CHAPTER 18

CURE AND PREVENTION

NEVILLE HICKS

IN THE MIDDLE of 1943, Dr G.H. Kendrew finally found a locum and was able to take a holiday from his general practice in Crystal Brook, 200 kilometres north of Adelaide. During Kendrew's absence Arthur Hicks, the primary school teacher in the neighbouring village of Narridy, had a septic throat. The locum prescribed the newfangled antibiotic 'M & B 693' in such heroic doses that Hicks suffered scarring of the kidneys and was admitted to Crystal Brook Hospital for 67 days. By the day of discharge the bill was £36 10s 6d, 10 per cent of the teacher's annual income. Kendrew's bill for the medical care came to 100 guineas: Hicks offered '50 guineas now or 100 guineas when I can afford it'; Kendrew settled for the immediate payment.

Hicks and Kendrew were experiencing a problem common in Australia in the early 1940s. Patients had trouble meeting the costs of catastrophic illness; doctors often collected less than their due fees. Patients and doctors alike relied on the financially insecure local hospital, which needed doctors who could keep the beds full and patients who could pay their bills. The scope of the problem was indicated clearly in 1943 by a Joint Parliamentary Committee on Social Security, representing both major parties and both houses of the Australian parliament. The system of private medical practice, this committee found, was hard on 'the middle-income group'—people not so poor that charitable and government agencies and individual doctors treated them free, and not rich enough to afford large expenditures on illness. The committee singled out industrial suburbs and country districts as regions 'badly supplied with medical aids'.

In scale and local significance, Crystal Brook is like Cowra or Narrandera in New South Wales, or Ararat or Benalla in Victoria. It is the centre of a wheat-growing area. Its population was about 1600 from 1939 until the late 1970s. Then some new housing was built in town for retiring farmers, but the population of the district has fallen as much as that of the town has increased. Until 1970 it was the market town for a catchment of 40 kilometres around and its hospital served the same district, despite the large government hospital 30 kilometres away at Port Pirie.

Arthur Hicks, fit and well in 1946, thanks to ten weeks of careful nursing in Crystal Brook hospital.
IN PRIVATE POSSESSION

Crystal Brook District Hospital: the original building, erected at Kendrew's urging in 1925. In 1974 the back was ripped off the hospital the townspeople had built. A modern theatre and wards were added, substantially funded by the state government.
CRYSTAL BROOK HOSPITAL

Dr G.H. Kendrew and his daughters Helen (left) and Kay, 1946. Kendrew's practice was so heavy in 1943 that Helen was released from war service as a physiotherapist to help.
IN PRIVATE POSSESSION

There has always been a single medical practice, usually with a sole practitioner, co-operating informally with other towns in the area.

The Crystal Brook District Hospital was established in 1925 with an overdraft which took 30 years to pay off. During the 1940s, interest on the overdraft ran at about 8 to 10 per cent of income. Arrears in payments by patients were common. Admissions were about 85 per cent of the hospital's capacity, and the average length of stay was twelve days. The length of stay did not reflect an old, chronically sick population but probably saved Dr Kendrew some motoring when wartime regulations meant that he had petrol and patients had not. Lack of transport prevented almost everyone from leaving the district for medical treatment in Adelaide or even Port Pirie. Because Kendrew, unlike many other doctors in rural practice, did not regard himself as a surgeon, non-emergency work would be saved until there was a sufficient list to justify bringing Dr Tassie from Port Pirie. In an emergency Tassie would be at Crystal Brook in half an hour. In 1939 there were 279 admissions, 40 per cent from the town, 30 per cent from villages and farms within 20 kilometres and a further 25 per cent from up to 40 kilometres away. Twenty per cent of admissions were for midwifery, the usual confinement being a fortnight. Mid-year brought respiratory illnesses and their complications, with the string of diagnoses upon admission running: pneumonia; influenza; influenza; hemiplegia; influenza; nephritis; myocarditis (fatal); septic throat (pneumonia); renal colic; boils; cardiac; infected hand; and two for 'observation'. Ten per cent of admissions in 1939 were for tonsillectomies, including eight on one morning in March and four children (aged fourteen, eleven, eleven and nine) from one family in Redhill another morning in September. There was an occasional hysterectomy or removal of a gall bladder and a rare laparotomy for hydatids. About once a week someone would come in to be treated for the inevitable injuries of a farming community. In 1940 business was even brisker, with 348 patients, hospitalised for

4900 days and generating £2179 in charges. One reason for the increased admissions appears to have been a measles epidemic. It struck with particular severity in Narridy, which produced twelve admissions in the first half of January, by which time the epidemic had spread 15 kilometres east and south to Georgetown and Redhill.

