A REVIEW OF THE ADMINISTRATION OF THE HEALTH SERVICES IN TASMANIA.

Being a dissertation submitted to the Faculty of Commerce of the University of Tasmania in June, 1959, by E.H.G. Matthews with the prayer that he be awarded the Diploma of Public Administration.

The term "Health Services" embraces a multitude of activities. It also covers a multitude of organisational sins.

Since 1945, when the Executive, in its wisdom, decided to appoint a Director of Hospital and Medical Services, a Director of Tuberculosis and a Director of Mental Hygiene in addition to the existing position of Director of Public Health, and then placed a layman, the Secretary, in the position of Permanent Head, the sorry tale of disorganisation has increased in woe year by year, until the situation as it exists in 1959 threatens a complete breakdown. My criticism of the arrangements made in 1945 has nothing to do with the appointment of a layman as Permanent Head, indeed I consider a trained and experienced lay administrator to have a better chance of success than the average medical practitioner. It is to the lack of foresight shown by those senior officers charged with advising the Government that I allude. Knowing that the Public Health Act of 1935 was framed to give wide powers to an officer also endowed with the authority of a Permanent Head under the Public Service Act, 1923, those senior officers apparently saw no incompatibility between the powers of the Director of Public Health, now to be a subordinate officer, and the new Permanent Head. If they did foresee difficulties, then it seems that they took the line of least resistance by hoping that the new arrangement would be made to work somehow; but the fact remains that the Office of Director of Public Health retained all its public health powers when it became a subordinate position, and thereby provided fertile

ground for clashes of personality with a Permanent Head, be he layman or medico.

Similar opportunities for friction between the Permanent Head and the Directors of Mental Health, Tuberculosis, and Hospital and Medical Services existed at that time, although to a lesser degree. However, the fact that they were not appreciated, or if appreciated, were ignored for want of original thought applied to their correction, seems to me to be a sad reflection on the quality of our senior advisors in 1945. The Public Service Commissioner's staff must be included in this criticism.

The reasons for this apparent lack of foresight may not be strictly relevant to the discussion, but are suggested at this point in fairness to those officers. In any Civil Service where it is the normal practice for clerical recruits to provide the pool from which the senior positions are filled, a large proportion of these senior positions must be allocated on a seniority basis following the effluxion of time and the necessity to fill "dead men's shoes". In this way, the upper levels of the Tasmanian Public Service became overburdened (at least until 1939) with officers of long and loyal service but of mediocre ability. Since the last war, by a positive policy of encouragement to those officers wishing to take part-time study courses, and an increasing awareness throughout the Service of the necessity for organised in-service training, the potential quality of all future senior officers has increased greatly. The apparent weaknesses of 1945 should therefore not occur again.

Before developing further argument on the events and consequent changes after 1945, I consider that a brief review of the history of health legislation in Tasmania will enable the reader to understand better the present difficulties, together with the reasons for their existence.

In the first place, it is important to realise that the original Department of Public Health was formed in 1903 to supervise and control environmental sanitation throughout Tasmania,

the purity of food on sale to the public, and the prevention of infectious and contagious diseases. It was not concerned with the running of hospitals, except those establishments concerned entirely with the nursing and isolation of infectious disease cases. Thus, it can be seen that its functions were completely preventive, if one can accept the contention that the nursing of an infectious disease case in an isolation hospital was undertaken with the prime purpose of preventing its spread. In fact, it was the outbreak of a smallpox epidemic in Launceston in 1903 that caused the Government of the day to realise that its Central Board of Health did not possess the power or the specialised knowledge to deal with such an emergency. An expert in Public Health was therefore obtained from without the State, given extraordinary powers, and proceeded to deal with the situation in a most efficient manner. The success of Dr. J.S.C. Elkington in subduing and preventing the spread of smallpox in 1903, resulted in the presentation to Parliament of a Bill to vest all the powers of the Central Board of Health, with many additional ones, in the hands of a Chief Health Officer, who was to be the Permanent Head of a new Department of Public Health. It was evidently intended at that time, as in 1935, to remove the control of public health measures as far as possible from political influence, and the smallpox scare of 1903 must have contributed in no small measure to the easy passage of the Bill.

The Public Health Act, 1903, therefore, came into operation on the 6th August, 1904, and replaced the Central Board of Health by a new Department of Public Health. The Permanent Head of this new department, the Chief Health Officer, was endowed with wide powers, but was given few staff with which to carry out his functions. The duties of Secretary were carried out by the Under Secretary of the day as a part-time occupation, and there were three clerks, two of whom were cadets.[1] Negotiations were still proceeding with the Government for the

creation of a position of Chief Sanitary Inspector, but in the meantime, three other Inspectors were attached to the new Department for part-time duties associated with certain portions of the Act. These officers consisted of a dairy expert and poultry expert (both Public Servants) and a Hobart Local Authority sanitary expert. They received no pay for their extra duties under the Public Health Act.

At the time the Act came into operation, there were 73 Local Authorities existing to administer its provisions in their several districts.[2] Upon investigation, it was found that only 45 of these were Councils or Town Boards possessing rating powers. The others were simply local Boards of Health without any means of raising the funds necessary to carry out the duties imposed on them by the Act. Fifty four Local Authorities reported to the Chief Health Officer that they possessed Sanitary Inspectors, but investigations showed that 28 of these authorities utilised the services of the Police in this connection, frequently without any extra remuneration. Very few of these authorities had any sanitary By-laws, and the ones possessing or employing sanitary inspectors had to admit that these persons were completely untrained, and in most cases unfitted for the work. Dr. Elkington, in his first Annual Report, cited a typical example of this system at Longford, where the local sanitary inspector was also the local policeman. This officer reported that all of 140 premises he had inspected in a certain month were in a satisfactory condition. An inspection of 25 premises taken at random by the Chief Health Officer revealed that only one was in even a moderately sanitary condition. The Chief Health Officer concluded his remarks on this example by drawing attention to the fact that Longford had been smitten with typhoid for several years in succession. He went on to say that the old idea of the Sanitary Inspector's duties consisting entirely of a cursory inspection of "back premises" was utterly

out of date. He listed the more important duties as the oversight of drainage, the control of the safe and cleanly disposal of organic refuse, the general cleanliness of the town, disinfection after infectious disease, and the taking of food samples.

The Local Government Act of 1906 reduced the number of Local Authorities to 51, and gave them greater rating powers for public health purposes than they had enjoyed before. However, although the new department now possessed a Sanitary Inspector, this one full-time officer, with his three part-time assistants, found it impossible to maintain supervision over all Local Authorities. In fact, their duties consisted in the main of investigating the causes of outbreaks of disease in any particular locality and advising the Local Authority how to prevent such things occurring in future.

It is interesting to note that from March 1907 to June 1908, 11,287 schoolchildren were medically examined in the schools.[3] "Some thousands" of these children had notices sent to their parents advising consultations with their private doctors for further checks and treatment. Although conducted by the Education Department, this service was in receipt of constant advice from, and supervision by, the Chief Health Officer. At a later stage, the School Medical Service was taken over entirely by the Department of Public Health, but the interest taken in it from 1907 demonstrates how the Health Department's functions were, even in those early days, increasing in complexity. This is clearly seen in Annual Reports covering the years from 1910 to 1915, which show that factory legislation was added to the responsibilities of the Chief Health Officer in the former year, and the registration of Midwives, the Wages Boards Act, and the Shops Act, in the latter. The Annual Report for 1914/15 mentions the "phenomenal increase of the past year in the Department's activities". These increased activities, coupled with their specialised nature, apparently made the Government decide to relieve the burden on the staff of a department formed to supervise the Public Health, and in 1916, the office of Chief

Inspector of Factories and the whole industrial section of the Department was removed to the Department of Labour, the Ministerial responsibility for Labour being added to the portfolio of Mines. It seems that functional specialisation had been recognised in 1916, even if the doctrine were to fall by the wayside in later years. [4]

Until 1917, the staff consisted of the Chief Health Officer, a full-time Secretary, a female clerk, and two Sanitary Inspectors. The growing awareness of the need for what is now termed "Health Education" to be directed at young mothers and mothers-to-be in an effort to reduce the appalling toll of disease and malnutrition during the first year or two of life led to the appointment of a Child Welfare Nurse in Hobart in 1917. The Department of Public Health followed this with the appointment of another nurse in 1918, this time to carry out the same duties in Launceston. In the same year, because of increasing responsibilities and the decision to bring the public hospitals under departmental control, an Assistant Health Officer was appointed. The passing of the Hospitals Act, 1918, therefore saw the end of the era when the Department functioned purely as an organisation for the prevention of ill-health. From 1918 onwards, when the responsibility for the inspection and recommending of grants for public hospitals was placed in the hands of the Director of Public Health, as Chief Health Officer, the provision of curative services grew side by side, although at a much slower tempo, with those designed for prevention. I suggest that the passing of the Hospitals Act of 1918 prepared the ground for the trials and tribulations experienced within the Department since 1945, and a short diversion now, will, I feel, enable the reader to more readily understand the forces motivating the protagonists in the struggles for power both before and after 1945.

In the first place, it is well known that there has always been, and probably always will be, a division of medical opinion on the merits of surgery in certain cases as opposed to the use of medicinal and remedial treatments. Thus we have our

Colleges of Physicians and separate Colleges of Surgeons. Note also that specialisation has brought in its wake Colleges of Obstetricians and Gynaecologists, with the clear implication that post-graduate study is vitally necessary to fit a medico for practice in these fields. Similarly, post-graduate study has been recognised in most English-speaking countries during the last 70 years as a necessary prerequisite for any medico charged with responsibility for public health in a particular area. Thus, the post-graduate Diploma of Public Health, when conferred, testifies that the holder has specialised in the work of Preventive Medicine, and should therefore be an expert in that field. Unfortunately, an ideological conflict has always existed between those members of the medical profession engaged in curative work and those concentrating on prevention. This is only to be expected when one considers that complete success for the public health experts would mean bankruptcy for the others. In fact, of course, the physicians, surgeons, and hospital administrators need have no fear of functional extermination, but my personal observation of both factions suggests that those engaged in curative medicine should take stock and ask themselves if they are not being obstinately intolerant of the specialised knowledge of the public health experts. The latter body is hopelessly outnumbered, firstly because almost the whole of medical undergraduate training is occupied by learning of the treatment of disease in individuals, and secondly, because work in the field of prevention offers far less in the way of financial and intangible rewards. The brilliant surgeon receives wide acclaim throughout the world for the development of a new operating technique, which incidentally brings him a huge fee every time he uses it. The discoverer of a new drug or mould or vaccine receives the publicity, if not the monetary rewards, to which he is entitled. What of the public health expert, who, because of his specialised knowledge, has applied himself industriously to the task of securing the best sewerage scheme possible in his area, coupled with vigilant oversight and control of food supplies over

a number of years? We are never likely to see newspaper headlines testifying to the fact that Dr. X has saved 1,000 lives during the last ten years. Yet it is probably true. I therefore suggest that the medicos engaged in curative medicine should look with a less jaundiced eye at the activities of their no less learned, but unhonoured brothers.

