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HEALTH AND MEDICAL RESEARCH

COMMONWEALTH GOVERNMENT HEALTH SERVICES

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 Commonwealth Institute of Health, 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 page 615-16), and the Health Insurance Commission (see page 588).

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 indicated 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 Programme

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

in which the community itself has been involved in the planning of programmes, together with the relevant State health authorities.

Originally, 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 took 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 had responsibility for determining the allocations to individual projects from their respective block grants, and had flexibility in the movement of funds from one approved project to another, to meet changing circumstances. The block grant system involved 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 had 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 made on the basis of 50 per cent of capital and operating costs since 1978. In addition to funds provided to the States for projects at State or local levels, the Commonwealth Government provided funds, generally on a 100 per cent basis, direct to approved national projects conducted by non-government organisations.

In 1981, the Commonwealth Government determined that, in respect of 1981–82 and subsequent years, it would change the basic character of Commonwealth assistance for health from assistance specifically related to health costs, to payments which are for general purposes but which are identifiable as a Commonwealth contribution towards the cost of health programmes in the States and the Northern Territory. The new arrangements are an interim step towards full absorption of health grants into the tax sharing grants; hence their inclusion in the tax sharing legislation.

Health Services Planning and Research Programme

Through this Programme, research activities concerned with the planning, organisation, staffing, financing, management, operation, and use of health services are supported. An amount of $1.48m was made available in 1981–82 for all States to develop and expand their health planning agencies.

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 was reduced to that of a private registered organisation (while still a statutory authority) and its former functions were taken over by the Commonwealth Department of Health.

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

VICTORIAN GOVERNMENT HEALTH SERVICES

Health Commission of Victoria

The Health Commission of Victoria commenced operations in December 1978. It operates through four line divisions—Public Health, Hospitals, Mental Health, and Mental Retardation. These are supported by four "service" divisions—Planning, Building and Services, Finance, and Personnel.

Public Health Division

The Public Health Division provides its services through six branches—Clinical Services, Inspection Services, Occupational Health, Dental, Pre-school Child Development, and Family Health.

Clinical Services Branch

Prison Medical Service. The Prison Medical Service provides medical and dental treatment for all prisoners in Victoria. In country prisons, treatment is provided through local general practitioners and hospitals. At Pentridge Prison there is a 20 bed hospital

with a large out-patient department staffed by Prison Medical Officers and a range of visiting specialists. There are also 12 beds in St Vincent's Public Hospital.

Other programmes include dental and optometry services.

Child Care. The Health Commission meets the cost of medical, dental and optical treatment rendered to State Wards and other children under the care of the Department of Community Welfare Services.

In addition, a range of medical and pharmaceutical supplies are provided free of charge to group homes, orphanages, and other child care groups.

Medical Assessment Services. These are responsible for the examination and assessment of applicants to the Victorian Public Service and semi-government organisations and for advice to various State Authorities on matters of ill-health and retirement of officers.

Communicable Diseases Centre. This is responsible for the operation of a specialist clinic for the free treatment of sexually transmitted diseases and for contact tracing and follow-up of patients.

Tuberculosis Services. These are 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 and special attention is being directed to the medical supervision of south-east Asian refugees arriving in this country. Other groups requiring surveillance include persons with a past history or significant radiological evidence of past tuberculosis infection and heavy users of alcohol. Because of their higher risk of developing active tuberculosis, these persons are asked to remain under review at clinics or by private doctors.

Tuberculin testing among school children continued and in 1981, 98,441 were tested and 57,121 were given B.C.G. vaccination.

Medical supervision of all new cases and diligent contact control have kept the situation within control. A major credit for improving the situation is the availability 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 reactivated 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 reactivation 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. Three mobile X-ray units have been retained by Tuberculosis Services and are being used for special community groups and others at special risk, for example, mental hospitals, prisons, homes for the aged and indigent, and "contact" surveys. The general situation of community surveys is reviewed periodically with special reference to high risk areas.

The constant danger to unprotected persons proceeding to areas of high risk is emphasised and the Branch considers that all susceptible persons should be advised to have B.C.G. vaccinations before leaving Australia. There were 32 deaths in Victoria in 1981 of persons with active tuberculosis.

VICTORIA—TUBERCULOSIS BUREAU AND CLINICS

Activities	1977	1978	1979	1980	1981
New cases referred *(a)*	8,088	5,399	5,877	6,732	7,031
Active cases—					
New	274	293	395	392	380
Reactivated	25	25	18	16	13
Chronic	7	4	3	4	6
Re-attendances	35,037	21,212	21,167	21,807	24,830
Home visits by nurses	12,996	10,006	13,970	15,863	15,433
X-ray examinations (films taken) *(b)*	37,007	36,312	35,368	38,235	39,535

VICTORIA—TUBERCULOSIS BUREAU AND CLINICS—*continued*

Activities	1977	1978	1979	1980	1981
Tuberculin tests *(c)*	6,904	6,076	6,870	7,222	7,031
B.C.G. vaccinations *(c)*	1,519	1,603	1,675	1,951	1,903
Chest X-ray surveys (X-rays taken)	45,461	48,301	40,848	48,501	39,993

(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.
(c) Excludes tests and vaccinations undertaken by the Schools BCG Section of Tuberculosis Services.

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

Inspection Services Branch

The Medical and Health Surveying Section. This Section superintends and advises local government in matters of public health. It is operated by medical officers and health surveyors, and is regionalised into six specific health areas for the State. The Section is closely involved in reported cases of food poisoning and infectious disease. With the assistance of local government, the Section locates all known contacts, arranges testing to be carried out and initiates appropriate action to insulate the community effectively from the causes of such problems. A mosquito vector programme is conducted throughout Victoria to control the breeding of the mosquito *Culex annulirostris.* This reduces the possibility of transmission of Australian arbo-encephalitis. A programme of screening of all Indo-Asian refugees for health problems is also conducted at time of their entry into Victoria.

The Engineering and Sanitation Section. This Section exercises responsibility in the installation of safe water supplies, the sanitary disposal of effluent, the fluoridation of water supplies, and the cleanliness of public swimming pools. Other activities include the approval of septic tanks installed by local councils, the supervision of sewage treatment processes, the approval of council-owned cattle saleyards and other offensive trade premises, and the licensing of waste water re-use.

The Poisons Control Section. This Section monitors the margin of safety that applies in the manufacture, storage, distribution, and use of poisons and deleterious substances. From advice of an expert Committee and recommendations of the National Health and Medical Research Council, it supervises the methods of manufacture, and sale of poisons and deleterious substances through a complete licensing system. Monitoring of required labelling provisions is also conducted. Included in the role of the Section is the detection of illegal supply and possession of restricted substances.

The Drugs of Dependence Unit. This Unit monitors and controls the use and misuse of drugs of dependence in the community. It prepares for approval and co-ordinates the issue of permits and authorisations for drugs of addiction, monitors computer records of drug movements and, from this data, detects drug dependent persons. The Unit also investigates the activities of pharmacists and doctors in relation to the Poisons Act.

The Proprietary Medicines Section. Through a registration system, this Section requires all medicines for human use to conform to certain standards of efficacy and safety in manufacture, storage, wholesale and retail distribution, and consumer use. All medicines considered acceptable for marketing in Victoria are given a specific registration number which must appear on the outer container of such medicine. Claims made in any labelling utilised in the sale of a product are screened to ensure that the formulation of the product can satisfy such claims. Within the context of this Section, matters related to therapeutic goods and devices are also considered.

The Food Standards Section. This Section superintends and advises local government on prescribed standards for food and food products. The standards are based on recommendations of the National Health and Medical Research Council and resolutions of an expert Food Standards Committee. Regulations prescribing appropriate standards for food and food products cover purity and wholesomeness, manufacturing and storage requirements, and the manner in which food and food products may be labelled.

The State Health Laboratories. These provide service to local goverment, the Commission and other government departments in analyses of material submitted for examination. Ongoing analyses of foodstuffs are carried out to ensure compliance with relevant food standards. Testing of toys and cosmetics for lead content is also carried out.

The Legislation Section. This Section is responsible for preparing new draft legislation from advice received from the various Branches and Sections of the Public Health Division. The Section is also responsible for conducting a continual review of existing legislation to ensure that it is both adequate and relevant to the current needs of the community. Exhaustive consideration is given to matters requiring legislation and all interested parties are given the opportunity to supply arguments for or against prepared drafts so that a desired result is obtained.

