communicable diseases, and in an era when the biological sciences were the least developed of the physical sciences. Its needs for assistance were minimal and related to analytical chemistry for water supplies and sewerage, complemented after 1896 by microbiology in discharging its functions of supervision of nuisances and the control of quarantine and infectious diseases. More typical of the board's divisional activities was the establishment of two Health Districts in 1898 servicing the Hunter River and Metropolitan areas. In this epoch the responsibility and loyalty of its Divisions was to the Board of Health as an independent Statutory Authority and not to the public service generally.

The second epoch was also of brief duration from 1904 to 1913, and coincided with a more restrictive role of the Board of Health and a wider area of responsibility of the Chief Medical Officer of the Government. This was illustrated in the transfer of the functions of the Board from Treasury to the Colonial Secretary's Department and the upgrading of the status of the Chief Medical Officer. It was a transitional period wherein new Divisions were appearing, under the control of the Chief Medical Officer, although on some occasions, as with the Bureau of Microbiology and the Dental Board, they were within the organisation of the Colonial Secretary's Department but outside the administration of the Chief Medical Officer. The incorporation of Federation in 1901 was also influential in a further disturbance of function when port health services and quarantine were transferred to the Commonwealth in 1913. Likewise in 1913 control of abattoirs and supervision of the meat industry were transferred from the Board of Health to become a separate section of the Colonial Secretary's Department. The Chief Medical Officer controlled an expanding health service which was loosely organised.

The final epoch extended from 1913 to 1973 consequent upon the establishment of the Ministry of Health and the position of Director-General of Public Health. The mechanism now existed to aggregate the health components within the Colonial Secretary's Department into an organisation catering largely for public health and lunacy, but providing also for administrative control of other services, such as the Pharmacy, Medical and Dental Boards, which did

Public health administration: Health Districts, Divisions and Branches

The development of public health administration is reflected in the growth of Public Health Divisions and Branches, each catering for specific components of service. Historically their growth covers three epochs corresponding with major changes in organisation. The first was of short duration from 1882 to 1904 when the executive authority of the Board of Health was singular and unchallenged. The board was established shortly after Pasteur had demonstrated the microbial theory of

not fit functionally within either of the two main streams. The Board of Health was now restricted to the exercise of a limited executive function and had no immediate responsibility for services flowing from such function. Lines of communication and responsibility were well defined and the loyalty and control of Public Health Divisions was to the Director-General of Public Health by virtue of his position in the public service. The responsibility for Health Districts was never wholly clarified although the Board of Health in its executive capacity was still influential. There was no administrative conflict as the Director-General accepted this position proudly and with loyalty to the board. It was during this period, and especially after World War II, that there were explosive advances in medical technology and science. The capacity of the Director-General was inadequate to the task of directing and coordinating increasing demands for public health services of increasing complexity. The need for expertise and specialisation was met by an increase in scientific and service Divisions and Branches. The development of Divisions and Branches will be discussed under two headings: Health Districts and Public Health Divisions.

Health Districts

The *Public Health Act of 1896* became operative on 1 January 1897. The Act was practically a local government measure, its administration being placed in the hands of municipal councils of municipalities, and, in unincorporated areas, such Officers of Police as were authorised by the Board of Health. The relationship of the Board of Health is 'that of a supervisory authority; though where a local authority fails to exercise any powers or perform any duties conferred or imposed on it, the Board of Health may exercise such power if of opinion that failure on the part of the local authority is likely to endanger the public health'. (Section 16)(104): Section 10 provided for the appointment by the Governor of Medical Officers of Health, and the first two so appointed in 1898 were Dr Robert Dick, M.B., Ch.M.(Syd), D.P.H.(Camb), to the Hunter River Combined Districts, and Dr W.G. Armstrong, M.B.(Syd), D.P.H.(Camb) to the Metropolitan Combined Districts.* At the date of establishment, in Newcastle there was a total population of approximately 66,000 throughout 19 local authority districts, and in the Metropolitan District 450,000 approximately extending to Parramatta in the west, Vaucluse in the east, Hurstville in the south and Willoughby and Hunter's Hill in the north. It is interesting that such suburbs as Ryde, Bankstown, Canterbury, Kogarah and Lane Cove were classified as Rural Districts.

