CHAPTER FIVE

TUBERCULOSIS AS A NATIONAL PROBLEM 1900 – 1930: Public Health Physicians and Policy Uniformity

This chapter traces the pursuit of a national policy by public health physicians from musings at the beginning of the twentieth century to the early 1930s by which time a federal health department had been established. Claudia Thame suggested that the medical profession became increasingly concerned with uniform treatment and control of tuberculosis during the 1930s.[1] But public health physicians had long held this view. The earliest attempt to bring about a national policy occurred in 1911 and intensified after World War I. War added a new dimension to Australian health policy, the repatriation and medical care of returned soldiers. The Federal Government took responsibility for medical care of returned soldiers and its policy on treatment of tubercular soldiers would later influence tuberculosis policy.

Much of the evidence for this chapter is drawn from reports to governments particularly to the Federal Government. This method has allowed me to trace anti-tuberculosis schemes devised by medical bureaucrats and put before governments as propositions for public health policy for managing tuberculosis. The chapter is structured chronologically. In 1911 a conference of State Medical Officers and the Director of Quarantine met to devise a uniform public health scheme against tuberculosis for presentation to State governments. In 1916 the Commonwealth Government's Committee on Death and Invalidity produced a range of reports on the health of the nation including one on tuberculosis. A Commonwealth Royal Commission on Health reported in 1925 and in 1929 Dr Mervyn John Holmes,

[1] Claudia Thame, 'Health and the State: the Development of Collective Responsibility for Health in Australia in the First Half of the twentieth Century', PhD Thesis, Australian National University, June 1974, p. 106.

Director of the Commonwealth Health Department's Division of Tuberculosis and Venereal Disease, presented a report on the status of tuberculosis public health measures and recommendations for the future. I also draw on the records of the Commonwealth Health Department to show that, from its formation in 1921, the Department attempted to steer tuberculosis policy towards a central and nationally uniform policy as much as possible within its limited jurisdiction.

A few Australian scholars have explored the beliefs and methods of medical professionals who sought to direct health policy and social practices towards strengthening the nation's health through, in their view, enlightened intervention and management by the state.[2] Michael Roe initiated this discussion in his study of nine Australian professionals who he categorized as Progressives in the Rooseveltian mould. Four of his subjects were medical doctors, two in the employ of government. One was John Elkington who held high level positions in Tasmania and Queensland before becoming the Federal Department's head of tropical medicine. The other was John Howard Lidgett Cumpston, the most senior medical bureaucrat in the Commonwealth Government from 1913 to 1945.[3] Cumpston has been introduced in chapter two but because of his prominent position and longevity in government employment he warrants more detailed discussion, which I will present in this chapter. John Powles followed Roe's interest in this medical cohort by exploring four state employed public health physicians whose world view, he argued, shared some of the beliefs falling within the pantheon of fascist ideas.

[2] Michael Roe, *Nine Australian Progressive, Vitalism in Bourgeois Social Thought 1890-1960*, University of Queensland Press, 1984. James A. Gillespie, *The Price of Health. Australian Governments and Medical Politics 1910-1960*, Cambridge University Press, Cambridge, 1991. John Powles, Naturalism and hygiene: fascist affinities in Australian public health, 1910-1940, conference paper 'Attractions of Fascism', University of New South Wales, July 24-25, 1987.

[3] Michael Roe, *Nine Australian Progressive,* 1984, *passim*

Powles categorised this group as national hygienists[4] a term Gillespie also used to explore the emergence of a new public health lobby at the end of World War I. Throughout this chapter I use the term public health physicians because it better specifies those employed by the state. Other medical professionals also figure as contributors to the commentary on tuberculosis policy but state employed officers were the main conduit to governments.[5]

Drawing on their experiences of military medicine during World War I, a prominent group of like-minded physicians took up employment in State and Commonwealth Governments during the inter-war years. Broadly their philosophy was to raise the importance of preventive medicine over 'curative' medicine.[6] For some this philosophy pre-dated the European conflict but the events of war strengthened and enlivened their ideas and created a more forceful cohort of public health physicians with a clear aim to persuade governments to develop national health policies.[7] Tuberculosis became an area of activity during the inter-war years in the struggle to increase activity in the field of preventive medicine and to establish a nationally cohesive health policy. Since its contagious nature had become medical orthodoxy public health physicians had argued that the spread of

[4] John Powles, Naturalism and hygiene*:* 1987, pp. 2-3, 10-11.

[5] A number of Australian historians have examined this intellectual movement and some of the individuals falling within Roe's category of progressives. In particular, the eugenic ideas of some Progressives have been of interest. Grant Rodwell, for example, highlighted the influence of Professor Harvey Sutton who Rodwell described as a 'dedicated national hygienist' with a strong eugenic message. Sutton held a number of government and university positions including, Principal Medical Officer in the New South Wales Department of Public Instruction, Chair of Preventive Medicine in the School of Public Health and Tropical Medicine and leader of school medical officers in the Victorian Department of Education. From these positions he promoted the establishment of special schools for 'mental defectives', anthropometric surveys in schools, segregation of the mentally impaired and sex-hygiene education as a preventive for syphilis. [Grant Rodwell, 'Professor Harvey Sutton: National hygienist as eugenicist and educator', *Journal of the Royal Australian Historical Society*, V. 84, no. 2, December 1998, 164– 79. D.R. Walker, 'Sutton, Harvey (1882 -1963)', *ADB*, Volume 12, Melbourne University Press, 1990, pp. 143-144.]

[6] Gillespie, *The Price of Health.*, 1991, pp. xi, 31-38.

[7] ibid., p. 33.

tuberculosis could be prevented by state interventions in the form of notification, isolation and education on hygienic and preventive behaviour in sanatoria as well as regular oversight and education from local health bodies. This made tuberculosis an ideal target for physicians zealous about raising the nation's health through preventing disease.

From the earliest days of the campaign against tuberculosis at the beginning of the twentieth century public health physicians believed that successful management of tuberculosis could only be achieved through uniform controls across the nation. Some foresaw an important role for the Federal Government. As early as 1902, the Hon. Dr Gamaliel Butler, Member of the Tasmanian parliament[8] and President of the Intercolonial Medical Congress of 1902, commented on the general understanding that consumption required a national approach and expressed the hope this might be achieved through a federal department of health. The recent federation of the Australian colonies, Butler thought, provided an avenue for coordinating the nation's health policy.

> With Federal Australia we can reasonably hope to have in the near future a Federal Health Department with uniform laws relating not only to quarantine, but to other matters appertaining to the public health.[9]

His colleague Dr Burnett Ham, Queensland's first Commissioner of Public Health,[10] agreed and recommended the appointment of a Commonwealth Minister for Public Health. Others opposed federal intervention in health affairs and the proposal for a Commonwealth Minister failed. Instead Congress agreed on a

[8] Michael Roe, *Life over Death. Tasmanians and Tuberculosis*, Tasmanian Historical Research Association, 1999, p. 60.

[9] Hon. G.H. Butler, M.R.C.S (Eng.), L.R.C.P. (Lond.), M.L.C., *Intercolonial Medical Congress of Australasia*, Sixth Session, 1902, p. xxvii.

[10] Thearle, M. John, 'Ham, Nathaniel Burnett (Bertie) (1865–1954)', *Australian Dictionary of Biography (ADB)*, National Centre of Biography, Australian National University, http://adb.anu.edu.au/biography/ham-nathaniel-burnett-bertie-12959/text23423. *Intercolonial Medical Journal (IMJ)* 20 July, 1909, p. 380

motion calling for a national body that included New Zealand to bring together ideas and information on public health.[11] Despite the reluctance of some doctors in 1902 to endorse Federal Government intervention, the issue of a Commonwealth department was again raised at the Medical Congress of 1908.[12] Many members of the medical profession, however, struggled to balance the growing belief in an expanded role for the state in public health matters and protecting the autonomy of their profession.

CONFERENCE OF PRINCIPAL MEDICAL OFFICERS, 1911

The struggle between public and private medicine was evident at a national conference on tuberculosis in 1911. Principal Medical Officers from each State met at a conference also attended by Commonwealth Director of Quarantine with the aim of designing uniform public health measures for tuberculosis in the hope that each Australian States would adopt them. The conference ultimately failed to excite the States into new policies illustrating the limitations of formulating national public health policy while States had sole jurisdiction over health. It also revealed something of the tensions between the States and the Commonwealth. The conference was instigated by the Western Australian Parliament through a motion on 24 August 1910 calling on the Government to ask the Prime Minister to bring the various States' medical officers together to design a national plan to fight tuberculosis. Edward Heitman, a Labor Member who moved the motion, proffered the view that the Federal Government, because of its quarantine powers, should

[11] Intercolonial Medical Congress of Australasia, *Transactions of the Sixth Session*, 1902, John Vail, Government Printer, Hobart, 1903, 1902, p. 432.

[12] E.G. Leger-Erson, L.R.C.P, in Australasian Medical Congress (Formerly the Intercolonial Medical Congress of Australasia), *Transactions of the Eighth Session*, October, 1908, Section of Public Health, p. 145, Melbourne, 1909.

take over the problem of infectious diseases. Frank Wilson, Liberal[13] Premier of Western Australia, disagreed arguing that the Prime Minister had no power to call the conference. The motion was therefore carried in an amended form excluding any reference to the Prime Minister.[14] Nevertheless, the proposal to recommend a broad agenda of 'devising systematic and uniform methods for combating tuberculosis'[15] was intended to have national implications.

The Conference of Principal Medical Officers met in Melbourne at Victoria's Department of Public Health on the 28th of February, 1911. All States except Queensland sent their principal medical officer to the conference. Queensland's Commissioner of Public Health, Dr. J.S.C. Elkington could not be present because he was serving as a commissioner on a royal commission into the health of miners in his State. Dr. J. Ashburton Thompson, Permanent Head of the Department of Public Health, President of the Board of Health and Chief Medical Officer of the Government, represented New South Wales. South Australia was represented by its Chairman of the Central Board of Health, Dr. W. Ramsay Smith, Tasmania by its Chief Health Officer Dr. J.S. Purdy and Victoria by Dr. B. Burnett Ham who was Chairman of the Board of Public and Administration of State Sanatoria. Dr. J.W. Hope, President of the Central Board of Health and Principal Medical Officer represented Western Australia. These States' chief medical officers were joined by Dr. W. Perrin Norris, the Commonwealth's Director of Quarantine. Dr Norris had

[13] Liberal does not refer to the present day Liberal Party of Australia, but to an earlier party formation. Labor, on the hand, refers to the Australian Labor Party as it would today.

[14] Western Australia, Legislative Assembly, *Parliamentary Debates*, 24 August, 1910, Vol. 38, pp. 470, 472, (Edward Ernest Heitmann, Labor Member for Cue), p. 1056 (Hon. Frank Wilson, Premier). R.M. Porter and T.C. Boag, *The Australian Tuberculosis Campaign 1948-1976*, Menzies Foundation, 1991, p. 3.

[15] Western Australia, Legislative Assembly, *Parliamentary Debates*, 24 August, 1910 p. 470. States of Australia, *Consumption. Report of a Conference of Principal Medical Officers on uniform measures for the control of consumption in the States of Australia*, Government Printer, Melbourne, 1911, p. 4, M.L.

been invited to the conference on the suggestion of the Premier of Western Australia.

At this conference the States' medical officers did not see the Federal Government as the coordinating or funding body but believed States ought simply to adopt individually a uniform set of anti-tuberculosis measures. Ever mindful of not encouraging the state to encroach too deeply into private practice rights, the recommendations of the Conference limited the state's role to broad preventive measures. The Conference interpreted the Western Australian motion to mean a standardized set of laws to prevent, not treat, tuberculosis. Its report noted,

> After consideration it was decided that the motion indicated a determination to endeavour to deal with the **prevention** [my emphasis] of consumption on practical, as well as uniform lines: …[16]

Though it might have been reasonable to interpret the word 'combating' tuberculosis in the motion of the Western Australian Parliament to mean all aspects of tuberculosis management, the States' medical officers were careful not to suggest relinquishing medical control to the state. Doctors were still to be the arbiters of treatment.

> …it may be remarked on the one hand that the communicability of consumption distinguishes it from many other chronic diseases, and points it out as one demanding supervision by governments; but, on the other hand, that consumption is on a footing with other diseases, as regards mere cure, and is not distinguishable among them as special responsibility of Governments.[17]

A problem emerged here for the medical profession as treatment and prevention often overlapped especially in the case of sanatoria considered to be preventive because it isolated and educated the tubercular, but also a method of treatment.

[16] States of Australia, *Consumption. Report of a Conference of Principal Medical Officers* 1911, p. 5.
[17] ibid., p. 6.

The recommendations of the 1911 Conference suggested a model of measures that were largely reiterated in medical reports to governments from then until the late 1940s. The proposed measures were extensive, Medical Officers proposing 29 measures including notification to public health authorities, early detection of the disease, data collection to ascertain the extent and geography of the disease, sanatoria for accommodation and segregation, tuberculosis dispensaries or clinics, home supervision by local health authorities, and state assistance to families whose breadwinner, understood to mean husband, was afflicted with the disease. Economic support for families whose male breadwinner was afflicted was a persistent theme in proposed prevention schemes. This gendered assumption was common in welfare policies throughout the early decades of the twentieth century and beyond, that is that state support should promote a society based on working men who supported wives and children.[18] The recommendations also suggested giving state health authorities legal powers to force intransigent consumptives into care. Although considered a measure of last resort, such powers would allow a police magistrate to order a tuberculosis sufferer to be segregated from the community in an institution. This would apply only when a sufferer could not or would not adjust their personal behaviour to take reasonable precautions against spreading their infection.[19] The report failed to excite a national policy[20] but it set out the first formal recommendations to governments that tuberculosis be considered from a national perspective.

[18] Alison Bashford, 'Tuberculosis & Economy: Public Health & Labour in the early Welfare State,' *Health & History*, 2002, 4/2: p. 29.
[19] States of Australia, *Consumption. Report of a Conference of Principal Medical Officers* 1911, pp. 8 – 16.
[20] Australia, Parliament, 1926, *Report of the Royal Commission on Health*, 1926, p. 23. Porter and Boag, *The Australian Tuberculosis Campaign*, 1991, p. 3.

