

**PUBLIC vs. PRIVATE HEALTH CARE:  
THE SCHOOL MEDICAL SERVICE IN NEW SOUTH WALES**

Dr Peter J. Tyler

Towards the end of the nineteenth century, modernist intellectual movements began sweeping European cultural and political life. “National efficiency” became the progressives’ mantra, expressed through measures such as improved industrial conditions, better housing, town planning, and the student-centred New Education movement which sought to replace the old rigid approach to teaching with methods that emphasised the social aspects of schooling, as well as the physical welfare of pupils.<sup>1</sup> Motherhood was venerated as an occupation requiring proper training so that a healthy population could be propagated. Most notably, progressives were concerned to reduce infant mortality and to discourage “mentally unfit” people from reproducing. Many educated Australians found a resonance with the American version of progressivism as espoused by Theodore Roosevelt, with its highly nationalistic overtones and concern for the future of the Anglo-Saxon race. It was a period when there was growing alarm about the health and fitness of children in the face of a perceived threat of a “Yellow Peril” from our north.

Progressivism was essentially an elitist philosophy, which believed that reforms should be carried out by experts, based on thorough research. Dr Mary Booth began anthropometric studies of school children in 1901 and her observations in a small number of NSW public schools revealed numerous defects in both the children and the school environment that would hinder educational progress. In particular, she noted that while Sydney boys were taller than their English counterparts, their chest expansion was much less. Dr Booth became lecturer in hygiene for the Department of Public Instruction in 1904.<sup>2</sup> Following this revelation, the school curricula were modified to include exercises, “Swedish drill”, and sporting activities in order to improve fitness.<sup>3</sup> This “marching drill” gradually evolved into military exercises and cadet training, which in 1911 became compulsory for boys from age twelve.<sup>4</sup> For girls, as future mothers, the aim was to promote erect posture and “beautiful carriage”.<sup>5</sup> These moves were part of the wider eugenics movement to improve national efficiency that was fashionable, although the Australian version did not advocate extreme measures such as sterilization of the mentally unfit, as practiced widely in Europe and the USA during the early decades of the twentieth century.<sup>6</sup>

Some writers pointed out that as school attendance was compulsory, the State acting *in loco parentis* had an obligation to ensure healthy conditions for the child during their attendance.<sup>7</sup> Dr J.S.C. Elkington in Tasmania was at the forefront of this “vitalist” movement,<sup>8</sup> and at his instigation medical inspectors were appointed in Tasmania, Victoria, South Australia and Queensland around 1905. Inspectors sometimes found difficulty in assessing vision because many children were functionally illiterate and could not name the letters on a Snellen chart.<sup>9</sup> Pupils with impaired sight were often classified as “backward” simply because they could not

read lessons on the blackboard. They were then sent to the back of the room, which aggravated their difficulties. Testing of hearing was carried out by holding a pocket watch behind the pupil and moving it closer until they could hear it. But many children had never seen or heard a watch and had no idea of what was expected of them.

In 1907 the Commonwealth Government asked the States to co-operate in a national scheme for collating data about children's age, weight and height, but this was not adopted immediately. However the proposal was revived in 1911, when the Australian Anthropometric Committee was established to conduct systematic surveys along similar lines to a British scheme, using identical methodology.<sup>10</sup> At the Australasian Medical Congress that year, Dr Mary Booth presented a paper on "The Scope and Organisation of a School Medical Service". She pointed out that the first step would need to be establishing good working relationships with existing health agencies. Dr Booth believed that treatment would be "the necessary corollary of medical inspection", but the question to be resolved was to what extent this should be free and compulsory.<sup>11</sup> She was aware of possible resistance from some quarters by pointing out that "It is very desirable that the work of medical inspection shall appeal to the general body of the medical profession," and argued that to meet any opposition, the educational authorities should "approach accredited medical associations and ask for their friendly co-operation."<sup>12</sup>

From the early days of Australian settlement medical practitioners in private practice adopted a "fee for service" ethos like their counterparts in the United States. In the 1840s, when the colonial government tried to encourage smallpox vaccination by offering doctors a miserly one shilling for each procedure, many resented this government intrusion, believing that vaccination was "better left to private practitioners who would reward themselves for an attentive performance."<sup>13</sup> Towards the end of the nineteenth century when concern about the intractable rate of childbirth mortality led to proposals for subsidised ante-natal clinics staffed by trained nurses, there was forceful opposition from the local branch of the British Medical Association (BMA) on the grounds that this was a threat to doctors' autonomy as well as an attack on their incomes.<sup>14</sup> The possibility that, nevertheless, it may have been an effective public health strategy was not discussed.