Beyond what the admissions register recorded, Kendrew did other, private, work in the hospital where he had installed diathermy and ultraviolet equipment, purchased with his own funds, to further his interest in 'electrical medicine'. The hospital rendered its bills independently, but Kendrew would pay the consultant or surgeon himself, then recoup that fee and his own from the patient when he could. His daughter, a physiotherapist who returned from war service to help him, says that he allowed 'generous credit' and often would raise no charge at all for patients he believed could not pay. His encounter with Arthur Hicks was unusual as to its amount but common as to causes. Up until 1920 friendly societies had been able to help their members to get medical assistance in times of need, by keeping medical costs down for many Australians and guaranteeing some payment to co-operating doctors, but then the medical profession had organised to break the power of 'the friendlies'. No insurance scheme had arisen in place of the friendly societies and by 1940, many Australians either went without medical attention, or scrimped to pay the doctor when consultation was essential or relied upon the kind of charity Kendrew displayed.

Medical insurance was not available to most, but hospital insurance was. The Mutual Hospital Association was formed in Adelaide in 1937, five years after the Hospital Contribution Fund in New South Wales and three years after the Hospital Benefits Association in Victoria. Arthur Hicks did not join immediately, and the confinement of his wife in 1940, for the birth of their first child, cost him £9 7s 6d in hospital fees. That bill, with Kendrew's standard five guinea charge for prenatal care, delivery and postnatal check-up, was equal to two weeks' salary for the head of a one-teacher school. When the cost of the first child had been accommodated, Hicks joined Mutual Hospitals. He went on to the 'top table' of benefits, as most insured South Australians were to do for the next generation, paying £3 12s per year to entitle himself and dependents to an allowance of '12/– per day ... if male and 10/6 per day ... if female for not exceeding twelve weeks ... in the aggregate for contributor and all dependents in any period of twelve consecutive months', plus obstetric benefits 'not exceeding fourteen days'.

The absence of comprehensive medical cover often meant going without medical attention, an unhappy solution sometimes assisted by patent medicines. Australian women's weekly, *9 Feb 1946.*

In 1939 Australia had clinicians competent by international standards, some good medical researchers, a tradition of up-to-date medical education, but poorly developed health services. Government had provided few medical or health services: primary responsibility for health rested with the individual. In fact, the possibilities of positive preventive health had been revealed by the Australian Army Medical Services in Gallipoli and France, where individual responsibility for health was shown to be inadequate, but back in Australia the commonwealth lacked constitutional power over health services, and the states had varying, divided health administrations. In the 1920s, however, interest in developing a healthy population grew, expressed in the slogan, a 'white race fit to people the tropics'. Improved health was seen as a step towards the goal of national efficiency. A commonwealth royal commission on health, sitting during 1925–26, recommended federal subsidies for state health programs, enquiries into special problems such as tuberculosis, expansion of commonwealth laboratory facilities and the

teaching of more preventive medicine in medical schools. The commission believed that health services were handled best by local government with medical advice, and it elaborated a model service headed by a state health council with a state medical director, working through elective committees and health districts which, in turn, would have full-time medical officers of health supported by laboratories, clinics and hospitals.

In 1941 the National Health and Medical Research Council (NH&MRC) and, in 1943, the Joint Parliamentary Committee on Social Security both issued reports which reiterated the royal commission's notion of a unified, preventive and curative health service under public auspices. By now, however, the main practical concern had become the organisation of curative medical services. The Joint Parliamentary Committee said that the deficiencies in the provision of public health were the result of the commonwealth's restricted powers in the field and 'a tendency for medical men to seek their living where they can best find it, which is neither in public health work nor in research'.

Both the Joint Parliamentary Committee and the NH&MRC suggested a salaried medical service as one means of providing public health and treatment services in country areas and the underserved parts of the cities. The Australian branches of the British Medical Association (later to become the Australian Medical Association, or AMA) put forward a scheme of their own as a defence against this wider view of national health. All three groups, NH&MRC, Joint Parliamentary Committee and AMA, agreed that the individualist system of treatment by private contract between doctors and patients had produced insufficient doctors in public health and hospital work, maldistribution of other practitioners and excessive medical costs for the 'deserving poor'. But while the parliamentary committee and the NH&MRC wanted a government-organised and funded health service, the doctors were opposed to salaried services except in remote areas, and wanted control of any general health service to be vested in a commission on which medical men had a majority.

The Royal Flying Doctor Service at work in the northwest of New South Wales, 1981. The service provides the 'mantle of safety' for people inland, of which the founder, the Presbyterian minister John Flynn, dreamed in 1928.
AUSTRALIAN INFORMATION SERVICE