JOHN HOWARD LIDGETT CUMPSTON

It is unsurprising that the 1911 national conference was initiated in Western Australia. That State's Acting Chief Medical Officer was John Howard Lidgett Cumpston who supported a national approach to tuberculosis and proposed the conference because of his investigations into lung disease among Western Australian gold miners.[21] He would later become the first Director-General of the Commonwealth Health Department and hold the position for 24 years. Cumpston became the most influential of the cohort described by Gillespie and therefore a brief reflection on his ideas about national health and tuberculosis are germane to this discussion.

Cumpston took up the position as a Medical Officer in the Western Australian Central Board of Health in 1907. In that year he wrote an essay titled 'Australian Type', in which he described an ideal Australian character that predicted some of the rhetoric soon to surround the Australian soldier in World War I. After the war he became enthusiastic about the possibilities of applying to civilian life, and particularly public health, the national qualities he believed had emerged during World War I. Importantly, he believed Australia's participation in the war had demonstrated its ability to organise at a national level, a talent he said that should be used to develop a 'sound national policy of public health.'[22] Furthermore, he believed governments needed to heed the advice of their medical advisors who for

[21] Porter and Boag, *The Australian Tuberculosis Campaign*, 1991 pp. 149 – 152. Criena Fizgerald, *Kissing Can Be Dangerous, The Public Health Campaigns to Prevent and Control Tuberculosis in Western Australia*, 1900-1960, University of Western Australia Press, 2006, pp. 32, 92-95.

[22] J.H.L. Cumpston, 'The War and Public Health', Lecture, Masonic Hall, Melbourne, 6 October 1915, in *University War Lectures,* pp. 193, 198, papers of J.H.L. Cumpston, MS 613 Box 9, NL.

their part must possess such a high level of competence and expertise that legislation followed the lines of their recommendations smoothly.[23]

Cumpston had graduated from Melbourne University with an excellent academic record and during his hospital residency year in 1903 became interested in preventive medicine. Following a short period of employment at the Parkside Lunatic Asylum in Adelaide he travelled overseas in 1905 as a ship's surgeon during which time he observed American public health officials in the Philippines and completed a Diploma of Public Health in London.[24] His proffered reasons for following a career in public health were both economic and scientific. Financial rewards in general practice at the time were uncertain,[25] while the latest medical discoveries promised a new era in preventive medicine.

> Two factors superimposed on a general inclination had helped to crystallize my decision. The first of these was the financial side of medical practice, even then presenting difficulties and even the increasingly a social problem. The second was the bright dawn of a new era of scientific knowledge. The medical world was afire with enthusiasm for the new bacteriology, the new pathology, the new epidemiology and these were beacons indicating the new road to the prevention of disease on a national scale. [26]

On his return to Australia in late 1907 he started his career in state employment in Western Australia.

Cumpston's views on the prevention of tuberculosis in these early years were revealed first in a paper given to the Australasian Association for the Advancement of Science (AAAS) in 1909 and again in 1910 during his investigation into miners' disease in Western Australia. He favoured tight public health controls commenting

[23] ibid.
[24] Roe, *Nine Australian Progressives,* 1984, p. 118
[25] Gillespie, *The Price of Health.* 1991, p. 4.
[26] Cited in Roe, *Nine Australian Progressives,* 1984, p. 118.

'it becomes evident that no measures for its prevention can be considered too stringent.'[27] Criena Fitzgerald's research on tuberculosis in Western Australia provided further insight into Cumpston's ideas on tuberculosis in the early years of his career.[28] He characterised the disease in Western Australia's gold miners as a general public health problem rather than an occupational one. He argued that miners were culpable in the development of their own disease because of immoral and unhygienic living. Cumpston had become an influential public health figure and his miners' investigation informed a Western Australian Royal Commission into miners' diseases in 1912. The Royal Commissioners agreed with his claim that high rates of tuberculosis among miners resulted from the immoral behaviour of miners and their mode of living, a perspective that depreciated the impact of their working conditions.[29] Despite his expressed enthusiasm for the new science of bacteriology, he discounted its precepts in the mining inquiry by imposing a moral judgement on miners rather than applying the knowledge of bacteriology to suggest ways in which the miners' plight might be ameliorated. This superimposition of morality over his expressed interest in prevention and science was also evident in his 1909 paper to the Australasian Association for the Advancement of Science when he said that Britain had achieved a decline in disease because of a 'livelier intelligence' whereas in Ireland 'dull lethargy' led to high mortality rates.[30]

Cumpston moved to the national arena in 1911 beginning his 34 year tenure with the Federal Government. He joined the Federal Quarantine Service, became Acting

[27] J.H.L. Cumpston, 'Statistical Inquiry into Pulmonary Tuberculosis in Australia' *Report of the Twelfth Meeting of the Australasian Association for the Advancement of Science*, held at Brisbane, 1909, Brisbane, 1910, p. 554.
[28] Fitzgerald, *Kissing Can Be Dangerous*, 2006, p. 146.
[29] ibid., pp. 150-153.
[30] Cited in Roe, *Nine Australian Progressives*, 1984, p. 120.

Director of Quarantine in 1913 and assumed the position permanently in July 1919.[31] As an employee of the Commonwealth Cumpston demonstrated a preference for centralisation of health policy and greater Commonwealth control, often to the chagrin of the States. When smallpox cases appeared in Sydney in April 1913, Cumpston responded by placing the fifteen miles around the centre of Sydney under quarantine and vaccinating everyone passing in or out of the zone. This intervention angered the New South Wales Government and Cumpston was accused of breaching the intent of the quarantine agreement of 1909. At the national Quarantine Conference in 1913 he was strongly criticised for his presumptive action, which was considered unjustified and inexcusable. The Commonwealth agreed to withdraw its quarantine cordon around Sydney and the conference delegates reached agreement on the conditions under which Commonwealth intervention in such cases could occur. Quarantine Office intervention was permissible if an infection might spread across States and if the State affected refused or ignored the advice of the Director of Quarantine. The tension though was not only between the Federal and State Governments, but also between the States. By early 1914 both Victoria and Queensland asked the Federal Government to intervene believing New South Wales's action against the smallpox epidemic to be unsatisfactory.[32] The Commonwealth had constitutional responsibility for quarantine but disagreements with the States over its operation arose.

In 1921 Cumpston became the first Director-General of the Commonwealth Department of Health and held the position until 1945. He has been described as a

[31] Roe, *Nine Australian Progressives*, 1984, pp. 121-123.
[32] ibid., pp. 123-124.

'tough, autocratic, astringent character'[33] whose relationships with other departmental officers were often strained.[34]

INVALID PENSION

The Commonwealth Government's first direct involvement in tuberculosis was the payment of an invalid pension to which tuberculosis sufferers deemed to be totally and permanently incapacitated were entitled limiting the pension to advanced cases. Granted powers to pay such pensions in the Australian Constitution, the Australian Government introduced an Invalid and Aged Pension Bill in 1908. The Protectionist Party led by Alfred Deakin was the main party in government in 1908 but it relied on the support of the Labor Party and pensions were a high priority for Labor. By the time the Act was proclaimed in April 1909 a Labor Government led by Andrew Fisher was in power and the invalid pension came into operation on 19 November 1910.[35]

Various conditions applied generally under the Act. Recipients were required to have had continuous residence in Australia for at least five years and sustained their incapacity within Australia. The pension was not paid if the incapacity was self induced nor was it paid if relatives could support the pension applicant. These conditions were irrelevant, however, to those who were excluded entirely from the Act. The infamous White Australia policy underpinned the Act in that indigenous people from Australia, Africa, Pacific Islands or New Zealand were unable to apply

[33] Douglas Gordon, M.B.,B.S., (Queensland), F.A.C.M.A., F.R.A.C.P.,F.R.A.C.G.P. (Hon), *Health sickness and society. Theoretical concepts in social and preventive medicine*, University of Queensland Press, St. Lucia, Queensland, 1976. p. 807.
[34] Roe, *Nine Australian Progressives*, .1984, p. 139.
[35] Australia, Parliament, *Acts of the Parliament of the Commonwealth of Australia 1942* with Tables and Index, Commonwealth Government Printer, Canberra, 1942, p. xiv.

for a pension as were Asian peoples, unless they had been born in Australia. Also excluded were 'Aliens'.[36] Aliens referred to immigrants who had not been naturalized for more than three years.[37] Pension policy was also predicated on the gendered notion of a social structure, which, as previously noted, consisted primarily of a working man supporting a wife and children. Although women could receive a pension, the invalid pension was largely structured around supporting the incapacitated male breadwinner in a family.[38]

Pensions to a maximum of £52 per year were paid for permanent incapacity to work. In the case of tuberculosis the pension was payable for advanced tuberculosis only and all pensions were suspended when a pensioner entered an institution and remained there for more than four weeks.[39] A tubercular claimant already in an institution may be granted a special hospital pension of 4/- per week.[40] The pension therefore gave no encouragement or assistance to early stage sufferers to undertake rest cures or shorten their working week. These restrictions did not aid the preventive effort pursued by public health physicians who urged the Government, particularly from the mid 1920s, to continue pension support for dependants while a breadwinner received treatment in institutions. In 1925 a Royal Commission on Health proposed legislative amendments to allow sustenance support for dependants of infective patients while in sanatoria and hospitals.[41] Cumpston wrote to the Minister on 3 April 1928 appealing to the Government to implement this

[36] *The Invalid and Old-Age Pensions Act 1908-1937* (C'wlth), s. 21.
[37] T.H. Kewley, *Social Security in Australia 1900-72*, Sydney University Press, 1973, p. 79.
[38] Bashford, *Health & History*, 2002, p. 29.
[39] Australia, *Statutory Rules from 1901 to 1914 made under Commonwealth Acts*, Vol. 2, Pension Regulations 1911-1914, pp. 1412-1414, 1416.
[40] NAA: A1928, 735/4, Letter, Assistant Commissioner of Pensions to Director-General of Health, 6 September, 1926.
[41] NAA: A1928/, 1105/29 Sect. 1, Letter, Director-General of Health (J.H.L. Cumpston), to Minister for Health (Sir Neville Howse), 18 April, 1928.

recommendation. The thrust of his appeal was to reverse the existing situation of withdrawing pensions during institutional care so that dependants continued to receive some support. He suggested an amount of approximately £2 per week for family sustenance.[42] In 1928 the maximum pension rate was £1 per week.[43] Demands for the tubercular to receive more monetary support was a consistent demand of most public health physicians. It related to the medical professions' struggle to contain this serious infection for which they had no cure and for which existing treatments were problematic.

DEATH AND INVALIDITY COMMITTEE

Three years after the Principal Medical Officers Conference, the national government committed the country to war in Europe and the health of the nation came under the gaze of the Commonwealth Government. The Hughes Labor Government, concerned about the number of men being rejected by the army, decided to investigate the general health of the population.[44] On 12th January, 1916[45] the Government commissioned a Committee to investigate the nation's health. As the Federal Government had no health department the Death & Invalidity Committee operated under the Minister for Trade and Customs, the minister responsible for quarantine. Part of the Committee's terms of reference was to find the principal causes of death and to recommend preventive action that might

[42] NAA A1928/1, 1105/29 Sect. 1, Minute, Director-General of Health (J.H.L. Cumpston) to Minister for Health (Sir Neville Howse), 3 April, 1928.
[43] Kewley, *Social Security in Australia 1900-72*, 1973, p. 134.
[44] In 1925 the Commonwealth Royal Commission on Health noted that 33.9% of men examined for overseas service in World War I were deemed unfit. [Parliament of Australia, *Report of the Royal Commission on Health*, 14 January 1926, p. 9. Parlt Papers, Vol. IV. Just as Boer War recruiting had revealed to the British Government the extent of poor health in Britain (at least among men of military age), so WWI recruitment in Australia revealed poorer levels of health than the Australian Government found palatable.
[45] NAA: A457, 501/16, Memorandum to the Prime Minister, from J.H.L. Cumpston, 2 April, 1917.

be taken against the main causes of death and invalidity.[46] The Committee identified tuberculosis as one of seven major causes of death and invalidity, and made it the subject of one of its special reports.[47] It also investigated typhoid fever, diphtheria, venereal disease, infant and maternal mortality, and risks of middle age.

The Death and Invalidity Committee comprised three medical doctors plus James Mathews, Labor Member of the House of Representatives as the Chair. Committee members were Doctors Sir Harry Brookes Allen, A. Jeffreys Wood, and Cumpston.[48] Allen, a pathologist and administrator from Victoria, was prominent in the Australian medical profession from 1879 when he became secretary of the Medical Society of Victoria and editor of the *Australian Medical Journal*. He chaired a royal commission on sanitation in Melbourne in 1888, was secretary of the 1890 Intercolonial Medical Congress, and held the positions of Dean of Medicine and Professor of Anatomy and Pathology at the Melbourne University. Allen also sat on the sub-committee on tuberculosis at the 1896 Intercolonial Medical Congress. His interests extended to preventive medicine and research which led to his involvement in establishing the Australian Institute of Tropical Medicine and the Walter and Eliza Hall Institute, a medical research centre in Victoria.[49] A. Jeffreys Wood was a prominent Melbourne paediatrician involved in the infant welfare movement in Victoria. He had upset reformers who were

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[46] Australia, Parliament, Committee Concerning Causes of Death and Invalidity in the Commonwealth, *Preliminary Report*, (J. Mathews, M.P., Chairman), Parl. Paper, 39, 17 May, 1916, Vol 5, p 3.

[47] Other causes for concern were typhoid fever, diphtheria, venereal disease, infant and maternal mortality, and risks of middle age.

[48] Australia, Parliament, Committee Concerning Causes of Death and Invalidity in the Commonwealth, *Preliminary Report*, 1916, p. 6.

[49] Russell, K. F., 'Allen, Sir Harry Brookes (1854–1926)', *ADB*, National Centre of Biography, Australian National University, http://adb.anu.edu.au/biography/allen-sir-harry-brookes-5002/text8315. *Australian Medical Journal*, 15 May, 1891. Intercolonial Medical Congress of Australasia, *Transactions of the Fourth Session*, Dunedin, New Zealand, February, 1896, Dunedin.

advocating pasteurized milk for babies when he tried to save money by using the milk of cows showing negative tuberculin results in place of pasteurized milk. In 1918 he headed the newly formed Victorian Baby Health Centres Association.[50] In 1916 Cumpston was the Acting Director of Quarantine.

