primary level of coverage against health costs provided by the Commonwealth Government, patients are classified as either "hospital patients" or "private patients".

A hospital patient is one who elects to be accommodated as a standard ward patient (where medically necessary the patient can be accommodated in a semi-private or private ward) and is treated by a medical practitioner arranged by the recognised hospital. As a condition of the hospitals agreement between the Commonwealth and State Governments this accommodation is provided free of charge if a hospital patient is uninsured. There are conditions in regard to the provision of medical treatment to these patients which must also be met.

State Governments are further required to make recognised hospital accommodation charges at the agreed rates (see below) in respect of insured patients. Private patients are charged by the hospital for both the accommodation at the approved daily bed rate and the medical services ($25 per day). For its part, the Commonwealth Government meets 50 per cent of the approved net operating costs of each State's recognised hospital system, expressed in aggregate budget form. Payments to the Victorian and other State Governments are made by way of monthly advances.

For persons who elect to be private patients, hospital coverage is available from private health insurance organisations. As a condition of registration these organisations must offer, separately, a basic hospital benefits table providing benefits which cover the semi-private ward accommodation charges raised by recognised hospitals. Currently, $50 per day is charged for this type of accommodation. By contributing to this (basic) and other (supplementary) tables it is possible to be covered against the private ward accommodation charges of recognised hospitals, currently $75 per day, and the majority of private hospital bed fees and other charges (e.g., theatre room fee, labour ward charge). It is possible to contribute to hospital benefit tables which incorporate deductibles arrangements. The joining of these tables is optional. However, where the care and treatment involve a person for whom compensation or damages are payable, the compensating authority is subject to a charge equal to the average daily bed cost of the hospital.

The Commonwealth Government provides assistance in meeting private hospital bed fees through a $16 per bed day payment directly to the private hospitals. Also, through its re-insurance account arrangements with the private health benefits organisations, the Commonwealth Government provides special assistance for those "basic" hospital table contributors with chronic or other illnesses requiring prolonged hospitalisation. These arrangements replace the former special account arrangement and incorporate a trust fund administered by ministerially appointed trustees. By a complex formula to ensure equality between the private health benefits organisations according to the claims experience of total membership, the cost of the chronic contributors' basic hospital benefit claims to each organisation is established by the trustees. The Commonwealth Government, through the trust fund, provides these organisations with assistance, currently equal to $50m per annum Australia-wide in meeting these costs. The remaining benefits liability for these chronic contributors is shared equally between the organisations.

A three man Commission of Inquiry into the efficiency and administration of hospitals was announced by the Federal Minister of Health in May 1979. The Commission was asked to make a preliminary report by June 1980 and its final report by December 1980.

Nursing home benefits arrangements

The current nursing home benefits arrangements are the result of major changes introduced by the Commonwealth Government on 1 October 1977. The ordinary care and additional nursing home benefits existing under the previous arrangement were combined to form the current basic nursing home benefit. This benefit is for nursing home patients

receiving ordinary nursing care and varies between States. At 8 November 1979, this benefit in Victoria was payable up to a maximum of $22.70 per day.

The supplementary nursing home benefit available under the previous arrangement for intensive care patients has been continued but at the increased rate of $6 per day. To avoid confusion with intensive care provided in hospitals, the name of this benefit has been changed from supplementary nursing home benefit to extensive care benefit. In addition, the appropriate type of nursing care is now referred to as extensive.

Prior approval for the admission of patients to participating or deficit financing nursing homes must be obtained from the Commonwealth Department of Health. Approval for admission also acts as approval for the payment of basic nursing home benefits. Approval is also required for the payment of extensive care benefits.

The Commonwealth Government pays the appropriate benefits on behalf of uninsured patients (i.e., patients who do not contribute to a basic hospital benefits table) accommodated in participating or State nursing homes. Uninsured deficit financing nursing home patients are covered by the deficit financing scheme (see below).

Private health insurance organisations pay the appropriate benefit on behalf of insured patients (i.e., patients who contribute to a basic hospital benefits table) accommodated in participating, State, and deficit financing nursing homes.

The notion of patients paying a prescribed minimum contribution towards the nursing home accommodation costs established under the previous scheme has been retained. In May 1978, the procedures for establishing this minimum patient contribution were altered so that this contribution is now set at seven-eighths (87.5 per cent) of the single rate pension plus supplementary assistance. At 8 November 1979, the rate of contribution in all States was $7.85 per day for participating nursing home patients and deficit financing nursing home patients. These rates may be waived or reduced in cases of financial hardship. State Government nursing homes set their own patient contribution levels, which are dependent on the means of each patient.

The rates of benefit now payable in any one State, when combined with the prescribed minimum patient contribution, are designed to cover fully the approved fees charged for 70 per cent of the beds in non-government nursing homes in that State.

Nursing home inspections are conducted to ensure that patients are receiving the appropriate level of nursing care and to ensure that the patient classifications are correct. The National Health Act includes provisions under which the construction of new nursing homes or extensions to existing approved premises require departmental approval.

The Commonwealth Government has maintained its control over nursing home fees by continuing to make it a condition of approval under the National Health Act that participating nursing homes cannot charge fees in excess of those determined by the Commonwealth Department of Health. This control is designed to ensure that the fees for such nursing homes are not increased beyond the level justified by rises in operating costs. Nursing homes operated by State Governments are not subject to the same control by the Commonwealth Department of Health, since it has been agreed that the fee fixing policies of such nursing homes are the responsibility of State Governments.

Since 1 January 1975, the Nursing Homes Assistance Act has provided for a deficit financing scheme for eligible organisations operating religious or charitable type nursing homes. Under the scheme, the nursing homes submit budgets for approval and their approved operating deficits are financed by the Commonwealth Government. Because of these arrangements the Commonwealth Government does not pay nursing home benefits on behalf of uninsured patients and no charge other than the prescribed fee of $54.95 per week is made for these patients.

VICTORIA—NURSING HOME BENEFITS PAID
($'000)

Particulars	1974–75	1975–76	1976–77	1977–78	1978–79
Commonwealth Government	36,631	43,019	51,831	55,922	50,505
Private health insurance funds	2,882	3,963	3,244	*(a)*17,676	*(a)*31,142
Total benefits paid	39,513	46,982	55,075	73,598	81,647

(a) The increase in benefits paid by the private health insurance funds is due to the change in the nursing home arrangements from 1 October 1977.

Domiciliary nursing care benefits

A Commonwealth domiciliary nursing care benefit is available to help meet the cost of home nursing and other professional care required by aged persons living in private homes. This benefit was previously available only for aged persons of 65 years of age or over. From 1 November 1979, the benefit was made available to persons 16 years and over.

A person who provides continuous care for a person aged 16 years and over may be eligible to receive the $2 per day benefit provided a number of conditions are met. The beneficiary and patient must live together in a private home. Aged persons may also live in an aged persons complex where that complex does not also contain a nursing home or hostel. Alternatively, the complex may contain a hostel, provided no nursing staff are employed. The patients must be at least 16 years of age and must have an official certificate from their doctor stating that because of infirmity, illness, or incapacity, they have a continuing need for nursing care by a registered nurse and they must, in fact, be receiving care from a registered nurse on a regular basis involving multiple visits each week. These visits can be made on a less frequent basis provided the beneficiary has a competency certificate. The benefit is not subject to a means test and is not considered as taxable income.

The Commonwealth Department of Health maintains a liaison with interested organisations such as the Royal District Nursing Service. In this way, a feedback of information is obtained to help the Department review the benefit.

VICTORIA—DOMICILIARY NURSING CARE BENEFITS

Particulars	1974–75	1975–76	1976–77	1977–78	1978–79
Number of beneficiaries *(a)*	2,282	2,426	2,296	2,475	2,565
Benefits paid ($'000)	1,667	1,811	1,831	1,794	1,965

(a) At the end of the financial year.

Isolated Patients Travel and Accommodation Assistance Scheme

The Isolated Patients Travel and Accommodation Assistance Scheme provides financial help for persons in remote areas of Australia who require specialist medical treatment or services. The Commonwealth Government will help to meet the cost of travel and accommodation for patients who have to travel more than 200 kilometres to the nearest suitable specialist for treatment.

Patients are required to pay the first $20 of the cost of travel. The Commonwealth Government will pay the balance and up to $15 a night towards the cost of necessary accommodation. The scheme also provides identical help for a person accompanying the patient when the medical condition of the patient warrants it. If the patient is a child under 17 years of age, the financial assistance will be given to a parent or other escort, irrespective of the child's condition. There is no means test for the scheme, which commenced on 1 October 1978.

Pharmaceutical benefits

The National Pharmaceutical Benefits Scheme was introduced in 1950, along with a restricted free list of life saving and disease preventing drugs. In 1951, an additional comprehensive range of medicines was provided free to pensioners. The Scheme, considerably expanded in 1960, introduced a patient contribution fee of 50 cents for prescriptions written for the general public. This contribution was increased to $1.00 in 1971, $1.50 in 1975, $2.00 in 1976, $2.50 in July 1978, and $2.75 in September 1979. Eligible pensioners and their dependants receive pharmaceutical benefit prescriptions free of charge.

