CONCLUSION

In the late 1940s Australia's public health policy on tuberculosis underwent a momentous shift from piecemeal policies across the States to a united national effort supported by funding from the Commonwealth Government, which resulted in an unprecedented mobilization of resources across the country to fight one disease. The groundwork for federal intervention in tuberculosis management can be found in the early 1920s when the Commonwealth Departments of Health and Repatriation were established. As Director-General of the Health Department until 1945 Howard Cumpston and his colleagues promoted Commonwealth involvement in health policies, research and disease management. From its inception the Repatriation Department attained control over the management of returned soldiers with tuberculosis and over time implemented a policy of pensions that supported arguments for providing protection for families and inducements for treatment..

In 1882 when Robert Koch announced his discovery of a bacterial cause for the dreaded tuberculosis not all Australian doctors accepted his conclusions uncritically. It was another two decades before the contagiousness of the disease was broadly understood and acknowledged by the medical profession. Nevertheless, by the turn of the twentieth century tuberculosis was seen as a disease with profound implications for public health and a movement to campaign against the disease began in most western countries including Australia. Participants likened the movement to a crusade.

Public health reformers demanded two fundamental public health measures to prevent the spread of tuberculosis. They sought legislation to add tuberculosis to the list of contagious diseases to be notified to health authorities and called for state

supported sanatoria. When the Australian colonies federated in 1901 the new Commonwealth Parliament obtained jurisdiction over a range of areas including international trade and commerce, postal service, the military and currency. The Commonwealth was also responsible for quarantine, but health policy remained with the new State parliaments. Public health structures in the States were underdeveloped and still concentrated on traditional public health targets such as unclean water, noxious trades, drains and sewers. As knowledge of contagious diseases grew in the late nineteenth century, health authorities implemented isolation and disinfection procedures for diseases such as diphtheria, typhoid fever and scarlet fever. When tuberculosis was added to the list of infections States struggled with the challenge to contain a contagion that was chronic rather than acute and episodic. Tuberculosis control was complicated by the delegation of health controls to poorly funded local councils.

As with any contagious disease the first requirement was to locate and diagnose the sufferer in order to treat, isolate or otherwise stop the spread of the infection. This process proved to be more complicated in the case of tuberculosis. Criteria for notifying to public health authorities varied between the States as did the timing of introducing the measure and notifications rates were low. Doctors in private practice, fearing the loss of patients' business, were often reluctant to report the disease. Patients themselves, facing a growing community fear of the disease, hid their condition fearing loss of employment and housing. Responsibility for acting on notifications rested with local councils but implementation of notification laws and regulations varied between local districts and most local councils lacked the resources to properly implement the prevention measures demanded.

Similarly, the establishment of public sanatoria failed to meet the goals of public health reformers. Australia's system of private sanatoria was less well developed than Europe and the United States and all States established public sanatoria during first decade of the twentieth century. Again variations occurred across the States in relation to locale, length of patient stay and bed numbers. At no stage did reformers consider that enough beds were available whether or not sanatoria were full. The requirements of the crusade not only overwhelmed the States' resources but governments were unwilling to invest in this public health problem to the degree believed necessary by public health physicians. Leaders of the medical profession, particularly physicians employed by the States and Commonwealth continued to voice their dissatisfaction at the inadequacy of investment in preventing tuberculosis. They insisted the sanatorium regime could educate the tubercular in hygienic behaviour thereby reducing the spread of infective material. They also argued that caught early, the disease could be cured. Despite disappointing results from notification and sanatoria over the first three decades of the 20th century physicians involved in the campaign did not question the methodology, merely the implementation. Examination of these two primary planks of the anti-tuberculosis campaign has illustrated the administrative and medical complexities faced by the States' health authorities.

From the beginning of the public health campaign against tuberculosis at the turn of the twentieth century a few public health doctors were keen to adopt nationally consistent public health measures. This idea developed strongly during the inter-war years when a cohort of publicly employed physicians, a number having served

overseas in the Army Medical Service during World War I, brought together a philosophy calling for state intervention in matters of health. A fundamental premise of their beliefs was the elevation of preventive medicine. These physicians promoted a nationally uniform approach to the prevention of tuberculosis. In 1921 the Commonwealth established a department of health built administratively on its quarantine service. Although not strongly supported financially by the Commonwealth, the Department under the leadership of its first Director-General, John Howard Lidgett Cumpston, tried to bring about a centralised and uniform national policy on tuberculosis coordinated by the Commonwealth Government and its health department.

The Federal Government entered into policy making on tuberculosis during World War I by taking responsibility for the medical repatriation of sick and injured returned soldiers. The Repatriation Department provided separate sanatoria for tubercular returned soldiers and paid pensions at higher rates than the ordinary invalid pension. Unlike most people suffering with a disease that carried moral opprobrium, returned tubercular soldiers pleaded their cases openly and were successful in securing a more liberal pension scheme than civilians, and in some cases, other categories of returned soldier. Repatriation policy was to prove influential in promoting the idea of additional allowances to tuberculosis sufferers to allow them and their families to be adequately nourished in order to build resistance to the disease and prevent its spread. By the late 1930s evidence gathered in surveys of the families of returned soldiers who received a higher pension that the invalid pension suggested that these families were less likely to become infected with the disease than those of sufferers on the lower invalid

pension. At the same time that this evidence was adding weight to the argument for better financial support, from 1941 a newly devised miniature x-ray technology allowed the military to screen recruits for signs of tuberculosis. This raised the prospect of widening such screening to the entire population.

