26

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 625-6), and the Health Insurance Commission (see page 598).

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

* Because of recent changes to some sections of this chapter it should be noted that the information was accurate at 30 June 1979.

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 was in 1978 made on the basis of 50 per cent of capital and operating costs. 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 $6.4m 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 $3m has been provided for 1978–79 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 1978–79, the Commonwealth Government intended to make $57.4m available for allocation under the Community Health Program. Of this $57.4m, $48.3m will be available to the States in the form of block grants, of which Victoria expects to receive $13.9m. Most of the remaining $9.1m 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 $880,000 was made available in 1977–78 for all States to develop and expand their health planning agencies. Also, $440,000 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. These are the Public Health Division, Hospitals Division, and Mental Health Division. Within these divisions are the sections

that now carry out the functions of the former Department of Health, which the Commission replaced. A Division of Mental Retardation Services is also planned.

Public Health Division

The main functions of the Public Health Division of the Health Commission of Victoria lie in the fields of tuberculosis (see pages 616–17), dental health (see pages 620–1), medical assessment, food and drugs, general health, pre-school child development (see page 619), maternal and child health (see page 618), and community services.

The officer in charge of the Medical Assessment Services Section is the Government Medical Officer, who is responsible for the medical examination and assessment of applicants for appointment to the Victorian Public Service and semi-governmental bodies. He 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 so that they meet the prescribed standards of wholesomeness and purity. These 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. These 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 ("D" Clinic), a psychiatric service ("G" Division), and the Pentridge Clinic ("E" Division). In addition to medical services a number of other programmes include tuberculosis screening at Pentridge, Prison Dental Service, Optometry Service, and Prison Psychiatric Service. The treatment service at Pentridge will be expanded with the construction of a new prison hospital which is expected to be in operation in mid-1979.

The Public Service Medical Centre provides an occupational health service to protect, promote, and improve the health of all Crown employees. The Centre is making a notable contribution to the physical and emotional well-being of staff, which will in turn influence their work performance.

At present, there are 758 listed public cemeteries and private burial grounds in Victoria, for which the Cemeteries Section exercises responsibility. The Cemeteries Act provides for a variety of duties, which include 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. These grants are allocated twice each year in May and November for various maintenance works.

The Industrial Hygiene Section carries out numerous 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 also 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. Considerable work is being done 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.

Traditionally, venereal disease control, which is overseen by the Venereal Diseases Section, has been one area of communicable disease control with its own statute and usually centering upon a special clinic. The sexually transmitted diseases clinic must

provide a high standard of diagnostic, therapeutic, and epidemiological services. With this objective, a new clinic now being established is expected to be in operation towards the end of 1979.

Under the medical and inspectorial services of the Division, the medical officers with qualifications in public health and 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 the agency responsible for the transport and discharge of all wastes, including solids, liquids, and sludges to land, i.e. the control of soil pollution. As such, it is responsible for receiving licence applications, issuing and amending licences, checking licence conditions, and investigating 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 within this area 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.

Finally, the following notes briefly examine the work of the Community Services Section of the Division, except for the Home Help Service (see page 621).

The Health Education Centre plans programmes of health education for schools and other organisations involved in the promotion of good health in the community. The Centre also provides speakers, leaflets, and health information for all communities in Victoria.

The aim of the audiological service is to provide throughout the State a 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 in the community a greater awareness of the importance of normal hearing for infants and young children in the development of speech.

The physiotherapy service provides an outreach programme designed to maintain, as far as possible, the independence of poliomyelitis sufferers in the domestic environment; to augment current services in the community for people suffering from multiple sclerosis; and 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 major objective of the Special Health Services Section is to promote the well-being of the Aboriginal people of Victoria, with particular reference to regions outside the 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 Aborigines 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 Health Commission of Victoria formally acquired responsibility for the administration of the *Hospitals and Charities Act* 1958. On that day, the Commission became the successor in law of the Hospitals and Charities Commission. The Hospitals Division, as one of the main line divisions of the Health Commission, is

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 under any Act of the Victorian Parliament, 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 through either capital and/or maintenance subsidies. The great proportion of financial assistance is allocated to hospitals and hospitals for the aged. The availability of funds and the purpose for which they are to be used is a contributing factor in the awarding of grants. Close scrutiny is maintained over hospital budgets. 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 be made available for use as a training school in any branch of nursing; it determines the establishment of nursing staff for hospitals; encourages prospective nurses to improve their general education before commencing training (through the provision of bursaries); maintains a continuous nurse recruitment programme throughout Victoria; produces publicity material, including films on nursing; offers scholarships for diploma courses in the nursing field conducted by the College of Nursing, Australia, or any college of advanced education; 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.

