26

HEALTH AND MEDICAL RESEARCH *

GOVERNMENT HEALTH SERVICES

Commonwealth Government

Commonwealth Department of Health

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

The Commonwealth Minister for Health is responsible for the administration of the Department and four statutory authorities—the Hospitals and Health Services Commission (see pages 658–61), the Capital Territory Health Commission the Commonwealth Serum Laboratories Commission (see pages 691–2), and the Health Insurance Commission (see page 661).

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.

Hospitals and Health Services Commission†

The Hospitals and Health Services Commission was established in April 1974, following the creation of an Interim Committee in February 1973. It has a broad charter to ascertain health care needs, to make recommendations concerning systems of providing care, the education of personnel, the accreditation of services, the levels of financing assistance to be made available to States, Territories, regions, local governments, and charities, and to make grants.

* Readers are also referred to the *Victorian Year Book* 1977 where several additional aspects of health and medical research are covered. However, material which has been omitted for reasons of space will again be included in future years.

† The Hospitals and Health Services Commission was superseded in March 1978 by a new Social Welfare Policy Secretariat located in the Commonwealth Department of Social Security which will have responsibility over the whole field of health and welfare. Details of the new body will be shown in the 1979 edition of the *Victorian Year Book*.

Community Health Program

The Community Health Program was introduced in 1973–74 to encourage the provision of comprehensive and integrated community-based health care and support services. Its objectives stress prevention, education, rehabilitation, and domiciliary services as an alternative to institutional care. Although by no means all community health services are supported under this one programme, it is seen as a major source of support for new initiatives in community health services. There is a clear preference for proposals in which the community itself has been involved in the planning of programmes, together with the relevant State health authorities.

In previous years, grants to projects in the States were approved on an individual project basis, but at the outset of 1976–77 this approach was changed. Financial allocations to the States now take the form of annual block grants for each State's total approved programme, including projects conducted by non-government organisations operating at State or local levels. Under these arrangements, the States have responsibility for determining the allocations to individual projects from their respective block grants, and have flexibility in the movement of funds from one approved project to another, to meet changing circumstances. The block grant system involves the Commonwealth Government in broad policy issues; in seeking agreement with the States on the inclusion of projects in annual programmes and the board priorities therein; and, in conjunction with the States, in evaluation and progress reporting. The States have primary responsibility for detailed administration of their annual programmes. Commonwealth Government funding to projects conducted by the States or by non-government organisations funded through the States was in 1977 made on the basis of 50 per cent of capital costs and 75 per cent of operating costs. In addition to funds provided to the States for projects at State or local levels, the Commonwealth Government provides funds, generally on a 100 per cent basis, direct to approved national projects conducted by non-government organisations.

One major national project which received funds in 1977 is the Family Medicine Program, sponsored by the Royal Australian College of General Practitioners. This Program provides vocational training in family medicine for recently graduated medical practitioners or doctors wishing to return to general practice after an absence. $4.8m was allocated for this Program in 1977–78. Through this Program incentive payments have been introduced and are made to the medical practitioners who train as general practitioners in identified areas of need.

The Commonwealth Government is concerned that assistance should be available to women and children in crisis situations and regards the financing of women's refuges as a matter of importance. Steps taken include the continued financing of 19 women's refuges already approved for assistance under the Community Health Program. Also, up to a further $1m was set aside to finance additional refuges in 1977–78.

During 1977–78 the Commonwealth Government intended to make $79m available for allocation under the Community Health Program—an increase of $10m over expenditure in 1976–77. Of this $79m, $72m will be available to the States in the form of block grants, of which Victoria expects to receive $18m. Most of the remaining $7m will be absorbed by national projects financed directly by the Commonwealth Government.

Hospitals Development Program

The Commission submitted a report entitled *Hospitals in Australia* to the Commonwealth Government in April 1974, and most of the principles contained in the report were accepted. Two of its major recommendations were that financial assistance should be based on assessed needs, not on a simple per capita distribution, and that the provision of additional capital funds by the Commonwealth

Government should be dependent on the Commonwealth Government assuming a share of the responsibility of ensuring that needs are evenly met. To enable recommendations to be made on funds to satisfy needs, Standing Committees have been established for each State, comprising representatives from the Hospitals and Health Services Commission, State health authorities, and the Commonwealth Department of Health.

During 1977–78, Commonwealth Government outlays for Victorian projects were expected to total $11m, which is considerably less than the $27m received in 1976–77. Australia-wide, the Commonwealth Government intends to spend $50m in 1977–78, compared with $108m in 1976–77.

Health Services Planning and Research Program

Through this Program, the Commission supports research activities concerned with the planning, organisation, staffing, financing, management, operation, and use of health services. $660,000, of which Victoria received $24,000, was made available in 1976–77 for all States to develop and expand their health planning agencies. Also, $440,000 was allocated to universities and other organisations for independent research and evaluation of health care systems.

While the Commission is advised of the activities undertaken by the States under the Program, it is only minimally involved in the details of the projects. A standing Committee comprising representatives from the Tertiary Education Commission, the National Health and Medical Research Council, and the Hospital and Allied Services Advisory Council considers applications for funds under the Program.

The Commission and the Commonwealth Department of Health, in conjunction with one another as well as separately, are themselves involved in research activities concerned with the planning, organisation, staffing, financing, management, operation, and use of health services.

Occupational health

The Joint Working Party on Occupational Health, established in December 1974, is responsible for the planning and evaluation of an Occupational Health Service for Commonwealth Government employees. The Working Party's report on proposals for the Service was completed in May 1975.

These proposals envisage the establishment of an Occupational Health Service for employees to provide a comprehensive range of community-type preventive and treatment services to all classes of Commonwealth Government employees through the operation of a number of occupational health field units. It has also been decided that the Hospitals and Health Services Commission should undertake planning and future evaluation of the Service and the Commonwealth Department of Health should assume responsibility for future implementation through a Bureau of Occupational Health operating within the health framework. Constraints on expenditure, and the continuing lack of trained professional staff in occupational health disciplines, have hampered development of this proposed service.

Rural health services

In rural areas distant from the main centres of coastal population, there is a continuing problem of attracting general practitioners, and this shortage of practitioners restricts the rural population's access to health care. To examine the existing situation and prepare a report, the Commission established a Working Party and an Advisory Committee on the provision of rural health services.

The Commission's report on this topic, entitled *Rural health in Australia,* was tabled in the Commonwealth Parliament in August 1976. The approved programmes have been referred to the Commonwealth Department of Health for introduction. Policy proposals are being constructed and work has commenced on some of the recommendations.

Health transport

Along with the substantial expansion of hospital and medical services there has been a rapid growth in demand for related transportation, affecting not only conventional road ambulance systems but also air transport. Consequently, it was decided that a programme should be formulated to support the development of adequate health transport services in an acceptably co-ordinated manner. A Health Transport Working Party was established to examine arrangements for the provision of patient transport and mobile health services, and to make recommendations on future policies for Australia.

The Working Party prepared a report entitled *Health transport policies for the 1970s and 1980s,* containing preliminary recommendations after an analysis of the submissions received from the appropriate bodies. This report has since been tabled in the Commonwealth Parliament, and subsequently referred to the Commonwealth Department of Health for implementation in terms of approved programmes. Work has commenced on a number of the recommendations and policy proposals are being developed.

Health manpower

The Committee on Health Careers (Personnel and Training) was set up to advise the Commission on manpower requirements for Australian health care delivery systems and on the range, nature, and location of the training appropriate to health workers. The Committee's report on Australian health manpower was tabled in the Commonwealth Parliament in March 1975. The report recognised that the provision of appropriately trained health manpower is an extremely complex process involving many different interests and authorities, hospitals, universities, other educational institutions, registration authorities, professional and occupational associations, and Commonwealth, State, and local governments.

Since the tabling of this report, the Commonwealth Department of Health has taken steps towards the completion of a comprehensive reference system on Australia's health manpower resources for the use of health service and educational administrators.

Further reference, 1977; National Hospital and Health Services Commission, 1975, 1976

Health Insurance Commission

The Health Insurance Commission, commonly known as Medibank, was established under the Commonwealth *Health Insurance Commission Act* 1973, and is responsible for the payment of health benefits and other amounts as outlined by the Commonwealth *Health Insurance Act* 1973, and any subsequent amendments to that Act. As such, the Health Insurance Commission represents an integral part of the health benefits arrangements currently operating in Australia, which are described in detail on pages 665–73.

A Health Insurance Advisory Committee provides an effective mechanism for consultation between registered health insurance organisations and the Commonwealth Department of Health on matters of common interest in the delivery and financing of health care with particular application to health insurance. The Committee consists of representatives of the private health benefits organisations, Departmental officers, and a representative of the Hospital and Allied Services Advisory Council.

Further reference, 1977

Victorian Government*

Victorian Department of Health

The Victorian *Health Act* 1943 established the Victorian Department of Health consisting of the Minister of Health, a Permanent Head and Secretary to the Department, a Chief Health Officer, and other officers necessary to promote the health of Victorians.

The Department of Health consists of the General Health, Maternal and Child Welfare, Tuberculosis, Mental Hygiene, and Alcoholics and Drug-Dependent Persons Services Branches. The latter two branches are the responsibility of the Mental Health Authority, while the former three branches are each under the control of a medical specialist and an administrator, all of whom are responsible to the Chief Health Officer. Within the sphere of the Department of Health are the Hospitals and Charities Commission, the Mental Health Authority, and the Commission of Public Health. Each of these bodies is set up under a different Act of the Victorian Parliament, and each has differing relationships with the Minister and Permanent Head of the Department of Health.

Responsibility for the health of the community is vested in the Minister of Health, whose principal activities are:
(1) Public health functions (administered by the Department of Health);
(2) support and surveillance of State subsidised institutions for the care of the physically sick (administered by the Hospitals and Charities Commission); and
(3) care of the mentally sick and the intellectually retarded (administered by the Mental Health Authority through the Mental Hygiene Branch of the Department of Health).