The Committee members' report on tuberculosis was presented to the Minister for Customs and Trade on 19th September 1916 and drew the Government's attention to the way in which tuberculosis had become a direct economic cost to the Federal Government because of the invalid pension scheme. It reported that 11% of pensions were paid to sufferers of tuberculosis and in the case of pensioners younger than forty years of age, almost 25%. The Committee also predicted the financial burden of paying invalid pensions to the tubercular would continue to increase as infected family members of pensioners ultimately also became pensioners, a situation that would become 'economically unsound'.[51] This was in addition to the general costs to the community of a chronic disease.

The Committee recommended a range of measures against tuberculosis including coordinated laboratory and field research into various aspects of tuberculosis in Australia including why death rates varied across the States and gender and how the disease spread within Australia. Recommendations also included tuberculosis dispensaries, a central bureau, sanatoria for early cases and separate accommodation for advanced cases. Segregating advanced cases from their family and community was a principal element in the Report based on the widely accepted

[50] Milton Lewis, *The People's Health, Public Health in Australia 1788-1950*, Praeger, Westport Connecticut, 2003, pp. 157, 159.

[51] Australia, Department of Trade and Customs, Committee Concerning Causes of Death and Invalidity in the Commonwealth, *Report on Tuberculosis*, 19 September, 1916 (J. Mathews, M.P., Chairman), Albert J. Mullett, Government Printer for the State of Victoria, 1916, pp. 19, 31.

medical view that such cases were the primary means of spreading the disease. The Committee stressed this point,

> It has been repeatedly affirmed by the most reliable authorities that no one immediately practicable measure offers so great promise of material reduction in the tuberculosis rate of a community as that of the provision of hospital accommodation for advanced cases.[52]

As a result of these findings the Death and Invalidity Committee urged the Commonwealth to secure sufficient hospital accommodation for tubercular pensioners living in large urban centres both as a humane gesture and as a cost saving for the Government.[53] Pensioners living at home infected their family and friends who in turn would become pensioners. But pensions ceased during stays in institutions, a situation the Committee viewed as an impediment to successful treatment and in particular to prevention because sufferers were understandably unwilling to enter hospitals or sanatoria and lose this vital income. Because of this the Committee thought it possible that pensions fostered the spread of the disease because pensioners stayed home infecting their families instead of entering institutions. It therefore called for pensions to continue during hospitalization in order to encourage entry to sanatoria and thereby segregate patients in advanced stages of the disease from their families and communities. A further suggestion called for legal power to order tubercular invalid pensioners into institutions because of the probability that those in need of a pension were in such poor social and economic circumstances that precautionary measures would be impossible.[54] Members of the Committee saw a need for the Federal Government to participate directly in tuberculosis policy. As well as urging the Commonwealth to provide

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[52] ibid. p. 26.

[53] NAA: A457, 501/16, Memorandum, J.H.L. Cumpston to Prime Minister Hughes, 2 April, 1917. Australia, Department of Trade and Customs, Committee Concerning Causes of Death and Invalidity in the Commonwealth, *Report on Tuberculosis*, 1916, pp. 31-32.

[54] Australia, Department of Trade and Customs, Committee Concerning Causes of Death and Invalidity in the Commonwealth, *Report on Tuberculosis*, 1916, pp. 31-32.

hospital accommodation for invalid pensioners, they also proposed a joint campaign with the Victorian Government against the disease in the gold mining town of Bendigo as a test case for determining the best methods of combating the disease in Australian conditions.[55] The Commonwealth Government was now armed with a report that set out current medical opinion on the most appropriate means of managing and treating tuberculosis. A critical element of the advice to the Government in 1916 was that advanced cases of tuberculosis should not remain at home and their pensions should be an inducement to remain in an institution. [56]

Bendigo: A Test Case

Bendigo's tuberculosis mortality rates were the highest in the nation[57] and because of this dubious record Bendigo was the subject of three attempts at joint Commonwealth and State initiatives in managing tuberculosis. The first initiative occurred between 1917 and 1922 following the recommendation of the Death and Invalidity Committee, the second in 1941 and again in 1945. Until the late 1940s these joint ventures struggled to achieve the necessary federal and state co-operation. A brief discussion of the first of these negotiations will demonstrate the administrative and jurisdictional obstacles to implementing tuberculosis policy and also the way in which federal officials, notably Cumpston, tried to enhance the federal role.

[55] ibid., p. 38.

[56] The Chairman of the Committee, Mr Mathews, advised Parliament that the reports had been commended by various medical authorities in different parts of the world. The *Lancet* had published a complimentary article on the Tuberculosis Report. [Australia, House of Representatives, *Debates*, 26 April, 1918, Vol 84, p. 4216, (James Mathews, Melbourne Ports)]

[57] For a discussion of miners' phthisis in Bendigo to the 1910s see Yolande Collins, 'Public Health in Bendigo: 1851 -1907', MA thesis, University of Melbourne, 1991, pp. 193 – 217.

Table 5.1 is a comparison of Bendigo with other Victorian cities showing that not only was Bendigo's mortality rate double that of Melbourne's, it also exceeded its neighbouring gold mining town of Ballarat. Just as the proposal for a joint government project was being put to the Commonwealth in 1916, the Prime Minster, Billy Hughes, changed his parliamentary seat from West Sydney to the seat of Bendigo.[58] This gave the proposal a powerful voice. Hughes participated in negotiations not just as the Member for Bendigo but as Prime Minister.

Viewed as an important public health initiative for Bendigo and as an example of what might be done around the country, the preliminary investigation of tuberculosis in Bendigo was conducted jointly by Cumpston as the Director of Quarantine and Dr. E. Robertson, Chair of the Victorian Board of Public Health. Their report, submitted to the Prime Minister in July 1917, recommended a tuberculosis clinic, hospital wards and a sanatorium for a total initial capital cost of £23,500, of which only £500 would be required to establish a clinic. Ongoing annual maintenance costs of the clinic were estimated at £1,350. The Commonwealth agreed to fund half the cost of the clinic to be jointly controlled by the Commonwealth and Victoria on the condition that the Victorian Government matched the funding and found a building for the clinic where patients could be x-rayed and tuberculin tested. The clinic should also arrange nurse visiting, and education on personal preventive behavior as well as directing patients to hospital wards or sanatoria.[59] Inaction by both governments delayed the commencement of

[58] *Parliamentary Handbook of the Commonwealth of Australia*, 21st Edition, 1982, AGPS, Canberra, 1982, p.270. Billy Hughes held the seat of Bendigo until December 1922 when he again changed seats by moving to North Sydney.

[59] NAA: A457, 501/16, Memorandum, J.H.L. Cumpston, Director of Quarantine to W.M. Hughes, Prime Minister, 2 April, 1917; Letter, Prime Minister to Victorian Premier, 18 April, 1917; Letter, Victorian Premier to Prime Minister, 17 May, 1917; Letter, Prime Minister to Victorian Premier enclosing joint report, 23 July 1917. 'Clinic for Bendigo',*The Age*, 13 October, 1921.

these initiatives. First, Victoria delayed its agreement to share costs until February 1920, and second, the Commonwealth stalled negotiations while it established its own health ministry and department in 1921.[60] The clinic finally opened late in 1922 but only in conjunction with a Commonwealth Serum Laboratory.[61]

Table 5.1

Death Rate per 100,000 From Pulmonary Tuberculosis in Victorian Towns and Cities 1891-1938

Period	Greater Melbourne	Ballarat	Bendigo	Geelong
1891 - 1900	167	171	241	Not calculated
1901 - 1905	139	153	227	Not calculated
1906 - 1910	108	115	212	Not calculated
1911 - 1915	91	103	165	Not calculated
1916 - 1920	83	112	160	Not calculated
1921 - 1925	69	67	119	46
1926 - 1930	59	52	107	42
1934	47	53	61	18
1935	48	47	92	33
1936	50	13	104	38
1937	44	37	94	65
1938	44	42	93	23

Source :NAA: Department of Health, Central Office; A1928, Correspondence files, multiple number series (first series); 458/10 Section 2, Public Health Department, Bendigo, Health Laboratory, Bendigo Co-operation with State Dept. of Health for Tuberculosis investigation. Section 2, 1940 - 1945; 'Tuberculosis in Bendigo', 19 November 1940. [Source of Health Dept Statistics Victorian Year Book 1938-39.]

[60] NAA: A457, 501/16, Letter, Victorian Premier to Prime Minister, 10 December 1917; Letter, Prime Minister to Victorian Premier, 8 March 1918; Letter, Victorian Premier to Prime Minister, 1 May 1918; Letter, Prime Minister to Victorian Premier, 5 September 1918; Letter, Victorian Premier to Prime Minister 19 February 1920; Letter, Prime Minister to Victorian Premier, 19 August 1920; Letter, Victorian Premier to Prime Minister, 11 November 1920; Memorandum, J.H.L. Cumpston, Director of Quarantine, to Deane, Secretary to Prime Minister, 7 February 1921.

[61] NAA: A457, 501/16, Letter, Prime Minister to Victorian Premier, 8 April, 1921; 'Establishment of Phthisis and Tuberculosis Clinic at Bendigo', Report, Prime Minister's Office, 9 March, 1922; Letter, Premier of Western Australia to Prime Minister, 22 May, 1922.

FEDERAL HEALTH DEPARTMENT AND TUBERCULOSIS

The Commonwealth Health Department was formed in 1921 and its chief officers, notably Cumpston and Dr. Mervyn John Holmes both of whom had long tenure in the department, tried to bring about a nationally consistent tuberculosis policy with federal government involvement. Since federation and the allocation of quarantine powers to the Commonwealth, the relationship between the States and the Commonwealth on health issues had often been troubled. Writing to his daughter shortly before his death in 1954[62] Cumpston said Commonwealth-State relationships were 'unpleasant for many years after federation …The old State gangs resent[ing] bitterly everything federal'.[63]

Michael Roe's analysis of the formation of this department stands as the best exposition of what was a significant development in the history of Australian public health. Roe located the origins of the department in quarantine concerns of the late nineteenth and early twentieth centuries. Quarantine powers were given to the Commonwealth Government, but tensions between the States and the Commonwealth emerged over the exercise if those powers. Roe saw World War I as the main reason for the success of pressure from centralist public health physicians for a national department.[64]

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[62] Roe, Michael, 'Cumpston, John Howard Lidgett (1880–1954)', *ADB*, National Centre of Biography, Australian National University, http://adb.anu.edu.au/biography/cumpston-john-howard-lidgett-5846/text9935.

[63] Letter, J.H.L. Cumpston to daughter Margaret, August 1953, Papers of J.H.L. Cumpston, National Library of Australia, MS 613, Box 14.

[64] Michael Roe, 'The Establishment of the Australian Department of Health: Its Background and Significance, *Historical Studies*, Volume 17, October 1976, Number 67, pp. 176-192.

The Death and Invalidity Committee had encouraged the Commonwealth to extend its role in public health beyond quarantine and invalid pensions. Its report noted

> In the opinion of your Committee, the Government of the Commonwealth has essential interests and essential duties in regard to public health.[65]

Ideas for how to do this included the promotion of uniform laws across the nation and support for nationally co-ordinated medical research. More directly the Committee saw the Commonwealth contributing to the cost of employing District Health Inspectors across the country.

Ideas about an expansion of the Commonwealth's role in public health policy had been gathering momentum during the war years but the tragedy of the influenza pandemic,[66] which reached Australia in 1919, brought the issue to prominence. Influenza alone, however, as Roe pointed out, would not have sparked the creation of a federal department. It also needed the pressure of the medical profession and in particular personalities such as Cumpston.[67] The lack of co-operation and squabbling between the States during the pandemic together with inconsistent States' support of Commonwealth quarantine measures highlighted the problems of disparate jurisdictions struggling with borderless infectious diseases.[68]

On 9 January 1919 the Federal Cabinet decided to raise the matter of co-ordinating Commonwealth and State powers on quarantine and other diseases at the upcoming

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[65] Australia, Department of Trade and Customs, Committee Concerning Causes of Death and Invalidity in the Commonwealth, *Final Report*, 1917, p. 8.

[66] For a discussion on Cumpston's role in handling the 1918-1919 influenza pandemic see Anthea Hyslop, 'A Question of Identity: J.H.L. Cumpston and Spanish Influenza, 1918-1919', *Australian Cultural History*, No. 16, 1997-1998, pp. 60-76.

[67] Michael Roe, *Historical Studies*, 1976, pp. 179-180.

[68] J.H.L Cumpston, 'Creation of Department of Health', handwritten manuscript for Health of the People, NL, MS 613, Box 11. Thame, 'Health and the State:', 1974, pp. 33-34. Michael Roe, *Nine Australian Progressives*, 1984, p. 129. Michael Roe, *Historical Studies*, 1976, p. 178. Gillespie, *The Price of Health*, 1991, pp. 37-38.

Premiers' Conference in Melbourne.[69] William Watt, Acting Prime Minister, presented to the Premiers a memorandum from Cumpston in which he argued strongly for the Commonwealth to recognise its responsibilities for preserving the nation's health. He proposed two alternative policies. One gave the Commonwealth full control of public health matters and the second established a Commonwealth Health Department with powers beyond that of quarantine. In Cumpston's vision this Department would investigate the causes of disease and mortality, give advice on how to prevent disease, collect sanitary data and educate the public. The Commonwealth would also subsidise state programmes of eradication or control of disease and run prevention campaigns across the States (as States desired) but do so 'without usurping States' power.[70] Cumpston had a vision of a federal department in which co-operation between the States and the Commonwealth was vital for success..[71] Cumpston's second more moderate proposal showed his understanding that the States were likely to resist a Commonwealth takeover. His experience as Chief Quarantine Officer would have made him acutely aware of States' likely resistance to Commonwealth interference in areas seen as the preserve of the States.