Cemeteries Section. The Health Commission's Cemeteries Section administers the Cemeteries Act and Regulations under which cemeteries and crematoria operate. The Commission's role centres around supervision, guidance of local cemetery trusts, and planning for future burial and cremation needs. Day to day operations at cemeteries are carried out by trustees appointed by the Governor in Council. There are more than 600 public cemeteries and 48 approved private cemeteries.

Occupational Health Branch

The Occupational Health Service investigates all forms of occupations and their possible effect on health and provides specialised knowledge and advice to industry and other interested parties as a means to overcome potential hazards to health. Surveillance duties include the level of cadmium pigments in manufacturing plants, the prevalence of carbon monoxide in factories and the occurrence of organophosphates and other pesticides. Work is continuing on radiation monitoring and the level of X-ray emissions from various items of equipment. Audiometric testing for noise level assessment is another function, as is pest control supervision.

Dental Health Branch

The main aim of the dental therapy scheme in Victoria (conducted by the Dental Health Branch of the Public Health Division) is to develop a comprehensive dental service offering free dental care to pre-school and primary school children. 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 dental surgery clinics being established in school grounds where practicable. Other schools will be visited by mobile dental clinics. A building programme in metropolitan and country areas is being continued to accommodate dental therapists as they graduate.

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 mainly posted to the western and north-western suburbs of Melbourne. In 1979, expansion of the scheme was centred in the Geelong/Bellarine Peninsula and Warragul/La Trobe Valley areas. In 1981, children in the eastern suburbs of Melbourne became eligible for treatment at the Dental Clinic at 448 St Kilda Road, Melbourne, on an appointment basis.

Because of lack of funds in late 1982, it was decided that, in future, dental therapists would concentrate on dental examinations and dental health education for all primary school children. Free treatment was only to be given to children classified as "disadvantaged" or handicapped due to geographic isolation. Other children requiring treatment would be advised to visit private dentists, and payment for treatment would be a parental responsibility.

Pre-school Child Development Branch

The Pre-School Child Development Branch of the Public Health Division is responsible for educational, care, and developmental services for children of pre-school age (until attendance at primary school). It is concerned with both government subsidised and privately operated centres.

The Branch has a staff of regional pre-school advisers. They work closely with community groups and the staff of shire and city councils to integrate services, where possible, and to utilise buildings to the fullest. The Branch's responsibilities, through its advisers, include: maintaining standards in kindergartens and other types of centres; being a resource to play groups, living and learning centres, and occasional care programmes; assisting councils and other organisations to establish services; being a liaison with infant health centres and other organisations involved in early childhood services; providing information and assistance to the public, parents, and staff of centres; conducting in-service work for teachers and advisory committees on the administration of centres; assisting in placing children with special needs in appropriate centres and establishing services for particular needs; and where appropriate, being part of the Early Childhood Development Programme team.

The type of service established varies according to the needs of the region and the age of the children. The range of services includes the following:

Toddler groups (Subsidised). For children aged between 18 months and three years and their parents. Conducted by a trained kindergarten teacher and infant welfare sister in an infant welfare centre, this service not only offers parents the opportunity to learn more about the growth and development of young children, but also demonstrates and recommends suitable learning activities.

Kindergartens and pre-school play centres (Subsidised). Provide educational programmes for children from three years of age onwards for up to five half-day sessions per week during the school term. A trained teacher with an untrained assistant plans an educational programme suited to the needs of the individual children in the groups.

Day care centres (Subsidised). Cater for pre-school children whose parents desire full-day care, either on a regular basis or occasionally. These centres vary in size and administration, from a large centre for up to 60 children, in the charge of a qualified director, to a small group, cared for by parents on a co-operative basis. Most centres employ trained staff to carry out an individually planned programme.

Private child minding centres. Centres must be registered, and although the programmes are not professionally supervised, the facilities and programmes are monitored by the regional pre-school adviser in accordance with child minding regulations.

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

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, Mallee (Mildura/Swan Hill areas), Footscray/Sunshine, Goulburn Valley, Eastern Divide (Lilydale area), Frankston, and Gisborne. They are at various stages of development and in some cases have not yet reached their full staffing strength. It is estimated that approximately 32 Early Childhood Development Programmes will be required to give a comprehensive coverage of Victoria.

Family Health Services Branch

School Medical Service. At a time of changing emphasis in community child health needs, the School Medical Service provides support to children and families with a wide variety of needs. Where early childhood development complexes are established, doctors and school nurses work closely with the allied health professionals based in these centres. In addition to this supporting role, increasing emphasis is placed on the preventive aspects of child health, in particular that of the early identification and management of a wide variety of handicapping conditions.

In 1981, a developmental medical examination was offered to children attending subsidised pre-school and day care centres and 44,806 were examined by medical officers. Previously unrecognised disability was found to be present in 6,090 of these children.

Examination of the school age child is conducted by specially trained school nurses and 33,989 Year 1 children were examined in 1981. In other areas doctor/nurse teams work

together and a further 3,551 Year 1 children received an examination by a medical officer, preference being given, where possible, to those children who had not been medically examined in pre-school.

The school nurse has an increasingly important and specialised role in the Service and works within a group of schools which are her responsibility. Vision is screened regularly in Year 1 and 4 and Year 8, pure tone audiometry is used to screen hearing in Year 1 and wherever hearing impairment is suspected. Children with a previously recognised disability are reviewed to ensure that ongoing management is appropriate, and referrals of children thought to be educationally or otherwise at risk are taken from teachers. In 1981, 259,322 school age children were examined of whom 16,490 were referred for further investigation.

Special services are provided to children with intellectual disability and 29 special schools and 15 special developmental schools in Victoria were visited throughout the year by a doctor/nurse team. Consultative services are also provided and 126 children were examined in the clinic for the partially sighted and 844 hearing impaired children were examined. These examinations are part of an inter-disciplinary assessment in collaboration with Victorian Education Department psychologists and teachers to determine the best educational programme for the individual child. Input is also provided to regional ascertainment committees for the hearing impaired.

Medical examinations were performed on children referred for assessment of learning difficulties at school and 294 pre-school children were seen for assessment and ongoing management of developmental delay. The services of 17 sessional paediatricians regionally based are now available throughout Victoria.

The uniformly high standards of examination required for this type of work in the educational-medical field are maintained by a constant ongoing programme of in-service training for all personnel, both nursing and medical. The aim of the service is as always to help the individual child to develop to his or her full potential and to promote better health within the community.

Maternal and infant health services. These services, operated by the Public Health Division's Family Health Services Branch, include the supervision of infants from the first weeks of life throughout the pre-school years, and the guidance of mothers during pregnancy, the post-natal period, and the early child rearing years.

The aim of the Infant Welfare Service is to promote health, in its broadest sense, from the pre-natal period through the child's earliest weeks to school age. The service is delivered, in conjunction with local government, by infant welfare nurses at infant welfare centres. There are 513 nurses employed in 798 centres throughout Victoria. The service is free and readily available to parents. The Health Commission employs a team of infant welfare nursing advisers to assist nurses employed by local government. Direct services are provided to migrant hostels, to Puckapunyal Army Camp, and to four infant welfare "circuits" in northern and eastern Victoria.

Family planning is an integral part of family health, and family planning clinics are conducted at a growing number of infant welfare centres. The centres are run jointly by the Health Commission and local government, and are staffed by Health Commission doctors and nurses trained in family planning methods. A wide range of free services is offered.

VICTORIA—MATERNAL AND INFANT HEALTH SERVICES

Particulars	1977	1978	1979	1980	1981 *(a)*
Family planning and pre-natal services *(b)*—					
Number of clinics	39	66	72	75	75
New enrolments	4,457	4,975	6,532	8,051	8,690
Attendances of patients	15,790	18,261	22,622	27,534	31,110
Pre-natal services—					
Number of clinics	21	18	*(b)*	*(b)*	*(b)*
Attendances of mothers	3,643	2,307	*(b)*	*(b)*	*(b)*
Infant welfare services—					
Number of infant welfare centres (all types)	781	783	787	795	798
Infant welfare sisters employed	473	481	492	507	513
Attendances of children	1,342,883	1,325,693	1,311,510	1,325,033	1,986,187
Home visits	160,975	164,468	163,941	170,667	254,032
Attendances of expectant mothers	19,253	20,368	21,259	21,944	*(c)*
Post-natal visits to hospital	25,709	26,770	26,516	27,903	49,612

(a) Statistics for these services are now collated on a financial year basis. Therefore this column covers the period January 1981 to June 1982, and is not comparable with previous data.
(b) Pre-natal services now absorbed into family planning clinics.
(c) Not collected after June 1981.