The Minister of Health is assisted by a central administrative branch containing a secretariat assisted by its various service sections. In addition, the Minister of Health is supported by other statutory bodies, various advisory, regulatory and functional boards, councils, and committees, as well as several voluntary agencies. His power to appoint consultative councils of experts to advise him on special problems concerning public health has been exercised on occasion. This procedure has been followed in matters relating to road accident mortality, poliomyelitis, quarantinable diseases, maternal and perinatal mortality, and anaesthetic deaths.

Commission of Public Health

Subsequent to the separation of the Port Phillip District from New South Wales in 1851, and the advent of the gold rushes, new demands for health, hygiene, and sanitation led to the passing of Victoria's first Public Health Act in 1854. The Act set up a Central Board of Health, which the *Health Act* 1919 replaced with a Commission of Public Health. Although the Commission is under the administration of the Chief Health Officer (who is also the Chairman of the Commission), it is directly responsible to the Minister of Health.

The function of the Commission is to promote and carry out research, investigations, and inquiries concerning public health, environmental aspects, and the prevention or treatment of diseases, and it is responsible for publishing reports, information, and advice in relation to these matters.

Currently, the Commission is mainly concerned with considering recommendations put before it by the full-time executive staff of the General Health Branch of the Department of Health. It acts as a body of review which can defer or veto Departmental proposals. This enables the seven members, if they so desire, to examine local opinion before reaching decisions, thus providing a community

* At the time of preparing this chapter, the proposed new Health Commission, which is intended to incorporate the existing Department of Health, the Commission of Public Health, the Hospitals and Charities Commission, and the Mental Health Authority, had not commenced operations. Consequently, some sections of this chapter are similar to material presented in the 1977 edition of the *Year Book*. It is intended to provide more up-to-date material on these matters in the 1979 edition.

link in decisions which will have a local impact. The open discussion of Commission meetings in the presence of news media representatives helps to keep the public informed of the Commission's work.

Functional administration is decentralised in accordance with the *Health Act* 1958, by placing the primary preventative health role with municipal councils.

Hospitals and Charities Commission

The *Hospitals and Charities Act* 1948 set up a Hospitals and Charities Commission consisting of three full-time commissioners, a secretary, and administrative staff. The Commission is directly responsible to the Minister of Health.

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

Registration makes such organisations eligible to share in the Hospitals and Charities Fund through either capital and/or maintenance subsidies. The great proportion of financial assistance is allocated to hospitals and hospitals for the aged. The availability of funds and the purpose for which they are to be used is a contributing factor in the awarding of grants. The Commission maintains close scrutiny over hospital budgets. Each institution is required to submit for Commission approval budgets covering the succeeding year's operations.

The cost of operating the public hospital system has increased substantially. The average cost per bed per day was $18.03 in 1967, compared with $104.4 in 1977.

The Commission exercises control of State funds for capital works, where Commission approval is required at all stages of a building project from the original narrative, through the preliminary sketches to documentation, tendering, and supervision of the project. Capital expenditure undertaken was $15.4m in 1967, compared with $66.4m in 1977.

One of the most important functions of the Commission is to co-ordinate hospital and institutional activities, and it has the power to inquire into the administration of institutions and societies. It is the authority responsible for determining the site and extent of new hospital construction.

The Commission maintains an Equipment Section, whose activities include the assessment and recommendation for approval of all major items of furniture, furnishings, and medical equipment purchases by hospitals and institutions under its control. The increasing complexity of equipment available, and the introduction of new techniques in fields such as radiology, nuclear medicine, pathology, and coronary and intensive care have been largely responsible for the markedly increasing cost of equipment requested.

The Commission promotes collective buying of standard equipment, furnishings, and supplies through the Victorian Hospitals' Association, which acts as a central purchasing organisation for Victorian hospitals, being a non-profit company of which the hospitals themselves are the shareholders. The Association operates as an active purchasing organisation handling all types of equipment, drugs, and commodities generally used by hospitals.

The Commission has various responsibilities for nursing in Victoria. It decides, in consultation with the Victorian Nursing Council, whether any particular hospital will be made available for use as a training school in any branch of nursing; determines the establishment of nursing staff for hospitals; encourages prospective nurses to improve their general education before commencing training (through the provision of bursaries); maintains a continuous nurse recruitment programme throughout Victoria; produces publicity material, including films on nursing; offers scholarships for diploma courses in the nursing field conducted by the College of Nursing, Australia, or any college of advanced

education; directs a staff of nurses to relieve matrons in country hospitals when they are on leave and assists when urgent shortages of nursing staff occur; and helps generally in nursing matters in hospitals and community health services.

Hospital regional planning, 1962; Historical outline, 1965; Hospital architecture, 1966; Charities in Victoria, 1968; Rationalised medical services, 1971

Mental Health Authority

The functions of the Mental Health Authority, defined in the *Mental Health Act* 1959 and subsequent legislation, are to formulate, control, and direct general policy and administration with respect to the treatment and prevention of mental illness, intellectual defectiveness, and alcoholism and drug dependence.

When the Authority was established in 1950, there were only two early treatment units (the receiving houses at Royal Park and Ballarat), ten long-term mental hospitals, six intellectual deficiency colonies, five day training centres for the mentally retarded, and four outpatient clinics. The medical establishment of the entire Department of Health then consisted of 67 positions, of which only 38 were occupied. There were only eight social workers, seven psychologists, and five untrained occupational therapists. The nursing staff, the largest single component, consisted of 1,411 members which was 350 under the approved establishment.

During the twenty-seven years of its existence, the Authority has embarked on the development of several early treatment units, some built in areas without previous psychiatric facilities (Dandenong, Shepparton, Bendigo, Traralgon, and Footscray), and some established as part of existing mental hospitals (Beechworth, Larundel, Mont Park, Plenty, and Warrnambool). An early treatment centre is now being built at Geelong in close co-operation with the regional general hospital. Simultaneously, the overcrowded long-term mental hospitals have been upgraded by reducing the number of beds, building new modern wards, and improving levels of staffing. The number of outpatient clinics currently operating is thirty-five. Child psychiatric services are also being developed and it is planned to provide an adequate child psychiatric team for each region of Victoria. Accordingly, the Authority, in conjunction with the Austin Hospital, is providing a two-year training course in child psychiatry, which will lead to the accreditation of doctors by the Royal Australian and New Zealand College of Psychiatrists.

The Authority has developed a community mental health programme, described in the section on psychiatric services (see pages 680–1). In the field of mental retardation, a specialised assessment centre has been set up at the St Nicholas Hospital, a new training centre established at Colac, and the number of day training centres has increased from five to fifty-three, together with fifteen special developmental schools. Current planning of retardation services, however, is based not on large institutions but on small community-based units close to or actually involved in the communities being served. An Alcoholics and Drug-Dependent Persons Services Branch has been established (see page 682).

Altogether, in 1977, the professional staff of the Mental Hygiene Branch of the Department of Health reached 296 medical practitioners (of whom 132 are specialists), 80 psychologists, 115 social workers, 103 occupational therapists, 1,228 psychiatric nurses, 543 student nurses, and 47 pharmacists.

Another specific function of the Authority is research and investigation into the causation and treatment of mental illness. For the postgraduate training of staff an Institute of Mental Health Research and Postgraduate Training has been established (see page 693), and the teaching functions of this unit are carried out in co-operation with the Department of Psychiatry at the University of Melbourne. The Authority also sponsors a community mental health education programme.

History of the Victorian Department of Health, 1961; Health of the Victorian Community, 1962; Committee of Inquiry into Hospital and Health Services in Victoria, 1976

Local government authorities

Local government councils are authorised to appoint such medical officers of health and health inspectors as are necessary, and as directed by the Commission of Public Health. These officers are required to be kept informed about the public health and sanitary circumstances of their municipal district, to make inspections and inquiries for that purpose, and to report to their councils on any health matters which should be considered.

Since the 210 medical officers of health in Victoria are only part-time employees of the various councils, most of the councils only assess proposals put forward for improved health facilities, and are rarely in a position to survey the total health needs of their municipalities. This task becomes the function of the municipal health inspectors, who are generally full-time employees of municipalities. Many large municipalities employ several health inspectors, while some of the less populated municipalities share their services.

GOVERNMENT HEALTH BENEFITS

Introduction

The existing health benefits arrangements in Australia replace the original Australian health insurance programme and were introduced on 1 October 1976. Under this modified scheme, the provision of universal health insurance is shared between the Health Insurance Commission and private health insurance organisations.

Australian residents are required to take one of the following three health insurance options:

(1) Remain in Medibank by paying the levy (Medibank Standard);

(2) remain in Medibank by paying the levy and, in addition, pay an extra premium to a private health insurance organisation, including Medibank Private, for hospital cover only (Medibank plus); or

(3) opt out of Medibank (Standard) altogether and take, at least, basic hospital and medical insurance with a private health benefits organisation (Private Insurance)—exemption from levy payments is thus obtained.

Pensioners who hold Pensioner Health Benefits Cards and low income earners are not required to make levy payments and they are fully entitled to the benefits (described below) which are available to levy payers.

Medibank no longer provides automatic health insurance cover for overseas visitors. Arrangement of this cover, advisedly prior to departure from the visitor's home country, is a personal responsibility. However, foreign students and dependants, for the purposes of health insurance, are treated as Australian residents during their stay. Consequently, the abovementioned three health insurance options are available to these students.

Medical benefits arrangements

Medibank standard coverage is provided by the Commonwealth Government and requires the payment of a 2.5 per cent levy on personal taxable income to a maximum of $2.90 per week ($150 per annum) for a single person, or $5.80 per week ($300 per annum) for a family. Payment of this levy provides entitlement to "basic" medical benefits. This includes medical benefits equal to at least 85 per cent of the medical benefit schedule fee, optometrical consultation benefits, and benefits for medical services performed by approved dentists and dental surgeons in recognised (public) hospitals.

