MEDICINE—THE COMMONWEALTH AND STATES

By Dr. T. H. Hurley and Mr. B. L. Murray, Q.C.

Delivered at a meeting of the Medico-Legal Society, held on 17th August 1968, at 8.30 p.m., at the Australian Medical Association Hall, 426 Albert Street, East Melbourne. The Chairman of the meeting was the President, Mr. J. McI. Young, Q.C.

Dr. T. H. Hurley:

I intend to discuss this evening some historical aspects of the provision and support of medical service to the Australian community by the Federal and State Governments. You may well question the wisdom of the committee when they suggested that a medical member introduce a subject so beset with legal aspects of the most complicated nature. On reflection, however, it becomes apparent that although the relationship between the Federal and State governments in the field of medicine is undoubtedly a matter in which the lawyers have had a great deal to say it is after all the doctors who have to work with it, and their views on it, however uninformed they may be, are perhaps not without interest.

A second reason possibly in the minds of the committee at the time is contained in the introductory remarks made to the Seventh meeting of this Society in November 1932, the subject being "Professional Confidences".[1] The speaker on that occasion introduced his subject as follows: Firstly he said "The existence of the Medico-Legal Society appears to me to be infinitely more important than the general run of members of both professions realized." He next remarked that his experience of Parliament, in case any members looked in that direction to have the intrests of the professions safeguarded, was that if they wished to have their legitimate interests protected and preserved in such a fashion that they might do their best work for the public they must do the protecting themselves.

He continued that it was important that the profession should get into the habit of looking for the solving of professional problems to their own professions. To do this it was first necessary to have a clear conception of what was in the best interests of the professions and having established that position, to discipline the

[1] *Proceedings of the Medico-Legal Society of Victoria,* Vol. II, p. 92.

professions. The speaker on that occasion was R. G. Menzies K.C., then Attorney-General.

Professional problems facing medical men today are certainly no less formidable than they were 34 years ago when that statement was made; indeed in many respects today's problems are even more daunting. Two occurrences have added to these problems, firstly the growth of medical knowledge during and after the second world war added many new dimensions to the practice of medicine in Australia, for example the tremendous growth in the science of medicine and in the medical research in the Commonwealth. This and other similar changes have greatly increased the complexity of existing professional medical organizations and many new ones have been formed. Secondly, Government has come to play an increasing role in the provision of medical care, medical teaching and medical research in the Australian community. Most doctors in Australia work as individual professional people and are, as the economist Galbraith puts it, one of the few examples of the entrepreneur still surviving in a society increasingly dominated by the groups he refers to as the technostructure. Their professional work, however, is increasingly regulated by Government action, this is inevitable as all the community looks to the Government to support or provide medical services of an increasingly comprehensive nature.

The great expansion of social services since 1900 is a reflection of a change in public opinion concerning the role of the state in social affairs. Throughout the 19th century and with the supposedly robust and almost Darwinian approach to the economics of the day the belief prevailed that the direct provision by the state of social benefits, and especially cash benefits, undermined self-reliance and initiative on the part of the individual and encouraged pauperism. This latter condition was considered to be about as contagious as small pox and equally to be avoided.

In this country the evolution of medical services has occurred against an interesting historical background, that of the federation of the Australian States and the social consequences of two world wars. Within a generation doctors have seen medical services become, for example, not only an increasingly important area of government support but a shift has also occurred from State-derived finance to Commonwealth support on an increasing scale. It is apparent that the relationship between the Government of the Commonwealth and the State Governments has been,

and will continue to be, a matter of first importance in this evolutionary development of medicine in Australia.

Let us consider briefly two aspects of Australian medicine today which illustrate the importance of this relationship. I mentioned a moment ago the great increase in the complexity of medicine and of medical organization which has occurred since the end of the Second World War. The growth of medical and surgical specialities has involved not only an increase in the number of practitioners in these fields but a parallel evolution of colleges, associations and societies in these new emerging disciplines. These professional bodies have been of critical importance to medicine in Australia and their activities have included the conducting of examinations for diplomas which, in some fields, are now regarded as the equal of and in some instances superior to their overseas counterparts.

These colleges and societies also accept responsibility in increasing degree for training in their special fields, for promoting clinical discussions and also sponsoring some clinical research. These colleges and societies, almost without exception, are organized on a Commonwealth level, frequently on an "Australasian" basis. The professional activities of the members, however, devolve around hospitals and universities which are basically State supported. As these institutions must in the final analysis be the training ground of future well-trained specialists, adequate financial support of these activities is not only desirable or absolutely essential if proper post-graduate training in the medical specialties is to be fostered in Australia.

At the moment, speaking from the viewpoint of the teaching hospitals, this activity is inadequately supported. This is the case because this activity lies outside the ambit of the Universities' activities and for this reason it does not attract support from Commonwealth sources as is the case with University-controlled activities. The States are not able to find the considerable amount of finance required to support them adequately.