The drugs and medicinal preparations available as pharmaceutical benefits are determined by the Commmonwealth Minister for Health on the advice of the Commonwealth Pharmaceutical Benefits Advisory Committee. Pharmaceutical benefits are supplied by approved pharmaceutical chemists on medical practitioners' prescriptions. In regions with no approved chemist, a medical practitioner may be approved as supplier.

The provision under the National Health Act to approve hospitals as pharmaceutical suppliers was incorporated into the agreement relating to the provision of hospital services which commenced on 1 August 1975.

VICTORIA—PHARMACEUTICAL BENEFITS

Particulars	1974–75	1975–76	1976–77	1977–78	1978–79
Number of prescriptions ('000)	25,927	25,734	22,604	23,659	23,873
Prescription cost ($'000)—					
Commonwealth Government contribution	68,116	65,701	56,246	61,636	65,543
Patients' contribution	18,568	25,959	29,647	30,697	35,397
Total	86,684	91,660	85,893	92,333	100,940

Further reference: ***Victorian Year Book*** **1978, pp. 665–73**

MEDICAL TRAINING AND MANPOWER

Training of doctors

Undergraduate training

Medical undergraduate training in Victoria is carried out at the University of Melbourne and Monash University. The Melbourne Medical School began in 1862 and now admits 220 students into the first year of the course, and 240 students into the second year. This enables an entry into second year of students who have a science or dental science degree or part thereof. The Monash Medical School admits 160 students into the first year of the course, and into the second and third years allows for a lateral entry of suitably qualified students to replace wastage. In both universities the pre-clinical course lasts three years, followed by three years of clinical instruction. After six years there is a qualifying examination which, if passed, confers on the student the degrees of MB, BS. The major hospitals where the University of Melbourne sends its undergraduates are the Royal Melbourne Hospital, St Vincent's Hospital, Austin Hospital, Repatriation General Hospital, Royal Children's Hospital, Royal Women's Hospital, Fairfield Hospital, and hospitals under the control of the Mental Health Division of the Victorian Health Commission. Monash University students are trained at the Alfred Hospital, Prince Henry's Hospital, Queen Victoria Medical Centre, Geelong Hospital, Fairfield Hospital, hospitals under the control of the Mental Health Division of the Victorian Health Commission, and a number of associated hospitals.

The Medical Board of Victoria grants provisional registration to new graduates who, after one year's experience as interns, are registered as legally qualified medical practitioners. The aim of the university medical schools is to produce a generalist who, with further training, may become a general practitioner, physician, surgeon, obstetrician, paediatrician, psychiatrist, or other specialist.

Postgraduate training

Vocational training of recent medical graduates is usually directed towards obtaining membership of the appropriate professional College, e.g., the Royal Australasian College of Surgeons, the Royal Australasian College of Physicians, and the Royal Australian College of General Practitioners. Assistance in providing such training is provided by the Boards of Graduate Studies in hospitals and by the Victorian Medical Postgraduate Foundation.

Each of these colleges is a body which conducts its own examinations for membership, stipulates the criteria required for the training necessary before examination can be undertaken and, in most instances, the post-examination training needed before membership and fellowship status can be achieved. In all, this normally takes between five and six years after the intern year.

The Graduate Boards of Studies at each hospital provide vocational training in each speciality, given by the specialist staff free of charge to the trainee. This is apart from the patient care that the trainee is giving to the patients of the hospital which pays the trainee for this service.

In addition, the Victorian Medical Postgraduate Committee arranges continuing education and conducts refresher courses for both specialists and generalists. These courses are conducted both in the Melbourne metropolitan area and in the country. Particular emphasis is placed on the continuing education of country medical practitioners. The universities have postgraduate degrees which they offer to medical graduates. These may be obtained by course work and/or thesis. Clinical academics also take part in training programmes arranged by Boards of Graduate Studies.

Specialist status

When a specialist qualification is granted by a college and the appropriate experience is gained, the recipient may be registered as a specialist with either the Medical Board of Victoria or the Commonwealth Department of Health. Registration as a specialist was introduced at the Commonwealth level as part of the differential fee rebate scheme. This does not provide at present for specialist recognition of general practice. However, it is the aim of the Royal College of General Practitioners to achieve such recognition.

Further references: Development in medicine, 1910–1960, *Victorian Year Book* 1963, pp. 230–8; Hospitals in medical education, 1967, pp. 519–20; Melbourne Medical Postgraduate Committee, 1963, pp. 264–5, 1967, pp. 527–8; Medical education: the second medical school, 1972, pp. 494–6; Registration procedure, 1977, pp. 765–6; Supply of doctors, 1977, p. 767

Nursing

Nursing is a discipline that provides a wide range and scope of health services in a variety of settings. The services include health education, promotion and maintenance of the prevention of illness or injury, rehabilitation, and implementation of prescribed medical regimes.

Nursing activities may include conducting preventive health examinations, teaching and counselling of children in schools, teenagers in clinics, adults at work, senior citizens in private and public nursing homes, new mothers in clinics and at home; performing complex tasks to help maintain life of patients in intensive care units in hospitals; and providing supportive physical and/or emotional care to individuals undergoing surgical, medical, or psychiatric care.

The majority of registered nurses in Victoria continue to work in hospitals. Other major areas of employment are psychiatric clinics, public health facilities, nursing homes and homes for the aged, doctors' professional rooms, community health clinics, industry, and educational institutions.

Nursing education and practice are supervised by the Victorian Nursing Council, the statutory nursing body constituted under the *Nurses Act* 1958. The Council membership consists mainly of nurses from various nursing interests; there are also members from legal, medical, hospital, and general education fields. The Council is particularly concerned with standards of nursing courses, teaching personnel, examinations, and training schools. Every person practising nursing for a fee or reward is required to be registered under the Nurses Act, and to hold a current annual practising certificate issued by the Victorian Nursing Council. Registers of nurses in each branch of nursing, and a roll of current practising certificate holders, are maintained by the Council.

At 30 June 1979, there were 4,844 general nurses in training, 993 nursing aides, 358 psychiatric nurses, 153 mental retardation nurses, and 268 mothercraft nurses. Although most basic nursing education programmes are conducted in hospital based courses, the trend is for these courses to be replaced by college based courses, with clinical nursing components of the courses being obtained in hospitals and other institutions.

Tertiary level nursing education is available at the Lincoln Institute of Health Sciences (nursing administration, nursing education, community health nursing, hospital nursing, and unit management), and at the Preston Institute of Technology (community health nursing).

To assist nurses who have been absent from nursing to return to the profession, some hospitals and health agencies offer orientation and refresher courses. In-service nursing courses in various specialist areas such as intensive care, operating theatre, cardio-thoracic, geriatric, oncological, eye, ear, nose, and throat, gynaecological, and communicable diseases nursing ensure a sufficient supply of skilled staff in these fields.

VICTORIA—NURSES, 1978-79

Courses	Approved training institutions (a)	Students at 30 June 1979	Completed course during 1978-79	Registrations approved, including interstate and overseas applicants	Annual practising certificates issued for year ended 31 December 1978 (b)
Basic courses—					
General nurse	31	4,844	1,592	2,597	34,446
Psychiatric nurse	10	358	91	192	2,097
Mental retardation nurse	5	153	48	64	
Mothercraft nurse	4	268	104	140	1,961
Nursing aide	48	993	1,028	2,034	14,326
Post-basic courses—					
Midwives	12	547	544	854	..
Infant welfare	4	53	71	92	..

(a) Some institutions conduct more than one type of training.
(b) An annual practising certificate is issued on the qualificatons attained in the basic course.
NOTE. Post-basic courses hitherto prescribed by the Victorian Nursing Council are to be, or are being, conducted as in-service courses, except for midwifery and infant welfare.

Further references: History of nursing in Victoria, *Victorian Year Book* 1961, pp. 240-1; Graduate nursing education, 1962, pp. 270-1; Nursing training, 1962, p. 263; Nursing recruitment, 1964, p. 277; Paramedical services, 1969, pp. 548-9; 1978, p. 675

INSTITUTIONAL HEALTH CARE

Public hospitals

Organisation

Since their inception in 1846, Victorian public hospitals have maintained a distinctive pattern. First, they are managed by autonomous committees elected by contributors, following closely the practice applying in Britain before the introduction of the National Health Service. Second, they have received financial assistance by way of government subsidies. With rising costs, this has steadily increased in amount. Third, medical staffing has followed the former traditional British pattern of honorary service. In recent years this has been necessarily supplemented by salaried doctors employed either in university teaching departments or in diagnostic and technical therapeutic fields.

In August 1975, honorary medical staff who had been treating public patients free of charge became paid members of the hospital staff on a fee for service contract, or sessional basis in caring for such patients. This system of paying all medical staff in hospitals that provide treatment for the "hospital" patients was brought about by the Hospitals Cost Sharing Agreement between the Commonwealth and Victorian Governments. By this agreement, both governments contracted to share equally in the net approved operating cost of all public hospitals in Victoria.