The position of Deputy Director-General was created in 1942 to relieve Dr E.S. Morris of the administration of public health services, so that he could concentrate on the obligations of his dual appointment as Inspector General of Mental Hospitals.

The initial Health Districts were based on the English model and essentially were detached units of staff, under a Medical Officer of Health, to provide professional expertise and inspectorial assistance to local government. They were constrained within the boundaries of a number of local government areas, and both boundaries and Medical Officers of Health were approved by the Board of Health. The provisions of the first *Public Health Act*, and the principles on which health districts were established in 1898, remained unchanged in theory and application until the abolition of the Board of Health as an executive health authority by the *Health Commission of NSW Act of 1972.*

The criteria were explained to me by Dr H.G. Wallace. The district to be proclaimed should have a population density which would warrant the employment of a Medical Officer of Health, preferably 100,000 or more. The area involved should be compact and contained within local government boundaries so as not to hinder personal communication between the Medical Officer of Health and the local authorities. A rough guide was that no portion of the boundary should be more than one day's travel from the centre of the health district. Although this was satisfactory in the days of horse and rail, or early motor car and rail, it was still the guideline applied by the Board of Health when the Riverina Health District was under consideration in 1965.

* They were known as Combined Health Districts because they were the combination of a number of local government Districts. Later they were known as Metropolitan Health District and Newcastle Health District.

Additional Health Districts were established whenever the Director-General of Public Health considered that the population and needs of a country region warranted a full time administration. From the 1960s there was some pressure from the Regional Planning Authority of NSW to proclaim Health Districts to coincide with regional boundaries. Whenever possible conformity was reached, bearing in mind that Health Districts had to relate to local government boundaries, which was not an obligation imposed upon regional planning.

From 1968 attempts were made to coordinate district public health administration with public hospitals by associating the District Officer of the Hospitals Commission with the Medical Officer of Health in the same office complex. Although it could not be claimed that this experiment was successful it laid the basis on which Health Regions were structured under the *Health Commission Act of 1972*.

The Health Districts in NSW, and the years of their incorporation by the board of Health were:

The Hunter River Combined Health District 1898
The Metropolitan Combined Health District 1898*
The Broken Hill Health District 1916
The South Coast Health District 1947
The Richmond-Tweed Health District 1947
The Mitchell(Western) Health District 1947
The North Western Health District 1962
The Riverina Health District 1965
The Western Metropolitan Health District 1969

The far western area of the State, largely inclusive of the Western Lands Division, was never proclaimed a Health District because of its sparse population and size. From 1963 I, unofficially, provided service to this area working in conjunction with bordering Medical Officers of Health and their staffs.

The local government Municipalities and Shires included in the Health Districts are given in Appendix 6, together with the Medical Officers of Health who were appointed to administer these Districts.

Medical Officers of Health

The Medical Officer appointed had to be a doctor experienced in sanitation and preventive medicine and this was tested by the qualification of the Diploma of Public Health. This Diploma has always remained an essential qualification for appointment and accreditation by the Board of Health. In the twilight of the last quarter of the nineteenth century and the first quarter of the twentieth century the only opportunity to obtain this diploma was to attend a course in England. As a consequence the number of qualified persons in NSW was minimal and this undoubtedly had an influence on the delay in establishing more Health Districts until after World War II. When facilities at the School of Public Health and Tropical Medicine were available for the Diploma of Public Health at Sydney University, the Department of Public Health supported this institution with postgraduate scholarships. After representations by Dr E.S. Morris, Director-General of Public Health, to the then Chairman of the Public Service Board, Mr Wallace Wurth, a policy was established that at least one Medical Officer from the Department would be seconded for one year to undertake the Diploma at Government expense. Dr Morris' representations were very vigorous and forthright including a caustic description of the salaries and incentives to join the Department, as 'attracting only drug addicts or alcoholics and usually combinations of both'. Wallace Wurth, who was totally absorbed in the reputation of his public servants, agreed to a minor hierarchical system whereby doctors obtaining the Diploma of Public Health would be promoted to Assistant Medical Officers of Health, with a line of succession to Medical Officer of Health and theoretically to Deputy Director-General and Director-General of Public Health. The two Health Districts of Newcastle and Metropolitan remained senior in salary and status compared to others throughout the State, with the Metropolitan Medical Officer of Health most senior with immediate expectation of next appointment to Deputy Director-General of Public Health.