The second example also relates to public hospitals and their teaching activities. These institutions were founded as charities for the treatment of the poor, who could not afford medical treatment elsewhere. This basic purpose still underlies the administrative and professional structure of the public hospitals although the work they do and the community they serve have both changed in many ways. Now the teaching activity of the public hospitals depends on a sufficient number of patients of the

right sort (unflatteringly referred to by doctors as "good clinical material") presenting to the hospital for treatment. In times past the number presenting was more than sufficient to cover the teaching requirements of the clinical schools. In the last ten years, however, and especially on the surgical side, the numbers have dwindled alarmingly and the very small number presenting for elective operations is only a fraction of what it was.

This matter was the subject of comment by the President of the Royal Melbourne Hospital in his last annual report. He indicated that the position was due to a combination of many factors including the policy of the State Government in establishing district hospitals with an administrative structure differing from that of the teaching hospitals. He then went on to point out that the position is further influenced by the failure of the Commonwealth Government to recognize attendances by patients in the out-patient departments of our public hospitals for the purpose of Commonwealth Hospital Benefit payments. This policy, he indicated, has made it financially more attractive for many patients to seek treatment at the rooms of their local general medical practitioner, as those who are insured can obtain reimbursement of a substantial portion of the medical fees paid. We thus have the curious paradox of a charitable organization set up to dispense medical services to the poor of the community which is now obliged to charge a higher net fee to patients for its services than is charged by private practitioners.

I realize that I have outlined in a very brief fashion two complicated problems facing the practice of medicine in Australia today. I have done this not with a view to analysing them or seeking a solution but rather as a means of indicating how relationships between the Commonwealth and the States directly influence the everyday practice of medicine in the community.

In my paper this evening I intend to deal with two aspects of the relationships between the Commonwealth and the States in medicine. Firstly I intend to outline some of the historical background of the present position. Secondly I intend to outline the present structure and function of the National Health and Medical Research Council, which important body brings together the several Federal, State and other bodies concerned with the maintenance of the National Health; I use it to exemplify an attempt to co-ordinate medical activities throughout the Commonwealth.

The relationship between the Commonwealth and the States began with federation in 1901. The provisions of the new Com-

monwealth Constitution which came into effect on the 1st January 1901 by virtue of the Commonwealth of Australia Constitution Act of 1900 laid down the relationship between the Commonwealth and the States. Here, Mr. Chairman, I am obviously skating on thin ice and I hope Mr. Murray will amplify this aspect of Commonwealth-State relations which is obviously critical and central to my whole theme. As I understand it, however, at Federation, certain powers were specifically vested in the Commonwealth having been withdrawn from the States. These powers were either exclusive and placed solely under the jurisdiction of the Commonwealth Parliament, or concurrent and exercisable by the State and Commonwealth Parliaments simultaneously. However, in the event of conflict between Commonwealth and State laws the Commonwealth law prevails. Disputes as to whether a given act of the Commonwealth or State Parliament is within its powers are decided by the High Court of Australia.

At the time of Federation, the powers left with the States covered a wide field of constitutional, territorial, municipal and social activity and included control over education and health. Concurrent powers vested in the Commonwealth under Section 51 of the Constitution included only quarantine and invalid and old age pensions. As we will see in a moment the Commonwealth's activity in the health field grew out of the quarantine activities given it under the Constitution and the present Commonwealth Department of Health evolved from the Federal Quarantine Service, originally a unit of the Department of Trade and Customs.

To come forward in time and to complete this brief survey of the Commonwealth's constitutional power in the field of health—Under Section 51 subsection xxiiiA carried by the referendum of September 1946, the Commonwealth Government was empowered to legislate for the provision of maternity allowances, widows' pensions, child endowment, unemployment, pharmaceutical, sickness and hospital benefits, medical and dental services, but not so as to authorize any form of civil conscription, benefits to students and family allowances. This referendum followed the High Court's decision in 1945 that the Pharmaceutical Benefits Act 1944 was invalid.

However, although Federation left the States as sovereign legal powers in matters not entrusted to the Commonwealth in the Constitution, and such matters included education and health, in fact we find that because of the Commonwealth's dominance in the financial field, it has been in a position to exert

more and more direct influence in these areas. Galbraith says "As it is wrong to deny the role of conscience in human affairs it is also an error to minimize that of economics."

It is clearly beyond the scope of this evening's discussion to consider in detail the financial arrangements existing between the Commonwealth and the States. However, the dominance which the Commonwealth now exercises in this field is so important an aspect of Commonwealth-State relationships in medicine that some account of the present position and its evolution must be given. The Commonwealth and the States have close financial relationships in two fiscal activities, firstly in relation to public borrowing where common policy and co-ordination are the responsibility of the Australian Loan Council established in 1927. This Council each year examines the works programmes of the Commonwealth and the States, determines the total borrowings for the year, and the overall level of expenditure, and arranges the actual loan-raising both within Australia and overseas. Although the States are consulted, the establishment of policy and co-ordination are in the final analysis matters for the Commonwealth government.