Improved medical methods and more effective drugs have shortened the average patient stay in hospital, with an important effect upon the community need for acute hospital beds. In Victoria, the present acute hospital bed need is assessed at approximately 4 beds per 1,000 persons as compared with 7.5 beds per 1,000 persons in 1948. The fall is significant, not only in its effect on hospital building costs to provide for an expanding population, but also in terms of cost of patient treatment.

In earlier times, hospitals could attempt to provide all possible services to their patients, but the increasing complexity of diagnostic and therapeutic services, as well as rapidly increasing costs, have encouraged the development of rationalised and co-ordinated services. The former Hospitals and Charities Commission made reference to a number of standing expert committees and consultants to advise on the implementation of such developments, e.g., on cardiac equipment, nuclear medicine, and regional dental services. The Hospitals Division of the Health Commission is presently maintaining these committees.

Certain metropolitan hospitals are designed for special purposes (e.g., maternity, rehabilitation, paediatrics), while others serve as general hospitals in their local communities, and may also function as referral centres for the smaller hospitals and offer services in certain specialised fields of medicine.

Since 1954, country hospitals have been organised on a regional basis. The smaller hospitals refer patients with more complicated conditions to the base hospitals which have more specialised staff and facilities. There are eleven regional councils which are designed to co-ordinate activities in a region and comprise hospital, Mental Health Division, community health centre, and ancillary service representatives. Each council has medical, nursing, engineering, catering, and administrative advisory committees which meet regularly. Services including pathology, pharmacy, radiology, blood banks, physiotherapy, speech therapy, audiology, and occupational therapy are being progressively established on a regional basis. Group laundries have been sited at strategic locations and each hospital has access to the services of a regional engineer.

VICTORIA—NUMBER OF PUBLIC HOSPITALS AT 30 JUNE

Type of institution	1974	1975	1976	1977	1978
Melbourne Statistical Division—					
Special hospitals (including Cancer Institute) *(a)*	11	11	11	12	12
General and auxiliary hospitals	30	30	31	31	31
Convalescent hospitals	1	1	1	1	1
Hospitals for the aged	4	4	4	4	4
Sanatorium	1	1	1	1	1
Total	47	47	48	49	49
Remainder of State—					
Base hospitals	10	10	10	10	10
General hospitals	96	96	96	96	96
Hospitals for the aged	6	6	6	7	7
Total	112	112	112	113	113
Total hospitals	159	159	160	162	162

(a) Special hospitals are those having accommodation for specific cases only or for women and/or children exclusively.

Mayfield Centre

Mayfield Centre was established in 1963 as the staff training and development centre for staff employed in public hospitals, geriatric institutions, ambulance services, and other organisations under the Health Commission of Victoria. It is funded through the Health Commission on an annual grant basis and has the power to levy a fee from course participants or their sponsors. The Centre is located in the suburb of Malvern in Melbourne and has both teaching and residential facilities.

The present organisation provides for a semi-autonomous body under the Health Commission of Victoria administered by a committee of management with a separate Board of Studies to give educational direction. The Centre offers training programmes in three broad areas, namely:

(1) Non-tertiary courses for aides, assistants, and technicians where no existing course is offered and where a significant component of the course can be undertaken concurrently with employment in a health care facility. The Centre is not involved in general nursing education;

(2) post-basic training for those already professionally qualified, but who require additional knowledge and skills not provided in their basic course and which effectively extend the functions of the professional; and

(3) in-service training for health personnel involving a variety of courses, in association with hospitals, to equip staff to carry out more effectively work for which there is no formal training available.

Mayfield Centre is also being developed as an educational advisory centre for the health services. It provides a consultancy service on education and training in hospitals and assists in the setting up of specific programmes for staff development.

The Centre employs a minimum full-time teaching staff, all of whom are highly qualified specialists who act as co-ordinators of the large number of programmes offered. Much of the teaching is conducted by sessional lecturers engaged from hospitals, universities, and colleges of advanced education. This arrangement has permitted a wide variety of programmes not normally possible in an institution the size of Mayfield Centre.

During 1980, more than 150 courses were expected to be offered, both at the Centre and in hospitals throughout Victoria. Numbers attending were expected to exceed 4,000 health service staff. Except for the large hospitals where the numbers employed justify a full-time training officer, Mayfield Centre is the main source of staff training and development for those employed in hospitals.

Further references: Fairfield Hospital, *Victorian Year Book* 1961, pp. 241–2; Geelong Hospital, 1962, pp. 273–4; Royal Melbourne Hospital, 1962, pp. 271–3; Alfred Hospital, 1963, pp. 265–6; Prince Henry's Hospital, 1964, pp. 286–7; History of hospitals in Victoria, 1964, pp. 267–72; Royal Children's Hospital, 1964, pp. 284–6, 1976, pp. 691–3; St Vincent's Hospital, 1965, pp. 266–7; Dental Hospital, 1965, pp. 267–8; Austin Hospital, 1966, pp. 250–1; Queen Victoria Memorial Hospital, 1967, pp. 529–32; Royal Victorian Eye and Ear Hospital, 1968, pp. 525–8

Private hospitals and nursing homes

Most private hospitals are privately owned and administered along profitable business lines, although some hospitals may best be described as non-profit organisations with their ownership resting mainly in religious denominations.

Those acute private hospitals which are approved training schools for midwives, general nurses, and nursing aides must meet the Victorian Nursing Council's requirements. While private hospitals accommodate short-term and acutely ill patients, private nursing homes accommodate patients requiring constant nursing care for an indefinite period. Patients may be the frail aged, bed-fast, near bed-fast, or totally dependent children.

Private hospitals and nursing homes must always be staffed according to the private hospital regulations under the Victorian Health Act; for example, the number of qualified nursing and domestic staff to patient ratio must not be allowed to fall below a determined level.

Repatriation hospital and clinics

The largest of the Commonwealth Department of Veterans' Affairs institutions in Victoria is the Repatriation General Hospital at Heidelberg. The Hospital is a teaching hospital for medical students affiliated with the University of Melbourne and is recognised for postgraduate training in surgery, medicine, anaesthetics, pathology, psychiatry, and radiology. Postgraduate studies are encouraged and clinical meetings and tutorials are held regularly. The Hospital is approved by the Victorian Nursing Council as a training school for male and female student nurses and trainee nursing aides. At 30 June 1979, the number of staff employed full-time at the hospital was 1,432 and, during 1978–79, 12,406 inpatients were treated at the hospital with an average stay of 12.6 days per patient. A total of 151,933 attendances were also made for outpatient services at various clinics within the hospital.

The other institutions conducted by the Department in Victoria are: Outpatient Clinic, St Kilda Road, Melbourne; Anzac Hostel, North Road, Brighton; Repatriation Artificial Limb and Appliance Centre, South Melbourne; Macleod Hospital, Mont Park; and Repatriation Hospital, Bundoora.

In administering the Commonwealth *Repatriation Act* 1920 and associated legislation, the Department has the responsibility for the medical care of eligible beneficiaries. An extensive range of treatment is provided for outpatients through some 8,652 (2,052 in Victoria) general practitioners under the Department's Local Medical Officer Scheme, and at the repatriation outpatient clinics, and by specialists in the various branches of medicine who have been appointed to Departmental panels. In addition, the Local Dental Officer Scheme, involving some 3,798 (892 in Victoria) dentists throughout Australia and dental units located at Departmental institutions, provides a full range of dental services for those eligible.

Nursing home care is also provided for patients with service-related disabilities which require long-term care. For certain other beneficiaries, nursing home care is provided for chronic conditions not related to service subject to a patient contribution.

Under arrangements with State Governments, psychiatric patients requiring custodial care are admitted at Departmental expense to separate repatriation psychiatric wards administered by State authorities.

In each State in Australia and at Darwin in the Northern Territory there is a Repatriation Artificial Limb and Appliance Centre, where artificial limbs and surgical aids

are provided. Artificial limbs are supplied free to all persons in the community who need them.

The Department also provides an extensive rehabilitation service for both inpatients and outpatients, including physiotherapy, chiropody, speech therapy, and social worker services.

State geriatric centres

Historically, providing facilities for aged persons has centred on making long-term accommodation available. This concept has been the basis on which many of Victoria's institutions have built up long lists of persons waiting for admission. However, changing patterns in geriatric care have made waiting list figures an unrealistic factor in gaining an accurate assessment of needs.

It will always be essential to provide accommodation for those patients whose physical condition has made them totally dependent on nursing support, and some 4,500 beds are available for this purpose within State geriatric centres or in units attached to public hospitals. Recently, the part played by these centres in a health system for the aged has been expanded beyond this one aspect of care. The responsibilities of each geriatric centre are to:

(1) Ensure that in each community there will be a co-ordinated, comprehensive, domiciliary care service incorporating nursing, housekeeping, medical, and paramedical personnel which will allow many aged persons to remain in their own homes;
(2) provide specialist assessment of each person's physical, psychological, and social needs and resources so that appropriate plans for treatment and future care may be made;
(3) develop rehabilitation programmes;
(4) assist the families of aged persons being cared for at home with planned, intermittent, short-term admissions for relative relief; and
(5) provide on-going education for all levels of staff engaged in geriatric care.