* A plan was prepared in 1968 to divide the Metropolitan Health Districts into the Western, Southern, Northern and Central Metropolitan Districts Only one such, the Western, had been established by 1972.

The role of Medical Officer of Health and his relationship vis-a-vis to the Department of Public Health, the Board of Health and the Local Government Authority has been confused and at times contentious. There was no doubt that the first appointments were intended to occupy an independent position to the board of Health, although they were permanent public servants and their salaries paid through the Health Department of the Colonial Secretary's Department. Dr Armstrong describes their duties and responsibilities in 1899, and this description is a fair summary of the position as existed certainly until 1913 and probably later:

> "The medical officers of health are not officers of the board of Health, but occupy a purely municipal position. Their duties are, in brief, to advise the local authorities of their districts in all matters affecting the public health, and on all sanitary points involved in the action of local authorities; to keep themselves informed respecting all influences affecting, or threatening to affect, injuriously the health of their districts; and to inquire into the cause, origin and distribution of disease. They are required to make an annual report for each year, and to make additional reports to local authorities on any sanitary matters when requested to do so by the local authorities, or without such request if the medical officer of health considers such report desirable. The local authorities are required by law to furnish copies of all reports received from the Medical Officer of Health to the Board of Health (105)."

The two Health Districts of Newcastle and Metropolitan remained senior in salary and status compared to others throughout the State...

The appointment of the first Minister of Health and Director-General of Public Health in 1913 was a period of reorganisation and audit of public health services. There was now a professional leader with personal responsibility for public health administration as distinct from his executive role as President of the Board of Health. Likewise, a career service of status and merit was now available within which Medical Officers, and particularly Medical Officers of Health, could aspire to senior positions. The Medical Officers of Health saw themselves as senior officers of this system and their loyalties were directed, and encouraged to extend, towards the Director-General of Public Health and the Public Health Department rather than to local authorities. They were Officers of the Public Health Department and as such regarded as professional experts in public health and infectious diseases within the Department, the public service and the medical profession.

This demand for recognition and acquisition of professional expertise equated with a narrow stream of seniority was ultimately to lead to bitterness between professional groups when the organisational structure and emphasis changed after the formation of the Department of Public Health in 1941. The significance of the Diploma of Public Health was progressively diminished as Scientific Divisions were established and expanded, and other professional post-graduate qualifications were recognised as equal and even superior to that of the Diploma of Public Health in status and promotional prospects. The situation worsened and became embittered as more candidates were selected and recruited direct to undertake the Diploma of Public Health, as much to support the course at the School of Public Health as to satisfy the needs of the Department of Public Health. Consequently Assistant Medical Officers of Health were frustrated and denied promotional prospects by the changed emphasis within the system, and were used as professional officers for minor administrative posts rather than as training positions for the self-sufficing positions of Medical Officers of Health.

The degree of resentment can be gauged by my initial appointment to the position of Director of Occupational Health. I was appointed, with the Diploma of Public Health, with a differential salary over other Directors, as was the late Dr Marshall Andrew to the position of Director of Tuberculosis at the same time. It could be said that we were the first two medical practitioners appointed from outside to senior positions external to the stream of Medical Officers of Health. I was surprised, as was Marshall Andrew, as the personal boycott from other professional staff for some months as a mark of disapproval, a reaction which conditioned me to refuse initially the appointment to Deputy Director-General of Public Health in 1952. The reaction was

even more dramatic after this appointment. The Metropolitan Medical Officer of Health resigned, and I was for some years bemused and bewildered by the reaction of my superior, who, inadvertently or otherwise, contained all the administration within his own personal capacity.