While the national committees were debating the organisation of a comprehensive health service, a South Australian country doctor and his local member of parliament were trying to achieve one. In an oval-shaped area about 30 kilometres east and southeast of Adelaide, surrounding Mount Pleasant in the north, Mount Barker in the south and Lobethal in the middle, Carl Clifford Jungfer, the Lobethal general practitioner, led a co-operative effort by ten doctors trained in public health by F.S. Hone, who had been a member of the royal commission on health. In 1939 Jungfer persuaded the NH&MRC to fund a study of the health of children in the oval-shaped district. Jungfer and his colleagues lived, worked and did their surveying in an area where the economy appeared to be stable, the climate is mild and the land had been settled for nearly one hundred years. According to the theories of social medicine, the children should have been healthy, but on examination it turned out that they were not. Jungfer and his team found among them levels of goitre and rheumatic fever no lower than among children in 'less favoured parts'. Why? They decided that the rheumatic fever probably was the product of untreated septic tonsils, and they noticed that more children who lived in the higher, wetter, colder parts of the district had septic tonsils. They also thought that tonsillitis might be the result of fatigue among children required to work long hours on family dairy and fruit farms before and after school. In general, the health of children was best where they lived in fruit-growing areas and supplemented their diet with the product of the trees. Health was worst in the dairying parts, where children who had spent their mornings in a mucky milking shed were not inclined to drink enough milk and had no opportunity to eat fruit.

Why had the parents not done more for their children's health? The team decided that the apparently stable population of the district was misleading. Over two generations, many young men had moved away from their small blocks in the hills to new farming and grazing areas. Economic migration and World War I, to which many young men had gone, had stripped the district of its natural leadership. Jungfer did not blame the parents. Rather, he said, it was the loss of young and ambitious people that explained the shortage of 'real amenities for community life', such as proper sanitation and reasonable hospital facilities.

As one remedy Jungfer used the survey itself, which lasted six years, as a form of 'organised leadership with a plain objective', stirring women in all the villages in the hills to fill the gap left by the missing young men, raise money, form committees and set up child welfare centres. He bullied successive South Australian governments into providing a school dental service, physical education in the schools and a common effluent drainage scheme for the hills towns. Jungfer supported the move from small village schools to larger area schools so that communities would be built up to a size where they could support themselves and generate their own bullying power. Defects of vision had been found in many children and reported to their parents, but when the survey ended many defects still had not been corrected: parents who had to milk cows every morning and night could not sacrifice the time to take the children to the city for treatment. This problem was discussed with the parents' committee of the new area school who decided to engage a refractionist to come from Adelaide and make the necessary examination. When this was done the children were provided with glasses for which the parents paid willingly.

Jungfer found much undernourishment among children in the Adelaide Hills and, as seen here, worked to make sure good food got to them in school.
IN PRIVATE POSSESSION

Above right.
Dr C.C. Jungfer as president of the Royal Australian College of General Practitioners, 1968. After funding for his Lobethal child health service was cut, Jungfer pushed for better standards of general practice and for teamwork between doctors, nurses and physiotherapists. Portrait by Owen Gard.
ROYAL AUSTRALIAN COLLEGE OF GENERAL PRACTITIONERS, SYDNEY

Henry Huntley Shannon, member for the local electorate of Onkaparinga, was secretary of Jungfer's child health survey. In 1943 he was the member of parliament best informed about health issues. He had assimilated the view that prevention and public health are as important as treatment services. He pushed hard for the co-ordination of medical services in South Australia and called for the supervision of private hospitals. He was supported by many other members of parliament seeking regionalisation of hospital services. In 1944 and 1945 his speeches in parliament invoked the Joint Parliamentary Committee, and he kept calling on the premier, Thomas Playford, to fund integrated services like the Lobethal Child Health Service, which had arisen out of Jungfer's study.

In 1943 and again in 1945, Shannon called for an inquiry into health services in South Australia. Playford resisted, but rumblings within his own party forced him to concede an inquiry, with Shannon as chairman. It reported in December 1946 that local government health services hardly existed, and state-wide public health services, such as tuberculosis services, were underdeveloped and short-staffed. It reported the Royal Adelaide Hospital and other public hospitals congested with chronically ill or senile patients. To ease pressure on teaching hospitals providing 'the highest types of medical and surgical skill', Shannon called for 'many more hospitals of a lower grade to provide for the care of patients suffering from chronic and sub-acute illnesses'. It was clear that health services in South Australia urgently needed to be co-ordinated and, for this purpose, Shannon proposed a health commission.

In 1949, almost three years after Shannon's report, Playford introduced a health bill to create a Director of Tuberculosis, a Director-General of Public Health, and an expanded advisory committee on health. Playford's slow response to Shannon's complaints reflected hesitation in the face of difficult problems in hospital administration then common to state authorities throughout Australia.

In South Australia the political situation made those problems more difficult. Thanks to a notorious gerrymander, which gave heavy over-representation to rural areas, small country communities exerted strong pressure in the allocation of government resources. Playford talked of the need to develop regional hospitals at reasonable distances apart but shillyshallied before local preferences, especially in farming areas like Crystal Brook, for smaller private or community hospitals. He was often accused of starving the few country public hospitals at the expense of neighbouring subsidised ones. The problem went beyond the mere proliferation of small hospitals. By 1949 there was also a wide disparity in such hospitals' operating costs, partly because of the advance of medical technology and partly because of the breakdown of a system through which government subsidised local initiative. As Duncan, the Labor member for Gawler, said in the estimates debate of November 1949, it had been usual for the auxiliary of a country hospital to raise money by growing wheat in the local railway reserve, selling morning teas at the weekly stock market, or running a sheepdog trial. With that income the hospital committee would approach the government for a subsidy at two pounds for every pound raised locally. By 1949 hospital subsidies went beyond conditional aid to a list of prescribed items such as X-ray plant, operating tables and anaesthetic machinery. Far sterner methods than Playford's were needed, Duncan declared, to change the existing situation in which 'according to the ambition of the [local] doctor and the enthusiasm of the people, so they erect hospitals'.