In 1976, the University of Melbourne established a Chair of Gerontology in conjunction with Mt Royal Hospital. The National Institute of Gerontology is also located at Mt Royal.

District nursing services

In the Melbourne metropolitan area there are two registered services and six services attached to public hospitals. In the country, 89 public hospitals have district nursing services and thirteen of these have a district nurse caring for patients in an adjacent town in which there is a private bush nursing hospital. Three small public hospitals share a service with larger adjacent hospitals and five other small hospitals have a combined community health/district nurse. In all, 110 country towns and surrounding areas have access to a district nurse.

During 1978–79, district nursing services employed 532 equivalent full-time nurses who treated 47,944 patients and made 1,219,061 visits.

Further reference: Royal District Nursing Service, *Victorian Year Book* 1975, pp. 787–8

Bush nursing services

Bush nursing centres

Each bush nursing centre functions as an outpatient service; patients attend the centre, or the nurse provides care for the patients in their own homes, thus alleviating long periods of hospitalisation. Accommodation is provided at the centre for a trained nurse and usually her family. The nurse is responsible for the health and welfare of her community with medical supervision from a distant town.

A local autonomous committee of management administers each centre, and is elected annually by contributors; the committee members act in an honorary capacity. Finance for administration and capital works projects is provided directly to each centre by the Victorian Government through the Hospitals Division of the Health Commission. Commonwealth Government finance is received through the pharmaceutical benefits and home nursing subsidy schemes. To supplement these funds, each centre's committee of management raises local finance by membership subscriptions, charging treatment fees, fund raising, and donations.

During the year ended 30 June 1979, 25,163 patients received treatment with 30,201 surgery visits and 17,593 home nursing visits. A staff of 17 full-time and 13 part-time trained sisters was employed at 30 June 1979.

Bush nursing hospitals

The first bush nursing hospital in Victoria was founded in 1923 at Cowes on Phillip Island, and by 1979 there were 39 bush nursing hospitals with a total bed capacity of 680 beds. This total includes 42 nursing home beds in separate annexes. Eighty per cent of patients are treated for surgical, medical, and obstetric conditions in the hospitals. In the event of complications or more specialised treatment, a nearby base or city hospital provides the expertise required for medical and paramedical services.

As with the centres, each hospital is administered by an annually elected local autonomous committee of management, and in recent years each has appointed a full or part-time paid secretary. Finance is granted through the Victorian Treasury and the Victorian Health Commission, and administered by the Council of the Bush Nursing Association. Hospitals apply annually to the Council for permission to incur capital expenditure and thereby receive a capital grant on a $3 to $1 basis for this expenditure. The 1978–79 capital works grant was $521,000 and some member hospitals proceeded with projects without any government assistance. The annual maintenance grant, totalling $470,000 in 1978–79, is determined by the Victorian Treasurer. The Council then allocates this grant to hospitals on a needs basis, with smaller hospitals receiving more sympathetic consideration than larger ones, since larger hospitals are in a better position to organise their own finances and priorities.

Bush Nursing Association

The original role of the Bush Nursing Association was to provide, through its superintendent, a nursing service which would extend to appointing staff to hospitals and centres. In recent years, the superintendent, a trained nurse, has continued to be responsible for appointing centre sisters and hospital matrons, but most local committees of management arrange for the appointment of staff to hospitals. When the local committees of management experience difficulties in maintaining adequate staff levels, the superintendent recruits staff on their behalf. Together with the honorary consultant architect, the superintendent also provides assistance in the designing of hospital extensions. This changing role has resulted in the appointment of a sessional administrator, experienced in hospital administration, to assist the council and hospitals with matters relating to finance and hospital and business administration generally.

The Bush Nursing Association is a voluntary organisation registered with the Hospitals Division of the Health Commission. The twenty-three member council includes twelve elected members, usually country persons associated with one of the hospitals or centres, thus providing local committees of management with direct representation on the council. The remaining eleven members are nominated by various other bodies or co-opted, and involved in an aspect of health care.

The nursing staff, employed by the Bush Nursing Association and paid centrally, totalled 200 full-time and 493 part-time nurses at 31 March 1979. The administrative and domestic staff are paid by the local hospital. At 31 March 1979, 21 full-time and 36 part-time administrative staff and 117 full-time and 264 part-time domestic staff were employed.

Psychiatric services

The State psychiatric services in Victoria are regionally organised. There are twelve regions, and the Mental Health Division aims to provide each with an early treatment unit supported by adjacent long-term wards for chronically ill and psychogeriatric patients, and by community mental health facilities appropriate to the needs of the region.

The Division's philosophy is to provide early treatment centres in association with general hospitals. The newer centres at Geelong, Footscray, and Mildura are examples of this continuing trend. This form of development requires a concomitant expansion of community facilities, and its corollary is the reduction in bed capacity of the older hospitals which, by modern standards, are too large.

The early treatment centres provide inpatient and outpatient care for those with established psychiatric disorders. The primary facilities are acute beds, day hospitals, and outpatient clinics. The patients are referred by community mental health centres, general hospitals, general practitioners, and private psychiatrists. Within the early treatment centre, the distinction between inpatient and day patient lies in the use of the residential

facilities, the day hospital providing care for patients not requiring hospitalisation but benefiting from the comprehensive treatment programmes available only in the hospital situation. Victoria has 833 hospital beds for short-term psychiatric patients, 60 per cent of whom are admitted voluntarily. The remainder enter on medical recommendation.

Outpatient clinics provide continuous specialised care, such as psychopharmacological treatment and psychotherapy, or they advise the patient's general practitioner on the required course of treatment. These clinics are located within psychiatric hospitals, in the community and, in twenty cases, at country general hospitals.

Long-term hospitals for the chronically mentally ill and psychogeriatric patients serve those persons requiring prolonged rehabilitative or inpatient care. Advances in psychotropic drug use has diminished the number of chronic patients, and the waiting list for psychogeriatric beds has been almost eliminated through the efforts of the Division's psychogeriatric services, which emphasise reliance on appropriate community support facilities and the use of mobile specialist assessment teams.

Child psychiatric services are based around one residential unit (Travancore, which is soon to be redeveloped) and the specialist outpatient facilities at Travancore, Bouverie, Children's clinics, Dandenong Psychiatric Centre, and the Austin Hospital's Department of Psychiatry. Most of these centres provide consultative services to outlying psychiatric facilities (on a regional basis) and most provide some form of community mental health care to the children of adjacent communities.

To meet the demand for specialist child care staff, the Mental Health Division and the Austin Hospital provide a training course in child psychiatry.

Community mental health centres have the aim of preventing the development of psychiatric disorders that would require the patient to go to hospital. Staffed by psychiatrists, psychologists, social workers, occupational therapists, and nurses, these centres are strategically located in shopping centres and residential areas, and offer a walk-in service to those with psychological, social, or family problems and to those in crisis situations. The Division operates 28 such services, including domiciliary services operating from psychiatric hospitals.

The three major categories of patient attending the community mental health centre are psychiatric patients who can be treated on an outpatient basis, discharged hospital patients needing help in adjusting to community life, and those who do not show an established psychiatric disorder but who nevertheless require help. The staff's activities include the organisation of self-help groups, the education of community leaders, detection of "at risk" groups, participation in community projects, assistance to educational, social, religious, ethnic, and other community organisations, and the practice of most forms of accepted mental health therapy.

VICTORIA—MENTAL HEALTH: NUMBER OF INSTITUTIONS

Type of institution	At 30 November—				
	1974	1975	1976	1977	1978
Mental hospitals *(a)*	11	11	11	11	11
Psychiatric and informal hospitals	16	17	17	19	19
Intellectual deficiency training centres	10	10	12	12	12
Alcoholic and Drug Dependency Rehabilitation Centres	4	4	4	4	4
Total	41	42	44	46	46

(a) Includes Repatriation Mental Hospital.

The Division provides three types of after-care for ex-hospital patients:
(1) Psychiatric after-care hostels and half-way houses for patients who are unable to manage independently — some patients require accommodation for short periods only, while others require it for the rest of their lives;
(2) day hospitals for patients staying with their families or in hostels but whose daily activities require some supervision; and

(3) sheltered workshops providing non-competitive work for the chronically mentally ill — some patients attend these workshops only until they find a place in the normal labour market, while other patients will never be able to transfer to unsheltered employment.

Further references: Compulsory chest X-rays, *Victorian Year Book* 1965, p. 241; Tuberculosis and mass X-ray surveys, 1967, pp. 507–8

Alcohol and drug services

The Alcohol and Drug Services Section of the Mental Health Division has been developed as a co-ordinated response to individual and community problems associated with the use of alcohol and other drugs. Four distinct, specialised centres, co-ordinated from head office, provide treatment, rehabilitation, research, training, and prevention programmes. In response to the complex community problems of alcohol and drug abuse, the Alcohol and Drug Services liaises closely with the many community agencies working in these fields.

