

## The administration of hospitals and charities

Prior to the establishment of the Ministry of Health, the administration of hospitals and charities was a function of the Colonial Secretary's Department. The lunatic asylums were the responsibility of the Office of the Inspector General of the Insane after the *Lunacy Act of 1878*. This aspect of the administration has been explored in the chapter relating to the administration of mental health. As a preliminary to the exposition of the organisation of the Ministry, a brief account will be given of the administration of general hospitals, State hospitals, and private hospitals and rest homes.

### General hospitals

It cannot be stressed too frequently that general hospitals developed as voluntary charities for the indigent poor, and survived essentially on the subscriber system, with irregular Government assistance, during the nineteenth century. Each hospital possessed its own executive authority in its hospital board and Government intrusion was minimal. They operated under the *Public Hospitals Act of 1896 Act No. 16*) which was enacted subsequent to the Acts 11 Vic. No. 59, 45 Vic. No. 3 and 58 Vic. No. 6. This Act defined the procedures for election of the boards of hospitals by subscribers, and nominated the Treasurer as the person who could sue or be sued on behalf of a hospital. The Act included a schedule of hospitals to which its provisions were to apply. The statutory hospitals were not included in the listing.

There was no section within the Colonial Secretary's Department prior to the Royal Commission on Public Hospitals and Charities in 1897 dedicated to the oversight of general hospitals, and such supervision as was necessary from time to time was handled by the Division of Charitable Institutions. It was not until 1912 that a degree of supervision was formally structured by the appointment of Dr Robert Paton as Inspector General of Metropolitan Hospitals and Charities, and this responsibility was transferred with him when he was appointed Director-General of Public Health in 1913. In his report of that year he drew attention to the shortage of accommodation in metropolitan hospitals, and the urgent need for increase in infectious diseases accommodation in both Sydney and Newcastle.

The main avenue of admission to general hospitals, as well as State hospitals, was the Hospitals Admission Depot, and some idea of the demands upon this agency can be gleaned in the 1916 report (reflected also in subsequent reports). Over 12,000 persons were examined for admission, of whom 3,420 were diverted to the Coast Hospital, 436 to the Royal Prince Alfred Hospital, 267 to Sydney Hospital 172 to the Women's Hospital Crown Street, and 117 to the Hospice for the Dying. The remainder were admitted to the State Asylums for the Infirm.

Robert Paton complained on several occasions about the haphazard arrangements for administration of public hospitals. He had little authority other than 'examination and revision of all plans for erection of new hospital buildings or for alterations and additions' (148). If approved, and if finance was available, assistance for capital expenditure was provided by the Government, which also met the deficit between income and expenditure on a £1 for £1 basis.

Paton's pleas were heard and in June of 1918 the Hospital's Advisory Board was created with himself as Chairman, and Doctors W.G. Armstrong, Richard Arthur, G.H. Taylor and the Under Secretary, Mr E.B. Harkness as members. The board was advisory only to the Minister, but nonetheless a forecast of what was to come.

By 1923 the situation had not improved. The Director-General, William George Armstrong was forthright (149):

"The question is a very important one for the State, as the method of control of Public Hospitals throughout NSW is rather haphazard... The Government which contributes practically half the cost of all hospitals retains very little effective control over these institutions, and hospital committees throughout the State have the power to do very much as they please. It is understood that a Bill is to be presented to Parliament at the forthcoming session."

A conference of various persons, organisations, and bodies connected with hospital administration took place in March and June, presided over by the Minister to assist him in drafting a new Hospitals Bill. William Armstrong was sent to New Zealand, Victoria and South Australia to report on the

legislation and administration of public hospitals in those areas. Dr M. MacEachern, who had a wide experience of hospitals systems in Canada and America, was invited by the Minister to report on the system in NSW during his visit in 1924(150).

Despite these reports, and continuing protests from Dr Dick who succeeded William George Armstrong, no action was taken until 1929. In that year the Hospitals Advisory Committee was dissolved and the *Public Hospitals Act* passed. It constituted a Hospitals Commission as a separate statutory authority within the Ministry of Health and external to the Department of Public Health. The significance of this Act was to confine the Commission to the administration of general hospitals. The administration of Charities and Private Hospitals remained with the Director-General of Public Health. The historical development subsequently of the Hospitals Commission is not pertinent to this document other than its location as a statutory authority within the Ministry of Health. Surprisingly the title granted to Paton in 1912 was only inconsequentially modified, and Robert Dick and all succeeding Directors General were still appointed as Inspector General of Hospitals and Charities.