In the same estimates debate H.H. Shannon cited as an unhappy effect of this emphasis on hospitals the suspension of the Lobethal Child Health Service. It had been cheap, effective and enthusiastically supported by general practitioners: rather than being retrenched, he said, it should have been extended. The service had been stopped because it could not recruit physiotherapists and dentists, who might have been available if there had been more money to pay or train them but 'health' budgets were increasingly committed to medical work in hospitals. The Lobethal case illustrated that, by 1949, the unified, regionalised, health-oriented system with general practitioners as the core medical element, which had been the goal of the 1926 royal commission, the NH&MRC, the Joint Parliamentary Committee and the Shannon Committee, was having its last gasp. Had this system been developed successfully, the 'hospitals for doctors' push of which Duncan spoke might not have happened. At it was, hospitals became the central issue for governments.

The Adelaide Hospital in 1939. The five buildings in the foreground remain today, but almost everything else was demolished for 'redevelopment' in the 1960s.
ROYAL ADELAIDE HOSPITAL

At Crystal Brook, policy debates in Adelaide or Canberra often seemed remote from local concerns in the 1940s and 1950s. Debate did not necessarily mean change. If change did occur, it took months to have an impact on the hospital. In the meantime it had to be kept going. A quorum for the annual meeting was always hard to round up, and it was harder still to find new blood to elect to the board of the hospital. The district councils of Crystal Brook, Redhill, Gulnare, Gladstone and Laura were often recalcitrant about paying to the hospital the annual levy which the government required and about occupying effectively the seat on the board to which each was entitled. For twenty years, apart from the perennial

Romantic view of hospital work. Australian women's weekly, *31 Mar 1951.*

problem of whether to keep a hospital cow or buy milk from the town vendor, the board agonised every month over staff shortages, increasing costs and declining patient numbers and revenue.

During the war Matron Coombe, thrust young into responsibility for the Crystal Brook Hospital, had been willing to go without holidays or to get up at 4 am with another nurse to do the hospital laundry when no laundress could be found. After the war, rural hospitals all over Australia were competing for double-certificated nurses to maintain midwifery services; but double duty, poor conditions and under-award pay would not attract nursing sisters—or many other categories of staff. By early 1946 at Crystal Brook the cook had given notice, a new wardsmaid was required, and two probationer nurses, as well as two certificated sisters, were needed to fill vacancies. The secretary was told to inform the South Australian Hospitals Association that the board was agreeable to paying the recommended nurses' salary but, to do so, there must be a corresponding increase in the government grant.

In 1946 the board accepted that nurses might receive free medicine while at the hospital and reluctantly agreed to the nurses' request for a tennis court. Some members of the board did not easily come to terms with the new era. At an acrimonious meeting in 1952, one member complained that the staff—still in short supply and often staying for only a few months—'were entertaining gentlemen in their rooms'. Another member thought that staff shortages could be overcome by increasing the facilities, but he could not raise sufficient support for his proposal that the sisters should have a sitting room of their own. Four years afterwards, when junior nurses were becoming more vocal about their conditions, the board was pleased to recruit a matron who instructed staff to report their return from weekly social outings, installed a padlock on the front door and brought the smack of firm discipline to the staff quarters. As late as 1963, despite its continuing complaint that no nurses would come to the country, the board gave staff permission to install a television set only 'on condition that there would be no cost to the hospital'.

The board's finances were strained and its freedom constrained increasingly by government regulation. From 1950 inflation and the introduction of quarterly cost-of-living adjustments to the basic wage (with flow-on effects to other wages and salaries) kept staff costs increasing constantly. Maintenance costs were kept down because the district engineer for the Water Supply department, with his base in Crystal Brook, was always a member of the board in company with his mechanical supervisor who, sometimes with nod-and-wink help from the workmen at the depot, kept equipment at the hospital going well beyond obsolescence. Nonetheless, new staff tended to demand new equipment, usually of 'a superior type'. Sometimes a £2 for £1 subsidy was available from the state government but only after long negotiation and not always for the 'superior type': even in 1961 the question of what type of refrigerator would be appropriate was settled by a debate in the hospital kitchen—between Matron, the chief secretary of South Australia and the director general of medical services.