Medibank medical benefits are payable in three ways: by cash or cheque payable to a person who has incurred and paid medical expenses; by cheque payable to the provider of the service, in a case where the person has incurred but not paid for the medical expenses; or by the direct payment to the provider of a service when the person incurring expenses has assigned his right to Medibank benefit. The last facility is not available to providers of pathology

services (see below), except where the recipients of the services are eligible pensioners and their dependants. Since 1 October 1976, unlike the original Medibank arrangements, the provider may, in addition to receiving the assigned benefit, charge the patient an amount not exceeding the difference between the schedule fee and benefit.

Medibank claims are lodged either by post, at a Medibank cash payment centre, at a registered private health insurance fund which has agreed to act as a Medibank agent, or with a pharmacist who has agreed to receive Medibank claims. There are 92 Medibank cash payment centres throughout Australia, of which 20 are located in Victoria (two in the central business district of Melbourne, and one each in Box Hill, Carnegie, Cheltenham, Croydon, Dandenong, Footscray, Frankston, Moonee Ponds, Preston, Ballarat, Bendigo, Geelong, Warrnambool, Shepparton, Hamilton, Horsham, Morwell, and Richmond). Seven private health insurance funds act as Medibank agents in Victoria, and 1,372 Victorian pharmacies receive Medibank claims.

Medibank claims are received in State processing centres, where they are sorted, batched, assessed, and coded for payment. They are then transmitted to the central computer processing complex in Canberra for processing and payment. The central computer also stores statistical information on all claims received. There are 23 processing centres throughout Australia, of which six are located in Victoria (central business district of Melbourne, Box Hill, Dandenong, Moonee Ponds, Geelong, and Morwell, the last named being operated by an agent fund).

Those persons who select the private health insurance option must be covered for the same " basic " medical benefits described above. Levy payers and those privately insured can also insure against the 15 per cent (maximum) gap between the schedule fee and respective benefit and/or insure against part of the cost of allied and ancillary health services such as dentistry, physiotherapy, chiropractic treatment and the cost of spectacles.

Since 1970, a feature of the Australian medical benefits arrangements has been the payment of higher rates of benefit for medical services performed by recognised specialists and consultant physicians. Thus, for medical benefit payment purposes, Specialist Recognition Advisory Committees were established in each State to consider applications for recognition from medical practitioners. At 1 October 1977, there were 1,709 recognised specialists and 669 recognised consultant physicians in Victoria.

To facilitate the payment of medical benefits, a Provider Register is maintained. This Register contains particulars on the registration by the various State Government medical boards of all medical practitioners in Australia. At 1 October 1977, there were approximately 5,900 registered Victorian medical practitioners on the Provider Register.

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 Medibank. 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.

Participating Optometrists Scheme

Underpinning the provision of optometrical consultation benefits is a Participating Optometrists Scheme, whereby optometrists or if applicable, their

employer, must sign an undertaking that consultations will be provided at fees no higher than those set out in the Schedule to the Health Insurance Act and that they will be provided generally at no direct cost to eligible pensioners and their dependants by means of assignment of Medibank benefits.

Most optometrists in Victoria appear to be participating in the Scheme. At 1 October 1977, 128 undertakings were in effect in respect of 217 practice locations. These undertakings covered a total of 223 optometrists.

Visiting optometrists arrangements

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

At 1 October 1977, seven Victorian optometrists were receiving such assistance with the per capita grants ranging from $1.30 to $3.80.

New pathology arrangements

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

A new pathology services and fees section of the medical benefits schedule was introduced which reduced the number of pathology items and fee levels, adjusted fees to stimulate the use of cost saving technology, and generally improved the rules on multiple testing of pathology specimens. The new section also contains a division of pathology items into two groups. The first group of items applies only where the pathology services are rendered by approved pathology practitioners. The second group of items applies where the services are performed by medical practitioners who are not approved pathology practitioners. Approval as a pathology practitioner is obtained from the Commonwealth Minister for Health through the Approved Pathology Practitioner Scheme. This approval is conditional on the signing of an undertaking to observe a code of conduct. Such observance is to be monitored by the Medical Services Committee of Inquiry (see page 668).

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

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

The Health Insurance Act has been amended so that medical benefits are not payable in respect of pathology services unless a practitioner has determined

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

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

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

Commonwealth Health Laboratories

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. It is expected to raise $3.3m in 1977–78.

There is one Commonwealth Health Laboratory in Victoria, situated at Bendigo.

Medical Services Committees of Inquiry

In August 1977, as part of the new pathology arrangements and also to monitor the rendering of medical services generally, a Medical Services Committee of Inquiry was established in Victoria in common with other States, under the Health Insurance Act. Each Committee has five members, one of whom is the local Commonwealth Director of Health. The other members comprise two general practitioners, a specialist surgeon, and a physician. These other members are selected by the Minister from nominations by various medical associations.

Where excessive medical services have been rendered or excessive pathology services initiated, the Committees may recommend to the Commonwealth Minister for Health for his determination, that the practitioner be reprimanded, that the medical benefits not be paid for the excessive services or, where benefits have been paid, that the practitioner repay the sum to the Commonwealth Government or the private health insurance fund(s) concerned.

Where a pathology services undertaking is concerned, the Committees may recommend the revocation of that undertaking in addition to the other actions above. Practitioners have a right of appeal against Ministerial determinations. These Committees do not examine cases of fraud, which are covered by other section of the Health Insurance Act.

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 cost of the medical benefits for services rendered.

With the introduction of the modified Medibank arrangements on 1 October 1976, there were significant changes in the way in which the costs of medical services were financed, with private medical benefits funds assuming a much more significant role. From that date, persons with basic private medical insurance have received medical benefits from their private medical benefits funds (including Medibank Private). Consequently, they have been excluded from receiving medical benefits from Medibank Standard.

The health programme grants were revised from 1 October 1976 as a result of the revised Medibank arrangements, and, as a general principle, organisations now receiving grants are required as a condition of the grant to raise fees for services rendered to privately insured persons, i.e., those who are insured for both basic medical and hospital benefits with a registered health benefits organisation. The levels of health programme grants to approved organisations since 1 October 1976, therefore, have been generally restricted to meeting the costs of medical services provided to persons on Medibank Standard.

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 deal with new and different forms of health care, quality assurance processes, and cost containment in health services. Funds of $250,000 have been made available to State authorities and approved organisations to conduct such projects.

Hospital benefits arrangements

Levy payers are entitled to standard ward accommodation or, where medically necessary, shared room (intermediate ward) or single room (private ward) accommodation in recognised (public) hospitals, all medical treatment deemed necessary during the period of hospitalisation, and outpatient treatment in a recognised hospital where that service is provided. Also, under certain circumstances, standard ward accommodation in private hospitals is available to eligible patients.

As a condition of the hospitals agreements between the Commonwealth and State Governments, this accommodation and treatment is provided without any direct charges being raised. As well, the medical treatment is provided by hospital appointed doctors who generally are paid on a sessional basis, although it is possible for payment to be made on other bases (excluding fee for service) providing agreement in this regard has first been reached between the two levels of government. State Governments are further required to make recognised hospital accommodation charges, at the agreed rates (see below) in respect of patients other than those covered by Medibank Standard. For its part, the Commonwealth Government meets 50 per cent of the approved net operating costs of State recognised hospital systems, expressed in aggregate budgets. Payments to the Victorian and other State Governments are made by way of monthly advances.

It is the responsibility of each State Standing Committee, comprising Commmonwealth and State officials, to prepare the aggregate budgets for Ministerial approval and to make recommendations on budget performance and

on levels of accommodation charges in recognised hospitals. A National Standing Committee of Commonwealth and State officials exists within the Hospital and Allied Services Advisory Committee to consider broad policy issues related to joint Commonwealth and State Government examinations of hospital expenditure. The operation of these committees is designed to bring about a much firmer and more rational scrutiny of Commonwealth Government expenditure on hospital cost-sharing and encourage a thorough analysis of hospital cost components at both the national and State levels.

Those persons who select the private insurance option must, in regard to hospital benefits, contribute to a "basic" hospital insurance table which completely covers the $40 per day shared room (intermediate ward) accommodation fee raised by recognised (public) hospitals. By contributing to this and other (supplementary) tables it is possible to be covered against the $60 per day single room (private ward) accommodation fee raised by recognised hospitals and the majority of bed fees charged by private hospitals. The Commonwealth Government provides assistance in meeting these private hospital charges through a $16 per bed day payment made by the Health Insurance Commission. Through the above supplementary tables, or separate tables, benefits are provided to cover such additional private hospital charges as labour and theatre ward fees.

A Commonwealth Government subsidy is available to those private health benefits organisations which are offering, in addition to their usual hospital and/or medical insurance, hospital insurance at the "basic" (shared ward of a recognised hospital) table level to those covered by Medibank (Standard), at a cost of $2.60 per week ($135 per annum) for family contributors and $1.30 per week ($67.50 per annum) for single contributors. In this way an economical form of private insurance is provided for pensioners and low income earners who prefer shared ward accommodation and their own doctor when in hospital.

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

The Commonwealth/State Hospitals Cost Sharing Agreement provides for charges to be made to privately insured persons for outpatient services as determined by the Commonwealth Minister for Health and the Victorian Minister of Health. By agreement between the Ministers, a charge of $6.00 per attendance for all outpatient services to privately insured persons in public hospitals has been introduced. An attendance is defined as one or more visits on a single day for the purpose of receiving any of the following hospital services on that day—medical, nursing, diagnostic, therapeutic, pharmaceutical, ancillary medical services, and supply of surgical aids, appliances, and prosthesis.

Nursing home benefits arrangements

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

varies between States. At the commencement of the revised scheme this benefit in Victoria was payable up to a maximum of $19.65 per day.