These two alternatives were put to the Premier's Conference without a recommendation from the Federal Cabinet but subsequently, on 4 February 1919, Cabinet supported the second proposal that established a department with limited powers.[72] Premiers indicated moderate support for the idea but made no firm

[69] NAA: CRS A2717, Volume 1, Folder 3, Cabinet decisions, January to December 1919, 9 January 1919.
[70] J.H.L. Cumpston, 'Chapter VII Creation of the Department of Health', manuscript for 'The Health of the People', NLA, MS 613, Box 11.
[71] ibid.
[72] NAA: CRS A2717, Volume 1, Folder 3, Letter, William Watt, Acting Prime Minister, to Premier of Victoria, 19 February, 1919, p. 2.

decision.[73] Acting Prime Minister Watt supported Cumpston and pursued the State Governments for a firm decision during the early months of 1919.[74]

Cumpston doggedly pursued the issue of a federal health department through bureaucratic channels and the forums of the medical profession. He accompanied a BMA deputation to Senator Edward Millen who was Acting Prime Minister in early August 1919. The deputation presented resolutions from the BMA that sought the assistance and co-operation of the Commonwealth to expand public health services in the States.[75] In February 1920 the Federal Council of the BMA presented further resolutions to the Prime Minister, this time calling for the Commonwealth to create its own health department.[76] At the 1920 Australasian Medical Congress Cumpston called for a Commonwealth royal commission to investigate Australia's public health system. His address to Congress expressed frustration, even anger, with the disparate and inadequate national public health system. He said,

> If preventive medicine in this country is ever to emerge from its present position of infantile impotence, the present system of so-called public health administration must disappear.[77]

[73] Roe, *Historical Studies*, 1976, p. 178.

[74] NAA: A1928, 443/11a,Telegrams, Acting Prime Minister Watt to Premiers of Tasmania, South Australia, New South Wales, Queensland, 15 May 1919; Telegram, Theodore, Acting Premier of Queensland to Prime Minister, 21 May 1919; Letter, Premier of New South Wales to Acting Prime Minister, 12 June, 1919; Letter, Acting Prime Minister to Premier, New South Wales, 3 July, 1919; Letter, Premier of New South Wales to Prime Minister, 16 October, 1919; Letter, John G. Rice, Premier of South Australia to the Prime Minister, 13 February 1920; Minute Paper, J.H.L. Cumpston, Director of Quarantine, to Comptroller General – Department of Trade and Customs, 13 April, 1920.

[75] NAA: A1928, 443/11a, Record of deputation to the Acting Prime Minister, Senator Millen, from the BMA, 31 July, 1919; Minute Paper, J.H.L. Cumpston, Director of Quarantine, to Comptroller General, Department of Trade & Customs, 13 April, 1920.

[76] NAA: A1928, 443/11a, Letter, Federal Committee of the BMA to the Prime Minister, 24 February 1920.

[77] J.H.L. Cumpston, 'Presidential Address in Public Health and State Medicine', *Australasian Medical Congress, Transactions of the Eleventh Session*, Brisbane, 21-28 August 1920, p. 86.

Cumpston had a strong personal interest in advocating a substantial re-organisation of public health. As the Director of Quarantine he was well placed to be the person to take control of any central or national health authority.

His colleague in the Federal Quarantine service, Mervyn John Holmes, went further than Cumpston and called for public health activities nationally to be co-ordinated by the Commonwealth.[78] In 1920 Holmes addressed the Australasian Medical Congress calling for central Commonwealth authority under the control of medical experts to direct public health policy nationally. The Congress passed a resolution to that effect.[79] Paradoxically, the resolution also called for greater autonomy for local health authorities.

Watt urged states to adopt one of Cumpston's recommendations[80] and a month after the January conference proposed the creation of a Commonwealth Department of Health in accordance with Cumpston's second proposal in which the department would play an investigative, advisory and data collection role that would not impinge on States' health powers. The States eventually agreed. States gradually sent their agreement to the proposal most wanting to be assured their own health powers would not be usurped.[81]

[78] M.J. Holmes, 'Application to Civil Life of the Lessons of Military Hygiene Derived from the Great War', *Australasian Medical Congress*, 1920, p. 502.
[79] Section of Naval and Military Medicine and Surgery, *Australasian Medical Congress, Eleventh Session, 1920*.
[80] Roe, *Historical Studies*, 1976, p. 178.
[81] NAA: A1928, 443/11a, Telegrams, Acting Prime Minister Watt to Premiers of Tasmania, South Australia, New South Wales, Queensland, 15 May 1919; Telegram, Theodore, Acting Premier of Queensland to Prime Minister, 21 May 1919; Letter, Premier of New South Wales to Acting Prime Minister, 12 June, 1919 Letter, Acting Prime Minister to Premier, New South Wales, 3 July, 1919; Letter, Premier of New South Wales to Prime Minister, 16 October, 1919; Letter, John G. Rice, Premier of South Australia to the Prime Minister, 13 February 1920; Minute Paper, J.H.L. Cumpston, Director of Quarantine, to Comptroller General – Department of Trade and Customs, 13 April, 1920.

Thame and Roe noted that an offer of assistance from the Rockefeller Foundation helped persuade Prime Minister Hughes to accede to requests for a federal department and other commentators such as Gillespie and Lewis have reiterated this view[82] thereby suggesting a lack of enthusiasm by Hughes for a federal department. Cumpston had links with the Rockefeller Foundation and had visited the United States as a guest of the Foundation to study public health problems.[83] The Rockefeller Foundation had also been involved with a campaign against Hookworm in Queensland. While the Foundation offer may have been persuasive for Hughes and the Cabinet, it is not clear that the proposal for a federal department would have languished without it. Not only would Cabinet have been aware of the limitations of long term support from the Foundation, but the new department was consistent with recent Government policy and was supported by Watt when he was Acting Prime Minister. A new Quarantine Act had been passed in 1920 and in the same year the Commonwealth had taken full responsibility for the rehabilitation of returned soldiers through the passage of a comprehensive Repatriation Act. The Australian Soldiers Repatriation Act laid down the Commonwealth's responsibility for the medical care of veterans. The Repatriation Department though was to receive far more substantial support than the Health Department.

The new Federal Health Department's administrative base was the old Quarantine Service. It was not equipped with new resources or with much funding. Nevertheless its medical personnel harboured great ambitions for the department and the impact it could have on co-ordinating and guiding health policy across the

[82] Roe, *Historical Studies*, pp. 180-181. Thame, 'Health and the State, 1974, p. 35. Gillespie, *The Price of Health*, 1991, p. 37.
[83] Unidentified newspaper clipping, NLA: MS 613 Box 8 (iii).

nation.[84] They quickly made tuberculosis a prime area of interest. The first forays into tuberculosis policy operated through the two arms of the Health Department in which the Commonwealth had jurisdiction, quarantine and Commonwealth health laboratories. Starting in 1922 Cumpston began to collect data on invalid pensioners suffering from tuberculosis.[85] He set up a system of that required the States to advise the Commonwealth Department through Quarantine Officers of their tubercular pensioners. Quarantine Officers were then to visit and examine each pensioner and as many of their immediate family and friends as possible to record their ages, gender, occupation medical condition, family contacts and their living and social conditions. A specially designed form was to be completed and sent to the Commonwealth Health Department where the information would be collated and analysed.[86] This information was to be passed to State health authorities who were expected to visit and undertake normal supervisory measures such as education on preventive measures and disinfection of homes.

Commonwealth Departmental officers optimistically reported early results in the *MJA* of April 1924. From the investigations they concluded that contrary to general impressions immigration had a limited impact on the level of tuberculosis with 77% of pensioners being born in Australia. Their figures also showed gender differences in that more men were pensioners than women but this ratio differed according to age with women dominating the younger age group of 16 to 30 years. They also concluded that residents of sanatoria largely observed preventive

[84] Gillespie, *The Price of Health*, 1991, pp. 38-39.

[85] NAA: A1928/1, 1105/13, Memorandum, Chief Quarantine Officer (General) Victoria to Commonwealth Director-General of Health, 11 March 1929. NAA: A1928/1, 735/4, Memorandum, Commonwealth Director-General of Health to Chief Quarantine Officer (General), Sydney, 4 March 1929.

[86] M.J. Holmes and Frank R. Kerr, Commonwealth Department of Health, 'Some Figures and Conclusions Drawn From an Investigation into Tuberculous Invalid Pensioners in Australia', *MJA*, 12 April, 1924, p. 355.

measures when they returned home, that poor sanitation was more important in spreading the disease than overcrowding and that few pensioners received visits from health officers.[87] The investigation, however, met with limited success. Quarantine Officers responded to the notification system haphazardly complaining of insufficient time and labour to complete this additional task. Victoria abandoned the investigation after 1923 even though Quarantine Officers continued to receive details of pensioners until 1927.[88] South Australia received the pensioner details but stopped sending forms to the Commonwealth Department in 1922. South Australia had even tried to comply by asking for the help of medical students but the attempt was abandoned in 1924.[89] In New South Wales the Quarantine Office continued to send information on tubercular pensioners to State health authorities throughout the 1920s but State officials were not able to visit and investigate every case.[90]

Quarantine Officers encountered much the same problems in this exercise as State health authorities did when trying to oversee sufferers following notification. Tuberculosis sufferers moved frequently, sometimes because they were impoverished by the disease, sometimes to avoid health authorities. They frequently had to hide their condition because they could be forced to move by landlords who evicted tubercular tenants when they discovered their condition. Many patients died before local authorities visited. Frustrated with the lack of compliance, Cumpston wrote to Quarantine Officers early in 1929 asking them to

[87] ibid., pp. 355-358.
[88] NAA: A1928/1, 1105/3, Memorandum to Chief Quarantine Officer, Victoria, from the Commonwealth Director-General of Health, 11 March 1929.
[89] NAA: 1928/1, 1105/3, Memorandum, Chief Quarantine Officer, South Australia, to Commonwealth Director-General of Health, 4 March 1929; Memorandum, Commonwealth Director-General of Health to Chief Quarantine Office, South Australia, 25 March, 1929.
[90] NAA: 1928/1, 1105/3, Memorandum, Chief Quarantine Officer, New South Wales, to Commonwealth Director-General of Health, 20 August 1928.

persist with the investigation of tubercular pensioners. Victorian health officials began to comply by regularly sending details of visits to the homes of pensioners and why so many of these visits were unsuccessful. In July 1929, for instance, of ten cases visited four had left the premises and one had died.[91] According to Victorian health reports a majority of patients were not able to be contacted despite a number of attempts to visit them.[92] The Commonwealth Department pursued the investigation until 1934 when the scant results finally persuaded Cumpston to abandon the Commonwealth's attempt to intervene in the management of tubercular pensioners. In a memorandum to Quarantine Officers, he stated, 'no further object appears to be obtainable in continuing this enquiry'.[93]

In another attempt to collect data and involve the Health Department in tuberculosis management Cumpston used the system of Commonwealth health laboratories. Disappointed by the unreliability of various data presented to the 1923 Australasian Medical Congress, Cumpston tried to impose uniform techniques in the laboratories to collect more accurate information. Tuberculosis had featured prominently at the 1923 Congress and a number of doctors offered a range of statistical findings. William Penfold, the Director of the Commonwealth Serum Laboratories, presented data on von Pirquet tests of patients in the Melbourne and Adelaide Hospitals and the Royal Prince Alfred Hospital (RPA) in Sydney. Amongst patients with diagnosed or 'undoubted' tuberculosis the Melbourne and RPA had a similar percentage of positive reactions to the Von Pirquet test, 91% in

[91] NAA: A1928/1, 1105/13, Memorandum, Chief Quarantine Officer (General), Victoria to Director-General of Health, Dept of Health, Canberra, 29 July 1929.
[92] NAA: A1928/1, 1105/13, Memoranda, Chief Quarantine Officer (General), Victoria to Director-General of Health, Department of Health Canberra, 16 August, 26 August, 4 September, 2 October, 28 October, 27 November, 1929, 4 January 1930.
[93] NAA: A1928/1, 1105/13, Memorandum, Director-General of Health to All Chief Quarantine Officers in all States, 23 August 1934.

the case of Melbourne and 100% at the RPA. At the Adelaide Hospital only 75% of 'undoubted' cases had a positive reaction. Among suspected cases the Melbourne Hospital had 72% of patients react positively, while at the RPA the percentage was 56%.[94] The variations in these data were an indication to the Medical Congress and Cumpston of the unreliability of research data conducted without consistent criteria. The Melbourne Hospital, for instance, had tested four times as many patients as the other two hospitals. These variations were also apparent in reports on the bovine form of the disease. Eustace Ferguson, principal microbiologist in the New South Wales Department of Health reported no tuberculosis infected milk on the Sydney market whereas Penfold had found an infection rate of 16.8% in dairy cattle in Sydney. Harvey Sutton, New South Wales's Principal Medical Officer in its Department of Public Instruction, had found tuberculosis in school children to be limited, yet a high proportion of children reacted positively to a Von Pirquet test.[95]

Cumpston took the opportunity of these mixed results to try to stimulate and co-ordinate research into the extent and geographic pattern of both human and bovine tuberculosis.[96] He promoted the Commonwealth Health Laboratories as the most efficient institution to carry out the necessary research. He wrote,

> Commonwealth Laboratories are in an unrivalled position to collect the necessary information, and to collect it in such a manner that its accuracy will be undoubted. … To ensure uniformity and completeness of method, the … instructions are issued for you to carry out carefully in all respects.[97]

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[94] W.J. Penfold, 'The Incidence of 'Tuberculosis in Australia', *Transactions of Congress, Supplement to MJA*, 3 May, 1924, pp. 264-265.

[95] 'Discussion on Tuberculosis, Combined session of all Sections,' *Transactions of Congress, Supplement to MJA*, 3 May, 1924, p. 545.

[96] NAA: A1928/1, Item 1105/5, For the Medical Officer in Charge of Commonwealth Health Laboratory from Director-General of Health, 29 March 1924.

[97] NAA: A1928/1, 1105/5. Instructions for the Medical Officer in Charge of Commonwealth Health Laboratory from Director-General of Health, 29 March 1924.