Essentially the role and status of Medical Officers of Health was changed by events rather than discrimination, as the impact and consequences of infectious diseases diminished because of scientific advances in medicine, medical technology and therapeutics. This trend was worldwide in Western countries and ultimately was to lead to the disappearance of the prestigious Colonial Medical Service from the British scene.

Sanitary Reports

The *Sanitary Reports* of the Medical Officers of Health provide an interesting panorama over the years of the pattern of disease and social responsibility throughout NSW. The format was set by the first reports from the Hunter River and combined Metropolitan Health Districts, and were confirmed by successive Directors General. Each commenced with a general description of the state of the health throughout the Health District, and were followed in succession by vital statistics; tables of notifiable infectious diseases (with descriptions of local outbreaks); details of sanitary inspections; personal activities of the Medical Officer of Health and his staff; and, miscellaneous involvements. Later, these latter included statistical activities in such public health involvements as pure food inspections, baby health centre workloads and the association of the Medical Officer of Health with other professional and community groups.

Originally the channel of communication was in accordance with the distribution of immediate responsibility, viz to the local authorities concerned and a copy to the Board of Health. After 1913 the order was reversed and the reports were made to the Director-General of Public Health with copies to appropriate local authorities. They formed the basis of the reports of the Director-General of Public Health, who collated the statistics for the State and published his collective comment, as well as the individual regional reports. Although the Medical Officers of Health were required to make an annual report no such responsibility was imposed by law on the Director-General. His reports were published by the device of presentation to the Minister and tabling in Parliament, after which they were printed as documentary proceedings of Parliament. The tale they unfold, and a detailed analysis of the changing pattern of health administration described within their pages will be elaborated elsewhere.

The Health Districts were the first health regions of the State. They were modified on the English model of Local Government responsibility for health to suit the needs of a State with substantially different demographic, social and economic considerata. Despite their vicissitudes they were valid for the time and purpose.

Health and Scientific Divisions and Branches

With the exceptions of the Division of Establishments formed in 1961 and the Division of Health Services Research and Planning in 1970, all health Divisions and Branches of the Department of Public Health were within the ambit of the administration of the Director-General of Public Health, and reported direct to him. They were separate administrative units dedicated to a defined function or purpose. Their annual reports were reproduced and published in the *Annual Report of the Director-General of Public Health,* which was also the vehicle in the first quarter of this century for their scientific publications.

Their formal designations as Branches and Divisions are confusing to the historian, and did not necessarily imply a difference in hierarchical status, or that the lesser was the appendage of the greater. After the 1960s it could be affirmed that Divisions were larger and more technical than Branches, but this distinction was by no means absolute prior to this period. The Government Analyst's Branch was the first technical service to be established by the Board of Health and its name was not altered until it moved its location in 1969 and became the Division of Analytical Laboratories. Similarly, the Government Medical Officer's Branch became the Division of Forensic Medicine when its function changed from a general purpose Branch to a specialist Division. There were no units nominated as Divisions before 1923, after which it became customary to ascribe

the title 'Division' to new units or to existing Branches which developed a specialist function. There was no formality associated with these changes. On occasions Ministerial approval was sought, otherwise there was informal usage of Division for Branch until it became the customary usage and letterheads were changed. Sometimes the consent of the Public Service Board was sought concurrently with a submission for reorganisation.

Two major Divisions were designated as Bureau and Institute, the Bureau of Maternal and Child Health in 1965 and the Institute of Clinical Pathology and Medical Research in 1959. Here there was significance in the variation of title. The Bureau signified the amalgamation of two existing major Divisions, the Division of School Medical Services and the Division of Maternal and Baby Welfare, and a change in function towards comprehensive public health programmes for mother and child. The Institute of Clinical Pathology and Medical Research was so named to emphasise new attributes of teaching and research, superimposed upon the responsibilities of its predecessor, the Microbiological Laboratories. Both variations provided the opportunity to pay differential salaries to attract Directors of note, without infringing industrial principles.