Further references: Hospital regional planning, *Victorian Year Book* 1962, pp. 261–2; Historical outline, 1965, pp. 253–5; Hospital architecture, 1966, pp. 241–2; Charities in Victoria, 1968, pp. 514–15; Rationalised medical services, 1971, pp. 511–12; Victorian Department of Health 1978, pp. 662-4

Mental Health Division

The Mental Health Division of the Health Commission of Victoria plans and directs the State'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 members, making the Division by far the largest within the Health Commission.

In December 1978, the Division was operating with 234 medical practitioners, of whom 108 were specialists. Other professionals included 55 pharmacists, 72 psychologists, 113 social workers, 86 occupational therapists, 1,380 nurses, and 696 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; Committee of Inquiry into Hospital and Health Services in Victoria, 1976, pp. 671–5; Local Government Authorities, 1978, pp. 665

HEALTH INSURANCE IN AUSTRALIA

Introduction

The current health insurance arrangements in Australia replace the modified Medibank scheme and were introduced on 1 November 1978. 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 health insurance levy, payable since 1 October 1976, has been abolished. 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, socially 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 paid the new Commonwealth medical benefit which is equal to 40 per cent of the schedule fee, with a maximum patient contribution of $20 for any one service where the schedule fee is charged. Each medical service which attracts a medical benefit has a schedule fee which is set by an independent tribunal. These fees are set for medical benefits payment purposes only and doctors are not compelled to adhere to them.

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.

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 September 1978, there were 1,769 recognised specialists and 734 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 September 1978, 136 undertakings were in effect in respect of 228 practice locations. These undertakings covered a total of 236 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 1978, seven Victorian optometrists were receiving such assistance with the per capita grants ranging from $1.40 to $4.20.

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 practitioner 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.

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 socially 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 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.

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, persons not privately insured for hospital care are entitled to standard ward accommodation or, where medically necessary, semi-private or private ward accommodation in a recognised (public) hospital.

As a condition of the hospitals agreement between the Commonwealth and State Governments this accommodation is provided without any patient charges being raised. There are conditions in regard to the provision of medical treatment to uninsured persons 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. 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 prefer other than standard ward accommodation, 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, $40 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 $60 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.

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.

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 1 September 1978, this benefit in Victoria was payable up to a maximum of $19.65 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 1 September 1978, the rate of contribution in all States was $7.00 per day for participating nursing home patients and $49.25 per week for deficit financing nursing home patients. The slight difference in the two amounts will be eliminated at the time of the next rate change. 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 Janaury 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 $49.25 per week is made for these patients.

VICTORIA—NURSING HOME BENEFITS PAID
($'000)

Particulars	1973-74	1974-75	1975-76	1976-77	1977-78
Commonwealth Government	25,523	36,631	43,019	51,831	55,922
Private health insurance funds	1,859	2,882	3,963	3,244	*(a)*17,676
Total benefits paid	27,382	39,513	46,982	55,075	73,598

(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.

A person who provides continuous care for an aged person 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. They 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 65 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	1973–74	1974–75	1975–76	1976–77	1977–78
Number of beneficiaries *(a)*	2,126	2,282	2,426	2,296	2,475
Benefits paid ($'000)	1,537	1,667	1,811	1,831	1,794

(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 up to a limit of eight nights. 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 14 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 and $2.50 in July 1978. 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	1973-74	1974-75	1975-76	1976-77	1977-78
Number of prescriptions ('000)	23,426	25,927	25,734	22,604	23,659
Prescription cost ('000)—					
Commonwealth Government contribution	58,791	68,116	65,701	56,246	61,636
Patients' contribution	16,665	18,568	25,959	29,647	30,697
Total	75,456	86,684	91,660	85,893	92,333

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 250 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 Hygiene Authority. Monash University students are trained at the Alfred Hospital, Prince Henry's Hospital, Queen Victoria Memorial Hospital, Geelong Hospital, Fairfield Hospital, and hospitals under the control of the Mental Hygiene Authority.