Costs are one part of the equation for any hospital board; revenue is another. Both the level of fees per patient and the number of patients admitted influence total revenue. The Crystal Brook hospital board usually tried to keep in mind those potential customers who were not insured so 'the price of ward beds [was] kept as low as possible to give the basic wage group a chance to meet their accounts'. At a time when South Australia prided itself on having the lowest wages in the commonwealth, and Crystal Brook was a rural service centre and a works depot for the Water Supply department, many potential patients probably were not insured. The notion of local charity, in the best sense of those words, did not

impress the inspector from the Hospitals Department in Adelaide, who was increasingly putting his nose in after 1950, complaining often that the hospital was raising its fees too little and too late. The board was told that the commonwealth now paid a subsidy of 12s per day if patients were privately insured. In fact the commonwealth paid 4s per insured patient through the patient's fund—Mutual Hospital Association, HCF, MBA, and so on—and 8s per day per patient (insured or not) to the hospital. The confusion is understandable: by the 1960s the hospital was deriving revenue for patients from at least six commonwealth sources.

There was also the problem of patient numbers. During the war the daily average number of patients had been eighteen. By 1960 it had fallen to 9.5 patients. When petrol rationing ended in 1950 people began to drive more often to the larger shopping centre in Port Pirie. While they were there, some preserved a historic attachment by consulting Dr Tassie about their surgical problems, which he would treat in the Port Pirie Hospital. Even if they stayed in Crystal Brook with their medical problems, the chances that they would go to hospital were declining. Dr North, who had bought Kendrew's practice, could treat with penicillin, sulphonamides and, after 1950, tetracyclines, many cases for which Kendrew would have prescribed restorative nursing and observation in hospital. The citizens who struggled throughout the 1960s and 1970s to maintain a hospital in Crystal Brook were dealing with changes in the practice of medicine that were affecting the whole of Australia, quite apart from any problems specific to rural areas.

In the House of Assembly on 23 September 1965 Playford, who was now leader of the opposition, and the premier, Frank Walsh, debated the first Labor budget in South Australia for a generation. They agreed that a tradition had died. Once it could be said that greater local voluntary effort led to a greater central subsidy for hospitals. Now changes in administrative practice saw the state move to a system of 'topping up' deficits, rather than subsidising the income of non-government hospitals. The advent of Labor brought by 1970 the end of the rural gerrymander. There were by now twice as many electorates in the city as in the country. Elections were won or lost in the outer suburbs of Adelaide, where hospitals were promised before one election and work began days before the next. Government hospitals in the cities had become the politicians' chief financial concern.

As Shannon pointed out in 1946, there was immense pressure on the resources of the Royal Adelaide Hospital in the city centre. Demands for a new public hospital in the western suburbs of Adelaide dated back at least to 1938, and during the 1940s much argument took place about whether government funds should be used for providing a new hospital for the expanding suburban population or to upgrade the technical facilities of the existing central hospital. The former idea won out, and a site was chosen for Adelaide's Queen Elizabeth Hospital.

Within two kilometres of the proposed site, Arthur Hicks came with his wife and two small children in 1948 to live as neighbours to several similar families of teachers brought from the country to city schools crowded by children in Housing Trust developments throughout the western suburbs. Enrolments in those schools were pushed up by the 'baby boom' and by the new migration from Europe which generated a politically urgent need for maternity facilities. In June 1948 the chief secretary announced that 'priority would be given to the maternity section of the new hospital as soon as finance and materials were available to begin building', thus

Nurses from different backgrounds work together at the Queen Elizabeth Hospital, 1975.
NATIONAL LIBRARY

Above right.
First block of the Queen Elizabeth Hospital, completed 1954. On the politicians' insistence higher priority was given to maternity patients than most doctors wanted. The first baby born here, Daryl Swiggs, returned as an apprentice surgical instrument maker.
QUEEN ELIZABETH HOSPITAL

blighting the hopes of specialists in other fields who did not regard maternity work, which was still substantially in non-medical hands, as a medical priority.

The Hicks family never used the new hospital, partly because they were passing through an age range where they could reasonably expect to avoid hospitalisation and partly because in 1953 the commonwealth enacted a voluntary medical benefits scheme which subsidised private medical insurance. For £5 4s a year a family could now claim an insurance fund rebate and subsidy amounting to 90 per cent of the cost of 40 general practitioner visits and 25 specialist medical visits per person per membership year, plus a range of ancillary benefits. If you were salaried, imbued with the caution of a post-depression South Australian Protestant, thought that the crush in public hospital outpatient rooms was slightly beneath your dignity and had lately moved from the Housing Trust homes to a district where doctors were readily available, then you paid your £5 4s (plus £3 2s a year for hospital insurance) to the Mutual Hospital Association or other fund and were free to choose the time and place, if not the content, of your medical services.

If you were not cautious, or had no choice, the situation was less rosy. By the late 1960s, in the northwestern suburbs of Adelaide (or Melbourne or Sydney) the medical insurance scheme was practically meaningless: it is not enough to ensure that northwesterners and people from the eastern suburbs get equal rebates on their doctors' bills if the northwesterners have no usual doctor to turn to. In any case almost 20 per cent of Australians could neither afford the insurance premium (and therefore received no commonwealth subsidy) nor qualify for a pensioner medical benefit from the commonwealth. Those who were insured found their cover diminishing because whenever the commonwealth raised its benefits, doctors raised their fees.