Hospitals Division

Under the *Hospitals and Charities Act* 1958, all institutions and benevolent societies as defined in the Act must be registered. The Division ensures that the main requirements for registration, that is, the setting of suitable objectives and the provision of appropriate constitutions, are complied with.

Registration of institutions and benevolent societies under the Act entitles such organisations to share in the Hospitals and Charities Fund for maintenance (operating) subsidies. The great proportion of financial assistance is allocated to hospitals and hospitals for the aged. The award of grants is dependent upon the availability of funds and the purposes for which they are to be applied. Close scrutiny is maintained by the Division over hospital budgets. Each institution is required to submit budgets for approval covering the succeeding year's operations. The cost of operating the public hospital system has increased substantially in the last decade. In 1969–70, the average cost per bed per day was $23.53 compared with $158.80 in 1981–82.

The Health Commission through the Hospitals Division, exercises control over State funds for capital works. Commission approval is required at all stages for hospital building projects from the original narrative, through preliminary sketch plans to documentation, tendering, and supervision of the projects. Capital expenditure for 1969–70 amounted to $18.2m compared with $49.8m in 1981–82. Included in this amount was a contribution of $10m from the Hospitals and Charities Fund for maintenance works at hospitals.

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

Mental Health Division

This Division of the Health Commission operates treatment and preventive services for mental illness, alcoholism and drug dependence, and forensic psychiatry.

Psychiatric care is provided by psychiatric and mental hospitals, clinics, child and adolescent centres, community mental health centres, domiciliary services, and day hospitals.

Direct alcoholism and drug dependence services are provided by assessment centres, detoxification units, and rehabilitation centres. The Division is also involved in the development of services through voluntary organisations.

Forensic psychiatry is provided to Victoria's prisons, and the Children's Clinic receives psychiatric referrals from the Children's Court.

Mental Retardation Division

This newly established Division has responsibility for the operation of training centres and other centres for the mentally retarded. The primary objective of the Division is to enable mentally retarded persons to live in the community with the greatest possible degree of independence and dignity.

The Division has four branches—Regional Services, Institutional Services, Resources Development, and Administration.

Further references: History of the Victorian Department of Health, *Victorian Year Book* 1961, pp. 215–17; Health of the Victorian Community, 1962, pp. 243–6; Hospital Regional Planning, 1962, pp. 261–2; Historical Outline, 1965, pp. 253–5; Hospital Architecture, 1966, 241–2; Charities in Victoria, 1968, pp. 514–15; Rationalised Medical Services, 1971, pp. 511–12; Committee of Inquiry into Hospital and Health Services in Victoria, 1976, pp. 671–5; Victorian Department of Health, 1978, pp. 622–4; Local Government Authorities, 1978, p. 665

HEALTH INSURANCE IN AUSTRALIA

In 1946, the Commonwealth Parliament was empowered by referendum to provide medical and dental services as well as pharmaceutical, sickness, and hospital benefits throughout Australia.

The original national health insurance system was introduced on 1 July 1953 to enable the public to obtain protection against the cost of medical and hospital services, by taking out insurance with non-profit registered health insurance organisations. The Commonwealth supplemented hospital and medical benefits paid by these organisations.

Under this system which remained virtually unchanged for nearly 20 years, a person who had incurred medical or hospital costs presented the receipt to his fund, which paid a benefit from the fund and also, as agent for the Commonwealth, a benefit from the Government.

Following extensive Parliamentary debate on health insurance issues in the late 1960s and the criticisms contained in the report of the Nimmo Committee in 1969, the system was modified in several ways.

A list of most common medical fees was drawn up and incorporated in the National Health Act as the Schedule of Fees for Medical Benefits Purposes (now known as the Medical Benefits Schedule and reviewed from time to time by an independent tribunal). Benefits were substantially increased to reduce the gap between cost and benefits. Commonwealth Government subsidisation was made available for low income and certain other disadvantaged groups to obtain private insurance, and funding was made available to increase the insurability for persons with chronic illnesses, disabilities, or pre-existing illnesses.

In July 1975, the Commonwealth Government introduced the scheme known as Medibank. This scheme provided for medical benefits to be paid to all persons at the rate of 85 per cent of the schedule fee with a maximum gap per service of $5; in addition, every Australian became entitled to free standard ward public hospital treatment. A bulk billing facility for doctors was introduced, the Commonwealth and State Governments entered cost sharing agreements for the funding of public hospitals on a 50–50 basis and a levy on taxable income was proposed to finance the Medibank scheme in part.

Following the Commonwealth Government's consideration of the deliberations of the Medibank Review Committee in 1976, changes were made to the Medibank arrangements from 1 October 1976. In the interest of maintaining universal coverage, Australians could choose to remain insured with Medibank by the payment of a levy, or contribute to a private insurance organisation.

On 1 July 1978, medical benefits were reduced to 75 per cent of the Schedule fee with a maximum gap of $10.

The health insurance levy, Medibank Standard, and the concept of compulsory health insurance were abolished on 1 November 1978. A universal new Commonwealth benefit was introduced to provide benefits to cover 40 per cent of the Schedule fee with a maximum gap of $20. Private health funds provided additional benefits as an optional extra and doctors could bulk bill the Commonwealth Government for pensioners and persons they identified as socially disadvantaged at 75 per cent of the Schedule fee. Persons had to register with a private fund to receive the Commonwealth Benefit.

On 1 September 1979, the Commonwealth Government abolished the 40 per cent—$20 scheme and substituted a Commonwealth medical benefit to meet the cost over $20 for each service up to the limit of the Schedule fee.

Further changes to the health insurance arrangements which became operative on 1 September 1981 were made by the Commonwealth Government with the objective of achieving a greater public participation in the cost of health care in Australia.

The individual elements of these latest arrangements are outlined under the headings "Medical benefits" and "Hospital benefits" below.

Medical benefits

General features

From 1 September 1981, a Commonwealth Medical Benefit (C.M.B.) became available only to persons insured with a registered medical benefits organisation for at least the basic level of medical benefits (except pensioners holding Pensioner Health Benefit cards

and their dependants and "persons in special need" and their dependants in receipt of a Health Care Card). The basic level of medical benefits is equal to 85 per cent of the Schedule fee or the Schedule fee less $10, whichever is the greater amount. This is a combined medical benefit, composed of a flat rate of C.M.B. of 30 per cent of the Schedule fee and the remainder fund benefit. The "Schedule" refers to medical benefits for services by medical practitioners and dental practitioners, benefits for consultations by participating optometrists, and medical benefits for services by accredited dental practitioners in the treatment of cleft lip and cleft palate conditions.

Doctors may continue to bulk bill the Commonwealth for pensioners with Pensioner Health Benefit (P.H.B.) cards and the current rate of C.M.B. for pensioners is 85 per cent of the Schedule fee or the Schedule fee less $5, whichever is the greater amount. Alternatively, pensioners may claim the same amount of C.M.B. through a registered medical benefits organisation should they be issued with a doctor's account.

The Commonwealth Department of Social Security identified the three groups of persons in special need. Those who qualified were issued with a Health Care Card. The three groups are:

(1) Migrants and refugees in the first six months in Australia, irrespective of income;
(2) unemployed and special beneficiaries with incomes below the P.H.B. limits; and
(3) low income groups, means tested as follows: married couple, income below $172 per week plus $20 for each child; sole parent with 1 child, income below $172 per week plus $20 for every other child; single persons, income below $103 per week.

The C.M.B. for Health Care Card holders is a flat rate of 85 per cent of the Schedule fee where the doctor bulk bills the Commonwealth at that rate in full settlement for the service, or, a claim for C.M.B. may be made through any registered medical benefits organisation on a paid or unpaid account for 85 per cent of the Schedule fee or the Schedule fee less $5, whichever is the greater amount.

Registered medical benefits organisations are now restricted to offering only a basic table of medical benefits (85 per cent or $10 gap, whichever is the greater amount) described earlier, a gap medical table (to cover the $10 gap) and ancillary tables for paramedical-type services and appliances. Contributions paid to a registered medical benefits organisation for the basic table of benefits are tax rebateable at the rate of 32 cents in the dollar.