The Hospitals Act of 1918, therefore, placed the supervision of three public hospitals, and the licensing of approximately 60 private hospitals, in the hands of a public health expert. Although I have found no direct evidence to support my next hypothesis, I suspect that the Director of Public Health of 1918 was less interested in his hospital responsibilities than his public health ones. At any rate, for the next ten years or so, public hospitals did not increase appreciably in numbers, although private ones did. It seems that the Government of 1918 was not sufficiently well advised to enable it to distinguish between the preventive and curative specialties in the medical profession; otherwise the administration under the Minister of the Hospitals Act would have been placed in the hands of an experienced hospital administrator. Similarly, the Government of 1935 was ill-advised when it appointed a hospital administrator as Director of Public Health. More will be said later about the manner in which this Director was induced to accept a new position of Director of Hospital and Medical Services in 1945 so that a public health expert (the ex Director of 1918, who had returned to Tasmania during the war) could again assume the title and responsibilities of Director of Public Health. This was, indeed, a deserving attempt to place the health services of the State on a sound footing, but it failed again for the reasons outlined on page one. Laymen can be excused to some extent for failing to perceive the differing philosophies of curative and preventive medicine, and the decisions of 1918 and 1935 can therefore be excused as a consequence of this ignorance. No such excuse holds for the decisions of 1945, however, where the problem was essentially

a lay exercise in administrative organisation. In spite of its unwieldy structure and legislative difficulties, a lay Permanent Head kept things going reasonably well - if for no other reason than that he could not be accused of favouring one Director at the expense of another. The deposition of the lay head and the elevation to that position of the Director of Hospital and Medical Services, however, undid the good work and goodwill built up from 1945 to 1950 by again subjecting the preventive services to the ordinative authority of a hospital administrator. This last hasty reshuffle of 1951, expedient no doubt for a Minister and Government intent on speeding up the hospital building programme, has been the cause of frustration ever since, and these difficulties will be dealt with in greater detail in due course. In the meantime, it would be better to return to the Department of Public Health as it was in 1920.

By that time, the demand for Child Welfare Services had made necessary the appointment of a second nurse in the Hobart area, in addition to the one already at work in Launceston. Small Bush Nursing Centres were also operating in a few isolated parts of the State, their services to their local communities being mostly curative in nature. Subsidies to public hospitals amounted to £39,529.16.3d. in the financial year 1919/20, and the Annual Report of 1921/22 raises the lament we hear so often these days, that the public hospitals were a serious drain on Public Finance. Mention is also made of the Mental Deficiency Act of 1920, which gives great responsibilities to the Chairman of the Mental Deficiency Board, then the Director of Public Health.

After the resignation of the Director of Public Health in December, 1924, it was decided not to fill the position until such time as a conference had been held to consider the co-ordination of health work throughout the State. It seems that doubts had already arisen about the wisdom of attempting to provide for the complete health needs of the community through one Government Agency, the Department of Public Health. The proposed conference,

if ever held, did not achieve anything, as the Secretary for Public Health remained as Acting Permanent Head until the Public Health Act of 1935 came into operation. During the Secretary's ten and a half year reign, all the powers of the Director of Public Health were delegated to him, and he therefore had to rely on the advice of the Assistant Health Officer (a medico) where decisions were required on medical matters.

The Annual Report for 1926 relates how the Secretary for Public Health attended a conference of State Health Ministers in Melbourne in July of that year "because of the inability of the Minister to attend". This conference decided to form a National Health Council (the forerunner of our present National Health and Medical Research Council) which was to concern itself mainly with preventive measures. Membership of the Council was to be confined to the "Professional Heads" of each State Health Department, but Tasmania was unique in sending the Secretary for Public Health to most meetings.[5]

No doubt to strengthen the preventive work of the Department, a new Assistant Health Officer holding the Diploma of Public Health was appointed in March, 1927. Legislation was also introduced that year to strengthen the powers of the Department, but this was thrown out by the Upper House.[6] Following a resolution of the National Health Council that all health services in a State should be under the control of one Minister, talks were held between the Director of Education, the Secretary for Public Health, and the Minister responsible for Health (it is not known what became of the Minister for Education) in the hope that some agreement would be reached on the subject of placing the School Medical Service under the control of the Department of Public Health. Apparently, the Minister for Education drew strength from his absence, since the Government refused to take any action. The year 1927 saw the formation of the Nurses' Registration Board (enabling Statute of the same name) but the Act made express provision for the appointment of a

Medical Chairman, and the Assistant Health Officer therefore performed this duty. Hospital subsidies were quoted as £59,230 for 1927.

In 1929 the amended and amending Public Health Bill finally passed through the Upper House, and this strengthened the powers of the Director (still delegated to the Secretary) in certain cases where Local Authorities failed to carry out their responsibilities. The same year saw a further advance in Departmental organisation and responsibility when the Chemist attached to the Department of Agriculture joined forces with the Government Analyst and the combined laboratory teams came under the direct control of the Director of Public Health.

By 1930, the number of private hospitals licensed had risen to 76, which indicates that in those days it was the policy of the Government to encourage the growth of these private institutions rather than to build new ones itself. The great social changes which had taken place (and were still developing) in the United Kingdom had not, at that time, spread their influences as far as Tasmania. The socialisation of Medicine was, in the early 1930's, still a dream only of the Labour Party, and this no doubt accounts for the little interest shown in the building and maintenance of public hospitals by the administrations in power before 1934.

The year 1930 saw the return to the Department of Public Health of all the industrial functions it had lost in 1916. The Secretary once again became Chief Inspector of Factories, and the Department administered the Factories Act, the Shops Act, the Wages Boards Act, the Workers' Compensation Act, and the Stamp Duties Act. The censorship of films was another sideline attached to an already overburdened administration.

On the 31st July, 1931, the position of Assistant Health Officer was abolished and replaced by a Government Medical Officer. Whether this was intended to set the stage for greater interest in the curative services or not, I have been unable to discover; but the next year saw the separation from the Department,

of all Child Welfare functions, which were to be carried out in future by local committees with the help of a Government Subsidy. In this connection, it is interesting to note that Child Welfare work by the Bush Nursing Service was increasing year by year, and accounted for the greatest number of visits, listed according to type of service.[7] The year 1932 also saw the responsibility for collecting Stamp Duty on wages removed from the Health Department to the Taxation Department on the 1st July. As an interesting example of preventive medicine, it is recorded that the Secretary for Public Health had to warn a certain factory owner that he was working his employees for longer hours than those allowed under the provisions of the Factories Act.

In 1934, the Municipality of Burnie appointed an unqualified Health Inspector, and the Secretary for Public Health found himself without the necessary power to veto the engagement. This weakness was removed in the following year, when the new Public Health Act of 1935 made every such appointment subject to the approval of the Director of Public Health. An additional Departmental Inspector was appointed in 1934 to police Wages Board Awards.

The Annual Report for 1935 took the form of a valedictory address by the Secretary for Public Health, as the new Public Health Act passed in that year had the effect of relegating him to his original subordinate position under the Director. The Act itself did not do this, of course, but the new Government's decision to fill the position of Director after a lapse of ten and a half years, indicated a definite policy of progress - but in the field of hospital and medical services, not prevention. The new Director of Public Health had been the Superintendent of Lachlan Park Mental Hospital at New Norfolk, and possessed no qualifications in the field of Public Health. His appointment brought with it an immediate increase in hospital responsibilities, for from 1935 onwards, the Department assumed control of the Mental Hospital of Lachlan Park and the similar institution at Millbrook Rise.

In retrospect, it seems certain that the appointment of a hospital administrator to the position of Director of Public Health was part of a long term plan by the Government of the day to interest itself more and more in the socialisation of medicine of the curative variety. This policy was very commendable, I have no doubt, but serious consideration should have been given to the means whereby it was hoped to achieve such ends. The Public Health Department had been born for one purpose only - that of securing oversight and authority over the means to secure the prevention of disease. Successive Public Health Acts had strengthened this authority. It was not until the passing of the Hospitals Act of 1918 that the administration of the preventive services had become confused with hospital administration, and from that time on, as the undoubted necessity for the provision of more curative services grew, these services were all added to the responsibilities of a department completely preventive in outlook and organisation. As I have said before, the Government of 1918 should have taken stock and considered the situation carefully before handing over to a Public Health expert the responsibility for administering the Hospitals Act. In 1935, the Government should have been even more wary of appointing a hospital administrator as Director of Public Health. Throughout the years from 1918 until the present day, it does not seem to have been appreciated by any Government that the preventive and curative factions in the medical profession possess widely differing philosophies. No intelligent layman would expect the best results from an architect appointed as a town planner - post-graduate study leading to the possession of a higher qualification are the prerequisites for such an appointment. Yet the town planner is an architect. Similarly, the orthodontist possesses higher qualifications in his specialty than other members of his profession. Yet they are all dentists. The term, "Engineer" covers a multitude of specialisations, including aeronautics, hydraulics, electricity, etc. In the same way, the

medical profession is made up of a large number of specialisations, included in which is the study of Public Health. To expect a hospital administrator to understand all the problems involved in the specialist field of Public Health, therefore, is like asking a general medical practitioner to perform a delicate brain operation. Yet this is what happened in 1935. I submit that it was at this point in time that earnest consideration should have been given to the formation of a separate body to guide and control the hospital building and inspection programme and the provision of the ever-increasing ancillary medical services. With careful planning and attention to existing legislative provisions, it would have been possible in 1935 to have laid the foundations for vigorous preventive and curative services to have developed harmoniously side by side within the one department. However, for want of appreciation of elementary principles and the need for wise planning, the opportunity was lost, and the stage was thereby set for the series of organisational somersaults which have resulted in the present explosive situation.

The Annual Report for 1938 records the start of another curative service - the employment of nine Government Medical Officers operating in eleven districts. This scheme, devised to overcome the hardships suffered by certain districts where no private medical practitioner could be induced to set up a practice, has been of great benefit to those areas.

In 1939, the number of Government Medical Officers had grown to 13, and the preventive services took another leap forward with the transfer to the Department of Public Health of the entire School Medical Service from the Education Department. This consisted of four School Nurses and eight Dentists. At that time, medical inspections of schoolchildren were only possible in those districts where Government Medical Officers were operating, but at a later stage, the need for specialisation in yet another field led to the recruitment of full time and part time School Medical Officers.

In 1940, the Director of Public Health was given leave to join the Armed Forces for the duration of the war, and the Secretary for Public Health thus found himself back in the seat of the Permanent Head, with a full delegation of powers, but increased responsibilities compared with those he had shouldered from 1925 to 1935. However, as interest in industrial matters was then increasing, the Office of Chief Inspector of Factories, together with all its responsibilities, was transferred to a new Department of Labour and Industry on the 19th August, 1940. This is an example of a specialised field in Preventive Medicine, termed Industrial Hygiene, being taken away from the parent Health Department and given to an organisation created specifically to deal with all labour and industrial matters. It is quite possible that in the near future it might be necessary for the Department of Labour and Industry to employ Medical Officers trained in industrial hygiene, and in this way, it could become another "Health" Department. This creation of a Department of Labour and Industry could therefore be used as a precedent for the creation of other departments, each charged with a different "Health" function.

The year 1940 saw the return to the Department of the Child Welfare Service, now greatly enlarged, and employing 16 nurses. In the following year, the appointment of the first full time School Medical Officer was made.