In 1969, after instituting an inquiry into the scheme (the Nimmo Inquiry) the Gorton government acted to remove some of the more blatant deficiencies of voluntary health insurance, partly by trying to gain the co-operation of the Australian Medical Association in restraining fee increases. By the early 1970s, however, there were broader problems to deal with, which might have involved re-examining the notion of health and the goals of health care but were reduced eventually to questions of administration and finance. Then, after 23 years, the Labor party gained power in Canberra in 1972. As part of its rhetoric of social reform, Labor had promised better and more accessible medical and hospital

services. To turn rhetoric into policy it established a Hospitals and Health Services Commission which produced a number of reports with remarkable speed.

The report on hospitals in Australia indentified three main forces at work. The first was the dominance of the hospitals, palaces of medical technology.

The second force was the power of specialist doctors. The ratio of specialist doctors to patients rose 3.5 per cent per annum between 1966 and 1971, 'Salaried hospital doctors' increased at the rate of 4.1 per cent per annum in relation to population in the same period. The commonwealth government had reinforced the doctors' specialising predeliction for some years by reimbursement according to schedules which paid a higher fee for the procedures undertaken by a specialist than for the same procedure done by a general practitioner.

The third force was a professional ferment among nurses. Discontent with pay and conditions brought high rates of resignation and chronic staff shortages but, beyond that, the commission thought the greatest single problem facing the hospital nurse was 'how to identify her role more precisely'. At each end of the spectrum of her work there were pressures: at the lower end, many traditional patient care routines were being taken over by nurse aides; at the upper end, nurses with particular skills found themselves performing duties that overlapped with those of junior medical staff, highly trained technicians and allied professional staff.

The forces thus identified were difficult enough for city hospitals, with their prestige, massive resources and trained administrators, to accommodate. For country districts such as Crystal Brook the problems were even more daunting. In a separate report on *Rural health in Australia*, the commission found that access to medical care was difficult for many country people, with those in towns of less than 3000 often poorly served. The country hospital was usually inadequately equipped for acute care, lacked appropriate support facilities and often used surplus capacity for nursing home purposes. Nonetheless, it usually had high public support, at least sentimentally. Change in the short term appeared unlikely, especially while services were poorly co-ordinated, because of shortages of both medical and allied health professional staff, lack of population to support specialised facilities and services, and the high cost of medical equipment. In the circumstances, with inflexible funding arrangements an additional inducement, the temptation to become an expensive nursing home was strong. At Crystal Brook the age distribution of patients had changed dramatically: 10 per cent of patients admitted (excluding confinements) were over 70 in 1940, but the over-70s (with an average age of 81.6) were 35 per cent of admissions in 1985.

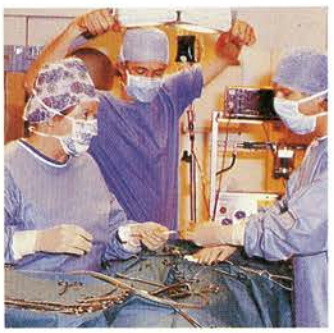
So long as 'occupied bed days' was the basis of funding, any hospital board was likely to fill beds if it could. The commission suggested that a change of outlook might be stimulated by developing the hospital 'as a base for coordinating and providing both community health and health related welfare services'. In Crystal Brook the hospital did become the base for meals on wheels, nurses from the hospital did begin to visit discharged patients in their homes on rare occasions, and the board were vigorous promoters of home units for the elderly; but this hardly amounted to integrated community health and welfare services.

A Community Health Program designed by the Hospitals and Health Services Commission was intended to overcome the problems of unequal access to primary health care and to reduce the fragmentation and improve the effectiveness of health services. It had a chequered career. At one level it was an ideal and a theory of intervention expected—as in 1926, 1941, 1943 and 1946—to produce health, more comprehensively defined, for more people. As an ideal it was ambiguous, and various interests played upon the ambiguities. 'Prevention' was a central word in the theory but it was not spelled out, was not related to specific policies and