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 medical graduates towards specialisation is primarily controlled by the Royal Clinical Colleges. Boards of Graduate Studies at the various previously mentioned hospitals, together with the Victorian Medical Postgraduate Foundation, assist in this programme. Each speciality has its own college, that is, the general practitioners have the Royal Australian College of General Practitioners, the physicians the Royal Australasian College of Physicians, the surgeons the Royal Australasian College of Surgeons, and the obstetricians the Royal College of Obstetricians and Gynaecologists. These are the Royal Clinical Colleges. There are also the Colleges of Pathologists, Radiologists, Psychiatrists, and others.

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

The Graduate Board of Studies at each hospital provides 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.

The Victorian Medical Postgraduate Committee arranges continuing education and conducts refresher courses for all specialists. 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 in the main are not obtained by course work but generally are achieved by 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 is then registered as a specialist either by 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 1978, there were 5,030 general nurses in training, 1,140 nursing aides, 359 psychiatric nurses, 152 mental deficiency nurses, and 305 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 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, 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.

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VICTORIA—NURSES, 1977-78

Courses	Approved training institutions (a)	Students at 30 June 1978	Completed course during 1977-78	Registrations approved, including interstate and overseas applicants	Annual practising certificates issued for year endcd 31 December 1977 (b)
Basic courses—					
General nurse	37	5,030	1,490	2,963	32,369
Psychiatric nurse	11	359	113	202	1,906
Mental deficiency nurse	5	152	20	38	
Mothercraft nurse	4	305	77	174	1,914
Nursing aide	52	1,140	1,228	2,034	12,990
Post-basic courses—					
Midwives	12	575	589	945	..
Infant welfare	4	72	52	86	..
Psychiatric	9	37	36	36	..
Mental deficiency	2	7	2	2	..

(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.

Since 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 standard ward patient was brought about by the Hospitals Cost Sharing Agreement between the Commonwealth and Victorian Governments. By this agreement, both governments contracted to share equally on the net operating cost of all public hospitals in Victoria.

At present, there are either hospital or private patients. If an individual chooses to be a hospital patient, he receives hospital care, medical treatment, etc., in a public hospital free of all charges unless privately insured, and without a means test, but he does not have the choice of doctor. Alternatively, a person electing to be a private patient is charged a fee of either $40 per day or $60 per day and has to pay all medical practitioner fees. Only rarely does the hospital fee cover the actual costs. Private patients may insure against the hospital charges and may, in addition, take a medical benefits cover to help meet the doctor's charges (see pages 601-2). 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. From 1 November 1977, a charge of $6 per attendance has been raised from privately insured persons attending public hospitals for an outpatient or casualty service. A means tested fee is charged in the case of dental services and the provision of spectacles.

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 AND NURSING HOMES AT 30 JUNE

Type of institution	1973	1974	1975	1976	1977
Melbourne Statistical Division—					
Special hospitals (including Cancer Institute) *(a)*	11	11	11	11	12
General and auxiliary hospitals	30	30	30	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	47	48	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	6	7
Total	112	112	112	112	113
Total hospitals	159	159	159	160	162

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

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 1978, the number of staff employed full-time at the hospital was 1,430 and, during 1977–78, 10,320 inpatients were treated at the hospital with an average stay of 14.5 days per patient. A total of 136,504 attendances were also made for outpatient services at various clinics within the hospital.

The other institutions conducted by the Department in Victoria are the 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 8,074 (1,944 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 3,550 (868 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 the State'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 4,000 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 safely and contentedly 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 Mount Royal Hospital. The National Institute of Gerontology is also located at Mount Royal.

District nursing services

District nursing services are conducted by 4 district nursing societies, some community health centres, 3 hospitals in the Melbourne metropolitan area, and 82 country hospitals. The district nurses are responsible for the general nursing care of patients in their own homes, thus reducing the number who would otherwise be admitted to hospital for care. During 1977–78, the 89 approved district nursing services employed 394 full-time and 231 part-time nurses who treated 56,014 patients and made 1,164,556 visits. An additional nine services were approved during 1977–78.