On the 1st October, 1942, the services of a former Director of Public Health (1918) became available, and this officer was enrolled as the Senior Government Medical Officer, quite the wrong title for the specialist in Public Health that he was. I have been unable to find the exact reason for this appointment, but I suspect that it was due to the influence of a medical member of Cabinet who still enjoys the distinction of being one of only five holders of the Diploma of Public Health in Tasmania at the present time. It seems that this medical Minister convinced the Government that as the preventive and curative services were both growing in size and complexity,

it was necessary to consider the appointment of experts in both fields if continued balanced progress were to be made. Planning this was made very difficult, however, as the curative expert had been appointed to the preventive post in 1935, thus leaving no opening for the newly returned preventive expert. I do not know what plans were being formulated at that time, but the Annual Report for 1944 illustrates clearly the embarrassment of the Government when the Senior Government Medical Officer resigned to take over the direction of Public Health in Western Australia. The hasty creation of a new position of Director of Maternal and Child Health managed to lure him back to Tasmania, and the fact that his services were so retained for the State leads me to believe that the Government of that time realised the need for specialists in both preventive and curative medicine to be employed for future expansion. It was, of course, not possible to do anything about it at that time, as the holder of the Directorate of Public Health was still serving with the forces. However, I suspect that the new Director of Maternal and Child Health was given some assurance regarding his future prospects.

The year 1945 saw great changes. For some time it had been apparent that more preventive work in the field of tuberculosis control was necessary. The Federal Government had discussed the position with all States, and plans were afoot to assist States financially if they decided to organise sound preventive measures. One of the terms under which this financial assistance was to be given was for each State to appoint a Director of Tuberculosis. Although the whole thing was still in the planning stage, Tasmania decided to proceed with the appointment of a Director of Tuberculosis, and this position was created and filled early in 1945. Thus, when the Director of Public Health returned from active service at the beginning of October, he found himself in charge of two Directors, Maternal and Child Health and Tuberculosis. This was the moment the Government had been waiting for. Within two months, whether

willingly or no, the Director of Public Health was induced to accept another newly created position of Director of Hospital and Medical Services, which then enabled the public health expert to take over the vacated position of Director of Public Health. To complete the picture, another new position of Director of Mental Hygiene was created and filled, all these changes being provided for in the Public Health (Administration) Act of 1945. This Act set up a Medical Direcorate consisting of the four Directors, left the title of the Department unchanged, and made the Secretary for Public Health once more the Permanent Head.

In planning the reorganisation of 1945, the Government was nearer than at any other time to the ideal of providing specialised health and medical services both preventive and curative, within the functional limits of one Department. However, as mentioned on page one, the planners brushed aside the difficulties foreseen or unforeseen inherent in legislation framed to give wide and sweeping powers to the head of a department, and hoped that goodwill on all sides would enable the new arrangement to work smoothly. Legislation which has to rely on goodwill for its effective administration is, in my considered opinion, bad legislation. Where goodwill is necessary, one might be tempted to ask if legislation is required at all. The Public Health Act of 1903, together with its amendments, and in its redrafted form of 1935, was framed to give that freedom of action to the Director that can be achieved only as Permanent Head of a department. If the same legislation is then left intact, and the Director is made a subordinate officer, frustrations are bound to arise.[8] In fairness to the planners of 1944/45, it must be admitted that the difficulties inherent in re-organising a department of such wide ramifications were enormous. It would have been difficult to justify the creation of separate departments because the full range of activities was only dimly seen by most. If new

departments were to be created, how many would there have to be? The newly appointed Directors could not so soon have their jobs taken away from them if the number of new departments was to be less than four, and if four new departments were to be created, which one would control the hospitals concerned solely with the treatment of tuberculosis or mental defectives? These and many more problems would have had to be faced, and, more important still, would have had to be debated in Parliament. For this latter reason, the question of reducing the powers given to the Director of Public Health by the Public Health Act could not be entertained. Amendments to the Act giving more discretion to the Minister and less to the Director, would have provided a solution, but the Upper House had always been wary of decreasing the powers of the Director of Public Health, and such amending legislation would have had little chance of success. Separate departments would also have had the effect of raising the status of the Minister for Health, which has always been a junior and honorary one in Tasmanian politics. So, the opportunity for reform was lost, and Tasmania is still reaping the harvest of the decisions which were not taken in 1945.

Another point to be considered is of human interest. Consider the feelings of the former Permanent Head, now relegated to the position of Director of Hospital and Medical Services, considered by all to be inferior in status to that of the Director of Public Health. It is against human nature to suffer demotion lightly, and it is therefore logical to assume that this officer would grasp any opportunity which might present itself to regain some of his former functions. This opportunity did, in fact, present itself in 1946, when the Federal Government asked for the services of the Director of Public Health to be made available for one year to advise and assist in the planning of the National Health Insurance Scheme. During the absence of the Director, his duties and responsibilities (by delegation) were given to the Director of Hospital and Medical Services, who combined both offices within normal Public Service working hours. An unfortunate

air accident robbed the Department of its Permanent Head in March 1946, and this unhappy event possibly paved the way for the developments of the next few years. This unfortunate officer had been Secretary of the Department since 1924 and its Permanent Head from 1925 to 1935, and again from November 1945 until his death in March, 1946. By years of experience in the one department he must have acquired a knowledge of its varied functions and history greater than any other officer. For this reason, the Directorate created in 1945 would probably have worked reasonably well if he had lived to continue as Permanent Head; if for no other reason than that he knew the legislative framework so well, having himself at various times been vested with all the authority now reposing in the hands of three Directors.[9] He also realised well the differing philosophies of preventive and curative medicine, and was undoubtedly the man best suited to smooth over arguments as they arose from time to time. The new Permanent Head, through no fault of his own, could not have had so many basic advantages, and this may account for his advice being over-ridden when further changes took place.

The year 1950 provided the next opportunity for change. The Directors of Public Health and Tuberculosis retired that year, and although the office of Director of Tuberculosis was filled at once, the Director of Hospital and Medical Services again took over all the functions and responsibilities of the Director of Public Health in addition to his own. To understand these moves, it would be better to return to 1949, during which discussions had taken place regarding the future organisation of a department designed originally for preventive work, and now embracing all health functions.

At this time (1949) the Government was planning a vigorous hospital building programme, and although alive to the needs of growing preventive services such as the School Medical and Dental organisations, Child Health work, etc., the larger portion of available funds was for some years to be used on hospital buildings. This building programme would undoubtedly have

the effect of increasing the responsibilities of the Director of Hospital and Medical Services, and it was therefore necessary to plan for an increase in the staff of the Department of Public Health. It seems that the Minister for Health (a medico with no public health qualifications)[10] was not in favour of the then existing arrangement whereby the Permanent Head was a layman. One reason for this attitude was his concern that the appointment of medical officers was, under the provisions of the Public Service Act, subject to the approval of the lay Head. He also thought it necessary for a medical co-ordinator to be placed within the Department. Discussions took place in 1950 between all four Directors, the Permanent Head, and the Public Service Commissioner, and these exchanges of views brought a qualified offer from all four Directors to work under the direction and assistance of a medical co-ordinator. Further comments by these Directors forced on the Commissioner the conclusion that it was too much to expect any lay administrator to have to make decisions on questions which were entirely medical in their operation and performance. More discussions clouded the issues involved to such an extent that at one time it was envisaged that the appointment of a medical co-ordinator would still leave the Secretary as the Permanent Head. How this officer was not to perform his function of recommending to the Commissioner the appointment of medical officers is not clear.

By mid 1950, talks had crystallised the need for some strengthened hospitals organisation, and at a meeting between the Commissioner, the Secretary for Public Health, and the Director of Hospital and Medical Services on the 5th June that year, it was agreed that it was essential for the hospital services to be segregated from the public health services, as the machinery of the Department of Public Health was not designed to deal with hospital control. This was stated to be becoming more apparent each year consequent upon the development and expansion of Government policy in relation to hospital services. The Director of Hospital and Medical Services was of the opinion

that he should have control of all hospitals in the State, including the institutions at Lachlan Park, Millbrook Rise (then under the supervision of the Director of Mental Health) and St. John's Park. Evidently, he did not think he could control these hospitals and institutions under the provisions of the Hospitals Act, 1918, unless he were Permanent Head of a department, either a new one, or the then existing Department of Public Health. As the powers given to him under the Hospitals Act are less sweeping than those of the Director of Public Health under the provisions of the Public Health Act, this opinion of the Director of Hospital and Medical Services in 1950 is cited in support of my contention that any subordinate position held by the Director of Public Health definitely restricts that officer's powers under the Public Health Act. The next step was to set up a committee consisting of the Directors, the Secretary, and the Commissioner, to devise ways and means of extending departmental control of all hospitals and public institutions within the State, including the Chest Hospitals, Lachlan Park, St. John's Park, and the Mothercraft Home, the responsible officer to be a Director-General responsible to the Minister. No mention was made at that stage as to where the Secretary fitted into the picture! The Parliamentary Draftsman then suggested that he send a representative to all meetings of this committee, as the legislative amendments were likely to be complicated. In the meantime, the Minister for Health had taken the matter to Cabinet, and approval was obtained on the 20th February, 1951, for a Director-General to be appointed as the Permanent Head of the Department of Public Health. Then followed in rapid succession various plans of organisation which must have been a nightmare to the drafting staff. At first it was decided to vest in a single Commissioner the powers of the Directors in the Public Health Department and to provide for their exercise. Then, for a few days only, it was decided to appoint a part-time

Director-General. There then followed a Bill to vest in a Director-General of Public Health all the powers of the Directors and to provide for their exercise. This amending legislation was withdrawn after fierce opposition in the Upper House on the grounds that each expert should have control of his own Division within the limits imposed by the particular legislation, and that it was dangerous to place in the hands of any one man powers intended for use by specialists in their particular fields. For obvious reasons, I am not at liberty to quote detailed statements placed on confidential files during the stirring times of 1949-1951, but in fairness to the then Public Service Commissioner, I think it should be made clear that he did not agree with the idea of vesting the powers of the Directors in a non-specialist Director-General.

The next step was a simple one. The Director of Hospital and Medical Services was, as I have already explained, acting as Director of Public Health in addition to his normal duties, following the retirement of the holder of the latter office. It was therefore decided to alter the title of the Director of Hospital and Medical Services to that of Director of Public Health and Director of Hospital and Medical Services and to create offices for two Assistant Directors, one to supervise the Hospitals and Medical Services Division, and the other to be in charge of the Division of Public Health. This was approved by the Governor in Council on the 17th May, 1951, with effect from the 14th May, 1951. Regulation 4 of the Public Service Regulations was amended as from the 27th June, 1951, naming the Director of Public Health as head of Department. On the death of this officer on the 29th November, 1951, the office was abolished, and a new one of Director-General of Medical Services was created and filled. Concurrently, the office of Assistant Director of Public Health was abolished and the old title of Director of Public Health restored and filled. This compromise still exists today. The Director-General of

Health Services is the Head of the Department of Health Services, but individual Directors retain their Statutory Powers under their particular enabling Statutes.