In the field of income taxation dominance of the Commonwealth dates from 1942 when uniform taxation was introduced as a wartime measure. At this time, because the States were already in the income tax field, the Commonwealth found that it was severely restricted in the revenue it could raise to carry on the Australian war effort. The agreement enabled the Commonwealth to raise all income tax, and the States, who retired from the field, were allocated portions of the moneys raised under a formula. It was envisaged at the time that this would be a wartime measure only. However, the system has been continued with the concurrence of a majority of the Australian States and in spite of the determined opposition from the larger two States, a fact of which we are especially conscious at this time.

The establishment of the uniform taxation scheme in 1942, which transferred the major taxation revenue to the Commonwealth but left the provision of Government services such as education and much other Government expenditure to the States, has meant that the Commonwealth has been called upon to provide financial assistance to the States under an increasing number of schemes. One such scheme is the aid given by the Commonwealth through the Australian Universities Commission to promote the development of State Universities. Financial support

of this nature is made under Section 96 of the Constitution which states, "during a period of ten years after the establishment of the Commonwealth and thereafter until the Parliament otherwise provides, the Parliament may grant financial assistance to any State on such terms and conditions as the Parliament thinks fit."

To summarize what I have said about the constitutional and financial background of Commonwealth-State relationships as they apply to medicine. Although the provision of health services was not amongst those responsibilities transferred to the Commonwealth at the time of federation and the States retain this responsibility, the increasing dominance of the Commonwealth in the financial field, particularly by virtue of its revenue from taxation, has meant that the States are in a position to be brought more and more under Commonwealth control. With this review of the background to the State and Commonwealth relationship as applied to medicine I now intend to proceed to an examination of the history of Commonwealth activity in medical matters since 1901. This is of course an undertaking of some magnitude as it covers public health activities, provision of health services in the territories administered by the Commonwealth, the evolution of the Pharmaceutical Benefits and National Health Schemes and Commonwealth support of undergraduate to medical education and medical research. To cover this whole field is clearly impossible and I intend to deal only with events up to the formation of the National Health and Medical Research Council in 1937 and then to briefly outline the present structure and function of that body.

Following Federation in 1901, and although as we have seen the Constitution gave the Commonwealth power to legislate with respect to quarantine, this power was not executed until 1909 under the Quarantine Act passed in the previous year. This provided for a mutual arrangement between the Commonwealth and the States and vice versa. The Chief Medical Officer in each State was appointed by the Chief Quarantine Officer. This arrangement continued until the States one by one for various reasons sought relief as far as general quarantine was concerned; then as each State withdrew from the field the Commonwealth appointed a full time Chief Quarantine Officer to take over. By 1916 this arrangement applied in all States but Tasmania, which persisted under the old arrangements until 1929. It was in this way that the Divisional Officers of the Commonwealth Health Department came to exist in the various States.

Before leaving this aspect of the quarantine services of the Commonwealth I think it appropriate to recognize its importance in protecting the Australian community from disease introduced from outside the country. This service was described by Sir Andrew Balfour, Director of the London School of Hygiene in 1924 as possibly the most advanced and efficient in the world. It is interesting to recall that the last case of smallpox in Australia outside quarantine occurred at Geelong on 21st August 1921, except for one isolated house contact in Perth infected by a case from India in April 1938. The last case of plague occurred in Sydney in June 1923 and the last plague infected rat was reported from Brisbane in 1922.

Two other activities of the Commonwealth in medicine arose from its brief work in the quarantine field. In 1913 the smallpox outbreak in Sydney raised questions of interstate quarantine all of which were settled, but it also raised doubts about the purity of the vaccine used at that time. It was thought that some action should be taken to ensure that all vaccines and biological remedies should be of a uniform and high standard of potency. The commercial dislocation of the First World War brought this matter into prominence again when serious difficulty was encountered in obtaining supplies of sera from overseas. To deal with this matter the Commonwealth Government established the Commonwealth Serum Laboratories at Parkville in 1916 and these laboratories came under the direction of the Commonwealth Department of Health when it was formed in 1921. This position continued until 1961 when the laboratories were placed under the control of a commission set up for this purpose by the Commonwealth Government.

The second additional Commonwealth medical activity which evolved from its quarantine powers were the various Commonwealth Health Laboratories. These were proposed in 1921 when the Commonwealth Health Department was first formed and sixteen were established between 1922 (Bendigo and Townsville) and 1948 (Tamworth, Wollongong and Albury). These laboratories were established with the purpose of investigating outbreaks of disease and of performing laboratory work of a public health nature and as an aid to doctors practising in country areas. Also, and to some extent making a virtue of necessity, they were a means of increasing the sale of C.S.L. products.