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 1978, 25,087 patients received treatment with 30,469 surgery visits and 18,654 home nursing visits. A staff of 16 full-time and 14 part-time trained sisters was employed at 30 June 1978.

Bush nursing hospitals

The first bush nursing hospital in Victoria was founded in 1923 at Cowes on Phillip Island, and by 1978 there were 39 bush nursing hospitals with a total bed capacity of 663 beds. 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.

During 1977–78, nursing home annexes were constructed at Hastings and Pakenham Bush Nursing Hospitals. The 14 beds provided in each of these annexes brings the total number of registered nursing home beds in bush nursing hospitals to 42. Total cost of these projects was $601,000 and capital grants totalling $340,000 were provided by the Commonwealth Government.

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 1977–78 capital works grant was $798,700 and some member hospitals proceeded with

projects without any government assistance. The annual maintenance grant, totalling $470,000 in 1977–78, 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 people 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 192 full-time and 491 part-time nurses at 31 March 1978. The administrative and domestic staff are paid by the local hospital. At 31 March 1978, 19 full-time and 33 part-time administrative staff and 107 full-time and 252 part-time domestic staff were employed.

Psychiatric services

Psychiatric services in Victoria are organised on a regional basis. The State is divided into twelve regions, with the Mental Health Division working towards the situation where each region can be served by one early treatment centre with attached long-term wards for chronically ill and psychogeriatric patients, as well as community mental health centres and other community facilities.

The Division's philosophy is to build early treatment centres in association with general hospitals. Footscray, Geelong, and Mildura provide recent examples of this, and negotiations are taking place with other general hospitals. As well, Royal Park will be provided with a new admission unit, and approval has been given for psychiatric facilities to be included in the developing Sunshine hospital and health services complex. This form of development requires the concomitant expansion of community facilities. It also requires the reduction in bed capacity of several existing mental health institutions which, by modern standards, are too large.

Early treatment centres, consisting of hospital beds for acute patients, day hospitals and outpatient clinics, provide inpatient and outpatient care for those with an established psychiatric disorder. Such patients are referred by community mental health centres, general hospitals, general practitioners, and private psychiatrists. Victoria has 884 hospital beds for short-term psychiatric patients, 75 per cent of whom are admitted on a voluntary basis, while the remaining 25 per cent enter on a medical recommendation.

Within early treatment centres, the distinction between inpatient and day patient lies in the use of the residential facilities. Day hospitals provide care for patients not requiring hospitalisation but benefiting from a comprehensive treatment programme of the type that can be supplied only in the hospital situation. Such treatment may include individual and group therapy. Outpatient clinics provide continuous specialised care, such as psycho-pharmacological treatment and psychotherapy, or advise the patient's general practitioner on the required course of treatment. These clinics are staffed by Mental Health Division psychiatrists and are located in Division hospitals 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. As a result of successful advances in psychotropic drug use, the number of chronic patients has been diminishing. More importantly, the waiting list for psychogeriatric patients has been markedly reduced 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 in Victoria consist of one residential unit (Travancore) containing 37 beds, and specialised outpatient clinics at the Travancore, Observatory, Children's, and Bouverie Clinics, and at the Dandenong Psychiatric Centre. In conjunction with the Mental Health Division, the Austin Hospital's Department of Psychiatry also provides child psychiatric services, and each of these centres provides regional consultative services to outlying psychiatric facilities. Plans have been made to completely redevelop the Travancore Clinic and to relocate Observatory Clinic from South Yarra to South Melbourne.

To meet the demand for staff, the Mental Health Division has joined with the Austin Hospital to provide a training course in child psychiatry, a course leading to the accreditation of the successful participants by the Royal Australian and New Zealand College of Psychiatrists. The Division and the Austin Hospital also provide a course in child psychotherapy for psychiatrists and other professionals in the child field.

Community mental health centres are staffed by teams of psychiatrists, psychologists, social workers, occupational therapists, and community mental health nurses, with the aim of preventing the development of psychiatric disorders that would require the patient to go to hospital. Located in shopping centres or residential areas, the community mental health centres offer professional help on a walk-in basis to those with psychological, social, or family problems and to those in crisis situations. There are 28 such centres as well as a number of domiciliary services operating from psychiatric hospitals.