The concept of medical examination of schoolchildren was not entirely original. France endorsed the principle as early as 1793, although it was not implemented in Paris until 1879, and was beaten by Brussels five years earlier. Other European countries and the United Kingdom followed gradually, while the USA introduced schemes at the close of the nineteenth century.<sup>15</sup>

New South Wales appointed two part-time medical officers in 1907 as "Special Instructors" at the teachers' Training College, Dr R.E. Roth and Dr May Harris. They were designated as medical inspectors and lecturers in hygiene, working alongside other special lecturers in non-academic fields such as music and drawing. The duties of the doctors were largely connected with training teachers in the elements of hygiene and public health, but they were able to carry out some surveys of children in Sydney and Newcastle which indicated the extent of the problem. They also examined individual children whose teachers thought they displayed symptoms of poor health. As Professor F.B. Smith wryly observed,

Most of the boys judged sound by their teachers must have gone on to become the one in three volunteers passed ready for service in 1914-18. That group supplied the sixty-six thousand Australians listed as dead or missing in foreign fields.<sup>16</sup>

A bacteriological laboratory was established to assist in the identification of infectious diseases, but this function was soon absorbed into the Government Microbiology Laboratory which had commenced in 1908.

The first Labor Government in New South Wales took office in 1910, with James McGowen as Premier. The new government had an agenda for social reform, measures seen by conservatives as “socialism naked and unashamed”,<sup>17</sup> including state provision of a range of health services; proposals that were strongly opposed by the organised medical profession, the friendly societies that funded much medical care, and the boards of the public hospitals which functioned as charities.<sup>18</sup> These groups had an obvious pecuniary interest in preserving the *status quo*, but there was also an ideological objection on the grounds that state intervention interfered with the freedom of the individual. In the case of school medical inspections, it was argued that the welfare of children was their parents’ responsibility.

In 1911 the medical officers were able to extend their medical inspection to the South Coast and some inland towns; four school nurses were appointed the following year to support this work. Meanwhile, the Dental Association of NSW had been making dental inspections in a few schools, which showed that there was a high percentage of pupils with defective teeth.<sup>19</sup>

The alarming extent of the health problems in 1911 is shown in this table:<sup>20</sup>

□ Schools visited by Medical Inspectors	144
□ Enrolment at schools visited	67,577
□ Children examined	16,909
□ Physical defects diagnosed	18,341
□ Boys with defects =	60.1%
□ Girls with defects =	57.9%
□ Total NSW population (1911)	1,646,734
□ Total number of State & Private schools (1910)	3,214

In February 1913 the Department of Public Instruction appointed Dr Charles Savill Willis, as Chief Medical Inspector of Schools, at a salary of £800pa. Since 1908 he had been the Assistant Medical Officer to the Government in the Department of Public Health. Aged 42 at the time, he was a graduate of the University of Sydney (1899) and had gained postgraduate medical and surgical qualifications from Edinburgh and London, as well as the Diploma in Public Health.<sup>21</sup>

The *Australasian Medical Gazette* noted his appointment with approval, on the grounds that this would ensure “that the future citizens of the State may be equipped as thoroughly as possible for the battle of life.” The aim in examining children, it argued, would be “to eliminate those who are mentally defective,” without specifying how this might be done. The *Gazette* said that doctors should not regard the school medical inspector as a rival practitioner, but rather, as a “guardian of the public health, it is our duty to assist in rendering this work as effective as possible.”<sup>22</sup>

By the middle of 1913, a separate Medical Branch was created within the Department of Public Instruction, with Dr Willis as Principal Medical Officer, together with ten other qualified Medical Officers, five nurses, and some clerical support staff. Six of the doctors were women, because child health was seen as an appropriate field for female practitioners. As was customary, they received a smaller salary than their male counterparts with identical qualifications - £400pa compared with £500pa for the men.<sup>23</sup> True, they tended to be a bit younger – Enid Macdonald was only 25, probably her first job since graduation. Women found it very difficult to get employment in a hospital, and private practice was out of the question for them at that time. Working for the Medical Branch did provide opportunities to practice their skills for women doctors, who F.B. Smith believes “were more dedicated and able than the men.”<sup>24</sup> Several went on to have notable careers subsequently.