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

The notion of patients paying a minimum contribution towards the nursing home accommodation costs, established under the previous scheme, has been retained. At 1 October 1977, the rate of contribution in all States was $6.70 per day. The rates of benefit now payable in each State, when combined with the prescribed minimum patient contribution, are designed to cover fully the approved fees charged to 70 per cent of patients in non-government nursing homes in that State. Automatic review of benefit rates occurs annually following a nursing home fee survey. Prior approval for the admission of patients to a participating or deficit financing nursing home must be obtained from the Commonwealth Department of Health. Approval of extensive care patients is also required.

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 makes specific 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 are not permitted to 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 the Victorian and other 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 this scheme, nursing homes submit budgets for approval and their approved operating deficits are financed by the Commonwealth Government. Patients in these nursing homes are required to contribute towards the cost of their accommodation. This contribution is set at a level which allows standard rate single pensioners in receipt of supplementary assistance to retain approximately $5 for their personal needs. The patient contribution at 1 October 1977 was $47.10 per week. This may be waived or reduced in cases of financial hardship.

From 1 October 1977, in order to share the Commonwealth Government's financial commitment to nursing home patients, the definition of an " insured patient ", for which the private health benefits organisations are liable in regard to the payment of nursing home benefits, has been extended to cover basic hospital table contributors in all three types of nursing homes, i.e., State, partipicating, and deficit financing. As well, the private health benefits organisations are now required to pay on behalf of " insured patients " their full benefit entitlement.

A Participating Nursing Homes Advisory Committee was established in March 1977. Its main function is to bring to the Commonwealth Minister for Health's attention matters relating to the delivery of health care through participating nursing homes.

VICTORIA—NURSING HOME BENEFITS

Particulars	1973–74	1974–75	1975–76	1976–77
Number of beneficiaries	276,988	287,525	242,315	249,044
Commonwealth Government benefits paid ($'000)	25,523	36,631	43,019	51,831
Private health insurance funds benefits paid ($'000)	1,859	2,882	3,963	3,244
Total benefits paid	27,382	39,513	46,982	55,075

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 at home.

A person who provides continuous care for an aged person may be eligible to receive the $2 per day benefit providing a number of conditions are met. The beneficiary and patient must live in a private home. They may also live in an aged persons complex where that complex does not also contain a nursing home or hostel. Alternatively, the complex may contain a hostel provided no nursing staff are employed. The patients must be at least 65 years of age and must have an official certificate from their doctor stating that because of infirmity, illness, or incapacity they have a continuing need for nursing care by a registered nurse and they must, in fact, be receiving care from a registered nurse on a regular basis involving multiple visits each week. The benefit is not subject to a means test and is not considered as taxable income.

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

VICTORIA—DOMICILIARY NURSING CARE BENEFITS

Particulars	1973–74	1974–75	1975–76	1976–77
Number of beneficiaries (*a*)	2,126	r2,282	r2,426	2,296
Benefits paid ($'000)	1,537	r1,667	r1,811	1,831

(*a*) At the end of the financial year.

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, and $2.00 in 1976. Eligible pensioners and their dependants receive pharmaceutical benefit prescriptions free of charge.

The drugs and medicinal preparations available as pharmaceutical benefits are determined by the 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. The provision under the National Health Act to approve hospitals as pharmaceutical suppliers was incorporated into the agreement relating to the provision of hospital services which commenced on 1 August 1975.

VICTORIA—PHARMACEUTICAL BENEFITS

Particulars	1972–73	1973–74	1974–75	1975–76	1976–77
Prescriptions—					
Number ('000)	19,967	23,426	25,927	25,734	22,604
Per head of population	5.6	6.5	7.1	7.0	6.0
Prescription cost ($'000)—					
Commonwealth Government contribution	45,100	58,791	68,116	65,701	56,246
Patients' contribution	13,737	16,665	18,568	25,959	29,647
Total	58,837	75,456	86,684	91,660	85,893

MEDICAL TRAINING AND MANPOWER

Training of doctors

Undergraduate training

Medical undergraduate training in Victoria is carried out at the University of Melbourne and Monash University. The Melbourne Medical School began in 1862 and now admits 220 students into the first year of the course, and 250 students into the second year. This enables an entry into second year of students who have a science or dental science degree or part thereof. The Monash Medical School admits 160 students into the first year of the course, and into the second and third years allows for a lateral entry of suitably qualified students to replace wastage. In both universities the pre-clinical course lasts three years, followed by three years of clinical instruction. After six years there is a qualifying examination which, if passed, confers on the student the degrees of MB, BS. The major hospitals where the University of Melbourne sends its undergraduates are the Royal Melbourne Hospital, St Vincent's Hospital, Austin Hospital, Repatriation General Hospital, Royal Children's Hospital, Royal Women's Hospital, Fairfield Hospital, and hospitals under the control of the Mental Hygiene Authority. Monash University students are trained at the Alfred Hospital, Prince Henry's Hospital, Queen Victoria Memorial Hospital, Geelong Hospital, Fairfield Hospital, and hospitals under the control of the Mental Hygiene Authority.

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

Postgraduate training

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

Each of these colleges is an Australian body which conducts its own examinations for membership and stipulates the criteria required for the training necessary

before examination can be undertaken and, in most instances, the post-examination training needed before specialist status can be achieved. In all, this takes between five and six years after the intern year.

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

The Victorian Medical Postgraduate Committee arranges continuing education and conducts refresher courses for all specialists. These courses are conducted both in the Melbourne metropolitan area and in the country. Particular emphasis is placed on the continuing education of country medical practitioners. The universities have postgraduate degrees which they offer to medical graduates. These in the main are not obtained by course work but generally are achieved by thesis. Clinical academics also take part in training programmes arranged by Boards of Graduate Studies.

Specialist status

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

Developments in medicine, 1910–1960, 1963; Hospitals in medical education, 1967; Melbourne Medical Postgraduate Committee, 1963, 1967; Medical education: the second medical school, 1972; Registration procedure, 1977; Supply of doctors, 1977

Nursing

The nurse is one of the most important persons in the health care system. The role and scope of the profession is diverse and varied. The original and still uniquely nursing activity is providing physical and psychological care to prevent or alleviate discomfort caused by illness. Despite the accepted practice that the nurse occupies a complementary role to the doctor and must not diagnose or prescribe treatment, it is often inevitable that she does, by virtue of her constant attendance with the hospitalised patient. In remote areas where there are few doctors, the nurse is continually making on-the-spot diagnoses and prescribing treatment. In addition to providing direct nursing care, nurses commonly perform numerous other activities, the most important of which are administration and teaching.

By far the largest employers of all classes of nursing personnel are hospitals. About 40 per cent of practising registered general nurses work part-time and on average from three to four days per week. Many hospitals depend to some extent on augmenting their staff with agency nurses. This facility is advantageous when short-term unexpected absences need to be covered. Outside of hospitals, the growing demand for community nursing includes the following areas: occupational health nursing, professional rooms—general and specialist medical practice, health services—Victorian Department of Health and educational services, district nursing services, maternal and child health centres, Aboriginal health and welfare, mental health, community nursing, community health centres, and other community services (e.g., Red Cross, family planning services).

Nursing practice and education are supervised by the Victorian Nursing Council, the statutory nursing body constituted under the *Nurses Act* 1958. Although the Council consists mainly of nurses from various nursing interests, provision is made also for members from legal, medical, hospital, and general education fields. The Council is particularly concerned with standards of courses, teaching personnel, examination, and training school. 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 qualified nurses and a roll of current certificate holders are maintained by the Council.

At 30 June 1977, there were 35 hospital-based courses, five technical colleges, and nine training schools for basic nurse training, and 97 institutions participating with in-service training of all nursing branches. Tertiary level nursing education is available at the Lincoln Institute of Health Sciences (nursing administration, education, community health nursing, hospital nursing, and unit management), and at the Preston Institute of Technology (community health nursing).

To induce 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 clinical, intensive care, operating theatre, audio-thoracic, geriatric, oncological, and communicable diseases nursing ensure a sufficient supply of skilled staff in these fields.

VICTORIA—NURSES, 1976–77

Courses	Approved training institutions (*a*)	Students in training	Training completed	Registrations approved (at 30 June 1977)	Annual practising certificates (year ended 31 December 1976) (*b*)
Basic courses—					
General nurse	35	5,174	1,429	2,786	31,153
Psychiatric nurse	10	345	118	172 }	1,759
Mental deficiency nurse	5	137	21	26 }	
Mothercraft nurse	7	91	97	163	1,860
Nursing aide	55	1,274	1,145	1,710	11,030
Total	112	7,021	2,810	4,857	45,802
Post-basic courses—					
Midwifery	13	580	606	898	..
Infant welfare—					
Hospital courses	2 }	41	85	104	..
College courses	2 }				
Eye, ear, nose and throat	1	13	11	13	..
Total	18	634	702	1,015	..

(*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 reference, 1977; History of nursing in Victoria, 1961; Graduate nursing education, 1962; Nursing training, 1962; Nursing recruitment, 1964

Paramedical manpower

VICTORIA—PARAMEDICAL MANPOWER

Category	Institute	Duration of training (years)	Number registered at 30 June 1977	Number who completed course in 1976
Dentist	University of Melbourne	5	1,598	41
Optometrist	University of Melbourne	4	257	21
Pharmacist	Victorian College of Pharmacy	3	3,950	98
Physiotherapist	Lincoln Institute	(*a*) 3½	1,305	44
Occupational therapist	Lincoln Institute	(*a*) 3½	(*b*) 265	43
Speech pathologist	Lincoln Institute	(*c*) 4	162	32
Medical records administrator	Lincoln Institute	(*d*) 2	147	23
Orthoptist	Lincoln Institute	(*d*) 2	199	11

(*a*) Diploma course given status of degree in 1973.
(*b*) Estimated full-time practising at 30 June 1976. No registration is necessary for occupational therapists in Victoria, but they may apply for membership.
(*c*) Diploma course given status of degree in 1972.
(*d*) Associate diploma course.