Treatment methods are based on the multi-disciplinary community medicine approach. Psychiatrists, doctors, nurses, social workers, and others provide individual and group therapy as a team. Family and other types of community-oriented therapy and rehabilitation are emphasised, and drug therapy, behaviour therapy, and other types of therapy based on learning, diet, work, crisis intervention, and so on are used where appropriate. The management programmes are flexible and varied to fit the needs of the patient.

Tuberculosis services

The Tuberculosis Branch of the Health Commission is responsible for the prevention, early detection, and treatment of the disease of tuberculosis, and maintaining public awareness of it. The broad policy of tuberculosis control continues as in recent years, but compulsory mass X-ray surveys have been suspended since December 1976. The number of beds reserved for treatment of tuberculosis patients continues to decline.

Persons born outside Australia show a considerably higher incidence of tuberculosis than those born in Australia, particularly in the first years after arrival and special attention is being directed to the medical supervision of south-east Asian refugees arriving in this country. Other groups requiring surveillance include persons with a past history or significant radiological evidence of past tuberculosis infection, and heavy users of alcohol. Because of their higher risk of developing active tuberculosis, these persons are asked to remain under review at clinics or by private doctors.

The mortality rate continued at a low level and was 1.0 per 100,000 persons in 1978. Tuberculin testing among school children indicates a low infection rate which has been fairly constant recently. In 1979, 1.8 per cent of children at 14 years of age gave natural positive reactions. These figures are the most reliable indicator of tuberculous infection in this group at present.

Improved social and economic conditions have continued to contribute towards this improved situation, as has the diligent approach to case finding, medical supervision, and contact control. The major credit for improving the situation is most directly related to the availablity of modern anti-tuberculosis chemotherapy. The four drugs — Streptomycin, Isoniazid, Rifampicin, and Ethambutol — make it possible to render virtually all persons with active tuberculosis non-infectious. This applies to both new cases and those who have relapsed, and both categories usually need only a short period of institutional care. Treatment on a domiciliary basis, under direct supervision, is being used when warranted. Experience is showing that relapse of tuberculosis is being markedly reduced among those who have had full courses of drug treatment.

Compulsory community chest X-ray surveys were conducted throughout Victoria from 1963 to 1976. One mobile X-ray unit has been retained by the Tuberculosis Branch and is being used for special community groups and others at special risk, for example, mental hospitals, prisons, homes for the aged and indigent, and "contact" surveys. The general situation of community surveys is reviewed periodically with special reference to high risk areas.

The constant danger to unprotected persons proceeding to areas of high risk is emphasised and the Branch considers that all susceptible persons should be advised to have B.C.G. vaccinations before leaving Australia.

VICTORIA—TUBERCULOSIS BUREAUX

Activities	1974	1975	1976	1977	1978
New cases referred *(a)*	9,334	8,543	8,291	8,088	5,399
Active cases—					
New	321	291	311	274	293
Reactivated	31	29	31	25	25
Chronic	8	7	4	7	4
Re-attendances	42,480	37,783	38,383	35,037	21,212
Home visits by nurses	19,179	17,917	15,414	12,996	10,006
X-ray examinations (films taken) *(b)*	44,423	43,367	39,412	37,007	36,312
Tuberculin tests	6,970	6,853	6,931	6,904	6,076
B.C.G. vaccinations	1,766	1,628	1,460	1,519	1,603
Chest X-ray surveys (X-rays taken)	354,256	401,397	412,044	45,461	48,301
School tuberculin surveys (Mantoux tests)	92,265	92,645	88,229	101,639	98,146

(a) Referred to investigation from all sources for the first time in that year.
(b) Large and micro films, excluding mass X-ray surveys with mobile units.

VICTORIA—TUBERCULOSIS SANATORIA

Year	Beds	Admissions	Discharges	Deaths
1974	301	564	538	23
1975	301	466	449	19
1976	208	495	468	29
1977	197	421	390	29
1978	175	564	525	22

Cancer Institute

The Cancer Institute, with its treatment section, the Peter MacCallum Hospital, is Australia's only comprehensive, specialist centre for treatment, research, and education in cancer and allied diseases. Established under the *Victorian Cancer Institute Act* 1949, the Institute today provides a full range of patient services, including inpatient and outpatient care, backed by supportive services such as social services, physiotherapy, and the visiting nursing service. In addition, it operates clinics in twelve Melbourne public hospitals and institutes and six country hospitals, and is responsible for radiotherapy services in Tasmania.

Research is a primary responsibility of the Institute and the wide-ranging research programmes comprise both clinical trials and laboratory research. There are three major research units—biological research, haematology research, and clinical immunology and immunogenetics. The new chemotherapy unit is also involved in basic research.

The Institute's education responsibilities cover medical, paramedical, and technical areas and the Peter MacCallum Hospital is a teaching hospital for the University of Melbourne and Monash University. The Institute also runs the only postgraduate school in oncological nursing in Australia.

The first section of the new hospital, the Douglas Wright Wing, was opened in September 1977 and it is hoped that work on the next phase, which will increase inpatient accommodation to 300 beds, as well as providing additional outpatient, radiotherapy, and other facilities, will begin shortly.

VICTORIA—CANCER INSTITUTE

Particulars	1974–75	1975–76	1976–77	1977–78	1978–79
Patients—					
Distinct persons treated (public patients at Peter MacCallum Hospital)	10,619	10,773	9,879	10,884	10,503
New patients registered (public patients) *(a)*	4,599	4,329	4,353	r4,303	4,501

VICTORIA—CANCER INSTITUTE—*continued*

Particulars	1974–75	1975–76	1976–77	1977–78	1978–79
Inpatients (ward and hostel)—					
Number of beds available at 30 June	122	122	122	*(a)*147	147
Admissions	3,937	4,419	r4,552	4,553	*(b)*6,294
Daily average	85.39	87.36	r84.93	87.68	*(b)*115.32
Outpatients—					
Attendances at consultative clinics (public patients) *(c)*	45,526	43,808	44,226	45,692	46,154
Radiotherapy Department *(c)* *(d)*—					
Attendances for treatment (public and private)	61,638	60,590	60,062	66,167	61,503
Fields treated (public and private)	114,977	120,422	119,548	131,932	124,316
Visiting Nursing Service—					
Patients visited	930	972	972	1,220	1,235
Total visits	38,286	36,283	34,547	42,349	51,368
Other services (at Peter MacCallum Hospital) *(d)* *(e)*—					
Attendances (public and private)	105,636	118,855	122,067	123,021	129,166
Paid staff—					
Medical	97	99	99	106	106
Nursing	178	183	205	240	242
Scientific and technical	203	229	242	342	342
Other	440	442	495	482	484

(a) Wards in the new Douglas Wright Wing were opened in January 1978.
(b) Includes day patients.
(c) Includes patients at Peter MacCallum Hospital and Peter MacCallum clinics at the Austin and Alfred Hospitals and in the country.
(d) Includes inpatients and outpatients.
(e) Includes diagnostic radiations, pathology, physiotherapy, pharmacy, medical, social work, theatre, and photography.

NON-INSTITUTIONAL HEALTH SERVICES

Youth services

Maternal and child health services

These services include health supervision of infants from the first weeks of life, throughout the pre-school years, and guidance of mothers during pregnancy and the post-natal period through the early child rearing years.

This service is given by infant welfare sisters who are triple certificated nurses at infant welfare centres. These are now sometimes called maternal and child health centres because the service given is to mothers and children, not just to infants. There are infant welfare centres in every municipality, so that this free service is readily available to all young parents.

Family planning is now recognised as an integral part of maternal and child health care and clinics are conducted at a growing number of infant welfare centres. The clinics are staffed by doctors and nurses trained in family planning methods, who provide free advice to young persons on sexuality, the responsibilities of parenthood, methods of contraception, the spacing of pregnancies, and conception difficulties.

The importance of play in the development of young children has long been recognised, and to help mothers understand this concept, the establishment of toddler play groups in infant welfare centres is encouraged.

The importance of early detection of defects or developmental delays is now well acknowledged and a comprehensive programme is being introduced progressively with the object of identifying disabilities or handicaps at an early age and ensuring that the best possible remedial action is taken. Through this early childhood development programme, support services are being made available readily to parents by specialist professional staff based in regions and working closely with local communities. These new services are being provided by medical and paramedical personnel such as visiting child health nurses, psychologists, social workers, physiotherapists, occupational therapists, speech therapists, dietitians, and audiologists.

A newly developed and successful programme aimed at early identification of infants with hearing defects is being conducted under the guidance of a staff of audiologists. Infant welfare sisters throughout Victoria have been trained in routine testing procedures for infants in their first year of life, and more sophisticated testing with modern equipment is provided at clinics conducted by the audiologists.