In order to mollify the fears of many doctors, Dr Willis addressed the BMA Branch in November 1913, in a paper that was subsequently published as a leading article in an issue of the *Australasian Medical Gazette* in order to reach a wider audience. After a detailed description of how the scheme functioned, Dr Willis asked for the co-operation of the medical profession in taking seriously the defects identified by the medical inspectors. He observed that in some areas “the attitude of the practitioners is so well known that we are already able to say, before medical inspection, that only a small proportion of the children will be treated.”<sup>25</sup> This criticism may have served to exacerbate the tensions that were emerging.

The NSW Branch of the British Medical Association had become nervous about this innovation, and asked the Government for any proposed legislation affecting the medical profession to be first presented to the Association “in order that, if possible, the success of the scheme may be secured.”<sup>26</sup> Within their internal committees, the BMA was more explicit:

We should take steps to protect our interests and rights in connection with the man and often hastily considered measures relating to our work which find their way into the statute book.<sup>27</sup>

The school Medical Branch aimed to inspect all of the children attending state government schools every four years. At this time the term of compulsory school attendance was eight years from 7 to 14, so each child could expect to be examined twice during their school career. The medical inspectors were to examine teeth, throat and nose, ears, eyes, hair, speech and assess “mental condition”. The examination would extend to heart and lungs if the inspector suspected any abnormality. In addition, they inspected school buildings for health hazards, instructed older girls about baby care and home hygiene, gave lectures to parents on sick nursing, and medically examined all candidates for teacher training.

One of the factors causing poor health in schoolchildren was the inadequate sanitary arrangements and poor hygiene in many schools, as well as lack of lighting and ventilation. Even in 1915 the School Medical Branch reported that it was common for children to share the towels, cups and toothbrushes provided in the school. The Board of Health had already observed that government buildings such as railway stations, prisons and schools were commonly the least hygienic premises in a town, but the Crown was exempt from public health legislation.<sup>28</sup>

Formal medical inspections began at State schools on 1 September 1913. In November, many non-government schools joined the program. When a smallpox epidemic erupted later in 1913, the medical and nursing staff began vaccinating children and teachers in the Sydney Metropolitan and Newcastle districts, as well as some country areas.<sup>29</sup> Nevertheless, by the Christmas vacation, 25,638 children had been examined, with 15,135 showing defects that needed treatment – 59 per cent of those examined. The problems were worst in the metropolitan district (70%), and lowest in small country areas (44%). Slightly more boys than girls showed defects.<sup>30</sup> Decayed teeth were the biggest problem, followed by infected tonsils, adenoids, enlarged glands and defective vision.

Initially, no treatment was provided. Parents were notified of the faults identified and asked to advise the Medical Branch when these had been attended to by a local practitioner. The results were disappointing: in the first year of the scheme only 46 per cent of metropolitan children were treated, while from country areas the response was barely 22 per cent. The Medical Branch noted that

although the non-treatment of some children is due to the indifference of parents, in many other cases it is due to inability to afford the cost of treatment, or to the absence of facilities...even in some of the larger country towns.

To address these issues, a Travelling Hospital was established in 1914, staffed by two doctors and a nurse, to visit remote country areas for short periods and provide treatment as well as medical examination. This innovation was not well received by some country doctors. Dr A.G. Cribb of Millthorpe wrote to the Minister for Education, A.C. Carmichael, proposing that

If the Government is in earnest in the matter of inspection and anxious for good results ... I suggest that the best way to accomplish the purpose is to make a contract with the local Government Medical Officer to provide the attendance at a moderate rate. ... [Parents] would undoubtedly be glad to take advantage of a free operation, but would prefer their own doctor to a stranger of whom they know nothing. My fee here has always been three guineas for the combined operation of adenoids & tonsils ... I should be prepared to make a contract with the department on these terms.<sup>31</sup>

In an attempt to discredit Cribb, Dr Willis remarked to the Minister that this was “the third attempt of Dr Cribb’s to obtain remunerative work from this department in the last few months.” The Minister concurred with the Principal Medical Officer’s advice that this would set a bad precedent and would be much more expensive than the scheme which was already being set up.<sup>32</sup>