Paramedical services, 1969

INSTITUTIONAL HEALTH CARE

Public hospitals

Organisation

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

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

At present, there are either standard or private patients. If an individual chooses to be a standard patient, he receives hospital care, medical treatment, etc., in a public hospital free of all charges and without a means test, but he does not have the choice of doctor. Alternatively, a person electing to be a private patient is charged a fee of either $40 per day or $60 per day and has to pay all medical practioner fees. Only rarely does the hospital fee cover the actual costs. Private patients may insure against the hospital charges and may, in addition, take a medical benefits cover to help meet the doctor's charges (see pages 665–6). However, where the care and treatment involves a person for whom compensation or damages are payable, the compensating authority is subject to a charge equal to the average daily bed cost of the hospital. From 1 November 1977 a charge of $6 per attendance has been raised from privately insured persons attending public hospitals for an outpatient or casualty service. A means tested fee is charged in the case of dental services and the provision of spectacles.

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

In earlier times, hospitals could attempt to provide all possible services to their patients but the increasing complexity of diagnostic and therapeutic services, as well as rapidly increasing costs, have encouraged the development of rationalised and co-ordinated services. The Hospitals and Charities Commission has 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.

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

Since 1954, country hospitals have been organised on a regional basis. The smaller hospitals refer patients with more complicated conditions to the base

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

VICTORIA—NUMBER OF PUBLIC HOSPITALS AND NURSING HOMES AT 30 JUNE

Type of institution	1972	1973	1974	1975	1976
Hospitals—					
Special hospitals (*a*)	11	11	11	11	11
Base hospitals	10	10	10	10	10
General and auxiliary hospitals	127	126	126	126	127
Convalescent hospitals	1	1	1	1	1
Hospitals for the aged	8	10	10	10	10
Sanatoria	1	1	1	1	1
Total	158	159	159	159	160

(a) Special hospitals are those having accommodation for specific cases only or for women and/or children exclusively and in this table include the Cancer Institute.

Fairfield Hospital, 1961; Geelong Hospital, 1962; Royal Melbourne Hospital, 1962; Alfred Hospital, 1963; Prince Henry's Hospital, 1964; Royal Children's Hospital, 1964, 1976; History of hospitals in Victoria, 1964; St Vincent's Hospital, 1965; Dental Hospital, 1965; Austin Hospital, 1966; Queen Victoria Memorial Hospital, 1967; Royal Victorian Eye and Ear Hospital, 1968

Private hospitals and nursing homes

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

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

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

Repatriation hospital and clinics

The largest of the Commonwealth Department of Veterans' Affairs institutions in Victoria is the Repatriation General Hospital at Heidelberg. The hospital is a teaching hospital for medical students affiliated with the University of Melbourne and is recognised for postgraduate training in surgery, medicine, anaesthetics, pathology, psychiatry, and radiology. Postgraduate studies are encouraged and clinical meetings and tutorials are held regularly. The Hospital is approved by the Victorian Nursing Council as a training school for male and female student nurses and trainee nursing aides. At 30 June 1977 the number of staff employed full-time at the hospital was 1,487, and, during 1976–77, 8,061 inpatients were treated at the hospital with an average stay of 15.5 days per

patient. A total of 113,215 attendances were also made for outpatient services at various clinics within the hospital.

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

In administering the *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 7,200 (1,849 in Victoria) general practitioners under the Department's Local Medical Officer Scheme, and at the repatriation outpatient clinics, and by specialists in the various branches of medicine who have been appointed to Departmental panels. In addition, the Local Dental Officer Scheme, involving some 3,300 (858 in Victoria) dentists throughout Australia and dental units located at Departmental institutions, provides a full range of dental services for those eligible.

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

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

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

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

State geriatric centres

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

It will always be essential to provide accommodation for those patients whose physical condition has made them totally dependent on nursing support, and some 3,500 beds are available for this purpose within State geriatric centres. Recently, the part played by these centres in a health system for the aged has been expanded beyond this one aspect of care. The responsibilities of each geriatric centre are to:

(1) Ensure that in each community there will be a co-ordinated, comprehensive, domiciliary care service incorporating nursing, housekeeping, medical, and paramedical personnel which will allow many aged persons to remain safely and contentedly in their own homes;

(2) provide specialist assessment of each person's physical, psychological, and social needs and resources so that appropriate plans for treatment and future care may be made;

(3) develop rehabilitation programmes;

(4) assist the families of aged persons being cared for at home with planned, intermittent, short-term admissions for relative relief; and

(5) provide on-going education for all levels of staff engaged in geriatric care.

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

District nursing services

District nursing services are conducted by 4 district nursing societies, some community health centres, 3 hospitals in the Melbourne metropolitan area, and 74 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 1976–77, the 81 approved district nursing services employed 367 full-time and 216 part-time nurses who treated 49,114 patients and made 1,097,168 visits. An additional five services were approved during 1976–77.

Royal District Nursing Service, 1969–1977

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 and Charities Commission. Commonwealth Government finance is received through the pharmaceutical benefits and home nursing subsidy schemes. To supplement these funds, each centre's committee of management raises local finance by membership subscriptions, charging treatment fees, fund raising, and donations.

During the year ended 30 June 1977, 24,235 patients received treatment with 30,346 surgery visits and 15,573 home nursing visits. A staff of 16 full-time and 14 part-time trained sisters was employed at 30 June 1977.

Bush nursing hospitals

The first bush nursing hospital in Victoria was founded in 1923 at Cowes on Phillip Island, and by 1977 there were 39 bush nursing hospitals with a total bed capacity of 626 beds. Eighty per cent of patients are treated for surgical, medical, and obstetric conditions in the hospitals. In the event of complications or more specialised treatment, a nearby base or city hospital provides the expertise required for medical and paramedical services.

During 1976–77, the Bush Nursing Association became involved in nursing homes with the opening of a nursing home annexe at the Mornington Hospital. This annexe is financed by the Commonwealth Government under a deficit funding arrangement. Two other hospitals are presently constructing nursing home annexes financed by the Commonwealth Government under the Aged or Disabled Persons Homes Act.

As with the centres, each hospital is administered by an annually elected local autonomous committee of management, and in recent years each has appointed a full or part-time paid secretary. Finance is granted through the Victorian Treasury and the Victorian Department of Health, and administered by the Council of the Bush Nursing Association. Hospitals apply annually to the Council for permission to incur capital expenditure and thereby receive a capital grant on a $3 to $1 basis for this expenditure. The 1975–76 capital works grant was $846,958. During 1976, four member hospitals proceeded with projects using their own finance, and received a capital grant amounting to approximately 25 per cent of the total cost. The annual maintenance grant, totalling $470,000 in 1975–76, is determined by the Victorian Treasurer. The Council then allocates

this grant to hospitals on a needs basis, with smaller hospitals receiving more sympathetic consideration than larger ones, since larger hospitals are in a better position to organise their own finances and priorities.

Bush Nursing Association

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

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

The nursing staff, employed by the Bush Nursing Association and paid centrally, totalled 177 full-time and 405 part-time nurses at 31 March 1977. The administrative and domestic staff are paid by the local hospital. At 31 March 1977, 18 full-time and 32 part-time administrative staff and 99 full-time and 228 part-time domestic staff were employed.

Further reference, 1977

Psychiatric services

Psychiatric services in Victoria are organised by the Mental Health Authority on a regional basis. The State is divided into twelve regions, and the Authority is working towards a situation where each region can be served by one early treatment centre with attached long-term wards for the chronically ill and psychogeriatric patients, community mental health centres, and other community facilities. Currently, the Wimmera, northern Mallee, and outer-eastern Melbourne regions have very limited mental health services. In the Barwon, West Melbourne, and Clayton regions, early treatment centres are being built in association with the regional general hospitals. Further development in the other regions includes expanding community facilities but reducing bed capacity of existing institutions which are too large at present and should only meet the needs of their regional populations.

Community mental health centres are staffed by teams of psychiatrists, psychologists, social workers, occupational therapists, and community mental health nurses, with the object of preventing the development of psychiatric disorders which would require the patient to go to hospital. Located in shopping centres or residential areas, the centres provide professional help on a walk-in basis to those who have psychological, social, or family problems, or who find themselves in a crisis situation. At 30 June 1977 there were 26 centres in Victoria, involving 123 professional staff, and 52 administrative staff. Persons attending the centres consist of psychiatric patients who can be treated on an outpatient basis, patients discharged from hospital but requiring assistance in adjusting to community life, and those who do not as yet show any established psychiatric

disorder. The activities of the centres include organisation of self-help groups, education of community leaders, detection of "at risk" community groups, participation in community activities, and assistance to educational, social, religious, ethnic, and other community organisations in dealing with mental health problems.

Early treatment centres, consisting of hospital beds for acute patients, day hospitals, and outpatient clinics, provide inpatient and outpatient care for those with an established psychiatric disorder and referred by community mental health centres, general hospitals, general practitioners, or private psychiatrists. Victoria has 904 hospital beds for short-term psychiatric patients, with 75 per cent of inpatients admitted on a voluntary basis and 25 per cent under medical recommendation. In most centres, the distinction between inpatient and day-patient lies in the use of the residential facilities. Day hospitals provide care for patients not requiring hospitalisation but who will benefit from a comprehensive treatment programme which includes individual and group therapy. Outpatient clinics provide continuous specialised care, such as psychopharmacological treatment and psychotherapy, or advise the patient's own doctor regarding the required course of treatment. They are staffed by the Authority's psychiatrists and many clinics are situated at country general hospitals.

Long-term hospitals for the chronically mentally ill and psychogeriatric patients serve those persons requiring prolonged rehabilitative or inpatient care. As a result of successful advances concerning drug usage in psychiatry, the number of chronic patients has been diminishing. To some extent this is being offset by the increased longevity of the chronic patients, and the ageing of the population implies that the number of psychogeriatric patients will grow. To ensure regionalisation and continuity of patient care, early treatment wards have been set up within each of Victoria's large psychiatric hospitals.