During the First World War many national health problems arose, particularly those associated with medical examination

of troops, their welfare and care while overseas, with rehabilitation of the physically disabled after the war. This was augmented by the world-wide epidemic of influenza which struck Australia in 1917-1919 and emphasized the need for wider development of the health services.

Two specific events were important in the move to create a Commonwealth Department of Health. Firstly the resolutions of the Australian Medical Congress of Brisbane in 1920 reflect the experience of a large number of medical men who were closely associated with the organization involved in providing the medical services in World War I. Amongst these resolutions was the following: "This section expresses the opinion that the real principles which underlay the success of military public health administration during the Great War can be readily adapted to civil life . . . the application of these principles implies (1) Control by a central Commonwealth authority directing public health activities through an expert medical staff and co-ordinating action and legislation between States; (2) The granting of the greatest possible autonomy to local health authorities; (3) The organization . . . of the closest possible liaison between administrative medical officers and the medical practitioners; (4) The advancement of research; (5) Public health education.

The second important event which bore on the establishment of the Commonwealth Health Department was an offer of support from the International Health Board of the Rockefeller Foundation in the following terms: "In the event of the creation of a separate Ministry of Health by the Commonwealth of Australia the International Health Board of the Rockefeller Foundation offers the services for a period of not less than one of the following: a specialist in industrial hygiene, a sanitary engineer, a specialist in tropical hygiene and public health administration." The International Health Board also offered four fellowships in public health.

On 2nd February 1921, Federal Cabinet approved the creation of a Ministry of Health, and the Director of Quarantine became the Commonwealth Director General of Health. In March 1921 an Order in Council gave statutory authority for the creation of the new department with certain specified functions under the Public Service Act. At the same time the Institute of Tropical Medicine established at Townsville in 1908 was placed under the control of the newly created Department of Health. This Institute is no longer in existence, its functions having been transferred

in 1930 to the School of Public Health and Tropical Medicine in the University of Sydney. In 1924 the National Museum of Australian Zoology came under the control of the Director General of Health, and in 1931 was re-named the Australian Institute of Anatomy. A division of industrial hygiene was established in 1921 but was abolished at the time of the depression in 1932. After the Second World War in 1948 a unit of this nature was established in the School of Public Health and Tropical Medicine in the University of Sydney.

In 1925 Sir Neville Howse, V.C., as Commonwealth Minister of Health was instrumental in securing the appointment of the Royal Commission on Health, chaired by Sir George Syme, and it made its report in the same year. The Commission held 88 public sittings between January and July 1925, and examined 319 witnesses. The Royal Commission was given eleven specific terms of reference which were very wide and which included: (a) the co-ordination of medical services of Commonwealth Departments in regard to all matters affecting public health; (b) the co-operation of the Commonwealth and State health authorities; (h) the encouragement and development of research work; (i) The relationship which should exist between public health authorities and medical practitioners in regard to the prevention of disease.

The recommendations of the Commission therefore covered a very wide field in medicine and, although the great majority of them were not brought forward as legislation, many of them are as relevant now as they were then. These recommendations included—

I (1) that standardized statistical investigations into the extent and character of morbidity in the Commonwealth should be instituted and maintained.

II b (2) that the medical services of the Army, Navy and Air Force should be co-ordinated under one Director General with sub-directors in each Branch keeping the three services distinct.

III (2) that legislation should be passed by the Commonwealth Parliament to provide funds for the establishment of a Health Council along the lines we have recommended. (I will deal with these recommendations in a moment).

IV (3) that the Commonwealth Department of Health should formulate the principles of a comprehensive campaign against the spread of tuberculosis.

VI uniform legislation with regard to the purity of food and

drugs; (i) that the Parliaments of the several States should refer to the Parliament of the Commonwealth the matter of the control of imported food and drugs; and of such foods and drugs of Australian origin as are or may be the subject of interstate trade, and that the Parliament of the Commonwealth should thereupon make laws for the regulation of such foods and drugs.

(2) That the Commonwealth Parliament should pass legislation for the establishment of a legal standard for a metric or decimal system of weights and measures in Australia.

X The encouragement and development of research work; that the Commonwealth by Act of Parliament should (i) establish a Health Research Council comprising a representative of the Government who should be a business or financial authority appointed by the Governor General in Council; the Director General of Health (ex officio); representatives of the Universities of Sydney, Melbourne and Adelaide, one each nominated by their respective Faculties of Medicine; three representatives of the medical profession nominated by the Federal Committee of the British Medical Association in Australia and one of whom should be or have been engaged on research; a scientist nominated by the National Research Council.

(ii) Provide a special appropriation or endowment of £30,000 per annum in aid of health research. This recommendation was the basis of the formation twelve years later, in 1937, of the Medical Research Endowment Fund.

XI (3) that the Commonwealth should endeavour to arrange for the transfer to the Commonwealth from the States of their powers with regard to registration of medical practitioners.