Persons attending these centres are psychiatric patients who can be treated on an outpatient basis, discharged hospital patients needing help in adjusting to community life, and those who need help but do not show any established psychiatric disorder. The activities of the centres include the organisation of self-help groups, education of community leaders, detection of "at risk" community groups, participation in community activities, and assistance to educational, social, religious, ethnic, and other community organisations in dealing with mental health problems.

The Division provides three categories of after-care for ex-hospital patients:
(1) Psychiatric after-care hostels and half-way houses are provided for patients who are unable to manage independently—some patients require accommodation only for short periods; other patients will require accommodation for the rest of their lives;
(2) day hospitals serve those patients staying with their families or in hostels but whose daily activities require some supervision; and
(3) sheltered workshops for chronically mentally ill persons provide work in a non-competitive situation. Some patients attend sheltered workshops temporarily until they are able to work in the normal labour market; other patients will never be able to transfer to unsheltered employment.

VICTORIA—MENTAL HEALTH: NUMBER OF INSTITUTIONS

Type of institution	At 30 November—				
	1973	1974	1975	1976	1977
Mental hospitals *(a)*	11	11	11	11	11
Psychiatric and informal hospitals	16	16	17	17	19
Intellectual deficiency training centres	9	10	10	12	12
Alcoholic and Drug Dependency Rehabilitation Centres	2	4	4	4	4
Total	38	41	42	44	46

(a) Includes Repatriation Mental Hospital.

Further reference: Modern psychiatric services, *Victorian Year Book* 1963, pp. 248–50

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 a central office, provide treatment, rehabilitation, research, training, and prevention programmes. By extending and supporting previously available facilities, the Section helps to improve a broad range of services. In addition, the new Section can co-ordinate the community's response to the complex problems of alcohol and drug use.

These services have been designed to incorporate cost-effectiveness controls, needs assessment, social cost-benefit analysis, and a continuing evaluation of all efforts in terms of a wide range of goals. These goals range from total or partial abstinence from drug use, through complete social and economic rehabilitation, to patient and staff satisfaction.

The treatment methods available in these services are based on a 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 also emphasised, but appropriate drug therapy (including therapeutic agents, Antabuse, vitamins), behaviour therapy, and other types of treatment based on learning, diet, work therapy, crisis-intervention, and similar treatment are also used where appropriate. The management programmes provided 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 this group and 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.

Mortality rates continue at a low level and were 0.8 per 100,000 persons in 1976. Tuberculin testing among school children indicates a low infection rate which has been fairly constant recently. In 1977, 1.5 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. vaccination before leaving Australia.

VICTORIA—TUBERCULOSIS BUREAUX

Activities	1973	1974	1975	1976	1977
New cases referred *(a)*	9,624	9,334	8,543	8,291	8,088
Active cases					
New	369	321	291	311	274
Reactivated	38	31	29	31	25
Chronic	10	8	7	4	7
Re-attendances	46,190	42,480	37,783	38,383	35,037
Home visits by nurses	21,324	19,179	17,917	15,414	12,996
X-ray examinations (films taken) *(b)*	49,369	44,423	43,367	39,412	37,007
Tuberculin tests	7,544	6,970	6,853	6,931	6,904
B.C.G. vaccinations	1,953	1,766	1,628	1,460	1,519
Chest X-ray surveys (X-rays taken)	598,721	354,256	401,397	412,044	45,461
School tuberculin surveys (Mantoux tests)	87,495	92,265	92,645	88,229	101,639

(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
1973	340	604	586	29
1974	301	564	538	23
1975	301	466	449	19
1976	208	495	468	29
1977	197	421	390	29

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

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 it is responsible for radiotherapy services in Tasmania.

Research is a primary responsibility of the Institute. There are three major research units—biological research, haematology research, and clinical immunology and immunogenetics. The wide-ranging research programmes comprise both clinical trials and laboratory 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 work on the next phase, which will increase inpatient accommodation to 300 beds, as well as providing additional outpatient, radiotherapy, and other facilities, is expected to begin shortly.