At the beginning of this exercise in 1924 six health laboratories had been established around the country one each in Bendigo, Townsville, Rockhampton, Toowoomba, Lismore and Port Pirie. Kalgoorlie was added in 1925, Canberra in 1928[98] and by 1929 in Cairns.[99]

Cumpston asked health laboratories to examine human and animal tissue known to be tuberculous or likely to be tuberculous in order to cultivate and determine the type of *tubercle bacillus*. He directed Medical Officers in the laboratories to collect and identify tuberculous material, determine bacillus type and extrapolate from the data information such as the presence of bovine and human tuberculosis in different regions and the extent of latent infection in adults and children. These results were to be sent to the Commonwealth Serum Laboratories for co-ordination. Other information to be gleaned was whether acid fast bacillus in neck glands were tubercule bacillus; the rate and type of tuberculosis in various animals, and whether living bacilli could be found in scarred organs post mortem in humans.[100] Cumpston made clear to the medical officers the importance he placed on the project when he wrote,

> Medical Officers should be advised that this is regarded as an important part of the work of the Department, and the degree to which this investigation is

[98] Gordon, *Health, sickness and society*, 1976, p. 807. NAA: A1928/1, 1105/5, M.J. Holmes, 'Tuberculosis Investigation To ascertain the incidence of bovine tuberculosis in children's hospitals population', circa April 1929. A Commonwealth Serum Laboratory at Royal Park in Melbourne had been created in 1916 in response to a war time shortage of drugs. It manufactured and distributed sera not available elsewhere. [Gillespie, *The Price of* Health, 1991, p. 37]

[99] NAA: A1928/1, 1105/5, M.J. Holmes, 'Tuberculosis Investigation To ascertain the incidence of bovine tuberculosis in children's hospitals population', circa April 1929. In 1929 the Commonwealth Government, having purchased 10 grams of radium for treatment of diseases especially cancer, established the Commonwealth Radium Laboratory at the University of Melbourne to determine the safest and most efficient way to use this hazardous material. ['Scope of the Commonwealth X-Ray and Radium Laboratory', typescript, NLA, MS613, Box 14.]

[100] NAA: A1928/1, 1105/5, Instructions for the Medical Officer in Charge of Commonwealth Health Laboratory from Director-General of Health, 29 March 1924.

> successfully carried out by them will be considered in estimating the value of their work for the forthcoming year.[101]

While the Commonwealth laboratories gradually increased in number the programme encountered difficulties with Medical Officers failing to collect complete and accurate data.[102] Laboratories encountered technical difficulties with Queensland and New South Wales reporting nothing during the first six months of the investigation. Queensland reported problems with its culture medium resulting in all specimens being contaminated. Four months later Queensland had been unable to commence the research properly because of a lack of time, with routine work including examination of swabs and cultures for other diseases like diphtheria and tissue samples from hospitals fully occupying both laboratory and clerical staff. In Townsville all specimens had been nullified because irregular gas supplies caused temperature fluctuations in their incubated destroying specimens.[103] By 1928 the Commonwealth Serum Laboratory in Royal Park, Melbourne reported that all cultures examined had been typed as the human bacillus and that the laboratory therefore required a greater variety of specimens to ascertain the degree of and geographic distribution of the bovine bacillus. Specific specimens such as from bone and joint lesions were needed[104] As a result of these problems Cumpston asked Mervyn J. Holmes, Director of the Tuberculosis and Venereal Division, whether the investigation was worth continuing. Holmes answered firmly that the

[101] NAA Series A1928/1, Item 1105/5Memorandum, Director-General of Health to Director, Division of Tropical Hygiene, Brisbane, 29 March 1924.

[102] NAA: A1928/1, 1105/5, Note, J.H.L. Cumpston to Director Division Tuberculosis and Venereal Disease, 7 January 1929.

[103] NAA: A1928/1, 1105/5, Memorandum, Acting Director-General of Health to Director Division of Tropical Hygiene, Division of Marine Hygiene, Chief Quarantine Officer (General), New South Wales, 11. October, 1924; Memorandum, Acting Director, Division of Tropical Hygiene, Brisbane to Director-General of Health, Melbourne, 11 November, 1924; Memorandum, J.S.C. Elkington, Director, Division of Tropical Hygiene to Director-General of Health, Melbourne, 23 February, 1925; Memorandum, J.S.C. Elkington, to Director-General of Health, Melbourne, 13 May, 1925.

[104] NAA: A1928/1, 1105/5, Memorandum, Director, Laboratories Division, Parkville to Director-General of Health, Canberra, 15 November 1928.

investigation ought to continue because reliable information on the extent of bovine infection would allow the bovine type of the disease to be incorporated into a scheme of control.[105] Cumpston accepted Holmes's advice and continued to pursue the investigation this time concentrating not on sputum but on a wider variety of tissue from bones, glands, joints, skin and autopsies primarily from children's and orthopaedic hospitals. The Federal Health Department took responsibility for arranging the collection from children's hospitals contacting children's hospitals directly and asking them to send specimens directly to the Commonwealth Serum Laboratory at Royal Park in Melbourne.[106] In 1930 the Commonwealth Department published a report on bovine tuberculosis entitled *Bovine Tuberculosis in Man and Animals in Australia* written by Holmes and Robertson. Holmes and Robertson concluded that tuberculosis of bovine origin was contracted by children but rarely by adults. Mortality among children was relatively low and compared favourably with the rest of the world. They concluded that bovine tuberculosis needed to be controlled but that an eradication plan was not necessary because children were able to resist small doses. Controls needed were testing of herds, pasteurizing milk and checking in laboratory for the presence of the bacillus in milk.[107]

ROYAL COMMISSION ON HEALTH, 1925

Within two years of the creation of the Commonwealth Department of Health Cumpston supported the establishment of a Commonwealth royal commission into

[105] NAA: A1928/1, 1105/5, Memorandum, M.J. Holmes, Director, Division of Tuberculosis and Venereal Disease, to Director-General, 14 January, 1929.

[106] NAA: A1928/1, 1105/5, Memorandum, Director General of Health to Director, Laboratories Division, Commonwealth Serum Laboratories, 26 April, 1929; Letter, Director General of Health, Canberra to Heads of State Health Departments, 2 September, 1929. Letter, Director General of Health, Department of Health, Canberra to Medical Superintendents of Hospitals, 2 September, 1929.

[107] NAA: CA17, 1925-1949, 1105/1 Section 1, Memorandum, J.H.L. Cumpston, Director-General of Health, 13 July, 1932. A.J. Proust, 'Bovine Tuberculosis in Relation to Public Health In Australia' in A.J. Proust, (ed) *History of Tuberculosis in Australia New Zealand and Papua New Guinea*, Brolga Press, Canberra,1991, pp.132-133.

the nation's health. At a national conference of ministers in May-June 1923, Prime Minister Stanley Bruce put to the States a proposal to appoint a Royal Commission to examine the administration of health in the various jurisdictions across the nation. Cumpston's hand can be seen in the Commonwealth's proposal, which suggested that it was time to consider the distribution of responsibility for health administration between States, the Commonwealth and local bodies. The intention was 'to consider the present system of health legislation and administration to make recommendations for securing the most economical and efficient results for all the money expended on public health'.[108] All States except Queensland rejected the proposal arguing instead that State health authorities were competent to make the necessary recommendations for coordinating and standardizing the nation's health administration. The States won the argument at the ministers' conference with the passage of a motion that Commonwealth and States Health Officers meet to consider questions regarding national health and make recommendations to their individual governments.[109] The Commonwealth invited the States to send representatives to a conference of Commonwealth and State Health Officers, but some States refused.[110] Despite this resistance the Federal Health Department continued to pursue the issue and Cumpston helped to gain the vital support of medically trained Commonwealth Ministers, Dr. Neville Howse, Minister for Health and former Director-General of Army Medical Services, and Dr. Earle Page, Federal Treasurer.[111] Federal Cabinet decided on 10 June 1924 to appoint a State

[108] Australia, Parliament, *Conference of Commonwealth and State Ministers held at Melbourne, May-June, 1923, Memoranda, Report of Debates, and Decisions Arrived At,* Government Printer for the State of Victoria, 1923, p. 80.
[109] ibid., pp. 80-84.
[110] Commonwealth of Australia, 1926-27-28, *Report of the Federal Health Council of Australia,* First Session 25-28 January, 1927, Parl Paper, 89, Vol. 5, p.4.
[111] Gillespie, *Price of Health,* 1991, p. 43. Australia, *Parliamentary Handbook of the Commonwealth of Australia,* 21st Edition, 1982, A.G.P.S, Canberra, 1982, p. 307.

and Federal Commission on health if States agreed.[112] Agreement was not reached with the States but, undeterred, the Commonwealth appointed the Commission announcing in it in parliament as part of the Budget speech on 31 July 1924.[113]

The Commission comprised four medical practitioners and one politician from New South Wales[114] Many interest groups and individuals considered the choice of commissioners to be too narrow. A number of excluded groups including friendly societies, health inspectors, dentists and psychologists sought representation on the Commission but all were denied.[115] Friendly societies protested their exclusion, the New South Wales Association complaining to the Prime Minister in these terms:

> [the Association]…enter[s] an emphatic protest against the action of your Ministry, in ignoring the work which Friendly societies are doing in the Commonwealth, and to point out these bodies are in a better position to advise regarding health matters, than several of those appointed to the Commission.[116]

The Commission was chaired by Sir George Syme, a recently retired leading Melbourne surgeon who had chaired a Victorian Royal Commission on sanitation in 1887-89 and was federal president of the BMA. Other medical practitioners appointed were Dr. Robert Henry Todd, the federal secretary of the BMA who was also a barrister, Dr Frank Hone, a leading South Australian practitioner, lecturer on

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[112], NAA: [Bruce Page Ministry] Cabinet Minutes 1924, 2718, Volume 1 Part 2, Cabinet Minutes 10 June 1924.

[113] Australia, *Gazette*, 8 January, 1924, No. 1, 8 January, p. 1. NAA: A460, A5/16, Royal Commission Health, Main File and copy of Report. Australia, Parliament 1926-27-28, *Report of the Federal Health Council of Australia, First Session*, Melbourne 25-28 January, 1927, Parlt Paper 89, Vol. 5, Canberra, p. 4.

[114] Commonwealth of Australia, 1926, *Report of the Royal Commission on Health* 1926, Government Printer for State of Victoria, p. 7.

[115] NAA: A460/, E5/16, Royal Commission on Health - Representations re; Letters to the Prime Minister from South Australian Friendly Societies' Association, Queensland Friendly Societies' Association, Friendly Societies' Association of New South Wales, 20 March 1925, 11 March 1925, 30 January 1925,; Letter J.K. Powell, Editor, 'Sparks Fortnightly" to Right Hon S.M. Bruce, Prime Minister, 8 December 1924. Memorandum, A/Director-General, Commonwealth Department of Health to Secretary, Prime Minister's Department, 18 December 1924; Letter, the Health Inspectors' Association of Australia to Rt Hon S.M. Bruce, Prime Minister, 4 October 1924; Letter, Harold V. Mattingly, Dental Surgeon, to Mr. Latham, MHR, 18 September 1924,

[116] NAA: A460/1, E5/16, Letter, Friendly Societies' Association of New South Wales to Prime Minister, 30 January 1925.

preventive medicine and that State's Quarantine Officer, and Dr Jane Stocks Greig, founder of the Victorian Medical Women's Society, Chief Medical Officer of the Victorian Education Department and public health advocate. Sidney Reginald Innes-Noad, a Member of the New South Wales Legislative Council who had a strong interest in health and welfare issues, joined them as the only non-medical Commissioner.[117]

The Commission interviewed some 350 witnesses, mainly doctors and other experts. Medical practitioners in private practice and government service provided most of the evidence. Other witnesses included leading public servants, statisticians as well as representatives of the Pharmacy Board, Health Inspectors Association, nurses, charities and local government. Delegates from organizations such as the National Council of Women and the Country Women's Association were also interviewed.[118] Missing from the evidence were the views of patients and their families, trades union, friendly societies and representatives of the general public. The Commonwealth Royal Commission on the Basic Wage held in 1920 provides a useful contrast. It heard evidence from wage earners and representatives of the general public. Questions from Commissioners were intrusive and often demanded intimate details of daily life from diet to the quality of women's underwear, but the answers revealed the often poignant stories of struggle for those on low wages. This Commission was not about health and disease, but one example revealed how hard it was for many to observe the dicta of tuberculosis prevention espoused by

[117] NAA A460,A5/16, Royal Commission Health. Main File and copy of Report; Letter, Minister for Health to the Prime Ministers, 25 November 1924. Michael Bosworth, 'Innes-Noad, Sidney Reginald (1860–1931)', *ADB*, National Centre of Biography, Australian National University, http://adb.anu.edu.au/biography/innes-noad-sidney-reginald-6794/text11751. Ruth Campbell, 'Greig, Jane Stocks (Jean) (1872–1939)', *ADB*, National Centre of Biography, Australian National University, http://adb.anu.edu.au/biography/greig-jane-stocks-jean-6480/text11103 Gillespie, *The Price of Health*, 1993, p. 44.

[118] Commonwealth of Australia, 1926, *Report of the Royal Commission on Health*, 1926, pp. 59-61.

the medical profession. Mrs. Farmer of Clarence Park, Adelaide answered questions about her ability to adequately clothe her family on her husband's salary as a machinist. Part of the dialogue between her and the Commissioners touched on tuberculosis:

> …[Mrs Farmer] The Dress I am wearing now belonged to my sister. She died twelve months ago of consumption, and I think you will agree that this dress should have been burned, but it was too valuable, we did not, and I am wearing it still.
>
> …*The Chairman* – As far as I know, there is no risk so long as it has been properly fumigated, as consumption is not communicated by touch? [Mrs Farmer] We fumigated it, but how are we to know that the sputum has not been over it – accidents will happen.
> [Chairman] One would deem that people would know enough to see that that did not occur? [Mrs Farmer] Yes. We took all necessary precautions, and I am wearing her clothes to-day.
>
> Mr. Foster [Commissioner] – Does the same apply to your underclothes? [Mrs Farmer] – Yes.
>
> *The Chairman* – Did they also belong to your late sister? [Mrs Farmer] Yes.[119]

Mrs Farmer's response suggests not resistance to public health advice but an inability to follow it to the letter. Even so, she had done what she could to observe the precautions laid down by the anti-tuberculosis campaign.