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

The Australian Medical Association (A.M.A.) publishes its own list of medical services and fees which in the opinion of the Association are fair, reasonable, and appropriate for the services listed. While there is some variation between individual items, generally speaking the A.M.A. fees are in excess of the schedule fees (e.g. G.P. standard surgery consultation: $12.60 A.M.A. at 1 November 1981 and $11.20 schedule at 1 July 1982).

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 30 June 1982, there were 2,099 recognised specialists and 974 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 30 July 1982, 167 undertakings were in effect in respect of 286 practice locations. These undertakings cover 299 optometrists out of a total of 336.

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 30 September 1981, eight Victorian optometrists were receiving such assistance with the per capita grants ranging from $0.90 to $4.20. The rates of payment for such assistance are currently under review.

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 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.

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 is able to ask them to show that the services requested were reasonably necessary for the adequate medical care of their patients.

In 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.

At 30 July 1982, there were 722 medical practitioners approved as pathology practitioners in Victoria.

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 was a Committee under the National Health Act).

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

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

An Optometrical Services Committee of Inquiry was established in 1979.

Claims review and investigation

The Commonwealth Department of Health has responsibility for ensuring that claims by medical practitioners or members of the public for payment of Commonwealth benefit for medical or hospital services are legally correct and justifiable under the provisions of the Health Insurance Act.

To this end, claims submitted for payment are reviewed by the Department and, where indications of fraud or other abuse of the health insurance programme are found, investigations are conducted by the Department to determine the nature and extent of the abuse.

Evidence of fraud or offences against the Health Insurance Act is passed to the Australian Federal Police for prosecution while evidence of non-criminal irregularities is dealt with by means of counselling, referral to the Medical Services Committee of Inquiry, and/or recovery of benefits overpaid.

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. From 1 September 1981, grants are generally restricted to meeting the cost of services rendered to eligible pensioners and Health Care Card holders and their dependants and those persons who, due to the nature of their dependancy and their private domestic arrangements, do not wish their consultation to be made known to other members of their family.

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 benefits

From 1 September 1981, the funding arrangements between the Commonwealth and the States provide that eligible pensioners and Health Care Card holders will have access to free public hospital accommodation and treatment as public patients. All other persons in Australia will be charged for public hospital accommodation and treatment. The public hospital charges in Victoria are $110 per day for shared ward accommodation and $150 per day for a private room. Where patients choose not to utilise the services of their private doctor while in hospital, an additional $60 per day is charged for professional services provided by the hospital staff.

The public hospital outpatient charges in Victoria were also altered on 1 July 1982 from the previous $15 per attendance to a $20 charge for each medical service provided. From 1 August 1982, the Victorian Government legislated to impose a levy on registered hospital benefits organisations which conduct business in Victoria. The purpose of the legislation was to provide an alternative method of funding outpatient services for persons insured under a basic hospital benefits table.

Registered hospital benefits organisations in Victoria are required to operate a basic table of hospital benefits. This table provides for a benefit of $110 per day for hospitalisation plus $60 per day if required, for inpatient professional services and benefits to cover the full cost of outpatient charges. Contributions paid to a registered hospital benefits organisation for the basic table of benefits are tax rebateable at the rate of 32 cents in the dollar.

All organisations in Victoria provide additional tables of benefit at a higher contribution rate to cover the higher charges for public hospital private room accommodation and private hospital accommodation.

The Commonwealth Government provides assistance in meeting private hospital bed fees through a payment of $16 per bed day, or $28 per bed day for surgical patients, directly to the private hospitals. The identification of surgical patients relates to certain specific Schedule items being provided. Also, through its Re-insurance Account arrangements with the private health benefits organisations, the Commonwealth provides special assistance for those basic hospital table contributors with chronic or other illnesses requiring prolonged hospitalisation. The Commonwealth Government contribution to the Re-insurance arrangements has been set at $100m annually from 1 September 1981.

Certain patients in public hospitals may be re-classified as "nursing home type patients" after a continuous period as an inpatient exceeding 60 days. All such patients will be charged an uninsurable amount towards the cost of hospital accommodation, currently $10.05 per day in Victoria. With the exception of the Commonwealth entitled persons, an insurable net hospital fee of $37.65 for extensive care patients or $31.65 for ordinary care patients is then payable.

In Victoria, certain inpatient and outpatient services are provided free of charge by public hospitals. These types of services are for victims of criminal assault, sexual assault, domestic violence, or child abuse where fee charges would exacerbate the domestic situation, and for persons attending clinics of a preventive services nature, persons with serious infectious diseases, and for renal dialysis.

Nursing home benefits arrangements

The current nursing home benefits arrangements provide for the payment of a basic nursing home benefit for approved patients in approved nursing homes. This benefit varies between States. At 30 June 1982, this benefit in Victoria was payable up to a maximum of

$31.65 per day. An extensive care benefit of $6 per day is available to persons who require and receive extensive care at the nursing home.

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.

From 1 September 1981, the Commonwealth Government pays the appropriate benefits on behalf of all patients in participating and State nursing homes direct to the nursing homes. Previously, hospital benefits organisations paid nursing home benefits from their basic table for insured persons.

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 30 June 1982, the rate of contribution in all States was $10.25 per day for participating nursing home patients and deficit financing nursing home patients. These rates may be waived or reduced in cases of financial hardship. State Government nursing homes set their own patient contribution levels, which are dependent on the means of each patient.

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

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

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

Since 1 January 1975, the Nursing Homes Assistance Act has provided for a deficit financing scheme for eligible organisations operating religious or charitable type nursing homes. Under the scheme, the nursing homes submit budgets for approval and their approved operating deficits are financed by the Commonwealth Government. Because of these arrangements the Commonwealth Government does not pay nursing home benefits on behalf of uninsured patients and no charge other than the prescribed fee of $71.75 per week is made for these patients.

VICTORIA—NURSING HOME BENEFITS PAID
($'000)

Particulars	1977–78	1978–79	1979–80	1980–81	1981–82
Commonwealth Department of Health	55,922	50,505	60,975	78,431	*(a)*124,043
Private health insurance funds	17,676	31,142	34,935	41,407	25,925
Total benefits paid	73,598	81,647	95,910	119,838	149,968

(a) The increase in benefits paid by the Commonwealth Department of Health is due to the change in nursing home arrangements from 1 September 1981.

Domiciliary nursing care benefits

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

From 4 September 1980, a person who provides continuous care for a person aged 16 years and over may be eligible to receive a fortnightly benefit of $42.00 (previously $2 per day) provided a number of conditions are met. The beneficiary and patient must live together in a private home. Aged persons may also live in an aged persons complex where that complex does not also contain a nursing home or hostel. Alternatively, the complex may contain a hostel, provided no nursing staff are employed. The patients must be at least 16 years of age and must have an official certificate from their doctor stating that because of infirmity, illness, or incapacity, they have a continuing need for nursing care by a registered nurse as would warrant his/her admission to a nursing home. They must receive 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.

VICTORIA—DOMICILIARY NURSING CARE BENEFITS

Particulars	1977–78	1978–79	1979–80	1980–81	1981–82
Number of beneficiaries *(a)*	2,475	2,565	3,474	4,268	3,693
Benefits paid ($'000)	1,794	1,965	2,363	4,259	4,899

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

Pharmaceutical benefits

The National Pharmaceutical Benefits Scheme was introduced in 1950, along with a restricted free list of life saving and disease preventing drugs. In 1951, an additional comprehensive range of medicines was provided free to pensioners. The Scheme, considerably expanded in 1960, introduced a patient contribution fee of 50 cents for prescriptions written for the general public. This contribution was increased to $1.00 in 1971, $1.50 in 1975, $2.00 in 1976, $2.50 in July 1978, $2.75 in September 1979, $3.20 in December 1981, and $4.00 from 1 January 1983. Eligible pensioners and their dependants who hold a valid Pensioner Health Benefits Card and sickness benefits recipients and their dependants holding a valid Health Benefits Card receive pharmaceutical benefit prescriptions free of charge. A concession of $2 per benefit item was introduced from 1 January 1983 for persons holding Health Care Cards and Social Service and Veterans Affairs' pensioners who are not eligible for a Pensioner Health Benefits or Health Benefits Card, and dependants of these groups.