Psychiatric services for children in Victoria consist of one residential unit comprising 37 beds, and specialised outpatient clinics at the Travancore, Observatory, Children's Court, and the Bouverie Clinics, and at the Dandenong Psychiatric Centre.

Psychiatric after-care hostels and half-way houses are provided for ex-hospital patients not requiring further hospitalisation, but who are as yet unable to manage independently. Some patients require accommodation for a transient period, while others will require it for the rest of their lives.

Day hospitals for chronically mentally ill persons serve ex-hospital patients staying with their families or in hostels, but whose daily activities require some supervision.

Sheltered workshops for chronically mentally ill persons provide work in a non-competitive situation. Some patients attend sheltered workshops temporarily until they are able to work in the normal labour market situation. Other patients will never be able to transfer to unsheltered employment.

VICTORIA—MENTAL HEALTH: NUMBER OF INSTITUTIONS

Type of institution	At 30 November—				
	1972	1973	1974	1975	1976
Mental hospitals (*a*)	11	11	11	11	11
Psychiatric and informal hospitals	15	16	16	17	17
Intellectual deficiency training centres	9	9	10	10	12
Alcoholic and Drug Dependency Rehabilitation Centres	1	2	4	4	4
Total	36	38	41	42	44

(*a*) Includes Repatriation Mental Hospital.

Modern psychiatric services, 1963

Alcoholics and Drug-Dependent Persons Services Branch

The Victorian Alcoholics and Drug-Dependent Persons Services, a Branch of the Victorian Department of Health and administered by the Mental Health Authority, are being developed as a co-ordinated response to individual and community problems associated with the use of alcohol and other drugs. Four distinct, specialised centres, co-ordinated from a central office, provide treatment, rehabilitation, research, training, and prevention programmes. By extending and supporting previously available facilities, they back-up and help to improve a broad range of services. In addition, the new services can co-ordinate the community's response to the complex problems of alcohol and drug use.

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

The treatment methods available in these services are based on a multidisciplinary community medicine approach. Psychiatrists, doctors, nurses, social workers, and others provide individual and group therapy as a team. Family and other types of community-oriented therapy and rehabilitation is also emphasised, but appropriate drug therapy (including therapeutic agents, Antabuse, vitamins), behaviour therapy, and other types of treatment based on learning, diet, work therapy, crisis-intervention, and so on, are also used where appropriate. The management programmes provided are flexible and varied to fit the needs of the patient.

Tuberculosis Branch

The Tuberculosis Branch of the Victorian Department of Health is responsible for the prevention, early detection, and treatment of the disease, and maintaining public awareness of it. Growing concern at the incidence of tuberculosis led to the establishment of a Tuberculosis Bureau in 1912 as part of the Department of Public Health. In 1949, the Tuberculosis Division of the General Health Branch became a separate Branch of the Department of Health. The broad policy of tuberculosis control continues as in recent years, but the Commonwealth Government has ceased to fund tuberculosis activities under the Commonwealth/State Tuberculosis Arrangement and the Division of Chest X-ray Surveys was disbanded on 31 December 1976. The number of beds reserved for treatment of tuberculosis patients has been reduced.

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

Mortality rates continue at a low level and were 0.8 per 100,000 persons in 1976. Tuberculin testing among school children indicates a low infection rate which has been fairly constant recently. In 1976, 1.5 per cent of children at 14 years of age gave natural positive reactions. Morbidity figures are probably the most reliable indicator at present.

Better social and economic conditions have continued to contribute towards this improved situation, as has the diligent approach to case finding, medical supervision, and contact control. The major credit for improving the situation is most directly related to the 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 relapsed, and both categories usually need only a short period of institutional care. Treatment on a domiciliary basis, under direct supervision, is being used when warranted. Experience is showing that relapse of tuberculosis is being markedly reduced among those who have had full courses of drug treatment.

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

VICTORIA—TUBERCULOSIS BUREAUX

Activities	1972	1973	1974	1975	1976
New cases referred (*a*)	10,106	9,624	9,334	8,543	8,291
Active cases—					
New	371	369	321	291	311
Reactivated	42	38	31	29	31
Chronic	15	10	8	7	4
Re-attendances	50,532	46,190	42,480	37,783	38,383
Home visits by nurses	22,216	21,324	19,179	17,917	15,414
X-ray examinations (films taken) (*b*)	55,248	49,369	44,423	43,367	39,412
Tuberculin tests	8,514	7,544	6,970	6,853	6,931
B.C.G. vaccinations	2,192	1,953	1,766	1,628	1,460
Chest X-ray surveys (X-rays taken)	652,752	598,721	354,256	401,397	412,044
School tuberculin surveys (Mantoux tests)	96,249	87,495	92,265	92,645	88,229

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

VICTORIA—TUBERCULOSIS SANATORIA

Year	Beds	Admissions	Discbarges	Deaths
1972	340	661	596	27
1973	340	604	586	29
1974	301	564	538	23
1975	301	466	449	19
1976	208	495	468	29

Further reference, 1977; Compulsory chest X-rays, 1965; Tuberculosis and mass X-ray surveys, 1967

Cancer Institute

The Cancer Institute was established under the *Cancer Institute Act* 1949 for the purpose of research and investigation into the cause, prevention, diagnosis, and treatment of cancer; providing inpatient and outpatient hospital treatment for cancer cases; and providing undergraduate training and post-graduate training in various medical and scientific disciplines relating to cancer. Most of the work is carried out at the Peter MacCallum Hospital's headquarters in Melbourne, but consulting and some treatment services are provided under the aegis of the Hospital in other metropolitan and country hospitals.

The building programme developed by the Institute's planning committee has progressed to the extent that the first half of the new extension to the Hospital was commissioned in September 1977. This new section will provide 170 beds, and with the completion of the multi-storey block in 1979, there will be nearly 300 beds and eight linear accelerators (high voltage X-ray treatment equipment). Projections indicate that progressive increases of a further 300 beds and four accelerators will be required during the early 1980s to meet Victoria's needs for radiotherapy requirements and associated surgical and chemotherapy needs. Thus, consideration is being given to developing the area behind the Royal Mint.

VICTORIA—CANCER INSTITUTE

Particulars	1972–73	1973–74	1974–75	1975–76	1976–77
Inpatients—					
Beds available (incl. hostel)	116	116	116	116	116
Admissions (incl. hostel)	3,317	r3,701	r3,937	r4,419	r4,552
Daily average (incl. hostel)	r83.96	r83.01	r85.39	r87.36	r84.93
Outdoor patients and casualty cases—					
Distinct persons treated	10,059	10,141	10,619	10,773	9,879
Attendances (*a*)	r189,487	r193,201	r218,457	r218,582	r226,844
Radiotherapy treatment—					
New patients admitted during year (*b*)	4,397	4,457	r4,599	r3,662	r4,335
Attendances for treatment	54,099	58,197	r61,638	r60,590	r60,062
Fields treated	r107,587	112,039	r114,977	r120,422	r119,548
Staff—					
Medical	83	85	97	99	107
Nursing	164	166	178	183	224
Scientific and technical	186	196	203	229	264
Other	r390	440	r444	442	564

(*a*) Excludes private patient attendances at pathology department.
(*b*) Includes city, country, and ward patients.

Further reference, 1977

NON-INSTITUTIONAL HEALTH SERVICES

Youth services

Maternal and child health services

The Maternal and Child Health Division of the Victorian Department of Health administers services promoting the health of mothers and young children. These services include health supervision of infants from the first weeks of life, throughout the pre-school years, and guidance of mothers during pregnancy and the post-natal period through the early child rearing years.

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

In 1970, the Victorian Government recognised that family planning was an integral part of maternal and child health care, and agreed to provide clinics in infant welfare centres as the demand arose. At these clinics, doctors and nurses trained in family planning methods advise young people on sexuality, the responsibilities of parenthood and methods of contraception, and parents seeking advice on either conception or contraception or the spacing of pregnancies. The demand for this service is growing as fast as the supply of trained personnel becomes available.

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

The importance of early detection of defects or developmental delays is well acknowledged and, in order to prevent these leading to disability or handicaps as the child grows older, a programme of education and care has to be designed to meet the child's needs and to help support the parents in their role. This requires the provision of more than just the normal infant welfare and pre-school educational services and, to meet these needs, the Consultative Council on Pre-School Child Development in 1973 recommended the establishment of early

childhood development complexes. These include the services of additional professionals such as psychologists, speech therapists, psychotherapists, occupational therapists, social workers, and medical specialists. It is planned that every region in Victoria will be served by such a complex. By December 1976, seven such complexes had been established.

VICTORIA—MATERNAL AND CHILD HEALTH SERVICES

Particulars	1971	1972	1973	1974	1975
Family planning services—					
Number of clinics	n.a.	7	17	23	33
New enrolments	n.a.	841	1,272	1,886	2,991
Attendances of patients	n.a.	3,009	4,571	6,586	9,607
Pre-natal services—					
Number of clinics	29	29	29	29	29
Attendances of mothers	25,415	18,879	14,161	12,309	8,356
Infant welfare services—					
Number of infant welfare centres (all types)	730	738	745	751	763
Infant welfare sisters employed	397	409	421	429	443
Attendances of children	1,646,159	1,607,334	1,505,761	1,342,809	1,399,310
Home visits to children	158,745	154,738	141,133	149,584	153,575
Attendances of expectant mothers	20,861	19,852	17,407	18,062	18,192
Post-natal visits to mothers in hospital	26,611	24,983	19,698	24,781	25,824
Immunisation—					
Triple antigen primary course	n.a.	n.a.	n.a.	62,157	61,246
Poliomyelitis primary course	n.a.	n.a.	n.a.	58,491	57,987
Measles	n.a.	n.a.	n.a.	32,957	33,801
Smallpox	n.a.	n.a.	n.a.	14,739	13,077

Pre-school child development

Responsibility for the provision of services to aid the development and growth of pre-school age children and to give support to their parents has rested with the Victorian Department of Health since 1942, when a pre-school section was set up within the Maternal, Infant, and Pre-school Division of the Department of Health. Educational staff were appointed, subsidies granted, and community groups encouraged to work towards the establishment of services appropriate to the age level of the children for whom they wished to cater.