The Travelling Hospital performed minor operations such as removal of enlarged tonsils and adenoids, often in rather primitive conditions. These conditions often manifested through mouth-breathing and foul breath, which were thought to indicate stupidity as well as bad manners. Some doctors thought these illnesses were a prelude to tuberculosis, or at least made patients more susceptible. This led to widespread campaigns during the 1920s and 1930s to surgically remove tonsils, enlarged or not. If this seems rather drastic, it must be remembered that this was before antibiotic treatment became available.<sup>33</sup>

The BMA saw this as a further example of the Labor government's "encroachment on our interests", just like the new Baby Clinics and Venereal Disease clinics.<sup>34</sup> The editor of the *Medical Journal of Australia* joined the fray, recognising that while "the care of the infant and the school child is the first factor in the building up of a strong race," the school inspectors should only look for treatable defects, and that "no treatment should be given at the clinic." If a family had no regular doctor, a local panel of willing practitioners should be set up, who would be adequately remunerated by the State on a fee for service basis, to treat children referred to them. On the one hand, the *MJA* argued for freedom of choice by parents, but at the same time advocated compulsion where parents did not get treatment for their child.<sup>35</sup> This would bring additional patients to their members' attention.

A separate Travelling Ophthalmic Clinic was established to visit the larger country towns and service surrounding areas. Staff oculists examined children's eyes, treated refraction errors and prescribed spectacles. In remote outback areas they treated ophthalmia (trachoma, popularly known as "sandy blight") and provided medication for ongoing treatment by parents. Nurses even visited parents of "mentally defective" children and provided advice on their care. Dental staff were added to the Medical Branch in 1915, and by the following year there were six travelling dental clinics, providing treatment in school classrooms, without the benefit of electricity or running water. The dental service never encountered opposition from the BMA, while the dental profession in that period was not so tightly organised. This arrangement differed from the New Zealand school dental service, which provided clinics within over 400 schools, colloquially known by the children as "the murder house", staffed only by dental nurses with minimal training, who did not pose a threat to qualified dentists.<sup>36</sup>

In 1915, medical examinations were extended to the special Aboriginal Schools, and to all children called before the Courts. Later, this was extended to all children in the care of the Child Welfare Department.<sup>37</sup>

Antagonism between the organised medical profession and the government soon escalated. The *MJA* described the Travelling Hospital as a "wrong-headed scheme of the Department [that] is not in the best interests of the children," and disputed the claim that the Travelling Hospital only worked "in those parts of the State where there are no resident doctors or dentists", pointing out that relatively large towns such as Wagga Wagga and Corowa were on the visiting itinerary.<sup>38</sup>

The Minister for Education, Arthur Griffith, responded that members of the BMA were "butchers and rogues" who were only interested in the potential loss of their fees. Nevertheless, the *MJA* may have had a legitimate criticism when they calculated from the Department's annual report that each medical officer must have examined at least 20,000 children, and treated over 2,000 of them in the previous year, which hardly suggests a very thorough process.<sup>39</sup>

The School Medical Officers were well aware of the difficulties imposed by their unreasonable workloads. At the end of 1916, the first national conference of medical inspectors from Australia and New Zealand took place in Sydney. At this gathering they tried to introduce uniform standards for conducting medical examinations and classifying any defects discovered. The *MJA*, always ready to buy into an argument about school inspections, suggested that "it would be more useful to restrict the

inspection to those organs whose defects produce the greatest impediment to development and growth.” It regarded “defects of the mind” as the most important of these, and proposed that thorough chest examinations were more beneficial than detecting deficient sight or hearing, although the latter obviously had a more immediate effect on their schoolwork.<sup>40</sup>

The Travelling Hospital was really too much for the medical profession to stomach. If the visiting school doctors only advised patients to see their own doctor about a problem that had been identified, that was desirable, but to actually provide treatment was unacceptable. To conservative eyes it was the beginning of nationalised medicine. The BMA called two special meetings in 1916, which resolved that members should not accept appointments to the hospital unless the government guaranteed that “the rights of private practitioners will be preserved.” Their only concession was that school doctors should only see pupils after means-testing.<sup>41</sup> The government wilted and the treatment of schoolchildren by the Travelling Hospital was abandoned.