Despite the criticism that can be levelled at the Commission's narrow choice of witnesses the Report and in particular the Minutes of Evidence provide valuable evidence for historians of social medicine. During the taking of evidence suggestions that the Commonwealth take control of tuberculosis arose.[120] Edward Fairfax, Honorary Physician at the Royal Prince Alfred Hospital, Sydney, for example, saw a circular problem in tuberculosis management arising from the jurisdictional divide between invalid pensions and public health management of

[119] Commonwealth of Australia, *Royal Commission on the Basic Wage, Evidence taken at Adelaide*, 1920, Questions 66527-666531, p. 1506, (Albert Bathurst Piddington)

[120] Edward Wilfred Fairfax, Hon Physician, Royal Prince Alfred Hospital, Sydney, Royal Commission on Health, 1925, *Minutes of Evidence*, Question 8052, p. 447. Also see J.S. Purdy, Metropolitan Medical Officer, New South Wales, Royal Commission on Health, 1925, Questions 8518, 8520 pp. 474 -475

tuberculosis. While the Commonwealth paid the pension, the States were responsible for containing infection. The Commonwealth therefore had no control over preventive measures for a contagious disease for which it was paying pensions. Fairfax said, 'as pensions are given by the Commonwealth, it would simplify matters if the whole tubercular scheme were in the hands of the Commonwealth'.[121] Such a suggestion, the Commission's Chair pointed out, would require an alteration to the Australian Constitution.[122] Not all witnesses agreed with Fairfax. Richard Bull the Director of the Bacteriological Laboratory at the University of Melbourne believed the tuberculosis problem to be too large for one jurisdiction, the States being better equipped to understand and manage the problem within their individual areas.[123] Nevertheless, the Commissioners in their final report noted the Commonwealth's vital interest in controlling the spread of tuberculosis advising it to act with the States to ensure all measures to reduce the disease were taken.

> …tuberculosis is such a national concern that the Commonwealth Government should realize its responsibility for placing the prevention and treatment of this disease on a sound and humane basis.[124]

Commissioners recommended that the Commonwealth Department of Health devise a programme against tuberculosis and that States receive subsidies to institute the programme. The Commission also proposed the Commonwealth Government pay invalid pensions to the dependants of sufferers during treatment in institutions.[125]

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[121] Fairfax, *Minutes of Evidence*, 1925, Question 8052, p. 447.
[122] Syme, *Minutes of Evidence*, 1925, Question. 8054, p. 447
[123] Richard Joseph Bull, Director of the Bacteriological Laboratory at Melbourne University, *Minutes of Evidence*, 1925, Questions 22097, 22098.
[124] Commonwealth of Australia 1926, *Report of the Royal Commission on Health* p. 24.
[125] NAA: A1928/1, 1105/29, Sect. 1, M.J. Holmes, Division of Tuberculosis and Venereal Disease, 'Tuberculosis, Proposed Subsidy to be paid by the Commonwealth Government to the States in Connection with the Control of Tuberculosis', 19 March 1929,

The recommendations of the Royal Commission were largely ignored[126] apart from a proposal to form a national advisory health body. This body was to consider ways in which the Commonwealth and the States could co-operate on health matters, including suggestions on areas conducive to uniform legislation and administration. The Federal Health Council was established in 1927 with Cumpston as its chair and comprised of chief officers of all State health authorities plus two more officers from the Federal Health Department. It held its first meeting from 25th to 28th January 1927.[127] The Council was an advisory body only with no powers to pursue legislative or administrative uniformity. State and Commonwealth representatives were limited to taking the Council's recommendations back to their respective governments. In the Commonwealth's case it had no constitutional power to implement separately any recommendations. Cumpston and his federal colleagues, however, used the Council to attempt to direct health policy nationally and tuberculosis featured in that promotion in the form of a comprehensive report on the prevention and management of the disease.

HOLMES REPORT 1929

In 1927 the Commonwealth Health Department created a division for tuberculosis and venereal disease and appointed Mervyn J. (M.J.) Holmes as its head. While Cumpston is a widely known figure his colleague M.J. Holmes proved to be more elusive. Holmes began his medical career in public service immediately after receiving his medical degree from the University of Melbourne in 1909 and remained a publicly employed physician until his retirement in 1944. His first

[126] ClaudiaThame, 'Health and the State: The Development of Collective Responsibility for Health Care in Australia in the First Half of the Twentieth Century', PhD thesis, Australian National University, June 1974, p. 307. Gillespie, *The Price of Health*, 1991, p. 45.

[127] Australia, Parliament 1926-27-28, *Report of the Federal Health Council of Australia, First Session*, pp. 1-2.

appointment was as "Medical Protector of Aboriginals" in the Northern Territory and after that Chief Health Officer. During his tenure as Chief Health Officer he and a colleague, Anton Brienl, investigated tuberculosis among the indigenous population in the north of the Territory. They found tuberculosis to be less pervasive than anticipated possibly because sufferers had died during epidemics of malaria, whooping cough and influenza. They believed Chinese migrants had introduced tuberculosis to the indigenous population.[128] Holmes and Brienl's conclusion regarding Chinese importation of tuberculosis points to the way in which assumptions about race may have dictated their medical conclusions. Investigations in the early 1920s suggested imported tuberculosis was a minor contributor to Australia's tuberculosis problem. Holmes served in the military overseas during World War I and on his return took a position as a Federal Quarantine Officer in 1919 and continued in this position under the new Commonwealth Health Department. Despite his long career in public health as a state employed physician, he has been omitted from studies of interwar public health and the cohort of public hygienists discussed by Powles and Gillespie. Like other Australian doctors he returned from military service with ideas about applying the type of structure and discipline employed by military medicine to preventive medicine in Australia. In 1920 he entitled an address he gave to the Medical Congress of that year 'Application to Civil Life of the Lessons Military Hygiene Derived from the Great War'. In this he advocated central administration of preventive medicine. Research, he argued, needed to encompass the laboratory, the work of clinicians and information derived from medical investigations in the

[128] Neil Thomson, 'Tuberculosis among Aborigines' in A.J. Proust (ed.), *History of Tuberculosis* 1991, pp. 71-72.

general community. Also important, in his view, was educating the general public on public health, a process he thought was best started in schools.[129]

During the 1920s Holmes acted as director of the Department's divisions of Marine Hygiene and Tropical Hygiene[130] before being appointed to the position of Director of the Division of Tuberculosis and Venereal Disease in November 1928.[131] Following the suggestion of the Royal Commission on Health in 1925, and at the urging of Cumpston, Holmes produced a comprehensive report on controlling tuberculosis as the Royal Commission had suggested.

Despite his work on tuberculosis his obituary in the *Medical Journal of Australia* in 1965 did not mention tuberculosis among his many medical interests. Noted instead were his investigations into cancer and radium therapy,[132] cerebro-spinal meningitis, and work for the Department of Defence during World War II particularly in the field of tropical medicine. He was made Chief Executive Officer of a joint committee of Allies that provided advice to General MacArthur on tropical medicine, hygiene and sanitation for the South West Pacific theatre of war. Having acted as Director-General of Health for Cumpston at times during the 1930s and been active on the Federal Health Council[133] he was a highly ranked medical bureaucrat and despite the omission from his obituary an important figure in articulating the tuberculosis problem and proposed solutions.

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[129] M.J. Holmes, 'Application to Civil Life of the Lessons Military Hygiene Derived from the Great War', *Australian Medical Congress*, 1920, pp. 498 – 505.

[130] Obituary, Mervyn John Holmes, *MJA*, 15 May 1965, p. 737. NAA: A1928/1, 1105/5Memorandum A/Director of Tropical Hygiene (Holmes) to A/Director-General of Health, Melbourne, 16 October 1924.

[131] L.O. Goldsmith, 'The Evolution of the National Tuberculosis Program', in A.J. Proust, (ed.), *History of Tuberculosis in Australia*, 1991, p. 205.

[132] Obituary, Holmes, *MJA*, 1965, p.737. M.J. Holmes, C.E. Eddy, 'The Commonwealth X-ray and Radium Laboratory, University of Melbourne', *British Journal of Radiography* (1937) 10, p. 318.

[133] Obituary, Holmes, *MJA*, 15 May 1965, p.737.

The report brought together most of the ideas about public health management of tuberculosis and remained the foundation of proposed tuberculosis schemes for the next two decades. Holmes' proposals are therefore summarised here in some detail Holmes surveyed the position in each State and then, while noting that he had been unable to canvass all possible anti-tuberculosis measures, made 67 recommendations. He identified eleven areas of action for state public health authorities.[134] The report in part, appears to be a list of hopeful suggestions rather than an integrated plan and as a result sometimes appeared contradictory.

The first general area for action was legislation for compulsory and uniform notification, still considered central to a system of control despite its problems. In his report Holmes urged States to immediately legislate for notification of all forms of the disease in all parts of the country and to notify directly to both local and state authorities. Other legislation should allow for compulsory isolation of patients unwilling to observe precautions and include a requirement on patients to notify changes of address.[135]

The second broad area was administration and co-ordination of anti-tuberculosis measures. The Federal Health Council had decided that the first essential ingredient of tuberculosis control was tuberculosis (or chest) clinics. In March 1928 The Council resolved,

> The first step in an organized campaign against tuberculosis is the provision of such clinics, which have, in other countries, been designated 'tuberculosis

[134] NAA A1928/1, 1105/30, M.J. Holmes, D.S.O., M.B.,B.S., D.P.H., *Report of the Control of Tuberculosis in Australia,* Commonwealth Department of Health, Commonwealth of Australia, Government Printer, Canberra, u.d. (1929), *passim*.
[135] NAA A1928/1, 1105/30, Holmes, *Report of the Control of Tuberculosis in Australia,* u.d. (1929), p. 24.

> dispensaries.' To these should be referred every case of tuberculosis, every member of the family concerned, and every child reserved by the school medical officers for further examination by reason of a suspicious degree of malnutrition. These clinics would serve also as co-ordination centres for all the social, economic, and sanitary activities associated with tuberculosis control.[136]

Holmes proposed every State appoint a full-time tuberculosis officer to co-ordinate all aspects of the prevention campaign and possibly direct the central chest clinic. The tuberculosis officer should be in close contact with local government authorities, general practitioners, hospitals and sanatoria in order to provide advice and assistance and also to ensure uniform measures were observed. Local authorities ideally would report on their home care system to the central officer regularly and the presence of a central office should not give local authorities an excuse to evade their responsibilities. Rather, the tuberculosis officer's involvement should spur local authorities into more efficient action. Similarly, the central office should advise general practitioners but not impinge on the doctor patient relationship. The clinic system was not intended to replace the general practitioner but would refer patients back to their own doctor for routine treatment. Doctors were to be encouraged to use the clinic for advice and help as much as possible but the clinic was to avoid interfering too much as this could alienate patients and practitioners and have a detrimental effect on early diagnosis and subsequent notification. Only cases needing immediate hospitalisation, special treatment not deliverable in the home, and anyone unable to pay a private fee would remain in the clinic's care. This notion of co-operation between a central clinic and private practitioners reflected the view often expressed by Cumpston of a partnership between general practitioners and public health authorities. He believed

[136] NAA A1928/1, 1105/30, Holmes, *Report of the Control of Tuberculosis in Australia,* u.d. (1929), p. 14.

this would improve the standard of health care and at the same time maintain the integrity of the doctor patient relationship.[137]

Fifteen recommendations on the clinics included details on administration, function, branch clinics, accommodation, staffing and interaction with hospitals. Clinics were to be named 'chest clinics' rather than tuberculosis clinics or dispensaries because of the fearful overtones associated with the disease. Their role would be to concentrate on prevention rather than treatment and as such investigate doubtful cases, classify cases on admittance to institutions and examine and observe contacts of confirmed cases. They would also collect data, offer advice to general practitioners, educate both the patient and the general public and provide specialised treatment where necessary. A vital component of the system would be nurse inspectors who were to supervise patients in their homes, advise on prevention in the home and arrange financial relief for patients when necessary.[138]

In Britain the appropriate proportion of dispensaries per population was considered to be one for every 150,000 of population but Holmes thought one for every 300,000 in larger cities would be sufficient for Australia with the addition of dispensaries outside the metropolitan area situated geographically to cover large districts.[139] He did not explain why Britain's ratio was not necessary in Australia but there are a number of probable reasons. Public health physicians were

[137]. NAA A1928/1, 1105/30, Holmes, *Report of the Control of Tuberculosis in Australia*, u.d. (1929), pp. 24-26.

[138] It was important, Holmes believed, to operate the clinics in co-operation with fully equipped larger hospitals so that a range of medical experts such as radiologists, dentists, and surgeons, might participate in diagnosis and treatment. He also suggested the use of branch clinics co-ordinated by the central State-run clinic.

[139] NAA: A1928/1, 1105/30, M.J. Holmes, D.S.O., M.B.,B.S., D.P.H., *Report of the Control of Tuberculosis in Australia*, Commonwealth Department of Health, Commonwealth of Australia, Government Printer, Canberra, u.d. (1929), p. 14.

struggling to persuade states to spend sufficient funds on public health, the mortality rate was generally lower than in Britain and the population spread over a very much larger geographic area. Holmes calculated the number of dispensaries required based on a ratio of one clinic for every 300,000 of population.

He also recommended at least three visiting nurses per 300,000 of population, access to temporary hospital beds and a free medical service in the proposed clinics.[140] Based on state populations in 1930, New South Wales would need eight to nine clinics and 25 to 26 visiting nurses, Victoria six clinics and 18 visiting nurses, South Australia two clinics and five to six visiting nurses, Queensland three clinics and nine nurses, Tasmania one clinic and two to three nurses and Western Australia one to two clinics and four to five visiting nurses. These figures do not take account of the geography of the States and would be an underestimation of the real numbers required. For example two clinics for large states like South Australia and Western Australia could only have hoped to serve metropolitan areas. When he investigated the current situation, Holmes found four dispensaries in New South Wales, one in Victoria with five nurses, one recently established chest clinic in South Australia with no visiting nurses, a recently established clinic in Tasmania and in Queensland no clinic and only one visiting inspector for the Brisbane City Council.[141] No States met Holmes' proposed level of clinical services.