Department of Health
1970

The origin of Divisions and Branches*

Most Divisions and Branches were created to provide a service component to the administration of the Board of Health and subsequently the Director-General of Public Health, or to meet a deficit in medical services which was not provided externally by the medical profession, the general hospitals or voluntary or other agencies. Thus the Board of Health required sanitary inspections to supervise the activities of local authorities and the Sanitation (Health Inspection) Branch was early established. The board needed chemical assays to assist it in its function of protecting water supplies and supervising sewage disposal and other sanitation requirements. The Government Analyst's Branch provided this need and its services were expanded to cater for other Government Departments. For a time it was separated from the board, because of its wide clientele, to become the Bureau of Microbiology. After its return to the Department of Public Health in 1913 it continued to provide an expanded service, primarily to the Department of Public Health and secondarily to other Government Departments in selected areas, as for example Government contract specifications. The Microbiological Laboratories were established after the Board of Health was granted responsibility for the control of infectious diseases. Pathology services were lacking in general hospitals at the turn of the last century, and it filled this void as a central pathology laboratory until the major general hospitals established their own pathology departments. Even to the present day vestiges of this function persist. Its successor, the Institute of Clinical Pathology and Medical Research, provides reference facilities and specialised services to the general hospital system and the medical profession, and a limited histopathology service to rural general hospitals. The Government Medical Officers Branch arose from the responsibilities of the Metropolitan Government Medical Officer in the Colonial Secretary's Department to the City Coroner; to the public service for medical examinations; to the Prisons Department for medical service to gaols; and to the State asylums for admissions through the Hospitals Admissions Depot. After it shed these latter responsibilities, it retained and expanded its responsibilities in forensic medicine, primarily to the City Coroners of Sydney and Newcastle, and secondarily to the State generally at police or coronial request. It became the Division of Forensic Medicine. Likewise, to fulfill needs peculiar to the

* A brief account of the historical development of each Division and Branch is given in Appendix 7.

Department of Public Health, the Division of Health Education, the Medical Examination Centre and the Police Medical Branch were established in 1964 1963 and 1971 respectively.

Some Divisions and Branches were established essentially to service legislation. In this category are the Food Inspection Branch (the *Pure Food Act of 1908*);the Private Hospitals and Rest Homes Branch (the *Private Hospitals Act of 1908*); the Venereal Diseases Branch, later the Division of Epidemiology (the *Venereal Diseases Act of 1918*); the Central Cancer Registry (*the Public Health (Amendment) Act 1970*, Part IIIA Dangerous Diseases; and the Division of Occupational Health and Pollution Control (the *Factory and Shops Act of 1962*, the *Radioactive Substances Act of 1957* and various Pollution Acts).*

The Bureau of Maternal and Child Health and the Division of Dental Services are traditional public health Divisions servicing children and mothers through the school system, child guidance and child health centres, and baby health centres (well baby clinics). The opportunity of these Divisions to provide treatment is limited by the policy that the Department of Public Health will not intrude into active treatment of individuals in competition with private practice. There has been no difficulty with child psychiatry where the Department has historically been the therapeutic agent, but elsewhere the policy is fairly rigidly enforced, and the two Divisions staffed on the basis of a restricted therapeutic role. One offset from the Bureau of Maternal and Child Health was the separation of programmes directed against maternal and perinatal mortality and morbidity in 1969 to a new Division, the Division of Maternal and Perinatal Studies, which services the prestigious Maternal and Perinatal Committee and its publications.

The Divisions and Branches of the Department of Public Health are classified in the report of the Director-General of Public Health for the year 1971 as follows:

Public Health Services

- Health Inspection Branch
- Food Inspection Branch
- Private Hospitals and Rest Homes Branch
- Division of Health Education
- Medical Examination Centre
- Poisons Branch
- Police Medical Branch

Preventive Medicine

- Bureau of Maternal and Child Health
- Division of Maternal and Perinatal Studies
- Dental Services
- Central Cancer Registry

Scientific Services

- Division of Analytical Laboratories
- Division of Forensic Medicine
- Division of Occupational Health and Pollution Control
- The Institute of Clinical Pathology and Medical Research

The exceptions to this list were the Division of Establishments and the Division of Health Services Research and Planning. The former has been described fully in the Chapter on Mental Health Administration. The latter was responsible to the Under Secretary of the Department. It was established on 27 January 1970, under Dr S. Sax, who have previously been Director of Geriatrics within the Division of Establishments. It was planned as a data finding unit to service both the Department of Public Health and the Hospitals Commission of NSW. Although placed within the Department of Public Health, the Chairman of the Hospitals Commission was granted direct access to the Director. Its function was '....to collect, analyse and present objective data in a form which would help decision making'(106).