VICTORIA—CANCER INSTITUTE

Particulars	1973–74	1974–75	1975–76	1976–77	1977–78
Patients—					
Distinct persons treated (public patients at Peter MacCallum Hospital)	10,141	10,619	10,773	9,879	10,884
New patients registered (public patients) *(a)*	4,457	4,599	4,329	4,353	4,304

VICTORIA—CANCER INSTITUTE *(continued)*

Particulars	1973–74	1974–75	1975–76	1976–77	1977–78
Inpatients (ward and hostel)—					
Number of beds available at 30 June	r122	r122	r122	r122	*(d)*147
Admissions	3,701	3,937	4,419	r4,511	4,553
Daily average	r83.26	85.39	87.36	r84.87	87.68
Outpatients—					
Attendances at consultative clinics (public patients) *(a)*	41,786	45,526	43,808	44,226	45,692
Radiotherapy Department *(a) (b)*—					
Attendances for treatment (public and private)	58,197	61,638	60,590	60,062	66,167
Fields treated (public and private)	112,039	114,977	120,422	119,548	131,932
Visiting Nursing Service—					
Patients visited	1,001	930	972	972	1,220
Total visits	35,639	38,286	36,283	34,547	42,349
Other services (at Peter MacCallum Hospital) *(b) (c)*—					
Attendances (public and private)	90,782	105,636	118,855	122,067	123,021
Paid staff—					
Medical	85	97	99	r99	106
Nursing	166	178	183	r205	240
Scientific and technical	196	203	229	r242	342
Other	440	r440	442	r495	482

(a) Includes patients at Peter MacCallum Hospital and Peter MacCallum clinics at the Austin and Alfred Hospitals and in the country.
(b) Includes inpatients and outpatients.
(c) Includes diagnostic radiations, pathology, physiotherapy, pharmacy, medical, social work, theatre, and photography.
(d) Wards in the new Douglas Wright Wing were opened in January 1978.
NOTE. The above figures are not comparable with previously published figures.

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, which 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 people 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 the State 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	1973	1974	1975	1976	1977
Family planning services—					
Number of clinics	17	23	33	38	39
New enrolments	1,272	1,886	2,991	3,704	4,457
Attendances of patients	4,571	6,586	9,607	12,509	15,790
Pre-natal services—					
Number of clinics	29	29	29	22	21
Attendances of mothers	14,161	12,309	8,356	4,496	3,643
Infant welfare services—					
Number of infant welfare centres (all types)	745	751	763	769	781
Infant welfare sisters employed	421	429	443	450	473
Attendances of children	1,505,761	1,342,809	1,399,310	1,352,640	1,342,883
Home visits to children	141,133	149,584	153,575	155,487	160,975
Attendances of expectant mothers	17,407	18,062	18,192	18,635	19,253
Post-natal visits to mothers in hospital	19,698	24,781	25,824	25,933	25,709
Immunisation—					
Triple antigen primary course	n.a.	62,157	61,246	58,240	55,581
Poliomyelitis primary course	n.a.	58,491	57,987	54,808	52,669
Measles	n.a.	32,957	33,801	34,084	30,571
Smallpox	n.a.	14,739	13,077	*(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 councilsm 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 the early childhood development complexes.

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 March 1978, there were 38 toddler groups, catering for 1,461 children, operating in Victoria.

Kindergartens 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 kindergartens are staffed, and programmes compiled, by a teacher with approved qualifications, supported by an untrained assistant. In March 1978, there were 1,065 subsidised kindergartens, catering for 54,041 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 programme

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 programmes

An Early Childhood Development Programme is a community-based network of services for young children and their families. It seeks to build on to and to integrate existing services in accordance with the developmental needs of families with young children. Through consultation 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 Programmes 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, Mildura, Sunshine/Footscray, Goulburn Valley, Eastern Divide (Lilydale area), Frankston, and Gisborne. They are at various stages of development and in most cases have not yet reached their full staffing strength. It is estimated that approximately 32 Early Childhood Development Programmes will be required to give a comprehensive coverage of Victoria.