A number of these recommendations were implemented and, for example, a Division of Tuberculosis and Venereal Disease was established but abolished with the financial stringency of the depression in 1932. The Tuberculosis Division was recreated by the Tuberculosis Act of 1945 amended in 1946 and replaced by a new Act in 1948. This brought an all out campaign against the disease and disbursed considerable sums of money to the States for this purpose, amounting for instance in 1963/64 to £6·4 million.

In 1926 the Federal Health Council was established for the purpose of securing closer co-operation between the Commonwealth and State Health Authorities and initially comprised the Commonwealth Director General of Health and his counterparts in the States. Between 1929 and 1936 the Council held ten ses-

sions and achieved a very full measure of co-operation between the Commonwealth and State Health Services.

In 1936 the Federal Health Council was enlarged to form the National Health and Medical Research Council. The composition of the Council was increased by adding representatives from other medical bodies and a prominent lay man and lay woman. Representation on the N. H. & M.R.C. now includes representatives of the Commonwealth Health Departments, of the Chief Medical Officers of the Health Departments of the States, the Territory of Papua, New Guinea, the Repatriation Department and the Commonwealth Serum Laboratories, together with representatives from the following professional and academic bodies: The Australian Medical Association, the Australian Dental Association, the Australian Paediatric Association, the Australian College of General Practitioners, the Royal Australian College of Physicians, the Royal Australian College of Surgeons, the Australian Regional Council of the Royal College of Obstetricians and Gynaecologists, the College of Pathologists of Australia, the College of Radiologists of Australasia, and a member representative of the Australian Universities which have medical schools; also an eminent lay man and an eminent lay woman, who by tradition is a registered nurse, appointed by the Commonwealth Minister of Health.

When the National Health and Medical Research Council was established its functions were (1) to advise Commonwealth and State Governments on all matters of public health legislation and administration, on matters concerning the health medical and dental care of the public and on medical research; (2) to advise the Commonwealth Government on the expenditure of money specifically appropriated to be spent on the advice of this Council; (3) to advise the Commonwealth Government on the expenditure of money in medical research and as to projects of medical research generally; (4) to advise Commonwealth and State Governments on the merits of reputed cures and methods of treatment which are from time to time brought forward for recognition.

The following year, in 1937, the Commonwealth Government established the Medical Research Endowment Fund, an annual appropriation of funds to assist medical research. The initial grant was for £30,000 in 1937/38, it rose to £60,000 in 1948/49, to £210,000 in 1957/8, £400,000 in 1964/65 and $1,065,000 in 1967/68, which gives some insight into the increased support

given to Medical Research through this source since the fund was first established in 1937. This brings me then to the end of this brief historical account of some aspects of the Commonwealth's participation in medicine up to the time of the setting up of the National Health and Medical Research Council. This has not been intended as an inclusive review and I have said, for instance, nothing about the provision of social benefits by the Commonwealth in this time. I have restricted my survey to the administrative relations existing between the Commonwealth and the States in the medical field. I have attempted to show how the National Health and Medical Research Council evolved to provide a link between the Commonwealth and the States, and between the States themselves, in the field of medicine. I now propose to examine the present structure and functions of this body and to comment on the nature of the problems with which it is confronted.

Currently the work of the National Health and Medical Research Council is done through three advisory committees each of which meet twice yearly before each meeting of the Council. These three advisory committees are the Medicine Advisory Committee, the Public Health Advisory Committee, and the Medical Research Advisory Committee. All members of the National Health & Medical Research Council serve on one or other of these advisory committees and a number serve on two. The Medicine Advisory Committee and the Public Health Advisory Committee, with the exception of the representation from the Commonwealth Department of Health, are composed entirely of members of the National Health & Medical Research Council.

As I will point out in a moment, the Medical Research Advisory Committee differs significantly with regard to its constitution and provides for up to one half of its membership coming from individuals who are not members of the National Health and Medical Research Council. The Council considers and if it sees fit acts on the recommendations made to it by these three advisory committees at its two meetings each year. I therefore propose to examine the terms of reference of these three committees and the way in which they function.

First the Medical Advisory Committee. This is comprised of representatives of the professional bodies represented on Council, the Commonwealth Serum Laboratories and the prominent laywoman on council being a qualified nurse, and the Chief Director (Medical Services) Commonwealth Repatriation Department. It

has at its terms of reference: (1) to enquire into and advise the council on matters relating to medical and dental care; (2) to enquire into and advise the council upon the merits of reputed cures or methods of treatment which are from time to time brought forward to them for recognition; (3) to receive, consider and transmit to council the reports of certain committees; (4) to report to council on the recommendations of all other committees of council in so far as they affect medical and dental care.