A standing committee was established to advise on priorities, to frame terms of reference for each project, consider budgets for each task and monitor progress.The membership of the committee was the Under Secretary, Department of Public Health, the Chairman of the Hospitals Commission of NSW, the Director-General of Public Health, the Director of State Psychiatric Services and a representative of the Public Service Board.

* Since 1973 the supervision of air and water pollution and domestic noise has been transferred to the Pollution Control Commission.

The administration of Divisions and Branches

The Divisions and Branches are discrete administrative units, self-contained with technical, clerical and supportive staff, and with degrees of freedom to pursue their responsibilities within the overall restraint of the parameters of their function. The larger, and particularly the Scientific Divisions, are located independently of the Headquarters of the Department and for all practical purposes operate as independent units within their budgetary appropriations. This latitude is illustrated on the growing emphasis on research and affiliation with tertiary education authorities. The only restriction imposed is unwritten and understood, that any such involvement or activity will not interfere with either the quality or quantity of services, which have an overriding priority.

Each Division and Branch is controlled by a Director or Chief, who is graded into senior and junior depending largely upon the size of the Division or Branch.Their salaries are graded accordingly, and also whether the Division is directed by a medical or non-medical Director. In general terms Branches are less independent than Divisions and restricted to advisory or minor administrative functions.

I have spoken elsewhere of the competition between Health Districts and Divisions for status and recognition and it might be assumed that sweet reason and tranquillity prevailed between Divisions and Branches. Here equally there was simmering resentment between non-medical and medically directed Divisions because of salary differentials and personal resentment of arbitrary status levels implicit in the latter and inbuilt into the system, and between medically directed Divisions because of the stratified system of senior and junior Divisions.

There was one area of mutual agreement, viz that they were central units of the public health organisation and should remain as such and not be dismembered by alteration of the structure and philosophy of Health Districts. This attitude was justified on number of grounds, many of which were valid:

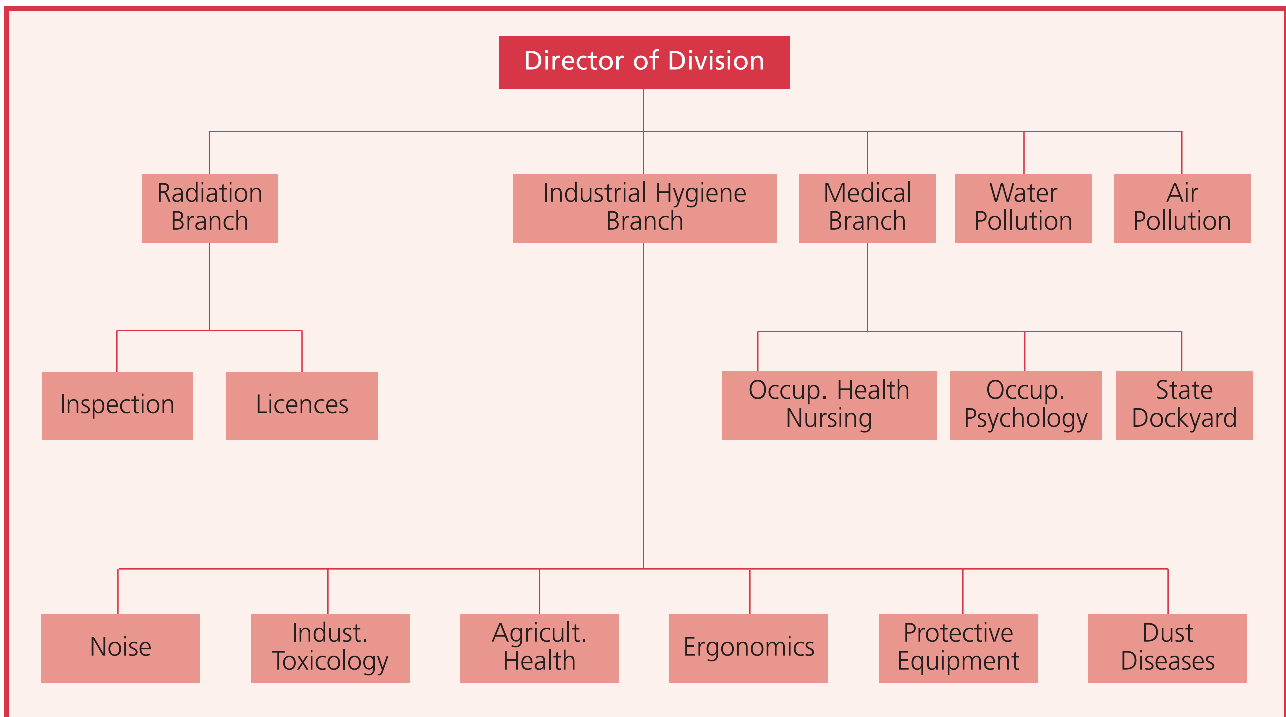
(a) The need to husband scientific resources and skills, the better to utilise expensive and sophisticated equipment and resources.