Plans to expand the service by creating four additional Travelling Hospitals had to be cancelled as a result of opposition from the British Medical Association, and the fact that no trained staff were available because most younger doctors and many nurses enlisted for service in the AIF during World War I.<sup>42</sup>

Underprivileged children in the Sydney metropolitan area faced similar health problems caused by parents who were unable or unwilling to pay for private treatment. The school medical inspectors could refer these children to the General Treatment Clinic for School Children, established in 1917 as part of the outpatients facility at the Royal Alexandra Hospital for Children in Camperdown, a poor inner-city suburb close to where many of the patients lived. Here, procedures such as tonsillectomies were performed almost on a production-line basis, subject to means-testing of the parents’ capacity to pay for treatment.

After Dr Willis died suddenly in 1919 he was replaced by Dr Harvey Sutton in 1920, when the Branch became known as the School Medical Service. Its functions did not alter substantially, except that it formalised the collection of anthropomorphic data about children’s weight, height and nutrition. Dr Sutton linked mortality with morality when he wrote that “the three great racial diseases or poisons are alcoholism, tuberculosis and venereal disease” which he believed could be eradicated by sound education to inculcate “the ideals of health, beauty and service.”<sup>43</sup> Sutton was a gifted all-round sportsman, who had represented Australia at the Olympic Games, so was a passionate advocate of exercise and the open-air life for school children.<sup>44</sup> In 1929 Harvey Sutton became Professor of Preventive Medicine at the University of Sydney.<sup>45</sup> On leaving the Department, he wrote that since 1909 he had been “convinced that of all health activities in the State, school health with its medical, oculist, dental and nursing aspects, is second to none in importance.”<sup>46</sup>

During the triennium 1921-23, a total of 230,967 school pupils were examined; of these, fifty per cent were found to have defects, but only half of these received any subsequent treatment.<sup>47</sup>

□ School pupils examined	230,967	
□ Dental defects	89,234	(34%)
□ Nose & throat cases	32,118	(14%)

<input type="checkbox"/> Vision problems	12,741	(6%)
<input type="checkbox"/> Hearing difficulties	6,604	(3%)
<input type="checkbox"/> Subsequently treated	50.4%	

Anthropometric studies showed that on average the children in small country towns were the tallest and heaviest, while children in the metropolitan district were the shortest and lightest, particularly in “the most thickly populated portions of the metropolis, inhabited mainly by industrial workers.”<sup>48</sup> At least school children did not have the twenty-first century affliction of obesity.

By 1927 it was realised that a permanent psychologist or psychiatrist was needed to provide assessments of children appearing before the courts or attending special schools for the intellectually disabled. These evolved into Child Guidance Clinics. Speech therapists were added to the team in 1944.

By the late 1920s the School Medical Service had grown to 21 medical officers, some of whom did the routine school inspections while others were engaged in special investigations, such as the incidence of tuberculosis in children and mapping the incidence of goitre throughout NSW. The staff were divided into metropolitan and rural groups. Each country team consisted of a female medical officer who normally worked in one of the railway towns where there was suitable accommodation, a male medical officer who visited the more remote areas where travel and accommodation could be rough. In the far western areas where trachoma was rife, there was also an ophthalmologist (“oculist”) in the team. In the metropolitan area there were 2 male and 4 female doctors engaged in medical inspections, supported by 8 school nurses whose main task was home visiting of parents who had failed to respond to official notification that their child had a health problem.<sup>49</sup>

The Medical Branch of the Education Department reached its peak establishment in 1924, but by 1938 this had altered little, with 19 doctors, 18 dentists, 18 nurses and dental assistants and a psychologist on the professional staff.<sup>50</sup>

<input type="checkbox"/> Principal Medical Officer	(Dr A.E. Machin)
<input type="checkbox"/> Senior Medical Officer	(Dr H.M. North)
<input type="checkbox"/> 17 Medical Officers	(8 women; 9 men)
<input type="checkbox"/> Senior Dental Officer	(Mr L. Pudney)
<input type="checkbox"/> 17 Dental Officers	(All men)
<input type="checkbox"/> Psychologist	(Miss Nancy Burton)
<input type="checkbox"/> Senior Dental Assistant	(Miss Agnes Williams)
<input type="checkbox"/> 7 Dental Assistants	(All women)
<input type="checkbox"/> 10 Nurses	(All women)
<input type="checkbox"/> 5 Clerical staff	(3 women; 2 men)

It was not an appealing occupation so it is not surprising that the Department found difficulty in attracting suitable staff. A proposal for a cadet training scheme for medical students who would be recruited for school medical work – like teachers and engineers in the public service – was being considered in 1929, but collapsed when the Depression struck later that year.