In 1973, the Consultative Council on Pre-school Child Development recommended that services for the pre-school age child should continue to be developed and administered by the Department of Health, but that a new Division be established. This recommendation was approved by the Victorian Government and, in February 1976, the Division of Pre-school Child Development was constituted. This Division is responsible for educational and care services for the child before attendance at primary school. It is concerned with both subsidised and registered services for the child of the working mother who requires full day care, and the child of the non-working mother who attends a sessional kindergarten.

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

The type of service established varies according to the needs of the region and the age of the children. The first subsidised service is the toddler group for children aged between 18 months and 3 years, and their mothers. Conducted by a trained kindergarten teacher and an infant welfare sister in the waiting room of an infant welfare centre, this service offers mothers the opportunity to learn more about the growth and development of young children, while their children are playing with materials suited to their age group. In December 1975, there were nineteen toddler groups, catering for 801 children, operating in Victoria.

Kindergartens present opportunities for group play, education, and parent discussions. This service is provided for children from 3 years of age onwards, who attend three or four sessions each week. To give as many children as possible the benefits of attending these centres, different groups of not more than 25 children each are taken in the mornings and afternoons. The kindergartens are staffed, and programmes compiled, by a teacher with approved qualifications, supported by an untrained assistant. In December 1975, there were 924 subsidised kindergartens, catering for 48,743 children, operating in Victoria.

The day care centre provides care and education for the child of the working mother. These centres vary from the large centre catering for up to 60 children, to the small neighbourhood centre in a house catering for 20 to 25 children. In the latter type of centre, parents employed on a part-time basis work at the centre in return for service. In December 1975, there were 25 day nurseries, catering for a capacity of 1,199 children, operating in Victoria.

Pre-school and childhood services programme

During 1975-76, agreement was reached between the Commonwealth and Victorian Governments on payment for pre-school kindergartens from January 1976, on the basis of the Commonwealth Government paying 75 per cent and the Victorian Government 25 per cent of the salaries of approved pre-school staff. The Commonwealth Government capital level of support for new pre-school kindergartens was $55,000 per centre, while the Victorian Government contributed $15,000 (soon to be increased to $30,000). The basis of this agreement was that, after January 1976, pre-school kindergartens, where appropriate, would integrate their services to include other forms of childhood services such as day care, after-school programmes, play groups, parent counselling groups, and other similar groups.

The Commonwealth Government also paid the approved capital and operating costs together with 75 per cent of the salaries of approved staff for a number of childhood service projects, which were administered by the Victorian Department of Health, including eleven holiday and after school programmes, ten day care projects, and 27 neighbourhood house projects.

Early childhood development programme

Under the Community Health Program, which arose from the recommendations of the Consultative Council on Pre-school Child Development, early childhood development centres are being set up throughout Victoria. There are already three in the Melbourne metropolitan area and four in country regions. As the Program will develop differently in each region according to its particular needs, full-time research officers are employed to work in each of these regions. There are three research officers working as part of the early childhood development programme at Knox, two in the Barwon Region, and one in each of the Central Highlands Region, Central Gippsland Region, South Western Region, and Broadmeadows early childhood development programmes. The research officers evaluate the adequacy of services provided under the early childhood development programme to meet the needs of the community, and are compiling resource maps for each of the regions.

School Medical Service

The School Medical Service, founded in 1909 as a branch of the Victorian Education Department, was transferred to the Victorian Department of Health in 1944. During 1976, the Pre-school Medical Services Section was transferred to the School Medical Service from the Maternal, Infant, and Pre-school Division, and the position of Assistant Chief Health Officer (Maternal and Child Health) was created to co-ordinate maternal and child health services during the current expansion and diversification of activities. The Service also supervises 32 special schools catering for handicapped children of various types. The first ten day training centres for the more severely handicapped children, transferred to the Education Department during 1976, became special developmental schools for which medical supervision has been provided.

During the year before entering primary school, all available children undergo overall developmental assessment by school medical officers and, where appropriate, by other professions. In 1975, Department of Health doctors examined children attending 639 subsidised pre-school centres, municipal council child welfare medical officers examined those attending 30 other centres, and private doctors examined those at another 20 centres. No medical examination was made at 330 pre-school centres. Department of Health doctors examined 30,486 children, which represented 96.55 per cent of enrolments at these centres. For most children it was their first medical appraisal, with only 3.45 per cent presenting for the second time. Department of Health doctors also examined children attending sixteen day nurseries. The other eight nurseries were covered by municipal council doctors. Children not seen at pre-school centres are examined on entering primary school. Supervision of health and development by school nurses continues throughout school life. School medical officers provide support and consultative facilities for parents and staff of infant welfare services, pre-schools, play centres, and day nurseries.

Further references, 1964, 1977

School Dental Service

In co-operation with the Victorian Education Department, the School Dental Service began functioning in 1921 with the opening of a dental clinic in South Melbourne. State school children visited the clinic for treatment and returned each year for a dental check-up. As children in country districts also needed dental care, the Service was extended by obtaining portable equipment which could be carried in dental vans.

Under the *Ministry of Health Act* 1945, the School Dental Service was transferred to the Victorian Department of Health. In 1951, when the Service became a separate division of the Maternal and Child Hygiene Branch, moves were made to revive and expand the considerable reduction in operations experienced during the Second World War, because of a loss of staff to the defence forces. The obsolete pre-war dental vans were replaced and new mobile units added. Country itineraries were resumed and the areas visited extended, with an emphasis being placed on more remote country regions.

In 1973, the Victorian Government agreed to join with the Commonwealth Government in the School Dental Service Scheme. Initially, treatment will concentrate on the 5 to 11 years age group, with complete coverage anticipated by 1983. When fully developed, the scheme will offer free dental care to all children under 15 years of age, and will be staffed by school dental therapists. Working under the general direction of dentists, therapists will provide dental health education, regular review, and minor reparative work.

Further reference, 1966; Pre-school audiology services, 1977; Child maltreatment, 1977; Childhood accident research, 1977; Family planning services, 1977; National audiological services, 1977; Occupational health, 1977

Services for the aged

Community health and welfare services for the aged

Health services

In 1977 nursing home and rehabilitation beds available in State, voluntary, and private hospitals totalled approximately 11,100, while hostels accommodated approximately 5,200 persons. Since the provision of beds alone could not adequately serve disabled or elderly persons, community health centres, improved domiciliary services, and more day hospitals are being established. Day hospital attendances approximated 276,000 during 1976–77, while district nursing services made approximately 1,097,000 visits, the majority of which were to persons over 60 years of age.

Meals-on-wheels services at 30 June 1977 were supplied by 85 hospitals in co-operation with a number of other organisations. Elderly people in the Melbourne metropolitan area receive dental care at the dental clinic in the Royal Dental Hospital of Melbourne. Treatment is also provided at clinics established in 18 major country centres and in geriatric centres.

Welfare services

The aim of the Home Help Service, senior citizens clubs, and municipal welfare officers engaged in the welfare of the aged is to assist the aged in pursuing independent lives in their own surroundings for as long as possible. Administrative responsibility for these community welfare services rests with the General Welfare Branch of the Department of Health, and the relevant subsidies refer either totally or partially to the well-being of persons over 60 years of age.

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

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

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

Care of the aged, 1962, 1965; Home Help Service, 1966; Elderly Citizens' Clubs, 1966; Care of the elderly, 1969

Community services

Health care of the physically and intellectually handicapped

Physically disabled

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

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

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

Many hospitals provide nursing home and domiciliary support services. The Victorian Department of Health 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 people to obtain medical care at a regional/local level.

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

Intellectually handicapped

The care and training of the intellectually handicapped, apart from educational services for the mildly retarded, is the responsibility of the Mental Health Authority, which has a centralised diagnostic and assessment service at St Nicholas Hospital where the headquarters of the mental deficiency services are also situated. In 1976 there were 3,656 beds in residential training centres for the retarded.

Under the auspices of the Authority, 62 day training centres, four private residential training centres, and two autistic children's centres have been developed throughout Victoria during the last twenty-five years and subsidised from Victorian Government funds. In addition, the Authority purchased a small 30 bed hospital for severely retarded children, which is leased at nominal rent to a local day training centre and managed by the centre's own committee.

Since the introduction of the *Education (Handicapped Children) Act* 1973, the Education Department has accepted responsibility in principle for educating children irrespective of the type and degree of handicap. At the beginning of 1977, 15 educational components of day training centres chose to be taken over by the Department, while others were expected to follow. The Department is also placing teachers and teachers' aides in the Authority's residential institutions to complement the roles of the clinical staff.

The Authority has adopted a policy of regionalising its facilities for retarded persons and providing local accommodation as close as possible to a domestic setting. It envisages a range of professional and support services to provide for the total needs of retarded persons and their families, based on the policy of normalisation. This involves making available to the mentally retarded circumstances which are as close as possible to the normal patterns of society.

Members of the Authority's staff were involved, with others, in the work of the Victorian Committee on Mental Retardation, which submitted a comprehensive report on the future of retardation services to the Victorian Government in September 1977.

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 75 branch stations. There are 38 stations operated by volunteers.

Organisation

Autonomous committees are responsible for the provision of service in their regions. Regionalisation has enabled service to be extended to all areas, including those of sparse population; co-ordination with hospital and medical services and of patients in each region; rational deployment and in-service training of staff; and adequate support when officers or vehicles are otherwise engaged or out of service. The Victorian Government, through the Hospitals and Charities 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 and Charities Commission. Since 1973, the Intensive Care Ambulance Unit has been manned by specially trained ambulance officers and is now a well established operation. There are five MICA vehicles in service in the Melbourne metropolitan area, of which four are operated by Ambulance Service—Melbourne from parent hospitals (the Austin, Alfred, Royal Melbourne, and Western General Hospitals). The fifth unit is based at Frankston and operated by the Peninsula Ambulance Service. The vehicles carry sophisticated medical and radio equipment and a range of appropriate drugs.