### Private hospitals

Since the passage of the first *Private Hospitals Act of 1908* the administration of private hospitals has been a responsibility of the Chief Medical Officer and the Director-General of Public Health. The *Consolidated Act of 1954* included rest homes in its licensing provisions, as the prelude to Commonwealth assistance under the National Health Scheme. The Private Hospitals Branch was responsible for periodic inspections of private hospitals and rest homes, for advice on licensing and renewals and for orders on licences in compliance with the Act. The licensing authority was the Board of Health and for this reason the administration was

originally placed with the Chief Medical Officer. From 1950 there was a dual inspectorial service from the staff of the Commonwealth Department of Health prior to approving individual private hospitals or rest homes for hospital or nursing home benefit under the *National Health Act*. The requirements of the State were published in the Regulations to the *Private Hospitals Act*; those of the Commonwealth were not published. This led to conflicts of opinion and confusion as to the standards which were never satisfactorily resolved.

The Branch was a small administrative unit with a Medical Officer of the Department in charge and a number of nurse inspectors. It was transferred to the Hospitals Commission of NSW in 1972 by amendment of the *Private Hospitals Act 1908-1954*.



**Newcastle Mater  
Misericordiae Hospital**  
Children's Ward, 1939

### State hospitals and homes\*

In many aspects the State asylums for the Infirm (the forerunners of the State hospitals and Homes) were complementary to the lunatic asylums in their function and development. Both systems were expressions of Government philosophy in the nineteenth century towards social and economic indigency, just as their development in the

twentieth century into therapeutic institutions reflected consequential changes in this attitude. They served, and still serve, segments of the community to which the State considers it has a social responsibility to discharge.

There was a critical point in each of these systems when change was inevitable. In the psychiatric services it was the *Lunacy Act of 1878*. In the State benevolent asylums it was the Royal Commission on Public Charities and Hospitals of the Colonies appointed in 1897 under the Chairmanship of Joseph Barling, who was also Chairman of the Public Service Board. Although it never took evidence on the State asylums for the Infirm (which were

\* A brief historical sketch of the development and function of each State hospital is provided in Appendix 9.

included in its terms of reference), undoubtedly it stimulated a coincidental inquiry by the Public Service Board. Unfortunately the proceedings of the Public Service Board Inquiry have been lost and it is not possible to estimate its influence in formulating changes in the administration of these institutions within the Colonial Secretary's Department.

Hitherto there was a small administrative unit within the Department, the Division of Charitable Institutions, under the Senior Inspector of Charitable Institutions. This provided a loose system of supervision of all charities including the government asylums for the Infirm. The reports of the Royal Commission consistently emphasised that this system be strengthened, especially towards public charities, as the basis for continuing subsidy. In 1901 this Division was split into two sections, the State Children's Relief Branch and the government asylums for the Infirm Branch. In 1906 the latter was extended to cover all subsidised charities and the Director was appointed Inspector General of Charities.

Dr Paton was transferred to this position in 1908, and when he was appointed Director-General of Public Health in 1913 the Department of Charities was amalgamated with the Department of Public Health. Thereafter until 1938 the position of Inspector of State hospitals was a senior post in the clerical administration of the Office of the Director-General of Public Health. After its abolition in that year responsibility for inspections and supervision generally was delegated by the Director-General to the Senior Medical Officer of Health and then the Deputy Director of Public Health, when the latter position was established in 1942. It remained a responsibility of the Director-General's administration until it was transferred to the Division of Establishments in 1963.

Admissions to State hospitals were via the Hospitals Admission Depot. In latter years hospital patients were accepted by the Depot on request from metropolitan general hospitals and private medical practitioners, each State hospital notifying the depot daily of its vacancies. The exceptions were the tuberculosis hospitals at Waterfall and Randwick. The tuberculosis waiting list was maintained and operated in strict chronological sequence by the Director of Tuberculosis. Prior to World War II, when the Coast

Hospital was the main repository for hospital admissions from the depot, most patients attended in person and were medically examined and classified at the depot. 'Home' inmates were required to present personally to the depot and make personal application for admission. There they were issued with a rail pass to Lidcombe, Liverpool or Parramatta stations when they were met by hospital attendants. On arrival at the State hospital they were compulsorily bathed and issued with institutional clothing. The routine on arrival was the same for female patients, who were delivered by relatives or friends at Newington having first receiving approval from the depot. After reception inmates were medically examined and classified as feeble (non-workers), or hospital cases, or fit to work.

The home sections of the State hospitals were modified poor houses and were units of all State hospitals including the tuberculosis hospitals, David Berry Hospital and Strickland Convalescent Home. The latter institutions were supplied direct with working inmates from the Hospitals Admission Depot. Those assigned to work were given set tasks under Outdoor Attendants on the farms or grounds, in the kitchens and laundries. They were paid one shilling per day and were known as 'bob a day' workers. Special overseer posts were paid three shillings a day. The hospitals provided a refuge for alcoholics, derelicts and unemployables who were the main cadre of the working inmates. The situation was ingrained and accepted, and despite continuous protests from medical superintendents, was justified on the grounds of economy and as a rehabilitation measure. I have never seen any statistics justifying the latter claim. Of recent years the situation was modified as the State hospitals became therapeutic geriatric units and as the farm lands were abandoned and used for other purposes, or disposed of as convenient land to other Departments or Divisions.