In fact this Medical Advisory Committee is called upon to consider matters concerned with the professional aspects of medical practice which bear on the national health. These matters may arise from the standing committees such as the Child Health and Maternal Health Committees which report through this body; alternatively matters may be referred to it from professional bodies or individuals. Examples of matters recently considered include the implications of the occurrence of renal disease associated with abuse of analgesic compounds, the advisability of labelling cigarettes with a health warning and with their tar and nicotine content, recommended standards for maternal and child health care, and most recently it recommended to council that it undertake a study concerning the rationalization of facilities for organ transplantation and renal dialysis and this study is currently proceeding. By virtue of its terms of reference this Medical Advisory Committee acts in an advisory capacity to the National Health and Medical Research Council which in turn is in most of its activities itself acting as an advisory body. The fact that this body is solely advisory and possesses no executive authority considerably limits the scope of its activities. This limitation is a direct consequence of the limited brief which the Commonwealth holds in the field of health as we have already seen. Nonetheless this Medical Advisory Committee serves a most important function as a means of obtaining appropriate advice in a wide area of medicine at a Commonwealth level, of informing governments both Commonwealth and State of some views of bodies represented on it and last but not least as a means of informing government and other bodies represented on it of some of the overall problems in the field of national health and medical research.

The second advisory committee to the National Health and Medical Research Council, the Public Health Advisory Committee, comprises the Assistant Director General of the Commonwealth Health Department, the Heads of the respective State

Departments of Health of the six Australian States, the Territory of Papua-New Guinea, and the Northern Territory, together with the Director of the School of Public Health and Tropical Medicine, Sydney. Their terms of reference are: (1) to enquire into and advise the National Health and Medical Research Council on all matters of public health and preventive medicine and matters involving health legislation and administration by the Commonwealth and State Governments. (2) to receive, consider and transmit to Council its recommendations on the reports of the following committees: Dental Health, Epidemiology, Food Additives, Food Standards, Medical Statistics, Mental Health, Occupational Health, Radiation Health, Traffic Injury, Tropical Medicine and Health and Veterinary Public Health, and others that Council may direct to report through it. (3) To receive, consider and report to Council upon the recommendations of all the other committees of Council in so far as they involve legislation or administration by the Commonwealth and for State Governments. (4) To receive, consider and make recommendations to Council in respect to all applications for public health travelling fellowships.

In effect this Public Health Advisory Committee is primarily concerned with public health standards and in establishing as high and uniform a standard as possible in this area throughout the Commonwealth. In this respect it has made very significant contributions to the national health and is continuing the work originally assigned to the Federal Health Council in 1927. However, it must be stressed that this body also is basically an advisory one and depends for execution of its recommendations through the National Health and Medical Research Council on the Health Departments and Governments of the respective States and Territories. This fact also inevitably limits the nature and scope of its recommendations.

The third advisory committee to the National Health and Medical Research Council, the Medical Research Advisory Committee, differs from the other two I have just mentioned in three respects. Firstly although by its constitution at least half of its members including its chairman and deputy chairman shall be members of Council they are not representative on this committee of the bodies nominating them to the Council but are appointed by the Council because of their ability to assist the Committee in its work. Secondly there is representation up to but not exceeding one half of the individuals who are not mem-

bers of the National Health and Medical Research Council. They are appointed by the Council for their ability to assist the committee in its work. This means they shall have a background and experience in the field of medical research. Thirdly, the Medical Research Advisory Committee differs from the other two advisory committees in that it has a measure of executive authority delegated to it by the Council, which empowers it to allocate grants in support of medical research from the Medical Research Endowment Fund in anticipation of Council approval at its October meeting. Its terms of reference are: (1) to advise Council on all matters connected with the application of the Medical Research Endowment Fund for the purposes of the Medical Research Endowment Act of 1937 and to make recommendations to the Council in May each year in the form of budget proposals for the distribution of grants the following year between the various disciplines of medical and dental research; (2) to receive and consider all applications for National Health and Medical Research Council grants in accordance with delegated authority and where no delegation of authority is made to make recommendations to Council; (3) to investigate, keep under review and report to Council upon medical research in Australia as a whole, to estimate its trends and developments and direct support where it is specially needed.

This Committee has the most direct executive authority of all the bodies connected with the National Health and Medical Research Council and in fact makes recommendations which disburse the largest single source of funds in support of medical research in the Commonwealth. The composition of this committee has been a matter of some criticism for years despite radical changes in its composition and structure on two separate occasions.

Initially it was composed of council members representing professional organizations and its competence to co-ordinate research and determine grants in a knowledgable way and on an equitable basis was challenged on the grounds that those actively engaged in medical research were inadequately represented. During the second phase of its existence it was composed solely of members experienced and actively engaged in medical research, but objections were raised on the grounds that it was unwise to entrust the co-ordination and balanced development of medical research throughout the country to a few research

workers who might find it difficult to dissociate themselves from the needs of their own departments or institutions.