School Medical Service

Where early childhood development complexes 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 complexes, and schools, and provide a consultative service where this is needed. In 1977, they offered a support medical examination to children attending subsidised pre-schools in the year before beginning school and examined 42,671 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 33,639 children received a standard examination with preference being given to children who had not been examined at the pre-school centre and 106,401 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 handicap; 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 or requiring special education for deafness 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 disability 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. An extensive building programme in metropolitan and country areas is being developed 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/LaTrobe 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 1978, nursing home and rehabilitation beds available in State, voluntary, and private hospitals totalled approximately 11,400 beds, while hostels accommodated approximately 5,500 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 272,000 during 1977–78, while district nursing services made approximately 1,164,556 visits, the majority of which were to persons over 60 years of age.

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 1978 were supplied by 92 hospitals in co-operation with a number of organisations. These meals were prepared for 120 meals-on-wheels services.

Welfare services

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.

The Home Help Service, subsidised through the Health Commission, is made available to municipal councils which establish, maintain, or financially assist this service in order to preserve the health of the elderly and their autonomy. This service is available to elderly persons on the basis of their 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 heavier household chores which may be beyond the capacity of the elderly, do the shopping, or prepare a meal. Assessment of charges is made according to the person's ability to pay. Regular visits are made by assistant advisers to discuss problems, and organisers of the service are encouraged to seek the Health Commission's advice so that the conditions of the subsidy are met.

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, to 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 Citizen's Clubs, 1966, pp. 230-1

Community services

Community health services in Victoria

Community health services in Victoria have expanded considerably since 1973 following the implementation of the Community Health Program of the Hospitals and Health Services Commission. The objectives of this programme were stated as follows:

(1) To emphasise neglected aspects of health care, prevention, health maintenance, rehabilitation, and primary care; and

(2) to improve the availability and accessibility of health services outside hospitals and nursing homes.

Towards the end of 1975-76, Victoria assumed the responsibility of developing and administering its own programme and determined the priorities for the projects and services to be supported from the available funds.

Community health services have existed for many years in the form of bush nursing posts, infant welfare centres, and other types of locally based health facilities; however, with the inception of the Community Health Program, increased expenditure has been directed towards new initiatives. The programme is based on the positive connotation of health as opposed to the traditional orientation of the treatment of disease provided by hospitals. An essential requirement to foster such an attitude and promote a successful delivery of health care is that both the providers and the consumers should be enthusiastic about the service in operation. Thus, prevention becomes the key to the implementation of the programme.

In Victoria the expansion of community health services depends on the involvement of local citizens, and interest is stimulated by focusing on a resource unit, usually a community health centre. Individuals and groups are encouraged to participate in the promotion of community activities and policy-making through the boards of management of such centres.

Since 1973, there have been some 117 separate areas of development of community health services. Included in this figure are 61 community health centres, 24 day hospitals or rehabilitation centres, and eighteen special projects. While the community health centres in general provide the principal resource, they in turn vary in respect of the range of services which are available. For example, only 37 of the 61 community health centres provide a primary medical care facility.

The first requirement for any community health service is to establish the need for its existence. Consequently, attention has been given to those metropolitan and country areas which are lacking in health services and, in particular, primary medical care. While local communities are responsible for initiating a submission justifying the need for a centre, it is the Hospitals Division of the Victorian Health Commission which is the overall planning and funding authority.

The centres have shown a continuing growth in the services provided, which include medical and nursing, health education, community rehabilitation, and geriatric services, as well as domiciliary care, training and evaluation programmes, youth and adolescent services, health, transport, and other specialised activities.

As the development of the centres has emphasised the delivery of health care, it has been necessary to provide various buildings to house the professional workers concerned. A wide range of new submissions by community groups is categorised according to a priority of need and availability of finance.

The improvement in community health services has resulted in more primary care being readily available in some areas outside hospitals and nursing homes. However, there is still much to be done in the areas of prevention, health maintenance, and rehabilitation. Now that the basic structures of the community health centres exist, more attention will be paid to the prevention of illness, the maintenance of positive health, rehabilitation after illness, and reducing the need for treatment of preventable disease. This will require major changes in public attitudes and social behaviour.

Thus, a long range programme of health education is fundamental to the provision of community health services, and this involves the notion that habits which are known to promote disease should not continue. Such a process of education seeks to improve health care delivery and is conducted by professionals in a wide range of disciplines.