The difficulties and frustrations of this system will be dealt with in the next section, but mention should be made here of the way in which it was hoped to circumvent the possibility of a layman ever again being appointed as Permanent Head. When the Secretary for Public Health retired in 1953, his office was abolished, and in its stead was created a new position of Chief Executive Officer on a much lower grading. Thus, after 1953, there was no longer a senior lay officer of sufficient status in the Department to have any say in the administration, and the door was left wide open for the professional officers to exercise their newly-found freedom.

Before passing to the next part of this narrative, mention should be made of the staffing organisation utilised to perform the Department's varied functions since the creation of the Medical Directorate in 1945. In that year, there were 24 clerical and technical staff employed in the Davey Street Building. These included three health inspectors, a psychologist, accounts clerks, inspecting sisters, and some general personnel who seemed to do anything and everything as the need arose. In fact, the staff then serving the four Divisions was the same as that which had previously served the one master, the Director of Public Health.

When the Division of Tuberculosis moved into its own premises in late 1946, it took some clerical and typing staff with it, together with part of the Records Section. The Division of Mental Hygiene found other premises in 1947, and took the psychologist and a clerk-typist cum records clerk went with it, thus leaving the two great rivals, the Divisions of Hospital and Medical Services, and Public Health, to share the same administrative, clerical, typing, and records staff. From that time onwards, the Hospitals Division staff grew like the cuckoo baby, and eventually squeezed its luckless parent right

out of the nest in 1955. In doing so, it retained the typing and records staff which had been providing services to itself, the Division of Public Health, and the Departmental Headquarters, and in fact turned itself into the Departmental Headquarters. In the meantime, the Division of Public Health had to recruit clerical and typing staff, and suffer the accusation of "Empire Building" in the process. Of course, it had taken with it the Health Inspectorate, the Nutrition Officer, and medical officer in charge of the School Medical Service.

The present organisation of the Department, therefore, consists of three semi-autonomous Divisions, and a combined clerical, technical, typing, and records staff of 36 persons performing between them the functions of the Departmental Headquarters, the Division of Hospital and Medical Services, and some services provided for all, i.e. mail despatch, provision of transport, and library facilities. The fact that there is in many cases no clear division of labour between these officers results in members of the Hospital Division Staff, the Accounts Section, and the Minister's Secretary, all being sometimes engaged on work which should logically be performed by the Chief Executive Officer and a small administrative staff.

As the Statutes administered within the Department and its Divisions are so numerous as to defy a detailed description in a composition of this brevity,[11] I will now attempt to compare some of the powers given to the Directors by the principal Acts under which they operate.

Although the Director of Mental Health has under his charge the Mental Hospital of Lachlan Park, New Norfolk, and the Psychopathic Home of Millbrook Rise, his greatest responsibility (and largest amount of work) is conferred on him by virtue of his Chairmanship of the Mental Deficiency Board, and as Director of the State Psychological Clinic. His powers, then, are not by reason of his office of Director of Mental Health, which could become almost entirely administrative in nature if some other person were appointed to the two former positions. However, as the present Director of Mental Health holds these appointments under the provisions of the Mental Deficiency Act, his powers have every right to be mentioned here. In the first place, it should be clearly understood that the Mental Deficiency Board set up under Section 39 of the Act is, in Section 50, made responsible to the Minister. This must necessarily mean that the Chairman has a right of access to his Minister which cannot be denied by the Permanent Head. As the function of the Board is to supervise all matters relating to the supervision, protection, and control of defectives, and as it is also charged with the superintendence of the State Psychological Clinic, it follows that many of its decisions have financial repercussions. Yet the Chairman, as Director of Mental Health, is a subordinate officer to the Permanent Head, and therefore has no right to argue his own case with the Under Treasurer when that officer is busily engaged in arguments with the Permanent Head about the necessity for reductions in the Departmental Estimates. The position could arise where the functions of the Board could be nullified by the arbitrary decision of the Permanent Head to withhold finance, or by his refusal to make adequate provision for the Board in the annual

estimates. Since these estimates are now computed in one set covering three Divisions, it is always possible for profligacy in one Division to lead to penury in another. Thus, to quote a simple example, if the Division of Public Health has used too much of the travelling vote, it might result in the Accountant having to inform the Director of Mental Health that his officers could not travel even if this travelling was at the express direction of the Mental Deficiency Board.

It is realised that similar problems exist, have existed, and will continue to exist for many years within the complex modern framework of Executive Government, but efforts should be made to abolish them wherever possible.

As Director of Mental Health, that officer is given extensive powers under the provisions of the Mental Hospitals Act, 1885. Section 7 provides for every such hospital and the insane confined therein to be under the general control and direction of the Director, although under the immediate control of a superintendent to be appointed by the Governor. Section 48 then makes provision for the Director to license any person to keep a house for the reception of such number of insane persons as may be specified in such licence. This gives the Director of Mental Health similar discretion in the issue of licences to that given by Sections 54, 55, 56, 57 and 58 of the Hospitals Act, 1918, to the Director-General of Health Services. Section 6A of the Mental Hospitals Act is interesting in that it commands the Director of Mental Health to submit a report annually to the Minister in writing. He is thus the only officer of the Department so charged.

The Tuberculosis Act of 1949, with the Tuberculosis (Campaign Arrangements) Act of 1950, provide the Director of Tuberculosis with his Statutory powers. However, the Minister is alone empowered to issue notices requiring people to submit to chest examinations (Section 5). Section 6 allows the Director to compel a person to undergo an examination if he believes that person may be suffering from Tuberculosis. Section 9 provides

for Boards to be created to which the Director may apply for permission to confine people for treatment, but these Boards have their powers of confinement limited to periods of six months duration. However, if a person fails to comply with such orders, or walks out of the hospital to which he has been confined, then it is the Director who may apply to any Justice of the Peace for a warrant to arrest the person and confine him again. This is contained in Section 8. Section 16 provides for the Act to expire on the 30th June, 1963.
12
This refers to the Agreement made between the Commonwealth and State Governments whereby all capital expenditure on buildings, land, the erection and improvement of buildings, and the provision of furnishings, equipment, and plant for use since the 1st July, 1948, plus net maintenance costs over and above the net costs incurred in the year ending on the 30th June, 1948, are met by the Federal Government. The Tuberculosis (Campaign Arrangements) Act of 1950 gives effect to this Agreement, the text of which is given as a Schedule to the Act. Section two then provides that so far as the exigencies of the public service and the moneys provided by Parliament (State) allow, the Governor shall take all reasonable steps to ensure that Tuberculosis is properly controlled. Section Three contains the interesting provision (overriding the State Public Service Act) that, "Notwithstanding anything contained in the Public Service Act, 1923, the Office of Director of Tuberculosis shall be continued during the continuance of the Principle Act, and the holder of that office shall, except for leave as provided by that Act (Public Service Act) devote the whole of his time to the duties of his appointment and shall not be permitted to engage in private practice".

The powers of the Director of Tuberculosis with regard to the confinement of sufferers is similar to those of the Director of Mental Health, as both have to rely on a Board to make the confinement decision. However, as the Director of

Mental Health happens to be the Chairman of his Board, his power is rendered greater by the combination of the two offices. Although the Director of Tuberculosis can find himself in conflict with the Permanent Head in much the same way as the Directors of Mental Health and Public Health, the financial provisions of his enabling Statutes are such that he is never likely to feel the power of the State purse. For this reason, his Division enjoys a degree of autonomy which is the envy of the others, and must account for the lack of friction that exists between it and the central administration.[13]

The Places of Public Entertainment Act, 1917, gives the Director of Public Health very wide powers to control the building and use of places where members of the public might possibly be exposed to danger. Section Four gives responsibility to the Director in no uncertain terms, viz., "The Director of Public Health, shall, under the Minister, administer this Act". Compare this with Section Five of the Hospitals Act, 1918, which simply states that, "The Minister is hereby charged with the administration of this Act". In fact, as will be seen, the Permanent Head of the Department, under the provisions of the Hospitals Act, 1918 (his principle Statute) has much less power and discretion allowed him than the Director of Public Health, the Director of Mental Health, or the Director of Tuberculosis. Section Six of the Places of Public Entertainment Act places in the hands of the local authorities the function of licensing public entertainments, but gives complete discretion to the Director of Public Health by making every such local authority decision dependent on the approval of the Director and "not otherwise". Section 8 then provides for the cancellation of licences, and for an aggrieved person to appeal to the Director. Subsection (5) of this Section makes the decision of the Director on an appeal final. It is an appeal only to "Caesar", and therefore gives the Director far more discretion than the Director-General under the Hospitals Act, because Section 69 of that Act allows an appeal (by summons served on the Director-General) to

a judge if any person is aggrieved at the refusal of the grant of a licence to run a private hospital.

The power to cancel a licence under the Places of Public Entertainment Act is given to the Director of Public Health, at his discretion, in Section 17, with no provision for appeal against the decision. However, only the Minister may revoke or cancel the licence for a private hospital (Section 66 of the Hospitals Act), and even then, Section 69 allows an appeal to a judge. The only provision for the Minister to control a place of public entertainment is contained in Section 24 of the Places of Public Entertainment Act. This section is peculiar in that it provides for the Commissioner of Police (with the consent of the Minister) to close or prohibit an entertainment or portion of an entertainment wherever he is of opinion that it is fitting for the preservation of public morality, good manners, or decorum, or to prevent a breach of the peace or danger to any performer or other person. Thus, the Minister can, in this one instance, override the decision of the Director. However, as this Section only applies to circumstances outside the control of the Director, it is not in fact, any serious curtailment of his powers.

Although the Public Health Act, 1935, gives the Director of Public Health wide powers to protect the public health, it is interesting to note that Section Four allows the Minister unlimited discretion to exempt any premises the property of His Majesty, by order in writing, from all or any of the provisions of the Act. Section Six then provides for the appointment of a Director of Public Health who shall, "in every case be a medical practitioner with special knowledge of sanitary and bacteriological science". Section 6A provides for the Director to delegate, with the approval of the Minister, all or any of his powers under the Act, and also of any Act that is incorporated with it. This delegation is revocable at the will of the Director, and does not prevent or affect the exercise of any power or function by the Director.