Air Ambulance Service

The Air Ambulance Service, managed by Ambulance Service—Melbourne, mainly carries patients from distant country hospitals to Melbourne hospitals, and back. Patients are also brought from interstate when necessary. The air service is more comfortable and far quicker than long road journeys, and is comparable in cost. During 1976–77, 3,411 patients were carried a distance of 618,147 nautical miles, over 3,979 hours.

Neonatal Emergency Transport Service (NETS)

NETS is a co-operative scheme between Ambulance Service—Melbourne and the four Melbourne hospitals with neonatal intensive care units (Mercy Maternity Hospital, Queen Victoria Medical Centre, Royal Children's Hospital, and Royal Women's Hospital). Based at the Royal Women's Hospital, a highly qualified

team of doctors and sisters, with a full range of equipment and drugs which fits into a standard ambulance, can travel to a hospital to treat a sick baby, then supervise transport to an intensive care unit. In full operation since October 1976, this service has improved the condition of many newborn babies on arrival at intensive care units, and contributed to an increased rate of survival, better condition after survival, and a shorter stay in hospital.

VICTORIA—AMBULANCE SERVICES

Particulars	1972–73	1973–74	1974–75	1975–76	1976–77
Ambulances	336	346	368	400	434
Ambulance officers	738	795	730	803	951
Subscribers	388,881	409,075	459,864	591,456	659,308
Patients carried	332,793	341,822	366,579	421,743	475,460
Distance travelled by ambulances (kilometres)	8,025,910	8,822,998	10,338,739	11,111,470	12,517,748

Communicable disease, 1964; Industrial hygiene, 1964; Food standards and pure food control, 1964; Control of poisons and deleterious substances, 1965; Inter-departmental Committee on Pesticides, 1965; Epidemics, 1967; Poisons Information Centre, 1968, 1969; Public health engineering, 1969; Drug and poison control, 1970; Environment protection, 1972; Community care centres, 1974; Community Health Program, 1977; Aboriginal health care, 1977; Red Cross Blood Transfusion Service, 1977; Pharmaceutical services in Victoria, 1977; Environmental health services in Victoria, 1977

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.

National Health and Medical Research Council awards and grants, recommended annually, form the major proportion of the total funds specifically spent on medical research in Australia.

Further reference, 1977

Commonwealth Serum Laboratories Commission

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

Originally under the control of the Quarantine Service, the Laboratories became a division of the Commonwealth Department of Health in 1921, and remained under its control until the *Commonwealth Serum Laboratories Act* 1961 established the Commonwealth Serum Laboratories Commission. From an original staff numbering 30, the organisation now employs more than 1,000 persons, more than 100 of whom are professionally qualified.

The Laboratories' standards of research and product quality have earned international recognition. They have become the official World Health Organisation reference centres in the Pacific region for influenza and brucellosis, and participate in world-wide monitoring of these diseases. A notable research project

of national and international significance, successfully undertaken by the Laboratories' scientists, was the world's first development of a method of producing a sub-unit influenza vaccine without harmful side effects, which could be made available to everybody. Many important overseas discoveries in medicine, biology, and biochemistry have been adopted by the Laboratories; for example, they have been producing Australia's supplies of insulin since 1922 and penicillin since 1943, while poliomyelitis vaccine was manufactured from 1956 until the trend towards oral vaccine resulted in production ceasing a few years later.

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

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

Further references, 1971, 1974, 1975, 1977

Victorian Government

Victorian Department of Health

Research activities within the Victorian Department of Health are conducted in the four main areas of road accident research, maltreatment of children, early childhood development programme (see page 686), and child accident research.

Road accident research

The Consultative Council on Road Accident Mortality uses a full-time research staff of medical, sociological, and engineering personnel, supported by administrative and secretarial staff. The function of the Road Accident Research Unit is to design and test a study of road accidents, within the terms of reference of the Council, in an attempt to determine the most appropriate form of accident after-care and preventative programmes as well as the relationships of design, alcohol, drugs, physical, and psychological factors to road deaths. The first stage of the study examined a random sample of all injury crashes and 50 per cent of all fatal crashes in the area serviced by the Victorian Civil Ambulance Service for one year. The second stage set up a control study of injury crashes by attending, at the same times, the site of all the injury crashes that the unit attended in the first year. A third stage was planned which would involve examining each accident investigated as a separate case study and subsequently as a part of a general data collection for further analysis.

Maltreatment of children

In September 1972, a steering committee was formed to examine maltreatment of children. The project linked the Department of Health, Mental Health Authority, Social Welfare Department, Children's Protection Society, and Royal Children's Hospital. A research sub-committee was appointed and a voluntary reporting scheme introduced to assess the incidence of child maltreatment in Victoria, and to obtain information about the nature of child maltreatment, including the medical, sociological, and psycho-pathological features.

In September 1973, information on the reporting system was sent to approximately 10,000 potential reporting agents, including medical practitioners, social workers, welfare officers, pre-school teachers, teachers, infant welfare sisters, district nurses, bush nurses, and the police. During the two years ended 30 September 1975, reports concerning 292 children were received, of which 66 met the definition of maltreatment being used for the reporting system.

A pilot assessment centre was established at the Royal Children's Hospital, staffed by a psychiatrist, social worker, and secretary, to evaluate methods of assessment. The Mental Health Research Institute provided a senior research psychologist to assist with the pilot project, and also helped in project design and data analysis.

The Department set up a workshop in June 1975 to develop programmes for prevention, management, and treatment of child abuse, and prepared its final report in June 1976.

Child accident research

A research unit began to examine children's accidents in January 1976 within the Department of Health. Initially it is surveying a sample of young children admitted to hospital to evaluate the factors which led to the accident with the major aim of determining the " vulnerability " factors and their contribution to the accident.

The research aims to collect accurate data about accidents severe enough to cause death or admission to hospital. Other accidents will highlight potentially dangerous situations and could be important in accident prevention programmes. However not all accidents can be investigated, because of the cost involved.

Institute of Mental Health Research and Postgraduate Training

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

The Institute has a research wing under the director of research, and a training wing under the director of postgraduate studies, who is also the clinical head of the Parkville Psychiatric Unit which constitutes the Institute's immediate clinical base. In addition, the Institute includes the Neuro-Psychiatric Centre at Mont Park, the Melville Clinic, the Central Library, and the Charles Brothers Museum. Epidemiological research carried out in the field of social psychiatry was recognised during the Pre-Congress Workshop on Psychiatric Epidemiology held at the Institute in October 1973 in conjunction with the World Mental Health Congress of the World Federation for Mental Health.

The Institute's computerised cumulative patients register, in operation since 1 July 1961, allows collation and linkage of all illness episodes in a particular patient, thus assisting in the long-term evaluation of psychiatric care. A five year follow-up of all schizophrenic patients admitted for hospitalisation for the first time between 1961 and 1967 was carried out. It showed that the mean total length of hospital stay for all patients declined from fifteen months for those admitted in 1961, to six months for those admitted in 1967. A corollary study examined changes in psychiatric hospitalisation patterns during the last fifty years.

Further references, 1969, 1977

Anti-Cancer Council

The Anti-Cancer Council of Victoria was constituted by an Act of the Victorian Parliament in 1936 and entrusted with the responsibility of co-ordinating in Victoria " all activities in relation to research and investigations

with respect to cancer and allied conditions, and with respect to the causation, prevention, and treatment thereof".

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

The Council provides lectures, films, literature, and specialised library services, and has taken over the original government commitment in the National Warning Campaign Against Smoking. Materials are distributed widely in primary schools. The Council publishes *Victorian Cancer News,* which is issued five times a year, has a circulation of 130,000, and is a useful aid in cancer education.

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

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

VICTORIA—ANTI-CANCER COUNCIL: EXPENDITURE
($)

Particulars	1972–73	1973–74	1974–75	1975–76	1976–77
Research (*a*)	271,426	290,012	380,700	480,213	642,511
Education	71,907	65,754	82,223	115,662	214,272
Patient aid	35,490	58,957	93,723	110,786	141,436
National warning campaign against smoking	..	56,309	54,209	62,660	..
Other	96,991	110,774	142,947	438,938	480,499
Total expenditure	475,814	581,806	753,802	1,208,259	1,478,718

(*a*) Includes expenditure on Central Cancer Registry.

Alfred Hospital, 1961, 1963, 1965; St Vincent's School of Medical Research, 1962, 1965; Medical research at the Royal Women's Hospital, 1965; Epidemiological Research Unit, Fairfield Hospital, 1962, 1966, 1969; Asthma foundation of Victoria, 1969; Baker Medical Research Institute, 1970, 1974, 1975, 1976, 1977; Walter and Eliza Hall Institute of Medical Research, 1970, 1972, 1975, 1977; National Heart Foundation of Australia, 1963, 1964, 1976, 1977; Howard Florey Institute of Experimental Physiology and Medicine, 1977; Royal Children's Hospital Research Foundation, 1970, 1976, 1977; St Vincent's Hospital, 1977; Royal Melbourne Hospital, 1977

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 reference, 1977; Medical research at the University of Melbourne, 1964; Medical research at Monash University, 1966

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4301.2 Hospital morbidity (irregular)

Central Office

4101.0 Social indicators
4102.0 General social survey, Bulletin No. 1—preliminary estimates of families (irregular)
4301.0 Hospitals and nursing homes
4303.0 Persons covered by hospital and medical expenditure assistance schemes (irregular)
4305.0 Chronic illnesses, injuries, and impairments (irregular)
4306.0 Apparent consumption of foodstuffs and nutrients
4308.0 Alcohol and tobacco consumption patterns (preliminary)
4402.0 Child care (irregular)