The drugs and medicinal preparations available as pharmaceutical benefits are determined by the Commonwealth 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. An amendment to the National Health Act in May 1981 established the Pharmaceutical Benefits Remuneration Tribunal as the body responsible for determining payments to approved pharmaceutical chemists for the supply of pharmaceutical benefits. Previously, approved chemists' fees were set by the Joint Committee on Pharmaceutical Benefits Pricing Arrangements.

VICTORIA—PHARMACEUTICAL BENEFITS

Particulars	1977-78	1978-79	1979-80	1980-81	1981-82
Number of prescriptions ('000)	23,659	23,873	22,395	23,558	26,421
Prescription cost ($'000)—					
Commonwealth Government contribution	61,636	65,543	65,904	72,789	94,501
Patients' contribution	30,697	35,397	33,098	34,630	42,555
Total	92,333	100,940	99,002	107,419	137,056

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

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

Postgraduate training

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

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

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

In addition, the Victorian Medical Postgraduate Foundation arranges continuing education and conducts refresher courses for both specialists and generalists. These courses are conducted both in the Melbourne metropolitan area and in the country. Particular emphasis is placed on the continuing education of country medical

practitioners. The universities have postgraduate degrees which they offer to medical graduates. These may be obtained by course work and/or thesis. Clinical academics also take part in training programmes arranged by Boards of Graduate Studies.

Specialist status

When a specialist qualification is granted by a college and the appropriate experience is gained, the recipient may be registered as a specialist with 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 health and 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 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 schools of nursing. 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.

Tertiary level nursing education courses are offered by the Schools of Nursing at Lincoln Institute of Health Sciences and Phillip Institute of Technology. The courses offered include the Bachelor of Applied Science, Advanced Nursing, (with major studies in clinical nursing, community health nursing, nursing administration and nursing education) the Diploma in Applied Science, Community Health Nursing and the Diploma in Applied Science, Advanced Psychiatric Nursing. Both of these colleges also conduct basic nursing education programmes leading to a Diploma in Applied Science, 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, coronary care, operating theatre, cardio-thoracic, geriatric, oncological, eye, ear, nose, and throat, gynaecological, and communicable diseases nursing ensure a sufficient supply of skilled staff in these fields.

VICTORIA—NURSES, 1981–82

Courses	Approved training institutions at 30 June 1982 *(a)*	Students at 30 June 1982	Completed course during 1981–82	Registrations approved, including interstate and overseas applicants	Annual practising certificates issued for year ended 31 December 1981 *(b)*
Basic courses—					
General nurse	27	4,341	1,427	2,700	38,813
Psychiatric nurse	10	409	142	298 }	1,818
Mental retardation nurse	6	167	51	83 }	

VICTORIA—NURSES, 1981–82—*continued*

Courses	Approved training institutions at 30 June 1982 *(a)*	Students at 30 June 1982	Completed course during 1981–82	Registrations approved, including interstate and overseas applicants	Annual practising certificates issued for year ended 31 December 1981 *(b)*
Basic courses—*continued*					
Mothercraft nurse	5	322	118	143	1,818
State enrolled nurses	46	1,156	1,041	2,015	18,189
Post-basic courses—					
Midwives	11	492	517	863	..
Infant welfare	2	n.a.	56	76	..

(a) Some institutions conduct more than one type of training.
(b) An annual practising certificate is issued on the qualifications 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, if variable, pattern. Essentially, they are corporate bodies under the provisions of the Hospitals and Charities Act and are managed by committees appointed by the Governor in Council. They receive financial assistance by way of government subsidies.

Staffing of public hospitals was, prior to 1975, based on the former traditional British pattern of honorary service. In 1975, the honorary medical staff who had been treating "hospital" patients free of charge became paid members of the hospital staff on fee for service, contract or sessional remuneration. This system of paying all medical staff who provided free treatment for "hospital" patients was brought about by the Hospitals Cost Sharing Agreement between the Commonwealth and Victorian Governments. Under this agreement, both governments contracted to share equally in the net approved operating costs of all public hospitals in Victoria. However, the agreement was terminated in July 1981, and replaced with one whereby the amount of money allocated by the Commonwealth Government is based on a block grant, and the State is required to meet the balance of net operating costs. Under this operation the user pays principle has been extensively applied.

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. Regionalised services including pathology, pharmacy, radiology, blood banks, physiotherapy, speech therapy, audiology, and occupational

therapy are being progressively established. Group laundries have been sited at strategic locations and each hospital has access to the services of a regional engineer.

The Hospitals Division has initiated two new services. The Central Health Interpreter Service, which comprises persons proficient in Arabic, Croatian, Cambodian, Greek, Chinese, Italian, Serbian, Turkish, Spanish, and Vietnamese, will assist in the health interpreting requirements of public hospitals, community health centres, and the voluntary non-profit organisations affiliated with the Health Commission in the north-western and central areas of Melbourne; and the Ethnic Health Service, whose members are deployed throughout Victoria to liaise between professional and public health organisations and ethnic communities.

VICTORIA—NUMBER OF PUBLIC HOSPITALS AT 30 JUNE

Type of institution	1978	1979	1980	1981	1982
Melbourne Statistical Division—					
Special hospitals (including Cancer Institute) *(a)*	12	13	13	13	13
General and auxiliary hospitals	31	30	30	30	30
Convalescent hospitals	1	1	1	1	1
Hospitals for the aged	4	4	4	4	4
Sanatorium	1	1	1	1	1
Total	49	49	49	49	49
Remainder of State—					
Base hospitals	10	10	10	10	10
General hospitals	96	95	95	95	95
Hospitals for the aged	7	7	7	7	7
Total	113	112	112	112	112
Total hospitals	162	161	161	161	161

(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; Mayfield Centre, 1980, pp. 629–30

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.

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 meet building regulations as laid down by the *Victorian Health Act* 1958, as well as regulations relating to private hospitals, uniform building regulations, and fire regulations.

At 30 June 1982, there were 369 private hospitals and nursing homes in Victoria totalling 13,767 beds.

District nursing services

District nursing services are conducted by four district nursing societies, some community health centres, four hospitals in the Melbourne metropolitan area, and 88 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 1980–81, the 96 approved district nursing services employed 471 full-time and 242 part-time nurses who treated 55,366 patients and made 1,410,861 visits.

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

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, and psychiatry. 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 1982, the number of staff employed full-time at the hospital was 1,402 and, during 1981–82, 14,307 inpatients were treated at the hospital with an average stay of 9.7 days per patient. A total of 152,328 attendances called on outpatient services at various clinics within the hospital.

The other institutions conducted by the Department in Victoria are: 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 10,403 (2,417 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 4,501 (1,088 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 Victoria, this is provided at the Repatriation Hospital, Bundoora for service related disabilities.)

In each State in Australia and at Darwin in the Northern Territory, there is a Repatriation Artificial Limb and Appliance Centre, where artificial limbs and surgical aids are provided. Artificial limbs are supplied free to all persons in the community who need them.

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

State geriatric centres

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

It will always be essential to provide accommodation for those patients whose assessed medical conditions have made them totally dependent on nursing support, and some 4,800 beds are available for this purpose within State geriatric centres or in units attached to public hospitals. The part played by these centres in a health system for the aged has been expanded beyond this original one aspect of care. The responsibilities of each geriatric centre are to:

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

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

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 Community Health Program and 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 1982, 35,832 patients received treatment with 32,042 surgery visits and 20,194 home nursing visits. A staff of sixteen full-time and thirteen part-time trained sisters was employed at 30 June 1982.

Bush nursing hospitals

The first bush nursing hospital in Victoria was founded in 1923 at Cowes, Phillip Island. In 1982, there were 39 bush nursing hospitals registered with the Health Commission of Victoria. These hospitals provide 648 acute beds and an additional 134 nursing home beds in separate annexes; twelve hostel beds are also provided.

Primary, non-specialised care is provided but in the event of complications setting in or specialist treatment and paramedical services being required, patients are transferred to nearby base or city hospitals.

As with bush nursing centres, each hospital is administered by an annually elected local autonomous committee. The members of the committee act in an honorary capacity but most committees employ a full-time or part-time secretary. The committees have the responsibility of providing funds for the operation of the hospital. Income is supplemented by a State Government maintenance grant which in 1981–82 amounted to $470,000. This represents approximately 2.5 per cent of the total income of all hospitals. The grant is allocated on a needs basis by the Association Council.