Section 7 then provides for the appointment by warrant of medical officers, inspectors, and other health officers by the Governor on the recommendation of the Director. Subsection (2) makes it necessary for these officers to be temporary employees or officers within the meaning of the Public Service Act, 1923, and Subsection (3) provides for these persons, in the performance of their duties as health officers, to be subject to the control of the Director of Public Health. Here is an example of how a confliction of authority between the Permanent Head and the Director can arise. Section 17 of the Public Service Act, 1923 makes the permanent head of a department responsible for its discipline, general working, and efficiency. Charged with these duties, a permanent head could be of the opinion that the journey of a health inspector 250 miles to point "A" and return, to carry out a special investigation at the request of the Director of Public Health, was unnecessary. If both Director-General and Director were determined to co-operate with one another, a short discussion between the two would make clear to both of them the reasons for or against the inspector's journey, and there the matter would be settled. However, when the Director, as provided for in the Public Health Act, must be an expert in Public Health in order to hold his office, it is difficult to understand how a Director-General, for whom no qualifications except that he be a medical practitioner are prescribed, can presume to tell the Director that the inspector's journey is unnecessary. It could be likened to the plumber telling the carpenter that nails would be better than screws for a certain piece of framework. It is certain what reply the carpenter would make to the plumber in such circumstances. Why then should we consider that similar frictions should not arise between the public health expert, the psychiatrist in charge of the Division of Mental Health, and the Tuberculosis specialist on the one hand, and the Hospital Administrator acting as Permanent Head, on the other? Unfortunately,

when circumstances arise giving cause for friction, the wise decision is seldom made. It is therefore possible that the permanent head could refuse to make funds available for the inspector's journey. In this case, the Director would have two alternatives open to him, provided he was determined to follow through his original plan. He could see his Minister with the request that the Minister himself should instruct the permanent head to make the funds available. In this case, the Minister would have to interfere with the day to day running of the department, which is undesirable. He might also be away from Hobart for a few days, and so cause a crisis! The second alternative would be the serious step of prosecuting the permanent head on a charge of obstruction. This is provided for in Section 23 of the Public Health Act which states that no person shall "Obstruct or hinder the Director or any health officer, or any officer of the local authority, in the execution of his functions and powers under this Act". The penalty for this offence is a fine of £50 and a further daily penalty of £10. It may seem fantastic to think that such a situation could arise, but the frustrations inherent in the present departmental organisation can reach a point where an explosion such as this could take place.

Section 16 of the Public Health Act provides for the Governor, upon the recommendation of the Director as he thinks fit, to make regulations for the purpose of preventing or checking the spread of any infectious disease. These regulations may include power to isolate any part of Tasmania, to control the berthing or direction of ships, and to control and manage any hospital for persons suffering from any infectious disease. However, Subsection (3) introduces Ministerial control in that the Governor may declare that any specified regulation shall have effect within the whole of such specified parts of Tasmania as the Minister, upon the recommendation of the Director, by notice in the Gazette at any time may direct. In this case, the power of the Director is a negative one, i.e. he may withhold his recommendation to the Minister, thereby ensuring that none of these

regulations are made to apply in any area where he considers there is no need for them. On the other hand, if the Director wishes to invoke the provisions of Section 16 (3), he must gain the Minister's approval.

Section 18 gives the Director, in cases of special emergency whereof he shall be the sole judge, the right to exercise himself all the powers and functions of a local authority for preventing or checking the spread of any dangerous infectious disease, the expenses of any such action being a charge upon the local authority in whose area the work was carried out.

Section 19 then gives the Director almost unlimited power to isolate any part of Tasmania, destroy buildings, forbid sea, land or air travel etc., for the purpose of checking or preventing the spread of any dangerous infectious disease.[14]

Section 20 then allows for the Director, in the exercise of his powers and functions under Section 19, to employ inspectors and workmen, and to be entitled to the co-operation and assistance of all magistrates, justices, police officers, and officers of marine boards. This again poses the problem of co-operation by, and subordination to, the permanent head, who has no statutory responsibility under the Public Health Act, yet is supposed to provide the Director with the tools for his job.

Section 22 then provides for the Director to obtain the services of medical officers and nurses from any hospital, and makes it obligatory for the hospital Board to grant to such medical officers or nurses leave of absence for the period during which their services will be required by the Director. In return for this piracy of staff from a public hospital, the permanent head could refuse to recommend to the Minister that such temporary assistance was required. However, the Minister would no doubt disregard this advice, and proceed to recommend the increased temporary employment to the Public Service Commissioner, if indeed, an emergency were present.

Further examples drawn from the Public Health Act or from the Food and Drugs Act, 1910, would serve to illustrate little

more than has been done already how the statutory powers of the Directors, and in particular, the Director of Public Health, can cause conflict between the permanent head and the Directors. When the permanent head also has a Division to look after, and when the staff and expenditure of that Division, following Government policy, expand at the expense of the others, it is difficult to convince the Directors that there is not some element of "Empire Building" present in the central administration. For one department to function at all within the general legislative framework existing at present, it is essential for the permanent head to have the confidence of all Directors. To secure this confidence, he must not have the legislative responsibility for the administration of a Division of his own, but must be completely free to concentrate on the administration of the whole department. If confidence in the head is to be consolidated, this officer must not be a medical practitioner. If he is, then he must be in either one or other of the ideological groups described in Part I, and this will undoubtedly perpetuate present conflicts. Again, if a medical practitioner continues as departmental head, it is obvious that he cannot be at one and the same time a psychiatrist, a specialist in tuberculosis, an experienced hospital administrator, and a public health expert. He must have had experience in one of these fields, and this would inevitably tend to bias his judgment. In any case, the argument would then continue to apply that an expert in say, psychiatry, could not be expected to understand, or have much sympathy with the aims of the Division of Tuberculosis. If the department is to continue to function, then, it is essential that a lay head should be appointed, if only for the reason that he would be expected to provide an unbiased central administration. In this way, the formation of the medical directorate in 1945, with the Secretary as the permanent head, was the nearest approach to efficient working that had been reached since 1918 (when the Hospitals Act made a public health expert responsible for the administration of hospitals) and if it could have been continued, might possibly have managed

to improve itself in due course. However, there would still have been the very real danger that the permanent head could have been confused as to his exact functions. The Public Service Act, Section 17, as has already been mentioned, makes the permanent head responsible for the department's discipline, general working, and efficiency, and also responsible for advising the Minister controlling such department in matters relating thereto. It is this Section that can confuse the permanent head into feeling obliged, on inauspicious occasions, to say that he is responsible for advising the Minister, and to do so he requires the views of the Directors so that he can present their cases to the Minister on their behalf. This, of course, infringes the right of every Director to consult with and advise the Minister on matters pertaining to his own particular enabling Statutes. Yet who can say where the Director-General's rights under Section 17 of the Public Service Act end, and the Directors' rights under their enabling Statutes, begin? This problem is further accentuated by the manner in which the departmental estimates are presented in the Appropriation Act. The original compilation is satisfactorily carried out by the Divisional staffs, but when these estimates are given to the departmental accountant, that officer has to combine them in such a way that the expenditure of any one Division cannot be obtained. These combined estimates are then argued with the Under Treasurer in the absence of the Directors, thus giving them no opportunity to decide for themselves what services will have to be cut if cutsare required. It has always been argued by the Directors that they have the right to advise the Minister on all matters concerning the reduction of estimates for their Divisions. Since they are responsible to the Minister for their administration of their particular Statutes, this is surely a logical approach. However, it is now the practice in the Department of Health Services for the Directors to be told after the event that such and such a service will have to be reduced or abolished this year. If the ideal of a discussion with the

Minister (at which the Head could be present) by each Director is not obtainable, then at least the Directors should be told by how much their estimates would have to be reduced, and then left to make the necessary reductions for themselves in the light of their specialised knowledge and of their statutory responsibilities. Yet it seems that Section 17 of the Public Service Act can so confuse the permanent head that he feels justified in advising the Minister on matters concerning the administration of laws under which he has no responsibility, and in most cases, no specialised knowledge.

It is now time to consider in detail what remedies are available to place the health services of the State on a sound and efficient footing, and this will be discussed in Part III.

As so much confusion of thought has always been displayed when plans for re-organising the health services of Tasmania have been considered in the past, it is essential for some close study to be given to the problem before any further palliatives are attempted. I suggest that it should be considered in six ways, viz.,

(1) To abolish the position of Director-General, revert to the title of Director of Hospital and Medical Services with equivalent status to the other Directors, leave statutory powers of all Directors untouched, and appoint a lay Head.

(2) To abolish the position of Director-General, revert to the title of Director of Hospital and Medical Services with equivalent status to the other Directors, and vest all statutory powers of the Directors in a lay Head.

(3) To leave the present departmental framework untouched, and vest all statutory powers of the Directors in the Director-General of Health Services.

(4) To create a Hospitals Authority as in Victoria and New South Wales, leaving the rest of the Department as a coherent whole.

(5) To split the present organisation into a number of separate departments.

(6) To abolish the position of Director-General, change the title to that of Commissioner for Hospital and Medical Services, change the titles of all Directors to that of Commissioner for their specialty, appoint a lay Chairman, amend existing legislation to vest all present statutory powers of the Directors in a Commission, this body to be recognised as the Permanent Head of the Department for the purposes of the Public Service Act, 1923.

I will now discuss each of these suggestions in turn.

1. The arguments in favour of appointing a lay Head are legion, but by far the most convincing one to my mind is that which is based on the fact that the person charged with responsibility under the provisions of the Public Service Act for the administration of a department employing approximately one-third of the entire Tasmanian Public Service should at least have had special experience and possess qualifications in Public Administration. Under existing legislation, however, the Director-General of Health Services has only to be a medical practitioner, with no specialist qualifications such as are demanded even of the subordinate Director of Public Health. A medical degree is evidently considered to be sufficient qualification for a person appointed to maintain oversight of the State's hospitals, but the provision in Public Service Regulation 4 that the officer holding the position of Director-General of Health Services should be recognised as the head of the department makes a mockery of the study of administration. It has long been considered by a large proportion of the lay population that a medical practitioner possesses mental capabilities far superior to other sections of the community. This no doubt springs from the knowledge that many years of study are needed to fit a man or woman for the practice of medicine. In the eyes of many laymen, therefore, a halo of knowledge and presumptive administrative efficiency surrounds every medico's head. This supposition probably clouded the judgment of those lay officers who agreed in 1951 to restore a professional head to the department. I do not imply that medical practitioners are necessarily bad administrators. The point I am trying to make is that because a person has qualified as a medical practitioner, it does not follow that he or she must be a sound administrator. This may be the case, but I suggest that the odds are very much against it.

The question that arises, therefore, is the exact intention of the Government in appointing a medical practitioner

as Director-General. If it was the intention that he should run the State hospitals, together with the ancillary services provided by the Government Medical Officers, Bush Nurses, and Tourist Nurses, then there would have been justification for the office to have been graded on the same level as those of the Directors of the other three Divisions. If, however, it was the intention that the holder of the office of Director-General should administer the whole department, then I suggest that the office of Senior Medical Officer should have been changed to "Director of Hospitals Services" or some other similar title, and filled by a trained hospital administrator. The office of Director-General could then have been filled by a trained and experienced layman, who would have been in a much better position than most medical men to appreciate the provisions of the Public Service Act. In 1950 it was argued that a layman could not be expected to make decisions on medical matters. What of the many lay Ministers for Health who have successfully carried on their administrations both in Australia and overseas? If lay politicians can assume Parliamentary responsibility for health services simply on the advice they receive from their medical officers, then surely the same situation could be duplicated within the departmental framework.

Let us assume, therefore, that the department is to be re-organised, with four medical Directors and a lay head. If the present legislative framework is retained, would there be any improvement in efficiency? Gone would be the possibility of accusing the permanent head of boosting his Hospitals Division at the expense of the other Divisions. Gone would be the criticism that a medical practitioner obviously lacking in administrative experience was placed in authority over a third of the Public Service. To that extent, therefore, the air would be cleared. However, the frustrations mentioned elsewhere, principally those of having a permanent head with authority to control the actions and purse strings of Directors having statutory powers under legislation in which the head has no responsibility whatever,

would still exist. With tact on the part of the lay head, the frictions that exist now could be reduced, but this is not enough. Legislation must not have to rely on goodwill and diplomacy for its efficient administration. It seems, then, that a lay head under the present legislative framework would offer some slight improvement, but not enough to make the change worthwhile.