VICTORIA—MATERNAL AND CHILD HEALTH SERVICES

Particulars	1974	1975	1976	1977	1978
Family planning services—					
Number of clinics	23	33	38	39	66
New enrolments	1,886	2,991	3,704	4,457	4,975
Attendances of patients	6,586	9,607	12,509	15,790	18,261
Pre-natal services—					
Number of clinics	29	29	22	21	18
Attendances of mothers	12,309	8,356	4,496	3,643	2,307
Infant welfare services—					
Number of infant welfare centres (all types)	751	763	769	781	783
Infant welfare sisters employed	429	443	450	473	481
Attendances of children	1,342,809	1,399,310	1,352,640	1,342,883	1,325,693
Home visits to children	149,584	153,575	155,487	160,975	164,468
Attendances of expectant mothers	18,062	18,192	18,635	19,253	20,368
Post-natal visits to mothers in hospital	24,781	25,824	25,933	25,709	26,770
Immunisation—					
Triple antigen primary course	62,157	61,246	58,240	55,581	55,901
Poliomyelitis primary course	58,491	57,987	54,808	52,669	53,429
Measles	32,957	33,801	34,084	30,571	34,169
Smallpox	14,739	13,077	*(a)*	*(a)*	*(a)*

(a) Now omitted from programme.

Pre-school child development

This section is responsible for educational, care, and developmental services for the child before attendance at primary school. It is concerned with both subsidised and registered services for the child of the working mother who requires full day care, and the child of the non-working mother who attends a sessional kindergarten.

One of the section's aims is to integrate services where possible and to fully utilise buildings to provide a variety of services required by a particular community. A policy of regionalisation of services is being implemented and the pre-school staff, who are persons with a kindergarten diploma and in most cases postgraduate qualifications, while appointed centrally, are seconded to work in a region. These regions vary in size according to the population and needs of the region. In one country region, for example, 23 shires are encompassed, while in the Melbourne metropolitan area the region could consist of only one large municipality. The pre-school advisers work closely with community groups and the staff of shire or city councils. They are thus able to become aware of the needs of the region and to help plan appropriate services. They are also available as resource persons to community groups and are involved in multi-disciplinary teams developed to provide health promotion and assessment services through early childhood development programmes.

The type of service established varies according to the needs of the region and the age of the children. The first subsidised service is the toddler group for children aged between 18 months and 3 years, and their mothers. Conducted by a trained kindergarten teacher and an infant welfare sister in the waiting room of an infant welfare centre, this service offers mothers the opportunity to learn more about the growth and development of young children, while their children are playing with materials suited to their age group. In July 1979, there were 51 toddler groups, catering for 1,846 children, operating in Victoria.

Kindergartens and pre-school play centres present opportunities for group play, education, and parent discussions. This service is provided for children from 3 years of age onwards, who attend three or four sessions each week. To give as many children as possible the benefits of attending these centres, different groups of not more than 25 children each are taken in the mornings and afternoons. The centres are staffed, and programmes compiled by a teacher with approved qualifications, supported by an untrained assistant. In July 1979, there were 1,114 subsidised kindergartens and 63 pre-school play centres catering for 59,774 children, operating in Victoria.

The day care centre provides care and education for the child of the working mother. These centres vary from the large centre catering for up to 60 children, to the small neighbourhood centre in a house catering for 20 to 25 children. In the latter type of centre, parents employed on a part-time basis work at the centre in return for service.

Commonwealth children's services programmes

During 1976–77, the Commonwealth Government changed the basis of its funding to the States from staff salaries to that of a lump sum block grant. From 1978–79, the block

grant represents the total Commonwealth contribution towards both recurrent and capital costs incurred by the State for pre-schools.

The Commonwealth Government also paid the capital and recurrent costs of a number of childhood service projects, administered by the Health Commission of Victoria. These consisted mainly of the establishment of day care centres.

Early Childhood Development Programs

An Early Childhood Development Program is a community-based network of services for young children and their families. It seeks to build on to and to integrate existing services such as infant welfare, pre-school, and school medical services in accordance with the developmental needs of families with young children. Through consultations and explanations a multi-disciplinary team is established, the aim being to take the services to the people rather than make people come to the services.

Fourteen Early Childhood Development Programs have so far been set up in the following regions: South Western, Central Highlands, Central Gippsland, Diamond Valley/Eltham, Knox/Sherbrooke, Barwon, Broadmeadows, City of Melbourne, Mallee (Mildura/Swan Hill areas), Footscray/Sunshine, Goulburn Valley, Eastern Divide (Lilydale area), Frankston, and Gisborne. They are at various stages of development and in some cases have not yet reached their full staffing strength. It is estimated that approximately 32 Early Childhood Development Programs will be required to give a comprehensive coverage of Victoria.

School Medical Service

Where early childhood development programmes have been established, this Service is now integrating with other services to children to promote better development in all areas.

Medical officers support teachers and health professionals working in infant welfare centres, pre-school centres, early childhood development programmes, schools, and other educational facilities, and provide a consultative service where this is needed. In 1978, they offered a support medical examination to children attending subsidised pre-schools in the year before beginning school and examined 41,673 children under this scheme, while a further group of children were examined by medical officers employed by Prahran and Melbourne City Councils.

Examinations at the school were performed by both school nurses and medical officers. A total of 31,053 children received a standard examination with preference being given to children who had not been examined at the pre-school centre and 142,000 children had routine vision examinations. In addition, many children were reviewed for previously detected disability to ensure that they were being protected from handicap, and referrals were taken from teachers. Special services were provided to children with handicaps; thus, all children enrolled during the year at 23 special schools for the intellectually handicapped and at 16 special developmental schools, as well as children recognised as partially sighted (190) or requiring special education for deafness (393), had a full medical assessment in collaboration with psychologists and teachers in order to determine the best educational programme for them.

School nurses played an increasing part in the examination of school children and many have now been educated to perform standard examinations. Where they are employed with the aid of Commonwealth Government funds, they are expected to spend an increasing amount of time in schools working with teachers and parents to support them in helping children with disabilities and to promote healthier living.

Dental health services

The Victorian Government has agreed to participate with the Commonwealth Government in a scheme whereby all children under the age of 15 years would be eligible to receive free dental treatment. This scheme will be staffed basically by dental therapists working under the general direction and control of dentists.

The dental therapy course extends over a period of two years and the students, who must have reached university entrance requirements, are appointed to the Victorian Public Service as cadets. The main theme is preventive dentistry with lectures and projects that emphasise this aspect in every subject. During second year, cadets experience several hours of practical dentistry each day. The maximum intake at the Dental Therapy School is sixty students.

After graduation, dental therapists work in one and two surgery dental clinics being established in school grounds where practicable. Other schools will be visited by mobile dental clinics. A building programme in metropolitan and country areas is being continued to accommodate dental therapists as they graduate.

The programme is being implemented gradually, commencing with the target of covering all pre-school and primary school children, before expanding to secondary school children under the age of 15 years. Having controlled existing dental decay and gum disease by treatment procedures, the dental therapists then aim to ensure that by regular re-examinations, clinical methods of prevention, and through dietary and oral hygiene education, children suffer from less dental disease. In 1978, newly graduated dental therapists were concentrated in the western and north-western suburbs of Melbourne. In 1979, expansion of the scheme was centred in the Geelong/Bellarine Peninsula and Warragul/La Trobe Valley areas.

Further references: Pre-school audiology services, *Victorian Year Book* 1977, p. 785; Child maltreatment, 1977, pp. 788–9; Childhood accident research, 1977, p. 789; Family planning services, 1977, pp. 789–90; National audiological services, 1977, pp. 790–1; Occupational health, 1977, p. 791

Services for the aged

Community health and welfare services for the aged

Health services

In June 1979, nursing home and rehabilitation beds available in State, voluntary, and private hospitals totalled approximately 12,400 beds, while hostels accommodated approximately 7,500 persons. Since the provision of beds alone could not adequately serve disabled or elderly persons, community health centres, improved domiciliary services, and more day hospitals are being established. Day hospital attendances approximated 345,000 during 1978–79.

Elderly persons in the Melbourne metropolitan area receive dental care at the dental clinic in the Royal Dental Hospital of Melbourne. Treatment is also provided at clinics established in 18 major country centres and in geriatric centres.

Meals-on-wheels services at 30 June 1979 were supplied by 82 hospitals in co-operation with a number of organisations. These meals were prepared for 120 meals-on-wheels services.

Welfare services

General home help

The aim of the Home Help Service, senior citizens' clubs, and municipal welfare officers engaged in the welfare of the aged is to assist the aged in pursuing independent lives in their own surroundings for as long as possible.

A subsidy is made available to municipal councils which establish and maintain a Home Help Service in order to preserve the family unit or the health and autonomy of the elderly and infirm. This service is now available in every municipality in Victoria. It originally developed for the main purpose of providing home help in the homes of parents with young families for periods of up to 3 weeks when the mother became incapacitated through pregnancy or illness. While this service to young families is continuing, the trend in recent years has been for an increase in the demand for the provision of home help to the elderly and infirm and this now constitutes the majority of the service provided. The service is available on the basis of medical need and allotted according to the priority of each case. Duties of a home help are to maintain the household's routine, assist with household chores, do the shopping, and prepare meals. Assessment of charges is made according to the person's ability to pay. Health Commission advisers are available to discuss problems and they make regular visits to municipalities for this purpose.