A feature of the State hospitals were the farming activities, copied from the mental hospitals where they were introduced as therapeutic facilities. In the State hospitals, as I knew them, the farming industry was largely restricted to pig farming, although in the past there had been dairy and other pastoral activities. Even the small obstetric and convalescent State hospitals of the 1920s reported proudly each year on the productivity of their vegetable gardens.

Even less desirable was the earlier practice to use inmate workers as maids, servants, cleaners, laundresses, ironers, cooks and nursing assistants. It was the use of this labour which permitted costs to be restrained in comparison with general hospitals, but it was also responsible for the ill-reputes in general of the State hospitals in public and professional opinion. It was almost a phobia within the Department that these hospitals had to demonstrate a financial self-sufficiency which was a carry over from the conditions so soundly condemned by the Royal Commission on Hospitals and Charities.

The Medical Superintendent and Matron of the State hospitals and Homes were the lord and lady of the manor, and ruled as such demanding obeisance from patients and staff alike. They were constantly bickering and at ends with each other, like a married couple after the first blush of the honeymoon had faded. But let any intruder dare to question their autocracy and they were united as one in defence. They were institutions within their institution and frequently as well renowned.

Next in the hierarchy was the Manager, which was the most senior clerical position to which the majority of clerical staff could aspire in the Department. Clerical progression was from junior clerk at entry, usually in the central office, to the ranks of hospital clerks of various grades, hospital accountant, assistant manager and manager. The bulk of their experience was obtained in State and mental hospitals, and they were responsible for the daily administration of the hospitals. The capacity of the medical superintendent as executive officer was a cause of conflict between managerial and professional staff, especially in the situation, which was not uncommon, of a strong manager and a weak superintendent.

One of the very positive contributions of the State hospitals was the nurse-training programmes, male and female. This was by a system of inservice training and lectures, and the dedication of this staff to their patients, often under most difficult circumstances, was deserving of utmost praise. Trained nurses were difficult to recruit because of the type of work and industrial conditions, and were used in key positions of a technical nature such as operating theatres. The burden was borne by State-trained nurses and adequately accomplished. The situation is now reversed as more wards qualify for Commonwealth assistance under the *National Health Act*, to the stage that Lidcombe Hospital is recognised as a training school for general trained nurses.

The State hospitals did provide a supplementary system to the general hospitals, catering for aged patients, or those with intractable chronic diseases. They can be classified under a number of headings: State hospitals, convalescent homes, general and maternity hospitals, and tuberculosis sanatorium.



**The Coast Hospital**  
Trainee nurses at 'The Coast'  
La Perouse, Sydney NSW  
Early 1900's

### State hospitals

These were the core of the State hospitals and the derivatives of the State asylums for the Infirm. They provided refuge for the indigent poor; sick and homeless. After 1950 much of their function was taken over by private rest homes operating within the National Health Scheme. Two major State hospitals were closed and the remainder developed as geriatric hospitals and rehabilitation centres. The list of State hospitals and Homes is: Liverpool State Hospital (1851-1958); Macquarie Street Home Parramatta\* and Aged Couples Cottages (1862-1936); Newington State Hospital (1882-1964); Lidcombe State Hospital (1893-); Garrawarra Hospital, previously Waterfall Sanatorium (1958-); and Allandale Hospital, Cessnock (1963-).

\* The Macquarie Street Home Parramatta was also known as the Home for the Blind and Men of Defective Sight and Senility.

## Convalescent homes

Convalescent homes were provided by the State to assist poor persons recovering from illness, or showing signs of malnourishment. With one exception, the State has opted out of this field of care. The three convalescent homes were: Denistone House Eastwood for males (1913-1933); Carrara (Strickland) Vaucluse for females (1915-); and Fernleigh Rest Home (Pre and Post-Maternity) Ashfield 1920-1930. Carrara has a dual purpose and provides permanent lodging for a group of women who are socially bereft and unable to cope with independent living,

## General and maternity hospitals

These are of historic interest and comprise: the Coast Hospital (1881-1935); the Lady Edeline Hospital for Babies Vaucluse (1913-1935); and the David Berry Hospital Berry (1909-). Both the latter were unique among State hospitals. The Lady Edeline Hospital had its own board and the David Berry Hospital was a foundation to the State confirmed by its own Act.

## Tuberculosis sanatoria

The Department of Public Health was always heavily involved in the treatment of tuberculosis and provided the major sanatorium in 1911 for this purpose at Waterfall, the State Sanatorium for Consumptives. Following the success of the anti-tuberculosis campaign, Waterfall was converted to a geriatric institution in 1958, and renamed Garrawarra Hospital. When the Coast Hospital ceased to be a State hospital in 1935 the Department accepted responsibility for its tuberculosis patients in the Randwick Auxiliary Annex. This was renamed the Randwick Chest Hospital and is still in operation for the diagnosis and treatment of tuberculosis. It was the centre for thoracic surgery for patients from departmental hospitals, including mental hospitals.