2. The second possibility is for all the powers of the Directors to be vested in the lay head, who would then be expected to delegate the appropriate ones to the existing holders of Divisional Offices. From the lay point of view, I see little to worry about with an arrangement of this sort. However, I am certain that any such move would encounter violent opposition in Parliament. When the last attempt to pass legislation of this type failed, the powers of only two Directors were to be given to a medical practitioner. If the opposition was then so great that the Bill had to be withdrawn, how much more vocal would the opposition be this time, if those same powers and more were to be given to a layman? There is one serious difficulty, though, that has to be considered. The vesting of all the powers of the Directors in a lay (or medical) head would have the effect of cutting off the right of the Directors to discuss matters with, and advise the Minister. If the Minister happened to be a layman, and a lay head decided to guard his prerogative of being chief advisor to the Minister, it could happen that the head would encounter difficulties in placing advice of a purely medical nature before his Minister. Although he might not realise it, he could, through ignorance of a medical matter, so misrepresent the medical viewpoint as to cause consternation and criticism of the Government when the resulting policy decision made itself felt. Of course, the same thing can happen deliberately if a medical head of opposite sympathies to one of his Directors insists on exercising his prerogative to advise the Minister on matters of moment to

that Director. Further trouble could arise if the Minister happened to be a Medico, as he would doubtless consider it an affront to his original profession if all medical policy matters had to be discussed with a lay head. I therefore feel it would be unwise to consider placing all power in the hands of a lay head, assuming that such a move could survive its exposure in Parliament.

3. At the time of writing, amending legislation is contemplated to vest all the statutory powers of the Director of Public Health in the holder of the Office of Director-General of Health Services. It has been said that this is the first of several moves to strip all the Directors of their powers, and vest these powers in the Director-General, thus giving him the freedom he requires to enable him to perform with complete efficiency his functions as Permanent Head. It has also been pointed out that full power to delegate all or any of the powers contained in the Acts being considered for amendment will be provided. In other words, the originators of this idea are at pains to assure enquirers that the contemplated changes are of an administrative nature only, and will not affect the status or duties of the present Directors. This reminds me of the reception that this sort of explanation received in Parliament in 1951, when the last attempt to vest Public Health Powers in the holder of the Office of Director-General was made. On that occasion, amid a storm of protest, ridicule directed to the fact that the Bill was intended to make things different so that delegation could make them the same again, caused the withdrawal of the measure. I realise that there is little substance in the frivolous denunciation outlined above, but I suggest that the present proposal is again a palliative, and will meet with no more success than any other re-organisation has done since 1950.

In No. 2, above, I mentioned that the vesting of all statutory powers in the Permanent Head would abolish the right

of the present Directors to consult with and advise their Minister. I also mentioned that the viewpoint of a particular Director (an expert in his own field) can be misrepresented, either deliberately or through ignorance of the issues involved, to the Minister by the Permanent Head. Mention has also been made of the futility of placing a public health expert in charge of hospital organisation, or a hospital administrator in charge of public health measures. In fact, this was recognised in 1945, when the hospital administrator was induced to accept the new position created for him so that the public health expert could be given the very great powers contained in the Public Health, Food and Drugs, and Places of Public Entertainment Acts. Yet the present legislative amendments are designed to return the powers conferred by the public health legislation to the hospitals expert, who, by definition in the Hospitals Act, need only be a general medical practitioner. The view is often propounded that the head of any department does not have to be a person with special technical or professional knowledge, because under our system of civil service organisation and tradition, professional or technical officers are always at hand to give any required advice. I suggest that this is probably correct when a lay head with many years of civil service experience behind him is in the seat of authority. However, when the Permanent Head of the Department of Health Services can be any general medical practitioner with no civil service experience whatever, and certainly no training in administration, consultation with advisors before making a decision would probably be the last thing to enter his head. In fact, my short experience of working with medical men has convinced me that unless they have spent many years in civil administration, they are a constant source of worry to their lay subordinates because of the continued repercussions of snap decisions made in defiance of good advice, precedents, and the legislative framework within which they are supposed to operate. This experience leads me to the conclusion

that a Permanent Head of the type defined in the Hospitals Act would seldom be prepared to delegate many of his powers, and even if he did so by written instrument, would all too often fall to the temptation to interfere in the work of his delegate, and to proffer advice on subjects that he knew little about, merely to maintain his authority. The other serious aspect of the proposal to vest all power in a Hospital Administrator is the Permanent Head's ability to control the purse strings of his department. Taking into account the widely differing philosophies of the curative and preventive factions in the medical profession, is it not logical to assume that to give all power to one side or the other is to ensure the supremacy of one and the decay of the other? From 1918 until 1935, the Department's functions were mostly preventive as a result of having, firstly, a succession of public health experts as Departmental Heads, followed by a layman who had gained all his experience under these men. However, the period from 1935 onwards saw a very significant increase in curative services, due in no small measure no doubt, to the influence of the hospital administrator who was Permanent Head until 1945. In the years since 1945 there has continued to be a significant increase in curative services, but necessary preventive services have also slowly expanded. It is as well to remember that since 1951, when the hospitals Director was made the Permanent Head, the other Directors have retained their statutory powers, and these powers have definitely put a brake on the possible decay into which the preventive work would have fallen if the logical outlook of a hospital administrator could have been given full rein. If the present proposals succeed in passing through Parliament, however, there will be no checks or balances (with apologies to Montesquieu) available, and the Permanent Head, whoever he might be in future, will undoubtedly exercise his prerogative to advise the Minister to reduce the financial

allocation to preventive work and divert the saving to his own specialty. Of course, the amount of loan funds available would control the hospital building programme, but the staff of the Hospitals Division would no doubt increase rapidly at the expense of the preventive services. If the Permanent Head did not have a Division of his own to look after, some slight improvement would be made. However, as I have said before, a Medical Head for the present Department will never be accepted by the Directors because he has to supervise and organise both preventive and curative services of widely differing specialties, whilst he must perforce belong in a general way to one faction himself. This complication, at least, does not arise if a lay Head is appointed.

Relative to the discussion of the merits and demerits of vesting the powers of the Directors in the Director-General, is the necessity or otherwise of demanding specialist qualifications of the Directors. Under existing legislation, none are required for the Directors of Mental Health or Tuberculosis, but the Director of Public Health must be an expert in bacteriological science. In the case of the Director of Tuberculosis, it is impossible for me, as a layman, to know if special qualifications are, in fact, required. It would seem, however, that the person appointed should have specialised in chest diseases of all kinds, although I know of no formal qualifications covering this aspect of medicine. In the case of the Director of Mental Health, where, in addition to his duties as Chairman of the Mental Deficiency Board and Director of the State Psychological Clinic, this officer performs clinical duties for the Courts and the Mental Hospital at Lachlan Park, it is obvious that a trained and experienced Psychiatrist is required. His powers of confinement being so great, a higher qualification in psychiatry is more than ever necessary. It has often been asked why so much power is vested in the office of Director of Public Health, especially

when, as has sometimes happened, this has resulted in defiance of Ministerial instructions of both positive and negative varieties.[16] It might be as well to remember that the powers of Medical Officers of Health in the United Kingdom are very similar to the Director of Public Health in Tasmania. The Local Government Act of 1933 (U.K.) Section 106 states that any Medical Officer of Health or Assistant Medical Officer of Health of any Borough where the population is 50,000 or over must hold the Diploma of Public Health or its equivalent. Since Tasmania has a population of approximately 350,000, and has living within its borders only five members of the medical profession who possess the Diploma of Public Health (not all of them being in practice, and one of them being the present Director), it follows logically that the person charged with the responsibility for the oversight and supervision of Public Health measures throughout the State should have the necessary knowledge to enable him to decide what measures are needed to protect the inhabitants from the ignorant and anti-social actions that always arise when supervision is slack. The English Local Government and Public Health Acts were framed to give unquestioned authority to Medical Officers of Health, so that they would be able to operate without any restriction from their political masters, the Borough and County Councils. The intention was, no doubt, to separate any public health decision (which might be extremely unpopular in certain areas where votes might be needed at the next election) from political influence. If we forget for a moment our legitimate pride in our home State of Tasmania, and compare our population to that of many English County Authorities, we find that the State Parliament could be likened in many ways to a County Council. As with any English Local Authority, the State coffers are replenished at intervals by a benign Central Government; it raises very little of its revenue itself, and its population is no greater, though more widely scattered. With this in mind, I suggest that the Director

of Public Health could be likened to a Senior Medical Officer of Health in England, and as such, he also must be free from the petty restrictions likely to be imposed on certain of his more unpopular actions by his political masters. In effect, politicians could not be expected to take the risk of making unpopular decisions, and it is therefore better to give the necessary authority to the Director, who can always be the scapegoat if anything goes radically wrong. To give this power to a hospital administrator, because he happens to be the Permanent Head of the Department, is akin to the appointment of a mining engineer to a building construction job. He might be able to do it, but would be out of his depth for most of the time.

4. The necessity for separating the hospitals administration from a department designed to deal mainly with preventive measures was recognised in 1949. The then Public Service Commissioner did, in fact, have discussions with senior officers in Sydney and Melbourne with the idea of advising the Government in the matter. However, headstrong political action, with its attendent publicity, presented the Commissioner with a "fait accompli", and the opportunity to consider objectively a separate organisation for the Hospitals and Medical Services of the State was lost.

If all the Divisions (including the Hospitals Division) enjoyed the same status, and all Directors could thrash out their policies with the Minister, including the vexed questions of budgetting and appropriation, then there would be little cause for friction between the Directors and the Permanent Head. However, as the Government's interest in the expansion of hospital building and facilities resulted in the appointment of the Director of the Hospitals Division to the position of Permanent Head, friction and frustration has been the order of the day ever since. The argument that the importance to the Government of the Hospital building programme made it necessary for the Director of the Hospitals

Division to be made the Permanent Head supports my theme throughout this dissertation that the powers of the subordinate Directors are curbed significantly by the very fact of their subordination to a Permanent Head with no responsibility (and therefore little sympathy) under their enabling Statutes. The reasons against the Permanent Head being given this statutory responsibility have been given at some length already, and the confident expectation that Parliament will never agree to a non-specialist medical practitioner or a layman being given these powers makes it a waste of time to explore the matter further. This seems to be the time, therefore, when some thought could be given to the possibility of creating a separate Hospitals Organisation.

The most obvious benefit to be derived from such a separation would be the ability of the Head to concentrate his entire energies on the activities of his specialty. This point seems to have been overlooked in 1951, when it was decided to make the Director of the Hospitals Division also function as the Permanent Head of the Department. I suggest that the Government has never had the full value for its money since that re-organisation. The Permanent Head of the Department of Health Services has had to be a "Jack of all Trades", and consequently has not been able to devote possibly more than half his time to the administration of the curative services. During the other half, he has become bogged down with a mass of detailed work covering all aspects of the Department's functions and organisation, much of it resulting from the doubts, arguments, and open conflicts thrown up by the improvised legislative framework under which it operates. The separation of the Hospital and Medical Services Division from the rest of the Department would therefore provide the benefits of a ull concentration of effort on the one job. Whether this eparate organisation should be a Commission as in New South ales and Victoria, or a Public Service Department, matters little. see no reason why it should not be possible to operate it as a partment, and in this case, it would probably have to have a

medical practitioner as Permanent Head. Co-ordination with the other health services would be no harder to achieve than under the present system, and Parliament would have the benefit of knowing just how much money was being spent on the hospitals and medical services.