Special home help extension

This is an extension of the General Home Help Service to provide the parents of handicapped children some relief from their constant responsibilities, so that they may participate in a family or social outing or in community life.

The parents of mentally handicapped children are required to obtain a certificate from St Nicholas Hospital, and the parents of physically handicapped children should obtain a

medical report on a special form available from the municipal shire or council, signed by their doctor or the child's medical adviser.

Elderly citizens' clubs provide facilities for fostering social companionship for the elderly and supply the environment for them to make new friends and to take a renewed interest in life. Municipal councils are paid a subsidy through the Health Commission to establish and maintain these clubs, which provide activities such as carpet bowls, billiards, crafts, and entertainment. Services such as hot meals and chiropody assist in maintaining the health and comfort of the elderly, while meals-on-wheels are confined to those housebound elderly persons unable to attend a club because of infirmity. Routine visits are made by assistant advisers to municipal councils to discuss existing clubs, the implementation of new services, or the formation of new clubs. Regular discussions are conducted with club members in an attempt to broaden club activities and instil a sense of reponsibility in members.

A municipal welfare officer, subsidised by the Health Commission, is employed by a municipal council to ensure the development, co-ordination, and continuing provision of the most appropriate welfare services to meet the needs of the elderly, supervise existing services, foster co-operation between welfare activities for the aged, promote purposeful activity within elderly citizens' clubs, and help the elderly realise that aid is available.

Further references: Care of the aged, *Victorian Year Book* 1962, p. 264, 1965, p. 258; Home Help Service, 1966, pp. 229–30; Elderly Citizens' Clubs, 1966, pp. 230–1

Community services

Health care of the physically and intellectually handicapped

Physically disabled services

The physically handicapped receive specialist treatment within the public hospital system, both at inpatient and outpatient levels. Many attend private practitioners for medical care and physiotherapy service.

Rehabilitation is an important area of health care, and programmes designed to meet individual needs are offered at public hospitals, including Mt Royal, the Royal Talbot General Rehabilitation, Caulfield, Hampton, St Vincent's, and Prince Henry's Hospitals. Occupational therapy, physiotherapy, speech therapy, and social work personnel provide the paramedical services in these hospitals to enable full assessment and planning of the individual's rehabilitation programme.

Many geriatric centres and day hospitals throughout Victoria have rehabilitation units which are also available to younger handicapped patients.

Further rehabilitation services are offered by the Kingston Centre and the Mt Eliza Geriatric Centre; the Commonwealth Department of Veterans' Affairs through the Rehabilitation Unit in Heidelberg; the Commonwealth Department of Social Security through rehabilitation centres at Glen Waverley, Toorak, Ballarat, and Geelong; and by the Mental Health Division of the Victorian Health Commission through the Willsmere Hospital Rehabilitation Unit. The Austin Hospital spinal injuries unit provides a State-wide service for those who suffered from paraplegia or quadriplegia as a result of an accident or injury.

Many hospitals provide nursing home and domiciliary support services. The Victorian Health Commission provides a domiciliary medical and physiotherapy service to poliomyelitis and multiple sclerosis patients throughout the State. The development of the community health centre and day centre network will enable more physically handicapped persons to obtain medical, paramedical, and nursing care at a regional/local level.

Several independent voluntary organisations provide medical and paramedical services (usually in association with specialists from public hospitals) in addition to their educative or other training functions. These include the Spastic Society, Yooralla Society of Victoria, Royal Victorian Institute for the Blind, Multiple Sclerosis Society, and the Association for the Blind. Most have medical panels and/or honorary medical consultants advising the particular organisation.

Free travel service

The Health Commission makes free travel on public transport available to pensioners and persons of limited means who require treatment at public hospitals. Eligible persons

can apply for rail vouchers and/or tram tickets at the Commission's offices at 555 Collins Street, Melbourne.

Mental retardation services

The care and training of mentally retarded persons is the responsibility of the Mental Health Division of the Health Commission through its mental retardation services, headed by a director and secretary. These services will soon become a separate Division of the Commission.

Currently, the Division maintains 3,427 beds in residential training centres for retarded persons, the majority being occupied by adults.

The Division has adopted the policy of regionalising its services for retarded persons. It has also adopted the policy of "normalisation"—making available to retarded persons the types of accommodation and services that are as similiar as possible to the normal patterns of society. This implies the phasing-out of over-large "bricks and mortar" institutions in favour of smaller, specialised, and community-based accommodation backed by a comprehensive and flexible staff support, including intervention, diagnostic, and assessment teams. This philosophy has already been implemented with the development of the St Gabriel's Centre, a 41-bed unit in the Melbourne suburb of Balwyn providing a variety of services for its adjacent region. On a larger scale are the long-term developments under way in the Loddon-Campaspe region and being planned for East Gippsland.

The Division and its predecessors have been closely involved in the planning and subsidising of day training centres for retarded persons for the past 27 years. There are currently 69 such centres (16 of which are now special developmental schools) throughout Victoria and all are subsidised from Victorian Government funds. In the same category are several private residential centres, autistic children's centres, and a 30-bed hospital leased to a day training centre.

The Victorian Education Department has the responsibility in principle for the education of handicapped children, irrespective of the type or degree of handicap. As well as controlling the educational component of 16 day training centres, the Education Department places teachers and aides in the Division's residential centres to complement the role of the clinical staff.

Ambulance services

Ambulances are operated by 16 regional services, collectively known as Ambulance Service—Victoria. They provide 24 hour cover by trained ambulance officers, with specially designed and equipped vehicles from 16 headquarters stations and 77 branch stations. There are 40 stations operated by volunteers.

Organisation

Autonomous committees are responsible for the provision of service in their regions. Regionalisation has provided extension of service to all areas, including those of sparse population; co-ordination with hospital and medical services and of patients in each region; rational deployment and in-service training of staff; and adequate support when officers or vehicles are otherwise engaged or out of service. The Victorian Government, through the Hospitals Division of the Health Commission, provides substantial capital and operating funds to each service.

Users are charged for ambulance transport, unless they are pensioners. To avoid this heavy expense, individuals and families are encouraged to become subscribers to their regional service. A small annual fee entitles them to free ambulance transport by any Victorian or interstate service. A central, computerised administrative unit has been developed, as has a common subscription rate.

Mobile Intensive Care Ambulance (MICA)

The MICA scheme was introduced into Melbourne in 1971 on an experimental basis, under the guidance of an expert advisory committee to the Hospitals Division. Since 1973, the Intensive Care Ambulance Unit has been manned by specially trained ambulance officers and is now a well established operation. There are five MICA vehicles in service in the Melbourne metropolitan area, of which four are operated by Ambulance Service—Melbourne from parent hospitals (the Austin, Alfred, Royal Melbourne, and

Western General Hospitals). The fifth unit is based at Frankston and operated by the Peninsula Ambulance Service. The vehicles carry sophisticated medical and radio equipment and a range of appropriate drugs.

Air Ambulance Service

The Air Ambulance Service, managed by Ambulance Service—Melbourne, mainly carries patients from distant country hospitals to Melbourne hospitals, and back. Patients are also brought from interstate when necessary. The air service is more comfortable and far quicker than long road journeys, and is comparable in cost. During 1978–79, 5,101 patients were carried a distance of 1,449,949 kilometres, over 5,110 hours.

Newborn Emergency Transport Service (NETS)

NETS is a co-operative scheme between Ambulance Service—Melbourne and the four Melbourne hospitals with newborn intensive care units (Mercy Maternity Hospital, Queen Victoria Medical Centre, Royal Children's Hospital, and Royal Women's Hospital). Based at the Royal Women's Hospital, a highly qualified team of doctors and sisters, with a full range of equipment and drugs which fits into a standard ambulance, can travel to a hospital to treat a sick baby, then supervise transport to an intensive care unit. In full operation since October 1976, this service has improved the condition of many newborn babies on arrival at intensive care units, and contributed to an increased rate of survival, better condition after survival, and a shorter stay in hospital.

VICTORIA—AMBULANCE SERVICES

Particulars	1974–75	1975–76	1976–77	1977–78	1978–79
Vehicles (including administration)	444	480	517	530	549
Staff (including administration)	904	968	1,126	1,154	1,211
Subscribers	459,864	591,456	659,308	724,275	801,176
Patients carried	366,579	421,743	475,460	485,532	464,868
Distance travelled by ambulances (kilometres)	10,338,739	11,111,470	12,517,748	13,160,524	14,336,462

Further references: Industrial hygiene, *Victorian Year Book* 1964, pp. 254–5; Food standards and pure food control, 1964, p. 258, Communicable disease, 1964, pp. 258–60; Control of poisons and deleterious substances, 1965, p. 245; Interdepartmental Committee on Pesticides, 1965, pp. 245–6; Epidemics, 1967, pp. 501–6; Poisons Information Centre, 1968, pp. 523–4, 1969, pp. 542–3; Public health engineering, 1969, pp. 520–1; Drug and poison control, 1970, pp. 529–30; Environment protection, 1972, pp. 477–8; Community care centres, 1974, pp. 529–30; Community Health Program, 1977, pp. 793–5; Aboriginal health care, 1977, p. 795; Red Cross Blood Transfusion Service, 1977, p. 798; Pharmaceutical services in Victoria, 1977, pp. 798–801; Environmental health services in Victoria, 1977, pp. 801–8; Community health services in Victoria, 1979, pp. 622–3

MEDICAL RESEARCH

Commonwealth Government

National Health and Medical Research Council

The National Health and Medical Research Council, established in 1937, is required by its constitution to advise the Commonwealth Government and the States on matters of public health legislation and administration and on any other matters relating to health, medical and dental care, and medical research. It is also required to advise the Commonwealth Government and the States on the merits of reputed cures or methods of treatment that are, from time to time, brought forward for recognition.