On the issue of monetary support for individual sufferers, doctors had long recognised how difficult it was for poorer families to maintain appropriate levels of nutrition. Holmes therefore recommended that State Governments set up special

[140] NAA: A1928/1, 1105/30, Holmes, *Report of the Control of Tuberculosis in Australia,* u.d. (1929), pp. 25-26.
[141] NAA A1928/1, 1105/30, Holmes, *Report of the Control of Tuberculosis in Australia,* u.d. (1929), pp. 19-29.

funds to give families in need enough relief to ensure adequate nutrition. His idea was to have funds administered by state health ministers with relief being granted on the basis of advice from clinics.[142] His formulation of state assistance to sufferers and their families typified the philosophy of the interwar public health physicians. Predicated on a belief in medically directed intervention in private lives for the betterment of the nation's health, the aim of financial support was to limit the spread of invalidity and thereby limit the national economic burden of invalidity. Holmes criticised the invalid pension as too meagre to meet the requirements of nutrition and hygienic living environments necessary for preventing the spread of infection. He reiterated criticism of the practice of granting pensions only when sufferers had become permanently incapacitated and of re-directing most of the pension to institutions after patients entered hospitals and sanatoria. His solution was not an open handed pension scheme, but carefully directed relief to individual families under the guidance of the tuberculosis clinic. He did not favour a more liberal pension scheme because, he argued, higher pension levels paid to returned soldiers had not had the desired preventive effect.[143] This perception was to change by the mid 1930s. On the question of accommodation in institutions or sanatoria Holmes recommended the bed formula of one to the average number of deaths annually. His recommendations on institutional accommodation had six themes: economy, standardisation, classification and separation of cases, length of stay, the role of the central tuberculosis officer, and home treatment. In order to save money governments might extend existing sanatoria rather than build new ones and 'weed out' unsuitable patients. Despite the noted importance of good nutrition, diets in

[142] NAA A1928/1, 1105/30, Holmes, *Report of the Control of Tuberculosis in Australia,* u.d. (1929), pp. 19-29.
[143]NAA A1928/1, 1105/30, Holmes, *Report of the Control of Tuberculosis in Australia,* u.d. (1929), pp. 19-20.

sanatoria should be economical as well as suitable for the patients' conditions. The philosophy of standardisation would also be applied to the function, equipment and management of sanatoria. As we saw in chapter three the separation of patients with some hope of cure or arrest from terminal cases was seen as crucial to prevention and treatment. To overcome the vexing issue of patients with a chance of some form of recovery generally did not staying long enough while advanced cases dominated the beds for extended periods, Holmes suggested that patients remain for a minimum of six months if a cure seemed possible (less if the purpose was educative only), but no case should remain for more than one year unless recommended by the State Tuberculosis Officer. On this he wrote:

> With a proper selection of cases by an expert officer (Director of Tuberculosis), many cases at present sent to institutions would remain in their own homes. This refers particularly to chronic cases, who are sometimes very slightly if at all infective, but who are retained in sanatoria or other institutions indefinitely and who, by reason of the fact that they are usually of an irritable and grumbling disposition, do considerable harm in detracting from the spirit of hopefulness which should characterize a sanatorium and leave more or less of a stigma on the institution from the fact of their prolonged residence in the sanatorium, without becoming cured. Such cases require no special medical or nursing treatment, and it is uneconomical to keep them in sanatoria.[144]

Despite his recommendation on duration of stay he also suggested that many patients could receive home treatment after short stays with the help of an efficient home supervision system.

As mentioned in chapter two, Australian university medical courses devoted little time to the study of tuberculosis and public health physicians therefore were anxious for universities to increase and improve the tuberculosis component of both undergraduate and graduate medical studies. Holmes recommended the establishment of undergraduate and post-graduate courses, particularly for a

[144] NAA A1928/1, 1105/30, Holmes, *Report of the Control of Tuberculosis in Australia,* u.d. (1929), p. 20.

Diploma in Health include, which would include a set amount of time devoted to the study of tuberculosis and its prevention and control.

What he did not recommend as a prophylactic was the recently discovered vaccine against tuberculosis, Bacillus Calmette Guerin, commonly referred to as BCG. The vaccine, developed by French microbiologist Leon Charles Albert Calmette and veterinarian Camille Guérin, was first used on an infant in 1921 and by 1924 was being produced in large amounts.[145] Many European countries were impressed by BCG and its use, particularly for infants, spread from France to other Continental nations during the 1920s. A BCG trial conducted on nurses in Oslo in 1927 convinced Scandinavian countries of its efficacy. Denmark began using the vaccine in 1927 and the Danish Red Cross would be a major initiator of European vaccination programmes in the late 1940s. In 1928 a Conference of the League of Nations held in Paris gave the vaccine its imprimatur. [146]

Despite European endorsement of the vaccine Britain and the United States were highly sceptical of both its safety and efficacy. Both countries attempted their own research on a vaccine without success. Leaders of British and American medicine continued to question European evidence of the vaccine's value. Feldberg noted the fears of some American doctors that the use of BCG would be seen as the

[145] Thomas M. Daniel, *Captain of Death. The Story of Tuberculosis*, University of Rochester Press, Rochester, NY, 1999, pp. 135-136. Simon Szreter, 'Healthy Government? Britain, c. 1850-1950', Review, *The Historical Journal*, 34, 2, 1991, p. 491. F.B. Smith, 'Tuberculosis and bureaucracy. Bacille Calmette et Guérin: its troubled path to acceptance in Britain and Australia', *MJA*, Vol. 159, 20 September, 1993, p. 408. Marine Gheorghiu, Micheline Lagranderie, and Anne-Marie Balazuc, 'Tuberculosis and BCG' in Andrew W. Artenstein (ed.), *Vaccines: A Biography*, Springer Publishing, 2010, pp. 128-131. Linda Bryder, ' "We shall not find salvation in inoculation" ', BCG vaccination in Scandinavia, Britain and the USA, 1921-1960', *Social Science & Medicine*, 49, 1999, pp. 1157-1158.

[146] Bryder, '*Social Science & Medicine*, 1999, pp. 1158-1159. Paul E.M. Fine, Ilona A.M. Carneiro, Julie B. Milstien, C. John Clements, *Issues relating to the use of BCG in immunization programmes*, World Health Organisation, Geneva, 1999, p. 5. Gheorghiu, Lagranderie, and Balazuc, '*Vaccines: A Biography*, 2010, pp. 131-133.

controlling mechanism for tuberculosis and usurp traditional methods of control especially the sanatorium regime, which was strongly supported by America's leading tuberculosis doctors. Vaccination, they argued, would undermine the concentration on environmental improvements such as good sanitation and building general resistance in the populace.[147]

Linda Bryder examined the scientific debate that raged between Europe, Britain and the United States over BCG by comparing Britain and the United States with Scandinavia. She concluded that though fought under the rubric of scientific debate, policies on the use of the vaccine emanated primarily from national differences in prevailing views on the hierarchy of causes of tuberculosis and differing political ideologies tinged with nationalism. Dominant medical views and policies in Britain and the United States held to the primacy of the dispensary and sanatorium programme, which medical leaders did not wish to disrupt. In Britain, for example, Sir Robert Philip founder of the famous tuberculosis dispensary in Edinburgh, strongly opposed BCG arguing that vaccine would create false security, a more appropriate approach being to raise resistance by healthy diet, moderate lifestyle, fresh air and exercise. Sir George Buchanan, chair of the British Ministry of Health Immunisation Committee, which was established in 1931, thought BCG would interfere with the scheme already in place. Calmette's evidence of successful trials and the safety of BCG also came under attack in Britain from the Medical Research Council. The different approaches, Bryder argued, also reflected the countries' traditional social welfare policies. Scandinavia's early development of social democratic welfare policies and higher levels of state intervention than

[147] Georgina D., Feldberg, *Disease and Class, Tuberculosis and the Shaping of Modern North American Society*, Rutgers University Press, New Brunswick, 1995, pp. 150, 152.

either Britain or the United States led to a preventive approach that included widespread vaccination. In Sweden after general introduction of BCG in 1937, vaccination became compulsory for some groups by 1944 at a time when Britain and America were still largely ignoring it.[148]

Australia followed the British rejection of BCG but not before asking Britain to try the vaccine. In 1923, two years after Calmette and Guerin proclaimed success with BCG, Britain held an Imperial Tuberculosis Conference in association with the British Empire Exhibition. At this conference leading politicians and health officers from both Australia and New Zealand suggested to the British Ministry of Health that BCG vaccination be tried in Britain. Although the suggestion was rejected,[149] some action on BCG was attempted in Australia. In 1925 Cumpston arranged the delivery of cultures from Calmette to the Commonwealth Serum Laboratory (C.S.L.) even though its director, William James Penfold, opposed the use of BCG. Early tests on animals by Penfold's deputy suggested the vaccine would be safe and effective and following the support offered by the League of Nations, Cumpston asked the CSL to prepare a vaccine for use on vulnerable infants in Australia. The matter went no further, however, after Australia's Medical Liaison Officer in England, C.L. Park, withdrew his support for the League of Nations endorsement and Penfold drew on British critiques and experiments to proclaim the vaccine to be dangerous.[150] F.B. Smith has outlined the Australian reaction to BCG noting in particular the role of older Australian physicians who were wedded to the British ideas of dispensaries and sanatoria and who resisted the introduction of BCG.

[148] Bryder, *Social Science & Medicine*, 1999, pp. 1157-1165.
[149] Smith, *MJA*, 20 September, 1993, p. 408.
[150] ibid., p. 410.

Holmes recommended against BCG until further investigation.[151] British, American and Australian resistance to BCG also gained credence when in 1930 an error in labelling in a laboratory in Lubeck, Germany led to the vaccination of children with a virulent *tubercle bacillus* resulting in the deaths of 72 children. Despite damage to its reputation, the use of BCG increased in Europe.[152] The vaccine was eventually introduced in Australia shortly after the end of World War II. An Australian manufactured vaccine from the Commonwealth Serum Laboratories was available from 24 December 1948, although some imported vaccine had been administered earlier. For example, using a Canadian vaccine, nurses in sanatoria and public hospitals as well as younger family members of infectious cases began to be vaccinated in Victoria in October 1947.[153]

Cumpston felt confident the Holmes report on tuberculosis would result in a uniform campaign of prevention and control across the nation. He wrote to the Department's Director of Laboratories,

> The question of the prevention and control of tuberculosis is now receiving close attention in the several States, and at the forthcoming meeting of the Federal Health Council the matter will be fully dealt with, when it is expected that the lines of policy will be decided upon for the guidance of the States in a definite campaign for the prevention and control of this disease.[154]

Cumpston's hope for a nationally consistent public health campaign arising from Holmes's investigation and guided by his Commonwealth department were not fulfilled. States continued to run their tuberculosis policies without a central co-ordinating role for the Commonwealth Health Department. The Department was left to etch its way into decision-making in other ways.

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[151] NAA: A1928/1, 1105/30, Holmes, *Report of the Control of Tuberculosis in Australia*, u.d. (1929), p. 23.
[152] Daniel, *Captain of Death.* 1999, pp. 136-137. Feldberg, *Disease and Class*, 1995, pp. 145-146.
[153] R.S.A. Marshman, 'BCG in Victoria', in A.J. Proust, (ed.), *History of Tuberculosis in Australia* 1991, p. 157
[154] NAA: A1928/1, 1105/5, Memorandum, Director-General of Health to The Director, Division of Laboratories, 12 February 1929.

SUBSIDIES

One way Cumpston and his colleagues in the Health Department attempted to influence States' policies was to lobby for Commonwealth subsidies for tuberculosis management under conditions that would allow the Federal Department some control. Subsidies had been recommended by the Royal Commission in 1925 and the States had received subsidies from the Commonwealth for treatment and control of venereal diseases since 1917. Following a recommendation of the Death and Invalidity Committee Report in 1916 the Commonwealth had offered subsidies to States on a pound for pound basis up to £15,000 to support treatment of venereal disease.[155] This was, as Thame suggested, related to concern about the high incidence of venereal disease among the First AIF and returning soldiers as the Commonwealth had paid little attention to other recommendations of the Committee.[156] Grants were made only if States followed the lead of Western Australia by enacting legislation for compulsory notification of venereal disease and establishing special clinics.[157] The Department gained the support of the Federal Health Council (FHC) for extending the subsidies to tuberculosis. In March 1928 members of the FHC urged the Commonwealth Government to offer the States a subsidy for tuberculosis dispensaries or clinics in the capital cities.

Cumpston quickly began lobbying his Minister, Sir Neville Howse, to pay subsidies for tuberculosis control. He proposed that the Commonwealth pay half

[155] NAA: A1928/1, 1105/29, Sect. 1, M.J. Holmes, Division of Tuberculosis and Venereal Disease, 'Tuberculosis, Proposed Subsidy to be paid by the Commonwealth government to the States in Connection with the Control of Tuberculosis', 19 March 1929. [156] Thame, 'Health and the State', 1974, pp. 124, 136.

[156] Thame, 'Health and the State', 1974, pp. 124, 136.

[157] NAA: A1928/1, 1105/33, Memorandum, the Director-General of Health to the Minister, 17 July 1930.

the cost of dispensaries. He laid down conditions under which the subsidy should be paid and carefully detailed specific requirements that would ensure the Commonwealth Department of Health had a measure of oversight of all state clinics. The conditions were primarily those contained in Holmes's report. Each state was to submit annual expenditure reports to the Commonwealth, provide details of its operation, ensure clinics were properly supervised and provided with adequate accommodation in which to operate. A subsidy would also require clinics to meet a long list of functions and criteria set out by the Commonwealth Department. Clinics were to investigate doubtful cases, classify patients and arrange for 'the disposal of cases to suitable institutions', and continually inspect contacts. Nurse inspectors would oversee patients in their homes arranging financial relief in some cases and the clinic staff would supervise patients discharged from institutions. In addition, the clinics were to advise general practitioners and teach patients and the general public about the disease and prevention methods. A medical Officer was to be in charge of the clinics with accommodation, equipment and all staff being approved by State health authorities. As well as submitting an annual report to the Commonwealth, the clinics could be the subject of inspection by the Commonwealth if deemed necessary. The clinics were to be constructed and maintained to the Commonwealth Health Minister's satisfaction.[158]

Howse agreed to proceed with the subsidies. He had come to politics after a remarkable medical career that included service in the Boer War and World War I. In the South African war he won the Victoria Cross for an act of bravery in 1901

[158] NAA: A1928/1, 1105/29 Section 1, Memorandum, J.H.L. Cumpston, Director-General of Health, to Minister for Health, 3 April 1928; Memorandum, J.H.L. Cumpston, Director-General of Health, to Prime Minister's Department, 24 April, 1928. NAA: A1928, 1105/29 Section 2, Memorandum, J.H.L. Cumpston, Director-General of Health, to Minister for Health, 28 March, 1929.

and in 1915 was appointed Deputy Director of Medical Services for the Australian and New Zealand Army Corps. He was promoted to the rank of major general in January 1917. Appalled at the evacuation system for the wounded at Gallipoli, he worked hard to improve medical organization, sanitation and food on the battle field. Like Holmes, Cumpston and others Howse saw the potential for transferring the lessons of war medicine to civil society to build a stronger healthier Australia. Rather than work within medicine and public health as a practitioner he ran for parliament and was elected as a National Party member in November 1922. He was Minister for Health from January 1925 to April 1927 and again from February 1928 to October 1929.[159]

When Howse put his decision to the Treasurer, Earle Page, in May 1928 Page was sympathetic but would not agree to immediate implementation because of financial constraints.[160] He wrote, '… I would suggest that the financial position of the Commonwealth is so serious that definite action in this direction should be deferred until the estimates for the forthcoming financial year have been considered.'[161] Seventeen years younger than Howse, Earle Page too was a medical practitioner. During the 1910s he gained a reputation as an excellent surgeon but his interests turned more to business and politics than medicine. He enlisted in the army in July 1916 but spent less than a year overseas as an AIF doctor returning home after arguing that he would face financial ruin otherwise. As the last remaining member of his general practice in Grafton had enlisted, he was needed in his practice. Page

[159] A.J. Hill 'Howse, Sir Neville Reginald (1863-1930), *ADB*, 1996, pp. 384-386. Commonwealth of Australia, *Parliamentary Handbook of the Commonwealth of Australia*, 21st Edition, 1982, AGPS, Canberra, 1982, p. 270.