The main difficulty with this scheme would be the problem of what to do with that portion of the present Department remaining after the separation of the hospital services. If the Divisions of Public Health, Tuberculosis, and Mental Health were again placed under a Co-ordinating Director or Director-General, who would have to become the Permanent Head, the same problems as now exist would be perpetuated. If the position of Director of Public Health (as the one having the widest ramifications and the greatest powers, and therefore needing the greatest freedom of operation) was designated as that of Permanent Head, similar problems would still exist under the present legislative framework. However, it would seem quite logical to place the Division of Tuberculosis under the Public Health "wing", as that Division's activities are simply a portion of general public health work, (more will be said on this under No. 5). The Division of Mental Health would pose a problem. It could be said that its work, like that of the Tuberculosis Division, forms part of the general framework of public health work. However, it is a specialised clinical unit in many ways,[17] and as such it needs a psychiatrist at its head. It also controls the large mental hospital at Lachlan Park, and the question could be posed, as in the case of the tuberculosis sanatoria, as to whether the Hospitals Authority should not take over these institutions because of its specialised knowledge of hospital management. It seems to be recognised, at least in New South Wales, Victoria, and Western Australia, that the problem of the mentally ill is not one for general hospitals, and in those States, the mental hospitals are outside the jurisdiction of the general hospitals organisation. It seems, therefore, that the

Division of Mental Health would have to remain untouched by these suggested changes, and if so, there would be no improvement on the present arrangements if it had to function as a portion of a Department of Public Health. A Director with Statutory powers cannot operate freely under a Permanent Head with none. The present system of co-ordination by subordination will never work smoothly, and must never be tried again. Of course, amending legislation could be drafted to vest all the powers of the Director of Mental Health in the Director of Public Health. This would certainly give the new Permanent Head the power needed to administer his new Department, but again, would cause a loss of efficiency by forcing the Head to devote more of his time to administration, and less to his general public health functions. There could be no question of giving the new Head the powers of the Director of Tuberculosis, as this would contravene the Commonwealth-State Agreement; so even if Mental Health became as one with the new Department, there would always have to be the Tuberculosis Division, swinging on the sidelines by a nebulous thread because of its financial independence. In any case, it is doubtful if Parliament would agree to the transfer of the powers of the Director of Mental Health to any medical practitioner not in possession of psychiatric qualifications, and this would seem to rule out any re-organisation of that kind.

As the problem of the efficient working of the Divisions of Public Health, Tuberculosis, and Mental Health in one organisation following the separation of the Hospitals Division appear incapable of solution in a manner any better than the present system, it is now time to consider an alternative arrangement.

5. In No. 4 it was argued that the separation of the Hospitals Division from the present departmental organisation would have the effect of relieving the Hospitals Director of the twin burden of administering the Hospitals Act and devoting a large part of his time to the general administration of the whole Department. As no obvious remedy for the disorganisation of the

remainder of the Department presented itself, perhaps it would be as well to consider the advisability of creating a number of new Departments, all having specialised health functions.

Let us assume, therefore, that the Hospitals Division becomes a new Department. We now have to decide on a plan for further separation, with the object of creating the least number of separate organisations which will enable the health services of the State to function in an efficient and economical manner.

An obvious choice for easy and efficient separation is the Division of Mental Health. As mentioned previously, the prevention and care of mental illness is a specialised operation, demanding qualifications in psychiatry of the person in whose charge its administration is placed. As the Director is already responsible for the supervision of the Mental Hospital at Lachlan Park, and a number of other institutions in other parts of the State, it is anticipated that this control would be continued if the Division became a Department in its own right. Criticism of the growing number of separate departments caused by the increasing complexity of Government responsibilities is often levelled on the grounds that the birth of new departments immediately gives rise to the demand for increased staffs because of the unavoidable duplication of duties in certain sections. If the present Division of Mental Health were made a separate department, however, there would be no need for any increase in staff whatsoever. The administrative section already existing at Lachlan Park Hospital provides the usual services (accounts, pay, equipment, etc.) for a staff of approximately 340, all under the Public Service Act. As the headquarters staff of the Division is so few in number it seems reasonable to suppose that the Lachlan Park administration could very easily cope with the additional responsibility of only fifteen more persons. Of course, the geographical location of the Mental

Hospital poses some problems, but as there is a constant interchange of mail, officers, and telephone contact between the Hospital and the Division, there seems to be no insurmountable obstacle to the Hobart staff receiving their pay from New Norfolk, or for Hobart staffing problems or equipment problems to be solved from the same place. In other words, the Hobart staff could be given all the services provided by so many departments for their regional offices, and these services could be provided very easily, because of the short distance between the two places. It seems reasonable to suppose, therefore, that the creation of a Department of Mental Health could be accomplished with no increase in staff.

The Divisions of Tuberculosis and Public Health must now be considered. The functions of both Divisions are preventive in nature, although the Division of Tuberculosis, through its "Chest Hospitals", provides curative services as well. However, much of this curative work is allied to prevention, in that during a patient's stay in hospital, the disease is prevented from being broadcast throughout the community; and after a patient is cured, there is no longer any danger of it being infectious. The whole purpose of the Federal Government's assistance in this sphere is to prevent the spreading of the disease, and thereby to control the incidence. The Tuberculosis Act is a Public Health Act in miniature. In fact, it provides many, though not all, of the powers vested in the Director of Public Health under the provisions of the Public Health Act; but these powers are given to the Director of Tuberculosis for the control of one infectious disease only, whereas the Public Health Act, apart from its other wide ramifications, covers all other proclaimed infectious diseases. With such similarity existing between their functions, therefore, surely it would be logical to combine both organisations. Under the terms of the Commonwealth-State Agreement, the Director of Tuberculosis must devote his whole time to the exercise of his duties, and his title must remain unchanged.

If his Division had to be absorbed within the framework of a Department of Public Health, therefore, the present Director and his successors would have to retain all the statutory powers now contained in the Tuberculosis Act. At first sight, this might appear to be a continuation of the present difficulties experienced within the framework of the Department of Health Services. However, as already mentioned, the Division of Tuberculosis enjoys a degree of autonomy within the Department which is the envy of the other two Divisions, and this could be expected to continue. There is never any great argument between the Division of Tuberculosis and the present departmental administration because it is realised by all that the Commonwealth Government will be paying most of the bills. In this one instance, therefore, the subordination of a Director with Statutory powers to a Permanent Head without any, can work smoothly, and could be expected to do so under the suggested re-arrangement.

Another factor which would effect the economy of this amalgamation is the absence of any need for additional staff to be employed. It has been seen how the Division of Mental Health could obtain all its accounting and administrative services from the existing staff at Lachlan Park. A new Department of Public Health formed by amalgamating the Divisions of Tuberculosis and Public Health would have the advantage of the services already existing within the Tuberculosis Division's framework. The present Division employs its own accounting staff and pays its own salaries. Although this keeps things tidy for purposes of claiming the Commonwealth subsidy, there seems to be no good reason why the Tuberculosis Accounts could not be kept separate from the Public Health Accounts if the two organisations were combined. As the staff of the Division of Public Health numbers nearly 140, it would appear that some increase in the accounting staff of the Tuberculosis Section would be necessary. The Public Health Division possesses no staff of this type, so the additional

members would have to be taken from the present departmental accounting staff. This should be quite feasible, as the present accounting staff numbers eight, and this provides services for all Divisions. It is quite probable that only four of these officers would be required by the Hospitals Organisation, and the other four could therefore be allotted to the new Department of Public Health to work with the present Tuberculosis Division Accounts Section.

The results of these moves, therefore, would be three separate departments, Mental Health, Public Health, and Hospitals, each with a professional Head. There need be no increase in the number of staff employed overall, and costs should not increase thereby. Co-ordination on policy matters would be secured through the Minister, who would also decide, subject to Cabinet's direction, just how much money was to be allocated to each of the three departments administered by him. In this way, there would be none of the present frustrations experienced by the Directors of Public and Mental Health when their estimates are slashed each year without any consultation. The three Permanent Heads would all have the right of access to their Minister, and they could therefore proffer first-hand advice, and be responsible for arguing their own cases. No doubt the Hospitals Department would still retain the "lion's share" of loan monies, and funds from Consolidated Revenue. This is only to be expected when one considers the political gain to be obtained from the building of a modern hospital, and compares this with the accusation of political infamy caused by a rise in rates in a certain district following the insistance by the public health authority, on the provision of a modern sewerage scheme.[18] Nevertheless, the Heads of the three departments would be free to run their own organisations within the limits of Government policy, their budgets, and the legislative framework applicable to each, and because of the separation of items in the Appropriation Act, Parliament (and the ordinary people) would

then know what was being spent on the various curative and preventive services. This information is now hidden under a mass of general headings, which bear a relationship in most cases only to the expenditure on a certain service throughout the Department. In this way, it is impossible for anyone to discover, for example, the annual cost to the State of the operations of the Mental Health Division. Parliament has a right to know these things, and the formation of three departments would ensure that this information was presented in an intelligible manner.

6. This final suggestion for the re-organisation of the Health Services of the State is put forward as a practical attempt to secure economy, efficiency, and co-ordination within the limits of one organisation, and to remove the existing frustrations and waste of professional time on what should be matters for administrative, rather than medical, staff. It should also overcome the objection of Parliament to the vesting of all the powers of the present Directors in the hands of one man.

The suggestion is that a Health Commission should be established in Tasmania, where operations are possibly on too small a scale to justify separate organisations as outlined in No. 5. This Commission would consist of a Hospitals Member, a Public Health Member, a Mental Health Member, and a Tuberculosis Member, who would all require special qualifications and experience to make them eligible for appointment. Thus, there would be four medical members, all experts in their own fields. The fifth member would be a layman of proved administrative ability, who would be appointed as the Administrative Member and Chairman of the Commission.

To enable this type of organisation to succeed, amending legislation would be necessary to vest all the statutory powers of the three Directors and the Director-General in the Commission, as a Body Corporate. Provision could be made in the

Bill to allow a delegation of power in specific Statutes to specified members. This would be desirable to allow any member to make on-the-spot decisions concerning his specialty, without having to wait for a meeting of the Commission to decide the issue. For the purposes of the Public Service Act, the Commission would be recognised as the Permanent Head of the Health Department, in much the same way as the Rivers and Water Supply Commission and the Forestry Commission are recognised and provided for. With a delegation of powers to each medical member, there should be little need for long and frequent meetings, thus leaving the medical experts free to concentrate on their principle responsibilities. The administration of the Department as a whole would be the responsibility of the Chairman, and under his direct control would be an administrative staff capable of providing a complete range of services to all sections. Thus, instead of having, for example, an Administrative Officer in each Division, as in the existing establishment, these officers could be replaced by one Officer working under the direction of the Chairman in a central Administrative Division. When one considers that Departments in the United Kingdom with establishments of four thousand officers and more provide centralised administrative services, any arguments that it cannot be done in Tasmania can be dismissed as frivolous. A major aim of this type of organisation would be to reduce as much as possible the amount of pure administration done by the medical members, so that they could be freed to devote most of their energies to their medical functions. This could be achieved by centralised services, which would also lead to a reduction in the number of administrative and accounting staff, now scattered throughout the Department. The existing administration at Lachlan Park would have to be retained, however, together with those of the two chest hospitals and St. John's Park, but these administrative staffs would form part of the Administrative Division in the care of the Chairman.