All community health centres help train students in the health professions. Opportunities are provided for community nursing and social work students, and both the University of Melbourne and Monash University medical schools now instruct their clinical students in the setting of the community as well as the hospital.

The Department of Community Health in the University of Melbourne seeks to train doctors in such a way that they understand both the kind and the extent of health needs in their communities. Educationally, community health is concerned with all aspects of health at a community level and with that of individuals in their community setting. The subject draws from the behavioural sciences, epidemiology, and primary medical care, and as a discipline it transcends its component parts, thus adding a new perspective to both the undergraduate and postgraduate training of doctors.

It is also important to evaluate the effectiveness of community health services in order to determine whether they are achieving their stated objectives and that the health of the community is, in fact, being improved. In spite of many difficulties, it is expected that all community health projects will include some inbuilt method of evaluation. This will measure both the quality and efficiency of the services provided and monitor the need for improvement and change. Information from such studies is vital to ensure the appropriate education of the professionals involved.

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 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.

Further rehabilitation services are offered by the Kingston Centre and the Mount Eliza Geriatric Centre; by the Commonwealth Department of Veterans' Affairs through the Rehabilitation Unit in Heidelberg and by 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 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 Children's Society of Victoria, 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.

Mental retardation services

The care and training of mentally retarded persons (apart from education services) is the responsibility of the Mental Health Division of the Health Commission through its mental retardation services, headed by a director and secretary. At October 1978, there were 3,486 beds in residential training centres for the retarded, the majority being occupied by adults.

The Mental Health Division has adopted the policy of regionalising its services for the retarded. It has also adopted the policy of "normalisation"—making available the types of accommodation and services that are as close 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 Balwyn which provides a variety of services for its adjacent region. On a larger scale is the long-term development planned for, initially, the Loddon-Campaspe and Gippsland regions.

The Division and its predecessors have been closely involved in the planning and subsidising of day training centres for the retarded for the past 26 years. There are currently 69 day training centres (16 of which are now special developmental schools) throughout the State and all are subsidised from Victorian Government funds. In the same category are four private residential centres, two autistic children's centres, and a 30 bed hospital leased to a day training centre.

Since the introduction of the *Education (Handicapped Children) Act* 1973, the Education Department has accepted responsibility in principle for educating handicapped children, irrespective of the type of degree of handicap. By October 1978, the educational component of 16 day training centres had been taken over by the Department, and the Department continues to place teachers and teachers' 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 1977-78, 3,805 patients were carried a distance of 381,400 kilometres, over 4,420 hours.

Neonatal Emergency Transport Service (NETS)

NETS is a co-operative scheme between Ambulance Service-Melbourne and the four Melbourne hospitals with neonatal 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	1973-74	1974-75	1975-76	1976-77	1977-78
Vehicles (including administration)	402	444	480	517	530
Staff (including administration)	795	904	968	1,126	1,154
Subscribers	409,075	459,864	591,456	659,308	724,275
Patients carried	341,822	366,579	421,743	475,460	485,532
Distance travelled by ambulances (kilometres)	8,822,998	10,338,739	11,111,470	12,517,748	13,160,524

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

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 1979, the National Health and Medical Research Council will provide awards and grants totalling in excess of $13m. This will 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 have become the official World Health Organisation reference centres in the Pacific region for influenza and brucellosis, and participate in world-wide monitoring 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 two full-time research fellows—one in basic research in leukaemia, and one working in the field of cancer chemotherapy. Much of this work has been accorded international recognition. The Council also conducts an education programme to inform people 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 has taken over the original government commitment in the National Warning Campaign Against 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 130,000, 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 disciplines 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	1973–74	1974–75	1975–76	1976–77	1977–78
Research *(a)*	290,012	380,700	480,213	642,511	815,120
Education	65,754	82,223	115,662	214,272	238,866
Patient aid	58,957	93,723	110,786	141,436	156,098
Other	167,083	197,156	501,598	480,499	545,201
Total expenditure	581,806	753,802	1,208,259	1,478,718	1,755,285

(a) Includes expenditure on Central Cancer Registry.

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; 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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