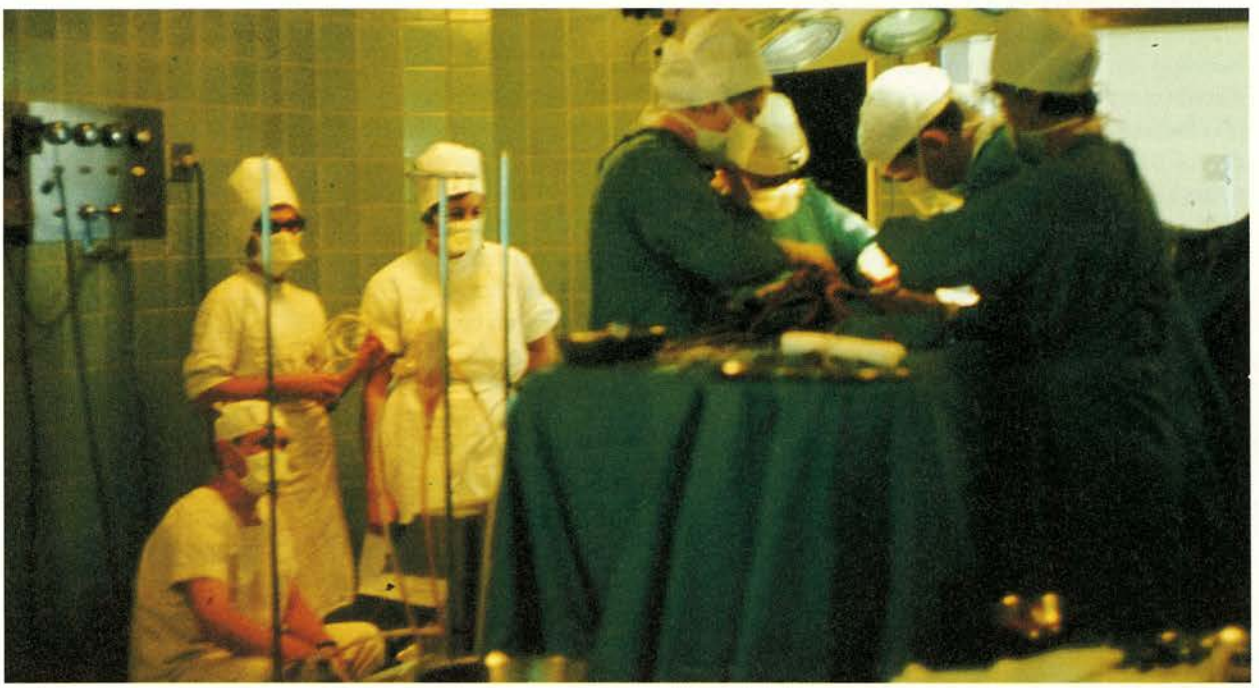
Nurse with patient at the Princess Alexandra Hospital, Brisbane, 1982. Caring remains her central job.
AUSTRALIAN INFORMATION SERVICE

usually was implemented only in an individualist fashion. Notions of participatory democracy, which some saw as integral to the ideal, were rarely implemented. The ideal was also vulnerable to the 'economic realism' and 'pragmatism' of the Fraser and Hawke governments. At another level, the Community Health Program was a set of agencies, services and staff designed to 'fill gaps' in the preceding system of health care. As such, it represented an intrusion into an arena of traditional state responsibility. Many general practitioners suspected that it might also intrude into their habits of work. In that climate, the responsiveness of state bureaucracies to the program was variable, and some co-operated with the Australian Medical Association in neutering the intention to improve primary medical care.

The community health movement had sects and pushes in its own ranks. It also had to struggle towards maturity in a harsh environment. After 1975 there was continuing turmoil over the funding of medical care by the insurance system and by commonwealth subventions to the states. A commonwealth-appointed inquiry into the efficiency and administration of hospitals yielded recommendations in 1979–80 that the states should assume their 'full constitutional responsibility' for health services and that people other than those in special need should pay for what they got, either directly or through insurance. The states, naturally, attended first to their major constituencies, the hospitals and their staffs; but they were not well prepared to face their 'constitutional responsibility' for services which years of increasing commonwealth provision had made the norm—and which continuing federally funded programs, such as the training of large numbers of doctors to work almost exclusively in hospitals, still influenced. In New South Wales, efforts to shift hospital beds as the population of Sydney moved west, to 'de-institutionalize' care for handicapped and mentally ill people and to place community health services under the control of hospitals, reduced the health resources available in the public sector. In New South Wales, Victoria and South Australia, various departments, divisions and large voluntary institutions were merged into Health Commissions during the 1970s. By 1985 two of the



A country practice *on television, 1985. From left, Matron Maggie Sloan (Joan Sydney), Brendan Jones (Shane Withington) and Dr Simon Bowen (Grant Dodwell). In real life the surgery done in small hospitals is more and more restricted by state regulation.* Australia now, *1985.*



The advance of specialisation: open heart surgery at the chest hospital in Chermside, Brisbane, 1975.
AUSTRALIAN INFORMATION SERVICE