State Government capital grants are made available on a $3 to $1 basis to bush nursing hospitals to assist with capital works programmes and the purchase of equipment. An amount of $1,096,581 was granted in 1981–82 while total expenditure amounted to $1,462,108. Several hospitals purchased major items of equipment and carried out building projects without the assistance of government grants.

Bush Nursing Association

The Victorian Bush Nursing Association is an incorporated body registered with the Hospitals Division of the Health Commission of Victoria. Its constitutional objects are to provide nursing, hospital, and related services to persons in country areas of Victoria.

The Association is administered by an honorary Council comprising twelve persons elected by members, six persons nominated by defined organisations, and five persons co-opted on an annual basis. The elected members are usually associated with hospitals and centres thus providing local committees of management with direct representation on the Council.

The Association, through the Council, employs a full-time administrator, who is the chief executive officer of the Association, and appropriate staff to maintain the Association office in Melbourne. A qualified architect is usually co-opted to the Council, providing, in conjunction with the administrator, an honorary consultancy for committees engaged in building projects.

The nursing staff are mainly employed and paid centrally by the Association. Some nurses and all domestic and administrative staff are employed and paid by local committees. Equivalent full-time staff employed at hospitals and centres on 30 June 1982 were: nursing, 452; domestic, 205; and administrative, 84.

Psychiatric services

The State psychiatric services are organised within twelve regions. The Mental Health Division intends that each will have an early treatment unit supported by adjacent long-term beds for chronically ill and psychogeriatric patients, and by community facilities appropriate to regional needs.

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

The early treatment centres provide inpatient and outpatient care for those with established psychiatric disorders. The primary facilities are acute beds, day hospitals, and outpatient clinics. The patients are referred by community mental health centres, general hospitals, general practitioners, and private psychiatrists. Within the early treatment centre, the distinction between inpatient and day patient lies in the use of the residential facilities, the day hospital providing care for patients not requiring hospitalisation but benefiting from the comprehensive treatment programmes available only in the hospital situation. Victoria has 800 hospital beds for short-term psychiatric patients, 60 per cent of whom are admitted voluntarily. The remainder enter on medical recommendation.

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

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

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

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

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

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

The Division provides three types of after-care for ex-hospital patients:

(1) Psychiatric after-care hostels and half-way houses for patients who are unable to manage independently—some patients require accommodation for short periods only, while others require it for the rest of their lives;

(2) day hospitals for patients staying with their families or in hostels but whose daily activities require some supervision; and

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

VICTORIA—MENTAL HEALTH: NUMBER OF INSTITUTIONS

Type of institution	At 30 November—				
	1978	1979	1980	1981	1982
Mental hospitals *(a)*	11	11	11	11	11
Psychiatric and informal hospitals	19	19	20	20	20
Mental retardation training centres	12	12	12	12	12
Alcoholic and Drug Dependency Rehabilitation Centres	4	4	4	4	4
Total	46	46	47	47	47

(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 provided through the Alcohol, Drug and Forensic Branch of the Mental Health Division have been developed as a co-ordinated response to individual and community problems. Four specialised centres, co-ordinated from head office, provide treatment, rehabilitation, research, training, and prevention programmes. In response to the complex community problems of alcohol and drug abuse, the Alcohol, Drug and Forensic Branch liaises closely with the many community agencies working in these fields. There is an increasing number of non-government agencies supported by government funds provided through the Health Commission which are providing direct service at the local community level. The Branch is monitoring these developments, providing assistance when requested and establishing guidelines.

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

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, occupational therapy, and the visiting nursing service. In addition, it operates clinics in twelve Melbourne public hospitals and institutes and six country hospitals, and is responsible for radiotherapy services in Tasmania.

Research is a primary responsibility of the Institute and the wide ranging research programmes comprise both clinical trials and laboratory research. There are four research units—biological research, haematology research, experimental chemotherapy and immunogenetics 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.

VICTORIA—CANCER INSTITUTE

Particulars	1977–78	1978–79	1979–80	1980–81	1981–82
Patients—					
New patients registered (hospital patients)	4,303	4,501	4,197	4,137	3,850
Inpatients (ward and hostel)—					
Number of beds available at 30 June	147	147	147	163	163
Admissions	4,553	*(a)*6,294	*(a)*7,809	*(a)*8,667	*(a)*9,120
Daily average	87.7	*(a)*115.3	*(a)*113.4	*(a)*115.8	*(a)*116.4

VICTORIA—CANCER INSTITUTE—*continued*

Particulars	1977–78	1978–79	1979–80	1980–81	1981–82
Outpatients—					
Attendances at consultative clinics (hospital patients) *(b)*	45,692	46,154	42,443	48,951	47,179
Radiotherapy Department *(b) (c)*—					
Attendances for treatment (hospital and private)	66,167	61,503	59,954	62,000	68,663
Fields treated (hospital and private)	131,932	124,316	118,876	126,311	139,029
Visiting Nursing Service—					
Patients visited	1,220	1,235	1,093	1,049	832
Total visits	42,349	51,368	51,289	47,302	43,132
Other services (at Peter MacCallum Hospital) *(c) (d)*—					
Attendances (hospital and private)	123,021	129,166	127,458	152,582	173,513
Paid staff *(e)*—	1,125	1,129	1,147	1,147	1,093

(a) Includes day patients.
(b) Includes patients at Peter MacCallum Hospital and Peter MacCallum clinics at the Austin and Alfred Hospitals and in the country.
(c) Includes inpatients and outpatients.
(d) Includes diagnostic radiations, pathology, physiotherapy, pharmacy, medical, social work, theatre, and photography.
(e) Effective full-time.

NON-INSTITUTIONAL HEALTH SERVICES

Services for the aged

Community health and welfare services for the aged

Health services

In June 1982, nursing home and rehabilitation beds available in State, voluntary, and private hospitals totalled approximately 16,000 beds, while hostels accommodated approximately 9,000 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 and centres are being established. Day hospital attendances exceeded 350,000 during 1980–81.

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, in geriatric centres, and in some community health centres.

Meals-on-wheels services for the year ended 30 June 1982 were supplied by 161 municipal councils. Approximately 11,700 meals were provided each week to senior citizen centres and 56,200 to dwellings.

Welfare services

General home help

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

A subsidy is made available to those municipal councils which establish and maintain a Home Help Service in order to promote the health and autonomy of the elderly, infirm and convalescent. This service is now available in every municipality in Victoria. It originally developed for the main purpose of providing home help in the homes of parents with young families for periods of up to 3 weeks when the mother became incapacitated through pregnancy or illness. While this service to young families is continuing, the trend in recent years has been for an increase in the demand for the provision of home help to the elderly and infirm and this now constitutes over 80 per cent of the service provided. The service is available on the basis of medical and social need and allotted according to the priority of each case. Duties of a home help are to maintain the household's routine, assist with household chores, do the shopping, and prepare meals. Assessment of charges is made according to the person's ability to pay. Health Commission advisers are available to discuss problems and they make regular visits to municipalities for this purpose.

Special home help extension and Senior Citizens' Centres

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

Senior citizens' centres 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. Senior citizens' centres also encourage health promotion through programmes of swimming, exercises, and dancing. They also provide community activities such as assistance with slow reading groups, and occasionally, handyman services. Municipal councils are paid a subsidy through the Health Commission to establish and maintain these centres, 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 centre because of infirmity. Routine visits are made by advisers to municipal councils to discuss existing centres, the implementation of new services, or the formation of new centres. Regular discussions are conducted with centre members in an attempt to broaden centre activities and the size and scope of membership.

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

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

Community services

Health care of the physically and intellectually handicapped

Physically disabled services

Physically handicapped persons can receive acute 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 extended care programmes designed to meet ongoing individual needs are offered at public hospitals, geriatric and rehabilitation centres, and in various day-care centres. Occupational therapy, physiotherapy, speech therapy, and social work personnel provide the paramedical services in these units to enable full assessment and planning of the individual's rehabilitation programme.

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

Several independent voluntary organisations provide medical and paramedical services (usually in association with specialists from public hospitals) in addition to their educative or other training functions.

Disabled Persons' Information Bureau

The Bureau is part of the Extended Care Section of the Hospitals Division of the Health Commission. It gathers and disseminates information relating to disability. The Administrator maintains close links with the self-help and service provision areas, which cover physical, sensory, and mental impairments. Information is provided, free of charge, to any interested person. Lists of relevant self-help groups, sheltered workshops, municipal advisory committees on disability, and service providing agencies are available on request.