Around this time, a separate Division of School Dental Services was established with its own Director.<sup>51</sup> There were then 11 dentists with 11 dental assistants working in

country districts. Children up to age 11 were eligible for free treatment; otherwise only emergency treatment was provided in areas where a private practitioner was not available. For city children there were two women part-time dentists attached to the Children's Hospital.<sup>52</sup>

Tooth decay was a common problem in Australians that was remarked on by overseas visitors as least since the 1820s, who ascribed it to eating over-refined foods, and drinking water that did not contain the phosphates and carbonates customary in Europe. Professor Smith has remarked that

yellowed, irregular, broken carious teeth, awkward plates and dentures in both women and men seem to have been so commonplace that they were not regarded as a salient component of good looks.<sup>53</sup>

In support of this comment, Smith observes that in posed wedding photographs taken before the 1940s, very few of the couples are smiling to reveal their teeth. Many Australian servicemen enlisting for WWII were proud that all their natural teeth had been replaced by dentures. Sometimes women had all their teeth extracted prior to marriage, to save their husbands the expense of dentistry. It is little wonder, then, that children's teeth were so poor.

As early as 1931 there had been a proposal to transfer the School Medical Branch from the Education to the Health portfolio. This suggestion was strongly resisted by the staff of the Branch. The executive officer wrote to the Secretary of the Department:

There are so many matters of a medical nature with which the Education Department is concerned that there should be available its own Medical Officers from whom authoritative reports can be obtained ... Members of the staff of the School Medical Service are now accepted by teachers and parents as co-partners in the education system of the State. It is very unlikely that the same spirit of camaraderie would exist between officers of the Education Department ... and officers of the Health Department.<sup>54</sup>

During World War II there was a resurgence of interest in the welfare of children as a result of an unprecedented number of "incomplete homes" because fathers were engaged in military service while many mothers were working in jobs formerly filled by men, as part of the war effort. A Care of the Child in Wartime Committee was formed in December 1942 following a conference of 150 education, church, welfare and trade union leaders. This conference, which was convened by the NSW Public School Teachers' Federation, called upon the Commonwealth Government to establish Child Care Centres with trained staff to look after children outside school hours, and provide medical and dental care as well as nutrition advice and guidance to parents.<sup>55</sup> Needless to say, the Government had other priorities.

In 1946 the School Medical Service was transferred from the Department of Education (Public Instruction) to the Department of Public Health, although the Child Guidance Clinic remained in a Medical Branch of the education department. By 1948 the staff establishment consisted of the Director and Assistant Director of School Medical Services, plus twelve Medical Officers (five women), ten nurses and a speech therapist. A separate Division of Dental Services contained ten dentists and eight dental assistants.<sup>56</sup>

By this time, the original progressivist commitment to improving national efficiency had vanished. Eugenics was thoroughly discredited because of its association with the Nazi regime. It became difficult to attract suitable medical staff to public health work, which had no social or professional cachet. Once a doctor had worked in the public health system for a while, there was little chance of returning to clinical practice. Dr Rod McEwin, the first Chairman of the Health Commission of NSW later remarked that some public service doctors were unsuited for medical careers.<sup>57</sup> This was a view shared by the former Director-General of Public Health, Dr E.S. Morris, who told the Chairman of the Public Service Board that salaries and conditions in the public sector were so poor that the Department could attract “only drug addicts or alcoholics and usually combinations of both.”<sup>58</sup>

This generalisation is probably a little unfair, because the senior officers were dedicated and well-qualified. Dr E.S.A. Meyers, who had been Director of the School Medical Service before promotion to the position of Director of State Health Services, wrote that

Health education is essential. It rightly belongs in the schools. It is of little use to have available modern scientific knowledge unless all members of the community are made aware of such knowledge, and how it can be applied to protect their health, the health of their children, and the community generally.<sup>59</sup>

To implement this policy, Dr S.J. Krister was appointed Health Educationist, the first such position in Australia.<sup>60</sup>

Then in 1967 the School Medical Service was amalgamated with the Division of Maternal and Baby Welfare to create the Bureau of Maternal and Child Health to provide a comprehensive integrated health service for the mother and the child from birth to school-leaving age. The School Medical Service became part of the Section of Child Health, which began using district Child Health Centres to identify abnormalities in school children through parent, teacher or medical referral.<sup>61</sup> Regular medical inspections were gradually supplanted by psychological counselling and child guidance services organised on a district basis rather than centrally. Although the Teachers’ Federation had achieved its objectives, the BMA/AMA creed of direct fee-for-service by private practitioners had prevailed once again.