(b) The approach to personnel recruitment in a competitive system, wherein career, research and other incentives could be offered within a larger organisation as contrasted with a number of barely viable smaller organisations.

(c) The stimulus of cross fertilisation between Government and private organisations of like nature which is possible in major centres of population. In this manner Divisional staff could participate in scientific and teaching functions of universities and similar organisations, and there are avenues for mutual exchange with obvious benefits to the repositories of knowledge and experience of each. This aspect was vigorously pursued from 1960.

(d) Central divisions were remote and unlikely to be influenced in translation of policy by local issues. Implicit in this concept is the principle that services and policy should be equally distributed with undiminished quality between urban and rural communities, irrespective of the capacity of the latter to financially support such services.

In their early and formative years, recruitment of staff was largely by a cadet system with emphasis on in-service training. In some areas this still persisted in the 1960s, although generally, as the Divisions increased in complexity emphasis was placed on recruitment of qualified staff trained by technical and tertiary educational authorities. Incentives were inbuilt into conditions of employment to retain staff by opportunities for post-graduate study, for ongoing education through seminars and overseas study tours, and to indulge in research. Above certain levels, promotion was assessed on the individual's administrative and professional progress through these opportunities. Promotional positions were increased within Divisions as they were organised into specialised sub-units. An illustration of this subdivision is the organisational pattern of the Division of Occupational Health and Pollution Control in 1971:



An issue of importance involving the scientific Divisions became apparent as they became more sophisticated in outlook and facilities, viz whether there should be some charter which would preserve their independence within the public service system, and enable them to contribute to the advancement of science and technology and professional education in NSW. After prolonged planning between the Director-General of Public Health and the scientific Divisional Directors, a proposal was advanced to the Public Service Board for an Institute of Health Science, whose charter would be defined by an Act of Parliament, which would remove these Divisions from the immediate authority of the Public Service Board, but still obligate them to the service needs and scientific support of the Department of Public Health. Although it was never specifically rejected the proposition was left in abeyance by the Public Service Board, and lapsed in the discussions over the next three years which were to lead to the formation of the Health Commission. The proposal is set out in Appendix 8.

The period 1960 to 1970 saw the rapid growth and expansion of the Divisions, but not the Branches whose functions were static and narrowly defined. It was obvious towards the end of this period that the impetus was slowing and that there would be increasing competition from universities and technical institutes in fields which were once the prerogative of Government and the Department of Public Health. Their significance in health administration and even the identity and the existence of some would be further threatened by any major reorganisation of the administration of health services as was proposed in the *Starr Report*(107).