Free travel service

The Health Commission makes free travel on public transport available to pensioners and persons of limited means who require treatment at public hospitals. Eligible persons can apply for rail vouchers and/or tram tickets at the Commission's offices at 555 Collins Street, Melbourne.

Mental retardation services

A regionalisation programme has been adopted to provide a more comprehensive and equitable development of services. This programme works in conjunction with the

Division's policy to allow the maximum number of handicapped persons to leave institutions, live in the community, and be given adequate support services to enable them to do so.

At July 1982, the Division operated twelve residential training centres with 3,136 residents. Another 3,683 retarded persons attend 64 day training centres and four private training centres subsidised by the Health Commission.

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 87 branch stations. There are 39 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 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 Mobile Intensive Care Ambulance has been manned by specially trained ambulance officers and is now a well established operation. There are six MICA vehicles in service in the Melbourne metropolitan area, of which five are operated by Ambulance Service—Melbourne from parent hospitals (the Austin, Alfred, Box Hill, Royal Melbourne, and Western General). The sixth 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 to deal with cardiac and other emergencies.

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 1981–82, 6,600 patients were carried a distance of 4,200,000 kilometres.

Ambulance Officers Training Centre

The Centre, which is fully maintained by the Health Commission of Victoria, provides trainee ambulance officers and higher ranks with the "classroom" components of their training, in conjunction with the services which provide the practical experience components. The basic course for ambulance officer training leads to the Certificate of Applied Science (Ambulance Officer), awarded by the Education Department of Victoria.

Newborn Emergency Transport Service (NETS)

NETS is a co-operative scheme between Ambulance Service—Melbourne and the four Melbourne hospitals with newborn intensive care units (Mercy Maternity Hospital, Queen Victoria Medical Centre, Royal Children's Hospital, and Royal Women's Hospital). Based at the Royal Women's Hospital, a highly qualified team of doctors and sisters, with a full range of equipment and drugs which fits into a standard ambulance, can travel to a hospital to treat a sick baby, and 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	1977–78	1978–79	1979–80	1980–81	1981–82
Vehicles (including administration)	530	549	560	560	593
Staff (including administration)	1,154	1,211	1,295	1,384	1,430
Subscribers	724,275	801,176	864,967	915,636	986,776
Patients carried *(a)*	485,532	465,868	534,800	585,875	610,669
Distance travelled by ambulances (kilometres)	13,171,865	14,336,462	15,634,687	16,753,413	18,004,994

(a) Basis of collecting statistics was altered from 1979–80 onwards.

Survey of Handicapped Persons

During February to May 1981 a survey was conducted throughout Australia by the Australian Bureau of Statistics (ABS) to obtain information about the nature and extent of various disabilities and handicaps in the Australian community. Final results from the survey were published in October 1982 (Catalogue No. 4343.0).

This was the first time in Australia that a national survey had directly examined issues associated with handicapped persons. Although the 1976 Census included a question on handicaps, the post-enumeration survey following the Census showed clearly that the question had different meanings for different people and that the resulting data was of poor quality. Previous ABS surveys on "Chronic Illness" and "Health" focused on illness rather than handicap and thus provided only a partial view of the situation of handicapped persons. Similarly, the information obtainable from records and reports of government departments or private agencies working with handicapped persons only relates to those who are known to the department or agency or who have some connection with it via the receipt of a benefit, the provision of aids, etc. This survey supplements such information by directly identifying handicapped persons in a representative sample of the whole population.

The survey examined the needs of and the kinds of problems experienced by persons with different types of handicaps. The areas examined in respect of handicapped persons included causes, disabling conditions, services, aids, accommodation, employment, education, income, transport, recreation, and institutionalised care.

The sample for the survey consisted of two distinct parts. The first part covered all households in Australia. A sample of 6,500 households was selected. In the second part, a sample of 950 patients or residents was selected from 130 randomly selected health establishments throughout Victoria.

Survey definitions

A "disabled person" is a person who had one or more disabilities or impairments. These had to have lasted or be likely to last for 6 months or more.

A "disabling condition" is that condition which caused one or more of the disabilities or impairments. Persons may have more than one disabling condition and the "primary disabling condition" is the condition identified by the person (or the person answering on his/her behalf) as causing the most problems.

A "handicapped person" is a disabled person aged 5 years or more who was further identified as being limited to some degree in his/her ability to perform certain activities or tasks.

Disabled persons aged under 5 years were all regarded as being handicapped.

The following activities were used in the assessment of each area of handicap. They were chosen as representative of the many and varied tasks involved and as indicators of the difficulties which may be experienced because of a person's disabling condition(s):

(1) Self care handicap—difficulties in showering, bathing, dressing, eating a meal.

(2) Mobility handicap—difficulties in using public transport, moving around a person's own home, moving around unfamiliar places, walking 200 metres, walking up and down stairs.

(3) Communication handicap—difficulties understanding or being understood in their native language.

Persons had a "schooling limitation" if they were unable to attend school, attended a special school, attended special classes in an ordinary school, needed time off from school or had difficulty at school because of their disabling conditions. This information was collected only from persons aged 5–14 years and those aged 15–20 years still attending school.

Persons had an "employment limitation" if they were limited in the number of hours they could work, required time off work, were limited in the prospect of changing/obtaining jobs, had lost or been refused a job, worked in a sheltered workshop, or were permanently unable to work because of their disabling condition(s).

Employment limitation was only determined for persons resident in households who were aged 15–64 years and not attending school.

Severity of handicap

Three levels of severity (severe, moderate, and mild) were determined for each of three areas of handicap; self care, mobility, and communication. These levels were based on the person's ability to perform the activities or tasks, and the amount and type of assistance required.

The highest level of severity in any one of the areas of self care, mobility and communication determines the severity of total handicap for handicapped persons.

Severity of handicap in each area and in total was not determined for children aged less than 5 years, because the questions were inappropriate for young children. Severity was also not determined for those persons with only an employment or schooling limitation.

Information from the survey is provided in the following tables. More detailed data is available on request from the Australian Bureau of Statistics.

VICTORIA—HANDICAPPED AND DISABLED PERSONS: TYPE OF RESIDENCE BY TYPE OF DISABLING CONDITION
('000)

Type of disabling condition *(a)*	Handicapped *(b)*			Disabled *(c)*		
	Households	Health establish-ments	Total	Households	Health establish-ments	Total
Mental disorders other than retardation, degeneration, or slow at learning	49.6	11.6	61.2	79.0	11.9	90.9
Mental retardation, mental degeneration due to brain damage, slow at learning, and specific delays in development	19.7	6.4	26.1	23.4	6.5	29.9
Total with mental disorders	67.0	16.1	83.1	100.2	16.4	116.6
Sight loss	28.4	6.4	34.8	42.8	6.4	49.3
Hearing loss	72.9	6.6	79.5	136.0	6.7	142.7
Nervous system disease	28.2	5.6	33.9	42.2	5.6	47.8
Circulatory disease	66.4	8.0	74.3	88.3	8.0	96.3
Respiratory disease	26.5	1.3	27.8	41.2	1.3	42.5
Musculoskeletal disease	114.0	8.2	122.2	155.7	8.2	163.9
Other physical condition	78.0	8.8	86.8	109.8	8.9	118.7
Total with physical conditions	290.2	22.2	312.4	459.2	22.6	481.8
Total	316.4	25.4	341.8	509.7	26.0	535.7
Percentage of total persons *(d)*	8.2(7.9)	91.4(89.7)	8.8(8.6)	13.2(12.6)	93.5(92.6)	13.9(13.2)

(a) Persons are shown against a condition category when any of the selected disabling conditions (as defined by the survey) was classified to that category. Persons are shown against each total once only.
(b) Includes all disabled children aged 0 to 4 years and persons who had a schooling or employment limitation only.
(c) Includes those determined as being handicapped.
(d) Total number of handicapped persons residing in households was 3,865,229. Total number of handicapped persons residing in institutions was 27,794. Australian percentages are shown in parentheses.