In 1973 the Department of Health was itself abolished and replaced by the Health Commission.<sup>62</sup> But that’s another story!

---

<sup>1</sup> J. Burnswoods & J. Fletcher, *Sydney and the Bush. A Pictorial History of Education in New South Wales*, Sydney, Department of Education, 1980, p.139.

<sup>2</sup> J.I. Roe, ‘Mary Booth’, *Australian Dictionary of Biography (ADB)*, Vol.7, 1979, p.345.

<sup>3</sup> *Official Year Book of NSW*, 1914, p.663.

<sup>4</sup> F.B. Smith, ‘Medical inspection of State schoolchildren in Australia, c.1905-14’, *Health and History*, Vol.10, No.1, 2008, pp.12-13.

<sup>5</sup> This expression was used by Dr Harvey Sutton, ‘The teaching of hygiene in schools’, *Medical Journal of Australia*, 7 May 1927. Reprint, p.4. “Hygiene” meant much more to Sutton than personal cleanliness; it had a distinctly moral overtone.

<sup>6</sup> M.J. Lewis, *Public Health in Australia, 1788-1950*, Vol.1, Praeger/Rodopi, 2003, pp.147-8.

<sup>7</sup> *The Medical Directory of Australia, New Zealand, etc.*, Sydney, Butterworth & Co., 1915, p.78.

- 
- <sup>8</sup> See M. Roe, *Nine Australian Progressives – Vitalism in Bourgeois Social Thought, 1890-1960*, St. Lucia, University of Queensland Press, 1984.
- <sup>9</sup> F.B. Smith, *Illness in Colonial Australia*, Melbourne, Australian Scholarly Publishing, 2011, p.169.
- <sup>10</sup> *The Medical Directory of Australia, New Zealand, etc.*, Sydney, Butterworth & Co., 1915, p.79.
- <sup>11</sup> M. Booth, 'The scope and organisation of a school medical service', *Transactions, Australasian Medical Congress, Ninth Session*, Vol.1, Sydney, 1911, p.650.
- <sup>12</sup> *ibid.*, 653.
- <sup>13</sup> Amy McGrath, 'The history of medical organisation in Australia', unpublished PhD thesis, University of Sydney, 1975 p.111.
- <sup>14</sup> *ibid.*, p.48.
- <sup>15</sup> Lewis, *op.cit.*, pp.162-5.
- <sup>16</sup> F.B. Smith, 'Medical inspection of State schoolchildren in Australia, c.1905-14', *Health and History*, Vol.10, No.1, 2008, p.18.
- <sup>17</sup> *Sydney Morning Herald*, referring to the public housing schemes, quoted in M. Hogan & D. Clune (eds.), *The People's Choice*, Vol.1, Sydney, 2001, p.129.
- <sup>18</sup> Lewis, *op.cit.*, p.158.
- <sup>19</sup> *Official Year Book of NSW*, 1914, p.663.
- <sup>20</sup> *Official Year Book of NSW*, 1914, p.664.
- <sup>21</sup> Public Service Board of NSW, *Public Service List*, 1913.
- <sup>22</sup> 'The profession and school medical inspection', *The Australian Medical Gazette*, 23 August 1913, pp.174-5.
- <sup>23</sup> *Public Service List*, 1914.
- <sup>24</sup> F.B. Smith, personal communication to author, 21 June 2011.
- <sup>25</sup> C.S. Willis, 'The recognised scheme for the medical inspection of children attending the State schools of New South Wales', *The Australasian Medical Gazette*, Vol.XXXIV, No.19, 8 November 1913, pp.425-7.
- <sup>26</sup> McGrath, *op.cit.*, p.129.
- <sup>27</sup> *ibid.*
- <sup>28</sup> P.J. Tyler, unpublished PhD thesis, UNE, 1998, p.79.
- <sup>29</sup> Information obtained from State Records *Archives Investigator* – Agency Detail number 2725.
- <sup>30</sup> *Official Year Book of NSW*, 1914, p.666.
- <sup>31</sup> Letter from Dr A.G. Cribb of Millthorpe to the Minister for Education, 27/1/1914. In addition to his private practice, Dr Cribb was the Government Medical Officer and Public Vaccinator at Millthorpe. [SRNSW 2/8566.4]
- <sup>32</sup> Memo to the Under Secretary, and the Minister for Education, by Dr Willis, PMO, 3 February 1914. [SRNSW 2/8566.4]
- <sup>33</sup> F.B. Smith, 'Medical inspection of State schoolchildren in Australia, c.1905-14', *Health and History*, Vol.10, No.1, 2008, p.13.
- <sup>34</sup> McGrath, *op.cit.*, p.129.
- <sup>35</sup> 'Medical inspection and treatment of school children', *Medical Journal of Australia*, 25 July 1914, p.84.
- <sup>36</sup> Information from 'Slice of Heaven' exhibition, Te Papa Tongarewa, the national Museum of New Zealand, Wellington, July 2011.
- <sup>37</sup> *Official Year Book of NSW*, 1933-34, p.377.
- <sup>38</sup> 'Schools and school children in New South Wales', *Medical Journal of Australia*, 5 February 1916, pp.125-7.
- <sup>39</sup> Reported in 'A red herring', *Medical Journal of Australia*, 9 September 1916, pp.210-1.
- <sup>40</sup> 'The conference of school medical officers', *Medical Journal of Australia*, 30 December 1916, p.563.
- <sup>41</sup> McGrath, *op.cit.*, p.129.
- <sup>42</sup> C.J. Cummins, *A History of Medical Administration in NSW, 1788-1973*, 1979, p.187.
- <sup>43</sup> Harvey Sutton, 'The teaching of hygiene in schools', *Medical Journal of Australia*, 7 May 1927. Reprint, pp.8-11.
- <sup>44</sup> D.R. Walker, 'Harvey Sutton', *ADB*, Vol.12, 1990, p.143.
- <sup>45</sup> C.J. Cummins, *A History of Medical Administration in NSW, 1788-1973*, 1979, p.188. Cummins incorrectly gives the date as 1925.
- <sup>46</sup> Letter from Dr Harvey Sutton to 'Fellow Colleagues in the School Service' on the occasion of his departure to take up position at Sydney University, 28 February 1929. [SRNSW 2/8566.4] Upon returning from Oxford in 1909 he became medical officer with the Victorian Department of Public Instruction until WWI.
- <sup>47</sup> *Official Year Book of NSW*, 1924.