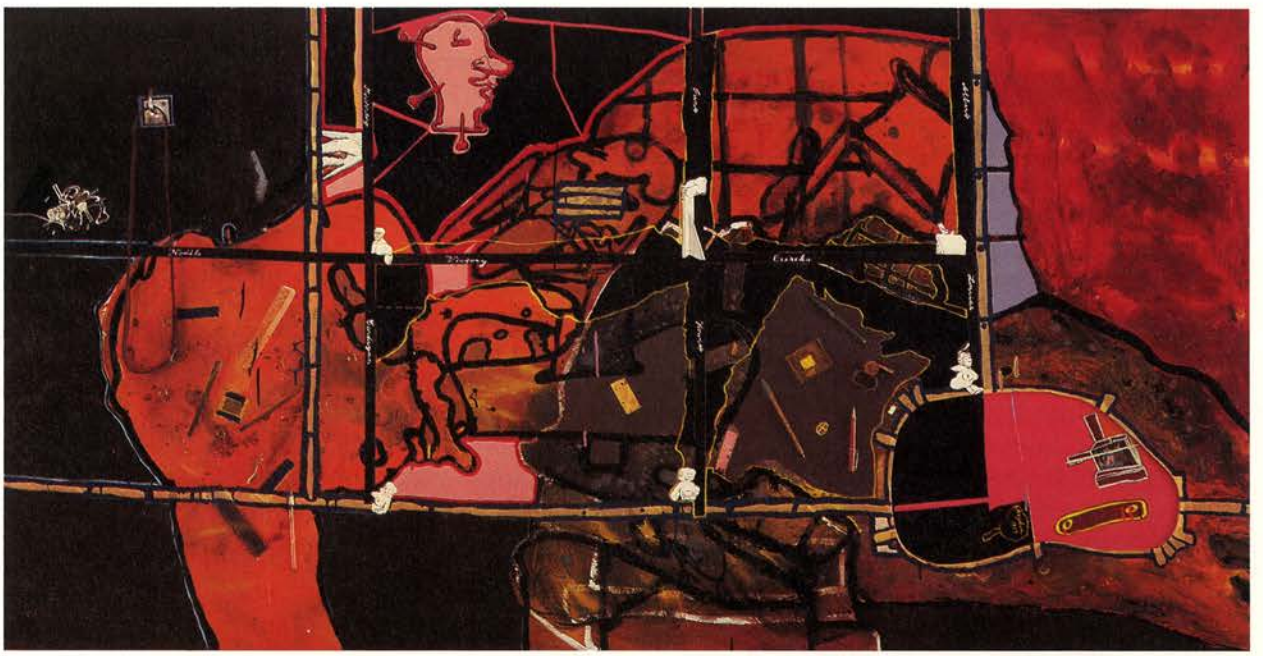
commissions had been abolished and the future of the third was in doubt. In each of those states and in the commonwealth Department of Health the internal administration was subject to almost constant change. Efforts were made to regionalise the administration of state health services—although rarely in a way that seemed likely to make the administration democratic.

In 1985 Mutual Hospitals—now called Mutual Community and expanding its business into lending and general insurance—acting for itself and the commonwealth government, paid Arthur Hicks $5100 in respect of his wife's episode of illness. That brought their total reimbursements for the decade to $10 536. To insure that cover, Hicks paid $10 per week, plus a levy of one per cent on his taxable income. Financially, sickness had never been less of a problem.

In other ways, sickness was becoming a problem, apart from what you might expect as you got older. Elderly friends across the street were getting meals on wheels, but the husband could have done with more home help when his wife's spine collapsed. The couple on the other corner had troubles, too, after they gave up their car, because there was no local bus service to get them to the shopping centre. Hicks's older brother, increasingly frail and infirm of eye, got stabilising medical and nursing care in his country hospital when he needed it but would have to be brought to the city for any investigation or radical treatment. That was a worry, too. Hicks's wife seemed to be cured of her cancer, but the treatment had taken a lot out of her and the doctors sometimes weren't very frank and seemed more interested in the treatment than they were in her, and their bills seemed longer than the time they had spent with her. One or two of his friends at bowls, when told that they had cancer, had said that they didn't want the treatment and had gone into hospital only at the last crisis. Most of these friends and relatives still trusted their general practitioners but were increasingly sceptical about the specialists. Scepticism, even bitterness, seemed to be the mood dominating health services if you could judge by the newspapers. Doctors in general were 'agin the government'; even nurses talked about going on strike; hospitals seemed impersonal and home care was hard to get.

One problem of health care in 1939 had been solved by 1985. Doctors certainly got paid for their work, and most people were not kept from medical care by reason of cost. Another problem of 1939 had not been solved. Prevention and treatment were as far apart as ever, and even treatment services were separated more sharply between general practitioners and specialists and hospitals. At least one new problem was noticed by some moral philosophers and some sensitive administrators. The philosophers observed that the qualities which might once have justified medical practitioners in saying that theirs was a self-regulating profession, which the public could take on trust, had been eroded as doctors' technical skills had become greater and more specialised. The administrators observed that, as medicine, especially in hospitals, became more specialised, the hospitals resembled ever less a workshop and ever more a factory, managed on factory lines.

In the USA, which had increasingly replaced the local Hones and Jungfers as source of ideas about medical practice, medicine looked more and more like yet another business organised to maximise the return on capital and integrated with industrial enterprises. No Australian would be wise to say it couldn't happen here.



Gareth Samson, Asylum, *1977. Enamel and collage of found objects on composition board.*
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