By the early 1940s, Australia, in common with other allied nations, began planning for a post-war society of peace and security. The image of tuberculosis with its long term invalidism, contagion and undertones of immorality as a causal factor was the antithesis of the post-war vision of Australian citizenry. Post-war reconstruction required a healthy workforce to build the nation and healthy young women for motherhood. Investigations into tuberculosis in the late 1930s brought more attention to the occupations in which workers were more vulnerable to tuberculosis. Further, the mortality pattern showing persistently higher levels of the disease among young women brought tuberculosis into discussions about how to ensure a nation of healthy mothers who would bear healthy children.

The vision of a post-war society of prosperity was accompanied by a new social welfare agenda. Leaders of the medical profession had been calling for additional financial support for tubercular sufferers for many years a proposal well accommodated within both the social welfare and the economic agenda. Additional pensions were acceptable under the rubric of social welfare policies and, with the aims of either bringing the tubercular back to economic productivity or ensuring that they did not undermine the health and economic productivity of those around them, supported the economic agenda.

At the end of 1976 the Commonwealth Government terminated their arrangement with the States and ceased funding tuberculosis programmes. The mortality rate for pulmonary tuberculosis declined from 24.8 per 100,000 in 1949 to 1.1 per 100,000 in 1976.[1] This led many commentators to the conclusion that the post-war campaign against tuberculosis was a great success. Fitzgerald, for example, noted of Western Australia that by 1960 most adults had been x-rayed and the goal of controlling and preventing tuberculosis in effect had been achieved.[2] Others, however, questioned this certainty. Roe asked the pertinent question of whether the campaign would have had the same impact without the new drugs introduced from the early 1950s or would improved living standards alone have had the same impact. He concluded that success was attributable to the combination of improved living standards, drugs and the well-funded campaign.[3] Tyler queried the need for the campaign raising the possibility that curative drug therapy accounted for the control obtained over the disease rather than the wide scheme of x-ray screening, chest clinics and sanatoria. He questioned the value of the extensive x-ray campaign and the compulsory nature of it noting that in Victoria, where a voluntary ex-ray scheme remained in place until 1963, mortality rates differed little from States in which x-rays were compulsory.[4] Porter and Boag drew a different conclusion from Victoria's experience arguing that the case detection rate of

[1] R.M. Porter and T.C. Boag, *The Australian Tuberculosis Campaign 1948 – 1976*, Melbourne, 1991, p. 91. This is a higher figure than the summary given in the introduction of this thesis because it is the rate of pulmonary tuberculosis only.

[2] Criena Fitzgerald, *Kissing Can Be Dangerous, The Public Health Campaigns to Prevent and Control Tuberculosis in Western Australia, 1900-1960*, University of Western Australia Press, 2006, p. 204.

[3] Michael Roe, *Life Over Death, Tasmanians and Tuberculosis*, Tasmanian Historical Research Association, 1999, Hobart pp. 144-145.

[4] Peter J Tyler, *Visualising Tuberculosis – Compulsory Radiography in Australia, 1950-1980*, Australian Historical Association 12th Biennial Conference, Newcastle, 5-9 July 2004, pp. 3-4. With thanks to the author.

pulmonary tuberculosis increased by 60% after x-rays were made compulsory.[5] Marianna Stylianou did not question the campaign's success overall but pointed to specific inequalities in mortality rates. She found that the indigenous population of Victoria did not enjoy the same decline in morbidity and mortality as the non-indigenous population.[6] More in-depth research into this question along with international comparisons would be a valuable addition to Australia's tuberculosis history.

The doubts expressed regarding the campaign's necessity raise the general question of why some public health campaigns receive support while others flounder. This is not to suggest that any public health campaign about serious health issues is without merit, but as historians of social medicine emphasise, social, economic and political pressures as much as morbidity, mortality and medical science dictate which diseases will generate public health campaigns. In the case of tuberculosis in Australia, a cohort of zealous public health physicians with a vision of promoting the role of preventive medicine were highly influential. They were assisted by the political climate of post-war reconstruction and the longevity of their campaign for an anti-tuberculosis campaign with a preventive imperative.

This thesis has broadened our understanding of the history of Australian public health policy. The proposition that Australia missed an opportunity to follow a path of a more collective national health policy in the post-war period was challenged in the case of tuberculosis. The jurisdictional expansion of the Federal Government into health policy for a health problem other levels of government found intractable

[5] Porter and Boag, *The Australian Tuberculosis* Campaign, 1991, p. 59.
[6] Marianna Stylianou, 'A Scandal Which Must be Corrected': Reconsidering the Success of the Australian Tuberculosis Campaign', *Health and History*, Vol. 11, No. 2, 2009, pp. 21-41.

has been illustrated. Tracing the management of tuberculosis from Federation to post-war reconstruction has also provided an illustration of the evolution of Australian public health from rudimentary and poorly funded focus on environmental hazards like drains and sewers to a point from which we might understand the substantial political and economic investment in health we recognise today. The study has also shown the administrative and jurisdictional tangle surrounding complex public health matters. A number of historians have analysed the power of the medical profession to curtail attempts to undermine their autonomy in relation to how they derive their income. This thesis has demonstrated the profession's desire and power to design public health programmes unchallenged.