The present composition of the Medical Research Advisory Committee introduced in 1966 has both members of the National Health and Medical Research Council and experienced medical scientists selected from outside the council serving on it. It will probably not surprise you to hear that this structure also has not been without its critics. It is however in my view an important attempt to maintain contact on this committee between the field of medicine and research on the one hand and the representatives of the various medical bodies of the Commonwealth on the other. The committee establishes and keeps under review salary scales for research workers and on its advice the Council has established a Central Register of Medical Research Grants with the object of minimizing wasteful duplication or overlapping in the allocation of funds of the National Health and Medical Research Council and other bodies involved in giving grants in support of medical research.

To summarize then, the Medical Research Advisory Committee is directly concerned with the main executive function of the National Health and Medical Research Council, namely, to advise Council on the distribution of grants from the Medical Research Endowment Fund. As I indicated earlier, the size of the fund has increased considerably in recent years and this reflects a rapid growth in the amount of medical research done on the Commonwealth since the Second World War and particularly in the last ten years.

Having brought the account of Commonwealth participation in the medical field up to 1937, when the National Health and Medical Research Council was first established and with this very brief account of its structure and functions I have completed my brief and I fear exhausted your patience. In a way of course I have brought you only to the beginning of the account, which continues to unfold, of the involvement of the Commonwealth in so many phases of medicine. I have said nothing of the Commonwealth National Health Scheme authorized by the National Health Act 1953, which covers pharmaceutical benefits, hospital benefits, pensioner medical service and medical benefits. This Act also, as you well know, has a history extending back at least as far as the Royal Commission of Health of 1926.

I have said nothing of the development and importance of non-Government professional bodies such as the British Medical

Association, the Australian Medical Association, the Colleges and the post-graduate medical organizations which have evolved at a Federal level and which have played so important a role in the evolution of measures taken to improve the standards of medical practice and the national health. I have said nothing of the oldest institutions of all, the public hospitals of the various States, nor anything of the newest, the John Curtin School of Medical Research in Canberra.

I have purposely confined my presentation to an outline of the historical background and the functions of a body devoted to finding wherever possible and practical a common approach of the Federal and State Governments and of the medical profession to the many problems of national health and medical research.

MR. B. L. MURRAY, Q.C.: In the course of the preparation which I did for tonight, I referred again to that well-known historical work, "1066 and All That", and noted that Mr. Gladstone was said to have spent most of his life seeking to solve the Irish question, and that he never solved it, because whenever he got close to it, the Irish secretly changed the question. With some reproach I look at Dr. Hurley because, about two weeks ago, he sent me what he then claimed to be a copy of the paper he was going to deliver, and I feel that he secretly changed the paper!

Actually, I do not think there is a great deal in what he said which touches the legal situation, and I wonder whether I have been asked to address you in the hope that I might trail my coat and possibly annoy you by giving you a particularly State-slanted view of some of these things. I must confess that it does occur to me that there is a considerable amount of misunderstanding of the State and Commonwealth relationship.

As time passes, one grows hardened to this and does not worry about it, and when I hear this word "Commonwealth" used as synonymous with everything good or with everything righteous, or both of these things, I think that it must be right because I hear it so often. But I wonder whether it is really right, or whether those of you medical people who have been through America, which is a federal State, have compared what you have seen in the public hospital/public health sphere with what you see in England, which is a non-federal State. If you ask me have I, the answer is "no", but those who have tell me that the United States, in terms of public hospitals, medical research, et cetera,

is ahead of England and some of them ascribe this to the competition which exists between the hospital and medical set-up in the various States of the U.S. as against the centralized system of control which exists in a very small country like England, where apparently there is much more emphasis on uniformity than there is on originality.

I have been Solicitor-General for the State of Victoria now for four years, and let me say at the outset I am not a politician. Consequently, I have no particular axe to grind, Commonwealth or State. But when you join a bandwagon I suppose you put on your glasses and look through those particular glasses, and obviously it would be impossible for me not to have achieved some sort of State slant. Even tonight, I have heard, not from Dr. Hurley, but at dinner, a remark which to me shows a complete misunderstanding and even a complete misconception of the Commonwealth-State set-up. The remark was to this effect: that the State had done something, but only because the Commonwealth had given it the money to do it. The implication was that therefore the credit lay with the Commonwealth.