[160] NAA: A1928/1, 1105/29 Section 1, Letter, Neville Howse, Minister for Health to Earle Page, Treasurer, 8 May, 1928, 21 May, 1928; Correspondence, Earle Page, Treasurer to Neville Howse, Minister for Health, 31 May, 1928.

[161] NAA: A1928/1, 1105/29 Section 1, Letter, Earle Page, Treasurer, to Neville Howse, Minister for Health, 31 May, 1928.

began his political career on his return from war when he was elected mayor of South Grafton. He then entered federal parliament as a Country Independent in the seat of Cowper. In January 1920 he and ten members representing farming areas formed the Federal Country Party. Page was a shrewd politician and businessman known for his energy and ability to create pragmatic solutions to political and governmental problems. Writing his entry in the *Australian Dictionary of Biography* Carl Bridge noted that Page thought of both medicine and politics as 'the art of the possible'.[162] Financially cautious, Page's 1927 budget had fallen into deficit and he would not agree to the health expense to which Howse had given his imprimatur. Ironically, Page would be Treasurer in the Liberal Government that oversaw the Labor initiated national anti-tuberculosis campaign after 1949.

Despite the Treasurer's reluctance Howse pursued the issue with Page seeking to confirm the provision for subsidies in the following year's budget and at the same time advising the States of the subsidies. Early in June 1928 he added to the official correspondence to the Treasurer by writing a personal letter of appeal to Page underlining how important he considered the subsidies to be arguing that the benefits of the scheme justified the expense. He wrote of the subsidy proposal:

> …the one step which offers best promise of dealing with this matter [of tuberculosis] – the importance of which you recognise as fully as I do – is the establishment of dispensaries. Probably you will realise, also, that this measure is one which the Government would be well-advised to adopt.
> …
> Notwithstanding the position with regard to the finances of the Commonwealth during the forthcoming year, I still feel that the amount of money involved, viz., £17,000 as a maximum is, by comparison with the object to be achieved, so small that no serious result would attach to a decision of this kind…[163]

No agreement was forthcoming from Page but Howse continued to press him writing again on 13 July 1928 informing him that New South Wales was asking the

[162] Carl Bridge, 'Page, Sir Earle Christmas Grafton (1880-1961)', *ADB* Online Edition, http://www.adb.online.anu.edu.au/biogs/A110127b.htm accessed 10 November 2009.
[163] NAA: A1928/1, 1105/29 Sect 1, Letter, Neville Howse to Earl Page, 7 June 1928.

Commonwealth for subsidies in order to establish and maintain tuberculosis clinics. Howse's tone suggested he was not willing to acquiesce on the matter when he wrote:

> …I shall naturally bring the matter up amongst other things in connection with the Estimates during the next meetings of Cabinet.[164]

With a federal election due late in the year Howse finally won support. During the campaign of November 1928 the Bruce Government promised Commonwealth subsidies for tuberculosis clinics to a total value of £17,200 per annum.[165]

The National and Country parties in coalition retained government after the 1928 election and Howse again became Minister for Health. Holmes wrote a detailed proposal for the operation of subsidies of £17,200 which Cumpston again put to the Minister for Cabinet submission in March 1929.[166] Cabinet considered the proposal on 2 May 1929 and approved it in principle, contingent upon 'finding the necessary money'. Cabinet also applied this rider to its subsidies for venereal disease.[167] Only five months before the Wall Street crash, most of Cabinet must have had little confidence the money could be found. Stanley Bruce, Prime Minister from February 1923 to October 1929, later wrote that early in 1928 'the clouds foreshadowing the 1929-1931 economic blizzard were in the skies'.[168] The Bruce-

[164] ibid., 13 July 1928.

[165] NAA: A1928/1, 1105/29 Section 1, M.J. Holmes, Director, Division of Tuberculosis & Venereal Diseases, to Director-General, 'Tuberculosis. Proposed Subsidy to be paid by the Commonwealth Government to the States in Connection with the Control of Tuberculosis', 19 March 1929, pp. 1-5; Memorandum, Director-General of Health to The Minister, 22 March 1929; Memo for Cabinet, 25 March 1929.

[166] NAA: A1928/1 1105/29 Section 1, M.J. Holmes, Director, Division of Tuberculosis & Venereal Disease, 'Tuberculosis. Proposed Subsidy to be paid by the Commonwealth Government to the States in Connection with the Control of Tuberculosis, 19 March 1929; Memorandum, Director-General of Health to Minister, 22 March 1929; Memo for Cabinet, 25 March 1929,

[167], NAA: A2718, Volume 6, Part 1, 1929 – 1929, [Bruce-Page Ministry] Cabinet Minutes and Submissions 30.4.29 – 7.6.29, Minutes of the Meeting of the Cabinet, 2 May 1929.

[168] NAA: A1494, 1, [Personal Papers of Prime Minister Bruce] [Select Documents concerning the Hughes Cabinet with an explanatory note written by Lord Bruce in 1959], 15 December 1921 – 2 November 1959, Rt. Hon. Viscount Bruce, 'Note re Memorandum dated 8 August, 1922' 2 November 1959.

Page Government fell in an early election called in October 1929 after it lost a vote on a maritime bill. The Labor Party under James Scullin took office week before the Wall Street Crash of 29 October, 1929 and Cumpston had to deal with a new Minister for Health, Frank Anstey.

A dramatically different character from Neville Howse, Anstey came to politics with a strong left populist philosophy. He had been a trade union activist in the 1890s in Melbourne and entered the Victorian parliament as the Labor member for East Bourke in 1902. A fiery and passionate speaker described as a mob orator he attained some prominence in Victorian politics. In 1910 he ran for Federal Parliament and won the seat of Bourke for the Labor Party. He developed a strong interest in finance and banking and having experienced the economic depression of the 1890s retained the working class mistrust of capitalism and the 'money power'. During World War I he held the populist left position against the war denouncing it as a capitalist conflict in which the winners would be financiers. Although an aggravation to Labor Prime Minister, Billy Hughes, Anstey railed against the war more in print than in parliament He was unsurprisingly an anti-conscriptionist and stayed with the Labor Party after the split of 1917 when Hughes and his supporters merged with the Opposition to form the Nationalist Party and Hughes retained the prime ministership.

Anstey was elected to the position of Assistant Leader of the Labor Party (ALP) in the House of Representatives at the commencement of the ninth parliament in January 1922. He resigned this position in March 1927 because of internal party politics but also because he found the routine work of parliament tedious. Nevertheless, when Labor won power in 1929 he became the Minister for Health

and Repatriation. Peter Love wrote of his ministry that he performed his duties 'with perfunctory, if undistinguished competence'.[169] Anstey had neither the knowledge nor the intense interest in public health of his predecessor. His interests were primarily in economic policy. He vehemently opposed the deflationary policy the government agreed to in 1931 and supported the Premier of New South Wales's policy of repudiating war incurred debt. In the ensuing bitter split in the Labor Party Anstey lost his ministry on 2 March 1931and retired from politics in 1934.[170]

Early in Anstey's term as health minister the Federal Health Council and Commonwealth Department again pursued subsidies for tuberculosis. In March 1930 the Health Council urged the Commonwealth to offer subsidies to the States for tuberculosis clinics.[171] Instead of the £17,200 Howse had wanted to allocate to tuberculosis alone the 1930-1931 budget proposed £19,000 for both venereal disease and tuberculosis. Cumpston appealed to Anstey on 17 July 1930 to allocate funding for subsidies for tuberculosis. He pointed out that a subsidy had been paid to different States since 1917 for campaigns against venereal disease and continued automatically without requiring reports on progress despite the original goals of the subsidies having been met. The original purpose of the VD subsidies was to induce states to legislate for notification of venereal disease and to set up special clinics. Cumpston proposed a pound for pound subsidy for expenditure on tuberculosis clinics provided it was associated with the sanatorium system, undertook

[169] Peter Love, 'Frank Anstey: From Heroic Persona to Embattled Identity', *Labour History*, No. 87, November 2004, p. 18.
[170] Ian Turner, 'Anstey, Francis George (Frank)', *Australian Dictionary of Biography*, Online Edition, 2006, http://www.adb.online.anu.edu.au/biogs/A070082b.htm. Love, *Labour History*, 2004, *passim.*
[171] NAA: 1105/29 Section 2, Tuberculosis Establishment of Tuberculosis Dispensaries, 1931-1942, Federal Health Council, Fourth Session, 11-13 March, 1930.

domiciliary supervision and employed modern diagnostic methods.[172] Despite these pleas and despite the precedence set by Commonwealth assistance for venereal disease no subsidies for tuberculosis were granted.

Officers of the Commonwealth Health Department held high aspirations for the Department but it was a minor federal department.[173] Only small administrative units such as the Governor-General and the Attorney-General's Department had lower budgets. In the Budget Estimates for 1930-31 the Health Department received £313,905. Large Commonwealth Departments such as the Post Master General's and War and Repatriation received £16,000,000 and £30,000,000 respectively.[174] While these large departments cover jurisdictional areas solely controlled by the Commonwealth and States were responsible for health budgets, the Health Department ran on a low budget. In the reduction of government expenditure that was to be implemented early in 1931, Health Department funding contracted even more.

Struggling under the weight of the depression and debts to Britain, the Scullin Government adopted a deflationary economic policy early in 1931 cutting wages, pensions and government expenditure. This decision followed a year of turmoil within the Labor Party as divergent views emerged. Scullin wanted to honour Australia's debts, Jack Lang, Premier of New South Wales, called for the repudiation of debt and the Federal Treasurer, Edward (EG) Theodore, urged raising Government spending with credit from the Commonwealth and other

[172] NAA: A1928/1, 1105/33, Memorandum, the Director-General of Health to the Minister, 17 July 1930.
[173] Gillespie, *The Price of Health*, 1991, p. 46.
[174] Australia, Parliament, *The Budget, 1930-31, Final issue*, 29 July 1930, Parlt Paper No. 106, Vol. 4, 1929-30-31, Canberra, p. 62.

banks.[175] The Government's handling of the economic depression split the Labor Party and the labour movement. Constrained by a lack of majority in the Senate and internal disagreement, the Government failed to resist pressure from the Commonwealth Bank, private banks and influential economists to cut public expenditure and wages.[176] As part of the cutbacks the Health Department lost the Tuberculosis and Venereal Disease Division. As soon as Anstey lost the Ministry of Health the Federal Health Council again passed a resolution calling for subsidies,[177] but the economic barriers were insurmountable. It was not until January 1944 that the Federal Cabinet again seriously considered subsidising tuberculosis clinics.[178]

Conclusion

The pursuit of nationally uniform policy on tuberculosis laid the foundation for the joint Commonwealth anti-tuberculosis campaign in the late 1940s. Faltering attempts to promote national measures started in the very early years of the twentieth century but after World War I a cohort of public health physicians called for nationally consistent preventive schemes for tuberculosis. Initially, consistency across state jurisdictions was the goal but the creation of a Commonwealth Health Department in 1921, coupled with the national government accepting responsibility

[175] Tim Rowse, *Nugget Coombs. A Reforming Life*, Cambridge University Press, Cambridge, 2002, p. 61. For a discussion of the influence of leading economists and their views see William Coleman, Selwyn Cornish, Alf Hagger, *Giblin's Platoon. The Trials and Triumphs of the Economist in Australian Public Life,* Australian National University E Press, 2006, Chapter 6.

[176] Coleman, Cornish, Hagger, *Giblin's Platoon*, 2006, pp. 6-12. Rowse, *Nugget Coombs.* 2002, pp 59-64.

[177] NAA: 1105/29 Section 2, Tuberculosis Establishment of Tuberculosis Dispensaries, 1931-1942, *Federal Health Council Fifth Session* 24-25 March, 1931.

[178] NAA: 571, 1943/173, Part 1, 1943-1946, Tuberculosis, Memorandum to Cabinet, 18 January 1944.

for the medical rehabilitation of returned soldiers, raised the prospect of a Commonwealth role in public health policy.

World War I had put the health of the nation under the political spotlight because war-time recruitment revealed health problems amongst recruits. With Australia's entry into the war the Commonwealth became responsible for the health and medical care of the army. It had no jurisdiction over civilian health policy but nevertheless instituted an investigation into the nation's health through the Death and Invalidity Committee with a view to finding ways to prevent or contain the leading causes of death, tuberculosis being one of the seven identified by the Committee. Some physicians who served in the army returned to Australia determined to improve the nation's health many joining State government health departments and after 1921 the Commonwealth Health Department. Their objective was preventive health through state action. With no cure for tuberculosis, prevention had been at the forefront of the struggle against the disease and it was quickly part of the Federal Health Department's agenda.