During 1980, the National Health and Medical Research Council intended to provide awards and grants totalling in excess of $14m. This would represent a major proportion of the total funds specifically spent on medical research in Australia.

Commonwealth Serum Laboratories Commission

The Commonwealth Serum Laboratories were established in 1916 as a central Australian institute to produce the nation's requirements of vaccines and antitoxins, previously imported from Britain. Located at Parkville, Melbourne, on an 11 hectare site granted to it in 1918 by the Commonwealth Government, the Laboratories are Australia's leading centre for the production and supply of biological products for human and veterinary use.

Originally under the control of the Quarantine Service, the Laboratories became a division of the Commonwealth Department of Health in 1921, and remained under its

control until the *Commonwealth Serum Laboratories Act* 1961 established the Commonwealth Serum Laboratories Commission. From an original staff numbering 30, the organisation now employs more than 1,000 persons, more than 100 of whom are professionally qualified.

The Laboratories' standards of research and product quality have earned international recognition. They are National or World Health Organisation reference centres for rabies, influenza, and brucellosis, and undertake the monitoring and/or diagnosis of these diseases. A notable research project of national and international significance, successfully undertaken by the Laboratories' scientists, was the world's first development of a method of producing a sub-unit influenza vaccine without harmful side effects, which could be made available to everybody. Many important overseas discoveries in medicine, biology, and biochemistry have been adopted by the Laboratories; for example, they have been producing Australia's supplies of insulin since 1922 and penicillin since 1943, while poliomyelitis vaccine was manufactured from 1956 until the trend towards oral vaccine resulted in production ceasing a few years later.

The Laboratories pioneered the processing of human blood products in 1925, and became the World Health Organisation blood group reference centre for Australia. Methods developed in the 1920s for treating blood donations from patients recovered from certain diseases were adapted during the Second World War to produce blood products on a large scale for the defence forces. For decades, blood donated to the Red Cross and not used immediately as whole blood in transfusions has been processed to recover and separate the individual blood fractions for use in medicine; these are used to control such diseases as infectious hepatitis, measles, rubella, tetanus, haemophilia, and other blood deficiencies. The outdated blood also yields large supplies of plasma.

In veterinary science, the Laboratories have been continually involved in research into animal and poultry diseases, and have developed vaccines and toxoids for active immunisation against clostridial infections, brucellosis, bovine mastitis, erysipelas, strangles, canine distemper, hepatitis, and many other diseases. The model farm maintained on a 618 hectare field station at Woodend runs many hyper-immunised Percheron-type draught horses to produce a basic serum required in snake antivenenes.

Further references: *Victorian Year Book* 1971, pp. 519–21; 1974, pp. 540–1; 1975, pp. 793–4; 1977, pp. 809–10

Victorian Government

Health Commission of Victoria

Information on research activities within the Health Commission of Victoria, is set out on pages 692–3 of the *Victorian Year Book* 1978.

Institute of Mental Health Research and Postgraduate Training

The Mental Health Research Institute was established in 1956, and renamed the Institute of Mental Health Research and Postgraduate Training in 1970. The Institute's director, who is also the Chief Clinical Officer of the Mental Health Division, is responsible for overseeing research into mental illness and mental retardation, training medical officers in the Division, and co-ordinating psychiatric treatment.

The Institute has a research wing under the director of research, and a training wing under the director of postgraduate studies, who is also the clinical head of the Parkville Psychiatric Unit which constitutes the Institute's immediate clinical base. In addition, the Institute includes the Neuro-Psychiatric Centre at Mont Park, the Melville Clinic (a research-oriented community mental health clinic in Brunswick), the Central Library, and the Charles Brothers Museum.

The Institute's epidemiological research has world-wide recognition, and its computerised, cumulative patients register, in operation since 1961, permits collation of all illness episodes in a particular patient, thus assisting in the evaluation of patient care.

Institute staff organise, assist, or oversee all research originating within the Division (and some originating outside). This research includes the psychiatric, psychological, sociological, and pharmacological areas. The most recent published study is the *Health and social survey of the north-west area of Melbourne.*

Further reference: *Victorian Year Book* 1977, pp. 811–12

Anti-Cancer Council

The Anti-Cancer Council of Victoria was constituted by an Act of the Victorian Parliament in 1936 and entrusted with the responsibility of co-ordinating in Victoria "all activities in relation to research and investigations with respect to cancer and allied conditions, and with respect to the causation, prevention, and treatment thereof".

The Council supports a substantial programme of cancer research in university departments, research institutes, and hospitals in Victoria. As part of its research programme, the Council endows three full-time research fellows—one in basic research in leukaemia, one working in the field of cancer chemotherapy, and the other in tumor immunology. Much of this work has been accorded international recognition. The Council also conducts an education programme to inform persons about early warning signs of cancer and to encourage those who have such symptoms to seek early diagnosis and treatment.

The Council provides lectures, films, literature, and specialised library services, and undertakes preventative educational programmes on the hazards of smoking. Materials are distributed widely in primary schools. The Council publishes *Victorian Cancer News*, which is issued four times each year, has a circulation of 165,000, and is a useful aid in cancer education.

The Council's welfare service aims at reducing and alleviating the many social and personal consequences of cancer and at the same time ensuring that maximum use can be made of the available treatment facilities. The Welfare Fund supplements existing statutory allowances—many cancer families are not aware of what is available and only need the relevant information to be able to utilise statutory and other community resources. With a minimum of delay, social welfare workers and other health organisations in the community can obtain grants for cancer patients and their families whose financial stability is at risk.

The Council's cancer registry has records of all cancer patients presenting to major metropolitan hospitals since 1939. To date, the registry has been hospital-based and has offered a specialised follow-up service. Increasing interest in the epidemiology of cancer is shown in the current expansion of the registry so as to register the total incidence of cancer in Victoria.

VICTORIA—ANTI-CANCER COUNCIL: EXPENDITURE
($)

Particulars	1974–75	1975–76	1976–77	1977–78	1978–79
Research *(a)*	380,700	480,213	642,511	815,120	846,535
Education	82,223	115,662	214,272	238,866	339,673
Patient aid	93,723	110,786	141,436	156,098	147,142
Other	197,156	501,598	480,499	545,201	542,773
Total expenditure	753,802	1,208,259	1,478,718	1,755,285	1,876,123

(a) Includes expenditure on Central Cancer Registry.

State Health Laboratory

The State Health Laboratory's activities embrace scientific testing, food standards administration, and consulting services. Over 3,000 samples are examined each year in the laboratory, covering foods, waters, drugs, and an extensive range of miscellaneous substances and articles of public health concern. Work includes checking of fluoridated water supplies, pesticide residue surveys, analysis of waters used in renal dialysis machines for public hospitals, mercury content of fish, penicillin residues in milk, and aflatoxin contamination of peanuts. Senior staff answer about 1,500 inquiries each year, from industry and the public, concerned with the Food and Drug Standards Regulations and various aspects of public health science.

Further references: Alfred Hospital, *Victorian Year Book* 1963, pp. 265–6, 1965, pp. 277–8; St Vincent's School of Medical Research, 1962, pp. 279–80; Medical research at the Royal Women's Hospital, 1965, pp. 273–4; Epidemiological Research Unit, Fairfield Hospital, 1962, pp. 277–9, 1969, pp. 549–50; Asthma Foundation of Victoria, 1969, p. 550; Baker Medical Research Institute, 1976, pp. 698–9, 1977, pp. 813–14; Walter and Eliza Hall Institute of Medical Research, 1972, pp. 502–4, 1975, pp. 788–9; National Heart Foundation of Australia, 1976, p. 699; Howard Florey Institute of Experimental Physiology and Medicine, 1977, pp. 812–13; Royal Children's Hospital Research Foundation, 1977, pp. 816–17; St Vincent's Hospital, 1977, p. 818; Royal Melbourne Hospital, 1977, pp. 817–18

Universities

A comprehensive list of projects carried out by departments and teaching hospitals, indicating the range of medical research at Victoria's universities, can be found on pages 819–27 of the *Victorian Year Book* 1977.

Further references: Medical research at the University of Melbourne, *Victorian Year Book* 1964, pp. 292–4; Medical research at Monash University, 1966, pp. 257–9

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