This type of organisation would provide a curb to any Director (or "Commissioner") who abused his delegated powers, because the delegation would be revocable at any time at the will of the Commission. This threat of immediate revocability would therefore hang like the sword of Damacles over the heads of all Directors. On the other hand, the system, being fair to all Directors, would be a great improvement on the present one where any Director subordinate to the Director-General could have his hands fettered arbitrarily by the Permanent Head, and could meet with grave disadvantages in trying to put his views before his Minister. It has been said that if the Agricultural Bank can function smoothly by having Subordinate Directors with statutory powers, there is no reason why the present Department of Health Services cannot. What has been overlooked in that contention is the fact that the Director of Land Settlement is a member of the Agricultural Bank Board, and therefore has some voice in the activities of the whole department, together with the right to argue his case personally, and to vote with the policy-making body. The Director of Housing is, and always has been, similarly empowered, even when that office was a subordinate one within the Bank organisation, and not the separate Department it is today. A Health Commission would provide the same opportunities to the medical heads of the Divisions, and should therefore lead to a better spirit of co-operation throughout the organisation. Even if a Director is outvoted on a particular issue, he will have had his say and cast his vote, whereas the existing situation gives him no such satisfaction. It would also provide the opportunity for any contentious matter on which voting happened to be equally divided (the Chairman would have a deliberative and a casting vote) to be submitted to the Minister for decision, thereby ensuring that in matters of this kind, Government policy would prevail.

APPENDICES.

(Page 3) First Report by Chief Health Officer covering period 6th January - 30th June, 1904, Page 2, Section I.

(Page 4) Ibid, Page 3, Section III.

(Page 5) Annual Report of Chief Health Officer 1907 - 1908, Page 8, Section IX.

(Page 6) (a) Industrial functions were returned to the Department of Public Health in 1930.

(b) Health Education was made the responsibility of Departmental Headquarters in 1951, instead of being placed, because of its completely preventive nature, within the framework of the Division of Public Health.

(c) Similarly, in 1958, the staff of the National Fitness Council was attached to Departmental Headquarters. As a body with similar aims to that of the Health Education Council, this should also have been attached to the Division of Public Health.

(Page 10) Tasmania now sends the Director-General to National Health and Medical Research Council meetings. This Officer is also Tasmania's representative on the Public Health Committee of the National Health and Medical Research Council, whose meetings are always held immediately after full Council meetings. It has been said that this single representation is an economy measure, i.e. it saves the necessity to pay the fares of two officers from Hobart to whichever Capital City is the venue of the meetings. As these fares are paid by the Federal Government, I fail to see why the State should worry about the saving of one air fare when this prevents effective and informed representation on an expert committee, whose

views are expected to bind the States on Public Health Policy. In fact, if the Tasmanian representative requested it, immediate permission would be forthcoming from the full Council for the public health expert, to sit on the Public Health Committee. As this has not been done, the Director of Public Health has notified the Commonwealth Health Department that he cannot be bound by decisions of the Public Health Committee. This statement has caused some heartburn within the Department, but to my mind is justified. For example, Tasmania's representative has to vote on motions which, if they become resolutions, may bind the State to a course of action in direct contradiction to the intention of a section of the Public Health Act, under which he has no responsibility.

6. (Page 10) A Bill to amend the Public Health Act. Annual Report of Secretary for Public Health for 1927, Page 7.

7. (Page 12)

Year	Total Visits	Child Welfare Visits
1928	10,861	2,681
1929	13,455	3,211
1930	7,829	4,790
1931	11,432	5,702
1932	10,532	6,180

8. (Page 17) The Places of Public Entertainment Act and Food and Drugs Act are included in this category, in addition to the Public Health Act.

9. (Page 19) The Directors of Public Health, Mental Health and Hospital and Medical Services.

0. (Page 20) Portion of communication from the Minister for Health to a Ministerial colleague written in February, 1959. "..... a member of the British Medical Association, of whom, quite frankly, very few, including myself, had any training in public health ....."

11. (Page 25) Acts administered in the Department of Health Services.

Headquarters

Hospitals Act 1918.
Nurses' Registration Act 1952.
Tasmanian Auxiliary Nursing Service Act 1949.
Medical Act 1959.
Tasmanian Cancer Committee Act 1937.
Queen Victoria Maternity Hospital Act 1952.
Meercroft Hospital Agreement Act 1947.
New Town Mothercraft Home Agreement Act 1949.
Commonwealth & State Hospitals Benefits Agreement Act 1945.
Physiotherapists Registration Act 1951.
Cecilia Button Memorial Hospital Agreement Act 1946.
Tasmanian Sanatorium Act 1950.
Meercroft Hospital Act 1939.
Mental Institution Benefit (agreement) Act 1949.
Mothercraft Nurses' Registration Act 1947.
Anatomy Act 1953.
Dentists Act 1919.
Opticians Act.
Southern Tasmanian Ambulance Transport Service Act.
Northern Ambulance Act.
Meercroft Home for the Aged Act.
Munnew Bequest (Application of Monies) Act.
Public Welfare Institutions Welfare Act.
Lachlan Park (Sewerage) Agreement Act.
Crippled Childrens' Hospital (Agreements) Act.
Psychopathic Hospital (Golf Course) Act.

Division of Public Health

Public Health Act 1935.
Food and Drugs Act 1910.
Places of Public Entertainment Act 1917.
Cremation Act 1934.
Poisons Act.
Pharmacy Act.
Radioactive Substances Act 1953.

Division of Mental Health.

Mental Hospitals Act 1885.
Mental Deficiency Act 1920.
Sexual Offences Act 1951.

Division of Tuberculosis

Tuberculosis Act 1949.
Tuberculosis (Campaign Arrangements) Act 1950.

12. (Page 27) See "The Schedule" attached to the Tuberculosis (Campaign Arrangements) Act, 1950.

13. (Page 28) No cause for argument exists when the annual estimates for the Tuberculosis Division are being considered, provided the Director can assure the Director-General that the Commonwealth Minister for Health has approved of the expenditure. If the Commonwealth Minister has so approved, then

reimbursement by the Commonwealth Government is automatic.

(Page 32) Section 19, Sub-section (1) of the Public Health Act 1935.

"In addition to the powers conferred by Section 18 for the purpose of more effectually checking or preventing the spread of any dangerous infectious disease within or with respect to a district, or any part thereof, the Director may:-

I Declare any land, building, or thing to be insanitary, and may forbid any insanitary building to be used or occupied for any purpose:

II Cause any insanitary building to be pulled down, and the timber and other materials thereof to be destroyed or otherwise disposed of as he thinks fit:

III Cause insanitary or infected things to be destroyed or otherwise disposed of as he thinks fit:

IV Cause animals, including insects, infected, or suspected of being or liable to be infected or to convey infection, to be destroyed in such manner as he thinks fit:

V Require persons to report themselves or submit themselves for medical examination at specified times and places, and, in the case of patients or contacts, may require them to submit to such prophylactic or preventive or curative treatment as he deems advisable in their own interests or for the public welfare:

VI For the public welfare isolate any part of Tasmania, and may require persons, places, buildings, ships, animals, and things to be isolated, quarantined, or disinfected as he thinks fit:

VII Restrict or regulate the use of, or close any building or place of public resort, or place to which the public or sections of the public have access, or where people congregate, and may make and issue any order necessary for the purpose:

VIII Forbid persons, ships, animals, or things to come or be brought to any port or place in the health district from any port or place which is, or is supposed to be, infected with any dangerous infectious disease:

IX Forbid persons to leave the health district or the place in which they are isolated or quarantined until they have been medically examined and found to be free from dangerous infectious disease, and may enforce the return of any person who unlawfully leaves such district or place:

X Forbid the removal of ships, animals, or things from the health district, or from one port or part thereof to another, or from the place where they are isolated or quarantined, until they have been examined and found to be free from infection:

XI Cause vessels and ships to be fumigated, and may require or undertake the destruction of rats in vessels and ships, and may recover from the owner of or agent for any vessel or ship all reasonable expenses incurred in the exercise of such powers:

XII Cause places, buildings, animals, and things to be inspected and examined:

XIII Require animals, or any specified description thereof, to be kept only in specified parts of the health district, or not to be kept at all in the health district, or within a specified distance outside the boundaries thereof:

XIV Order owners and occupiers to destroy all rodents on their premises:

XV Require the effectual cleansing of streets and public ways and places by those entrusted by law with the care and management thereof:

XVI Require watercourses and the sources of water supply to be purified:

XVII Forbid the discharge of sewage, drainage, or insanitary matter of any description into any water-course, stream, lake, or source of water supply, whether situate in the health district or outside the same:

XVIII Cause to be established such hospitals or places of isolation as may be necessary:

XIX With the approval of the Minister, use or authorise the local authority to use, as a temporary site for a special hospital or place of isolation or quarantine ground, any reserve or endowment suitable for the purpose, whether the same is situate in the health district or outside the same, not-withstanding that such use may conflict with any trusts, enactment, or condition affecting the reserve or endowment:

XX Prohibit, limit, restrict, or regulate traffic within, to, from, or as to any part of Tasmania."

5. (Page 43) The Sexual Offences Act 1951 has the effect of making the Director of Mental Health a servant of the Courts.

6. (Page 44) A recent instruction from the Minister to remove a certain disease from the proclaimed list of infectious diseases was ignored by the Director of Public Health, after consultation with his public health colleagues in the other States, the Emeritus Professor of Public Health in the University of London, and the recently retired Chief Medical Officer of the British Ministry of Health. In reply to the Minister, the Director of Public Health pointed out that expert opinion was against such a move, which would require his recommendation to the Governor under Section 14 of the Public Health Act, and this he was not prepared to do.

(Page 47) As Director of the State Psychological Clinic, the Director of Mental Health has to examine persons referred to the Clinic by the Mental Deficiency Board.

(Page 52) Curative medicine (hospitalisation and treatment) is now so expensive as to be financially impossible for

many people. The average daily cost per occupied bed in Tasmanian Public Hospitals during 1957/58 was £4. 19. 4d. The socialisation of medicine has the effect of transfering these costs to the taxpayer, with the obvious result. The Tasmanian Governments financial contribution to the Public Hospitals in 1957/58 was £1,697,373, i.e. 64.8% of total costs. Patients' fees brought in a further £634,016, or 24% of total costs. Commonwealth aid amounted to £282,043, or 10.7% of total costs. In spite of health insurance, therefore, the taxpayer contributed £1,979,416 to the hospital expenses of Tasmania during 1957/58. Surely the stage has now been reached when serious efforts should be made in the field of prevention in an effort to build up a healthy Nation that will not require so many hospitals. The Health Education and National Fitness Councils were formed for this purpose, and therefore belong logically to a preventive organisation, i.e., the Division of Public Health.