If we go back, we find that at Federation there was a number of States, then self-governing colonies, which joined together to form the Commonwealth and gave the Commonwealth certain powers. If there is one characteristic which is common to those powers it is a characteristic of organization, which was necessary for a number of bodies joining together. One of the features which was almost entirely lacking was the power over people—people as individuals. Perhaps the most notable exception to that is that in the original Constitution the Commonwealth was given the power to make laws with respect to old age pensions and invalid pensions. That, as far as I recall, is about the only power in which the Commonwealth was dealing directly with Joe Blow or Bill Smith. All the other powers were things like defence, taxation, posts and telegraphs, immigration, excise, trade, et cetera—organizational types of power. Of course, the Commonwealth had the power to impose taxation, it could not survive if it did not, but this did not mean that the States did not also have the power to impose taxation, and until the last war, both Commonwealth and States did impose taxation. Then in about 1942, the Commonwealth conceived the idea that it would impose a tax on incomes on behalf of itself and of the States, and it would grant money back to the States to reimburse the States for the tax that the States would have gathered if they had continued to

impose income tax. This was sensible and logical, because in time of war, obviously, the Commonwealth had to impose very high rates of taxation. The States were given an amount simply designed to allow them to carry on in a time of national emergency, while the residue, necessarily, had to go to the Commonwealth for defence purposes.

After the war, this scheme was kept on. Commonwealth tax powers, I suppose, can be summarized broadly as: income tax, customs, excise, sales tax, and company tax, which, after all, is really only income tax imposed on companies; but those taxes are particularly significant in that they are what the financial experts call "growth taxes", which means that they move with movement in the economy.

The sort of taxes that the States are left with are land tax, probate duty, stamp tax, et cetera. If you get inflation or a rise in the economy, just as incomes go up in times of inflation, so do income taxes go up, but it takes a while before this reflects in probate duty, because you must wait for the customers to die before collecting the money on their increased assets. The States were left in the field of what are called "non-growth taxes", and the Commonwealth, by assuming the sole right over income taxes, alone remained in the field of growth taxes.

When the basic wage goes up, the Commonwealth has to pay increased wages to its employees. But it collects increased tax from the whole community and, in the result, actually makes a profit. The States, on the other hand, have to pay increased wages to their employees but they do not receive any immediate increase in revenue.

Probably some of these things do not matter. I have no strong views whatever on the question of whether many of these things are better controlled by the States or the Commonwealth, but it does intrigue me a little to hear people talk about the States doing something but only because the Commonwealth has given them the money. The real position seems to be that the Commonwealth has taken the money in the first place and the credit it claims from the grants it makes to the States seems a little misplaced.

When we hear of the Commonwealth's munificence in various fields let us bear in mind that it has robbed the bank first. I suppose the truth is that it does not matter where the money comes from, the services have to be provided and the important question is which body is the better to provide them.

It is obvious, I would have thought we all would agree, that it is undesirable for any one State or even one portion of the Commonwealth to be in an over-all richer position than the rest. It is obviously desirable that there is a pretty generalized level of education, health and various other things maintained in all States of the Commonwealth. I would not argue about that for a moment. But suppose we get to the stage when all things are governed by Canberra—is it really desirable that all these things in your home and in my home are governed from Canberra? If you believe it is, well and good. If you do not, it is just not good enough to say the Commonwealth has got the money. You have to go back a bit because the Commonwealth has got the money only because of the position it has taken up in relation to income tax. It is as simple as that.

I myself have serious doubts whether it is desirable that a country as territorially large as Australia should be entirely governed from Canberra. My doubts would resolve a little bit if I saw promulgated in the Commonwealth Gazette that everybody above a certain status in Canberra must spend three months every five years in one of the capital cities.

The enlargement of Commonwealth control, and control from Canberra, is going on in every field. The Commonwealth has got no specific power in education; there is a power in the amended section of the Constitution which was brought in since the last war which related to the granting of Commonwealth scholarships but apart from that I think it has no specific power in the field of education. It has no specific power in the field of medicine except that it now has power to make, under the amendment to the Constitution, laws with respect to medical benefits and so on. It has no power in relation to roads, no power in relation to dozens of things in which it is now busy assuming a very marked power, and it is able to do so simply because it has the money.

The Commonwealth still pays I think $2 per day per patient to the public hospitals in the States and, of the money that is required to maintain the public hospitals in the States 48% comes from the States. Of the other 52% something like 16% is provided by the Commonwealth through its $2 per day and the remaining 36% comes from the patients themselves, mainly through accident insurance and workers compensation and so on; but fundamentally the States are still running and paying for the public hospitals. The Commonwealth interference in the

field of public health, apart from at a higher level of councils and so on, is devoted to giving things to people. You can give money to people but you still must have hospitals for the people who receive the money from the Commonwealth to go to.

If the idea of inviting me to speak here tonight was to give you my thoughts on the Commonwealth-State relations, I have fallen for the bait and given them to you. It just irritates me to hear all this building up of Commonwealth munificence and the extension of Commonwealth power when it simply is no more and no less than a question of who has the money. It irritates me because it is not the way in which the Constitution is drawn and, as a lawyer, I suppose I am inclined to think that we should either stick to the Constitution as it exists, or, if we don't find that satisfactory, amend it in the manner provided for.

The history of Australia from now onwards will be, for better or for worse, an increasing dominance of the Commonwealth—the increasing dominance of Canberra over all our little parochial affairs, our health, our homes, our schools, our education, maybe even our churches.