- 
- <sup>48</sup> *Official Year Book of NSW*, 1914, p.666.
- <sup>49</sup> 'Administrative aspects of the School Medical Service in New South Wales', Unsigned report, 4/2/1929, p.3. [SRNSW 2/8566.4]
- <sup>50</sup> *Public Service List*, 1938.
- <sup>51</sup> 'Notes on the School Medical Service – Department of Education', revised May 1965, p.2. [SRNSW 2/8566.4]
- <sup>52</sup> 'Administrative aspects ...', p.6.
- <sup>53</sup> F.B. Smith, *Illness in Colonial Australia*, Melbourne, Australian Scholarly Publishing, 2011, p.173.
- <sup>54</sup> Letter from Secretary, Medical Branch (?), on proposal to transfer School Medical Branch to the Jurisdiction of the Health Department, 17 June 1931, possibly addressed to Secretary of Department. [SRNSW 2/8566.4]
- <sup>55</sup> Care of the Child in Wartime Committee, *A Square Deal for the Nation's Children*, Sydney, 1942, p.6.
- <sup>56</sup> *Public Service List*, 1948.
- <sup>57</sup> Dr R. McEwin, oral history interview with author, Kingsford, 20 April 1983.
- <sup>58</sup> C.J. Cummins, *A History of Medical Administration in NSW, 1788-1973*, 1979, p.96.
- <sup>59</sup> E.S.A. Meyers, *Report of the Director of State Health Services to the Director-General of Public Health*, Sydney, 1964, p.9.
- <sup>60</sup> P.J. Tyler, unpublished PhD thesis, UNE, 1998, p.251.
- <sup>61</sup> Cummins, op.cit, p.188.
- <sup>62</sup> *State Records Archives Investigator* – Agency Detail number 51.