VICTORIA—DISABLED PERSONS *(a)*: AGE BY TYPE OF DISABLING CONDITION ('000)

Type of disabling condition *(b)*	Age group (years)									Total
	0–4	5–14	15–24	25–34	35–44	45–54	55–64	65–74	75 or more	
Mental disorders other than retardation, degeneration, or slow at learning	*(c)*	*(c)*	5.9	14.1	12.7	14.5	20.2	8.8	11.5	90.9
Mental retardation, mental degeneration due to brain damage, slow at learning, and specific delays in development	*(c)*	9.0	7.4	*(c)*	*(c)*	*(c)*	*(c)*	*(c)*	*(c)*	29.9
Total with mental disorders	*(c)*	11.9	12.3	17.0	14.4	15.5	21.0	9.9	13.4	116.6
Sight loss	*(c)*	4.2	3.9	*(c)*	*(c)*	4.3	6.5	6.6	16.4	49.3
Hearing loss	*(c)*	9.4	6.3	9.3	11.8	16.8	26.7	26.3	33.9	142.7
Nervous system disease	*(c)*	6.2	4.7	4.8	4.8	4.5	7.7	6.1	7.8	47.8
Circulatory disease	*(c)*	*(c)*	*(c)*	*(c)*	5.8	13.1	27.3	23.2	21.6	96.3
Respiratory disease	*(c)*	6.6	3.8	4.1	*(c)*	6.3	8.0	6.6	3.7	42.5
Musculoskeletal disease	*(c)*	4.3	9.4	17.6	20.1	23.7	31.0	28.5	28.6	163.9
Other physical condition	4.9	9.3	8.2	10.1	11.7	14.9	24.0	17.2	18.4	118.7
Total with physical conditions	10.2	36.8	31.7	43.9	48.6	66.4	93.2	78.1	72.8	481.8
Total	10.7	43.5	39.8	54.5	56.7	74.7	100.6	81.2	74.0	535.7
Percentage of total persons *(d)*	2.0 (2.0)	8.1 (8.1)	7.4 (7.5)	10.2 (9.7)	10.6 (10.1)	13.9 (13.1)	18.8 (18.9)	15.2 (16.7)	13.8 (13.9)	100

(a) Includes those determined as being handicapped, and also includes all disabled children aged 0 to 4 years and persons who had a schooling or employment limitation only.
(b) Persons are shown against a condition category when any of the selected disabling conditions (as defined by the survey) was classified to that category. Persons are shown against each total once only.
(c) Subject to sampling variability too high for most practical purposes.
(d) Australian percentages are shown in parentheses.

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; Pre-school audiology services, 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; Youth services, 1982, pp. 619–22; Community Health Program, 1977, pp. 793–5; Aboriginal health care, 1977, p. 795; Red Cross Blood Transfusion Service, 1977, p. 798; Pharmaceutical services in Victoria, 1977, pp. 798–801; Environmental health services in Victoria, 1977, pp. 801–8; Community health services in Victoria, 1979, pp. 622–3

MEDICAL RESEARCH

Commonwealth Government

National Health and Medical Research Council

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

During 1983, the National Health and Medical Research Council intended to provide awards and grants totalling in excess of $33m. This would represent a major proportion of the total funds specifically spent on medical research in Australia.

Commonwealth Serum Laboratories Commission

The Commonwealth Serum Laboratories were established in 1916 as a central Australian institute to produce the nation's requirements of vaccines and antitoxins, previously imported from overseas. 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. An amendment to the Act in 1980 empowered the laboratories to produce and sell pharmaceutical products of a non-biological nature.

The Laboratories' standards of research and product quality have earned international recognition. They conduct National and World Health Organisation reference centres for rabies and influenza, and undertake the monitoring and/or diagnosis of these diseases. A notable research project of national and international significance, successfully undertaken by the Laboratories' scientists, was the 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 commenced penicillin manufacture in 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 blood group reference centre for Australia. Methods developed in the 1920s for treating blood donations from patients who had 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; 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, 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 for antitoxins and antivenoms.

The Laboratories are also active in the field of the manufacture and distribution of products of importance in. diagnostic procedures used for human and veterinary health care, as well as in fundamental research being conducted in various institutions throughout Australia and in some overseas countries.

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 Post-graduate Training in 1970. In 1980, under the Mental Health Division, the Institute reverted to a purely research role under the Assistant Director, Education and Research. The Director of the Mental Health Research Institute supervises research activities in the Institute under the immediate direction of the Chief Psychiatrist, Education and Research, who also takes a Divisional research responsibility and directs divisional education and training programmes with the assistance of a Director of Post-graduate Psychiatry Training and a Director of Child and Adolescent Psychiatry Training. The Director of Post-graduate Psychiatry Training, organises the five year training programme for Divisional medical officers, leading to fellowship of the Royal Australian and New Zealand College of Psychiatrists.

The Mental Health Research Council conducts a forum monthly to examine research proposals and the Executive decides on the acceptability of projects and any modifications needed after each forum. Consideration is given to research projects in the Division and some research projects from outside the Division which relate to Divisional facilities or patients. The Council Executive considers mental retardation projects only in an advisory capacity on request from the Mental Retardation Division.

The Institute is adjacent to the Parkville Psychiatric Unit, which fulfils a clinical training role for medical officers preparing for the Diploma of Psychological Medicine or the Membership of the Royal Australian and New Zealand College of Psychiatrists. Attached to the Institute is the central library and the Charles Brothers museum.

The Institute's epidemiological research has gained 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.

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 a full-time research fellow in basic research in leukaemia. Much of this work has been accorded international recognition. The Council also conducts an education programme to inform persons about early warning signs of cancer, to urge persons to avoid known cancer hazards, and to encourage those who have such symptoms to seek early diagnosis and treatment.

The Council provides lectures, films, literature, and specialised library services, and undertakes preventative educational programmes on the hazards of smoking. Materials are distributed widely in primary schools. The Council publishes *Victorian Cancer News*, which is issued four times each year, has a circulation of 180,000, and is a useful aid in cancer education.

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

The Victorian Cancer Registry, established in 1940, is a data bank of clinical details on cancer patients. Originally it registered full information on the patients from only ten large Melbourne metropolitan hospitals and followed up these patients annually, thus providing a picture of the course of the disease and the results of treatment. More recently, in response to the increasing awareness of the need to document each case of cancer occurring in a defined geographical area, in order to study the epidemiology of the disease, the Registry has been expanding its activities to measure cancer incidence for Victoria. Complete incidence data were sought for the first time during 1982 when cancer became a notifiable disease.

VICTORIA—ANTI-CANCER COUNCIL: EXPENDITURE
($)

Particulars	1977–78	1978–79	1979–80	1980–81	1981–82
Research *(a)*	815,120	846,535	1,088,132	1,195,833	1,301,816
Education	238,866	339,673	329,612	394,851	488,007
Patient aid	156,098	147,142	166,135	173,693	198,749
Other	545,201	542,773	634,977	692,191	748,733
Total expenditure	1,755,285	1,876,123	2,218,856	2,456,568	2,737,305

(a) Includes expenditure on Central Cancer Registry.

State Health Laboratory

The State Health Laboratory's activities embrace scientific testing, food standards administration, and consulting services. Over 3,000 samples are examined each year in the laboratory, covering foods, waters, drugs, and an extensive range of miscellaneous

substances and articles of public health concern. Work includes checking of fluoridated water supplies, pesticide residue surveys, analysis of waters used in renal dialysis machines for public hospitals, mercury content of fish, penicillin residues in milk, and aflatoxin contamination of peanuts. Senior staff answer about 1,500 inquiries each year, from industry and the public, concerned with the Food and Drug Standards Regulations and various aspects of public health science.

Further references: Alfred Hospital, *Victorian Year Book* 1963, pp. 265–6, 1965, pp. 277–8; St Vincent's School of Medical Research, 1962, pp. 279–80; Medical research at the Royal Women's Hospital, 1965, pp. 273–4; Epidemiological Research Unit, Fairfield Hospital, 1962, pp. 277–9, 1969, pp. 549–50; Asthma Foundation of Victoria, 1969, p. 550; Baker Medical Research Institute, 1976, pp. 698–9, 1977, pp. 813–14; Walter and Eliza Hall Institute of Medical Research, 1972, pp. 502–4, 1975, pp. 788–9; National Heart Foundation of Australia, 1976, p. 699; Howard Florey Institute of Experimental Physiology and Medicine, 1977, pp. 812–13; Royal Children's Hospital Research Foundation, 1977, pp. 816–17; St Vincent's Hospital, 1977, p. 818; Royal Melbourne Hospital, 1977, pp. 817–18; Mayfield Centre, 1980, pp. 629–30

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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