A Grassroots View of Spanish Influenza in Melbourne

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Abstract

*Although what came to be known as 'Spanish influenza' remains the world's worst health disaster in terms of lives lost, little attention has been devoted to the effect the pandemic had on individuals. Yet much can be learnt from a microhistory of the event, for history from a grassroots level can provide details of people's lives otherwise less obvious and thus offer a more comprehensive understanding of what happens in a disaster. This article presents a microhistory that focuses on the public health legislation and management of the crisis in Melbourne, with particular reference to its poorer districts where legislative weaknesses were more clearly manifest.**

Background

After the onset of COVID-19, the pandemic that arose following the First World War is no longer a neglected topic in Australia's history. However, little as yet has been written about the effect of what came to be called 'Spanish influenza' on individuals at grassroots level, particularly those in Victoria. In contrast to other states, no government reports have survived, nor was a royal commission or any other form of enquiry conducted in Victoria.[1] Nonetheless, local government records and newspaper reports provide valuable insights into the grassroots effects of the pandemic on ordinary people, especially in Melbourne and its inner suburbs. The depth of detail and wealth of information in files created by inner city councils, specifically those generated by Richmond, Footscray and Melbourne and held at the Public Record Office Victoria, influenced my decision to focus this article on the experiences of people living in these parts of inner Melbourne during the health crisis. The survival of local newspapers such as the *Richmond Guardian, the Footscray Advertiser* and

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the *Independent* provided further impetus to approach the effects of the pandemic using the tools of microhistory. In exploring this material, the article pays particular attention to public health management of the crisis in some of Melbourne's poorest districts. While influenza was prevalent in Australia in September 1918 and gave rise to speculation about a 'herald wave', it did not take hold until the following year, and so my focus here is on three waves that occurred in Victoria 1919 (Figure 1).[2]

The city's inner suburbs have been chosen for several other reasons. First, the peculiarities of Victoria's Health Act placed a particular onus on local health authorities during the health crisis, and the deficiencies and complications that resulted were more obvious within municipalities with the lowest revenue sources and the most impoverished communities. These areas recorded the highest morbidity and mortality rates in Victoria. Severity of disease was more marked in these areas too, for historically this was where those most vulnerable to disease lived—in the worst houses in the most crowded portions of the city, as Charles Rosenberg also found in his study of cholera in the United States during the nineteenth century.[3] Svenn-Erik Mamelund revealed similar patterns in his research on the Spanish influenza pandemic in northern Europe and Alaska,[4] and Peter Curson also demonstrated in *Deadly Encounters* that the most severe cases in New South Wales (NSW) during the pandemic were among persons 'living in dilapidated and overcrowded homes' in Sydney.[5] The domestic impact of the Great War had exacerbated poverty in Australia's largest cities. Escalating food prices during the war and the failure of wages to keep pace compounded the health problems of the urban poor. As Judith Smart has shown, retail food and groceries prices in Melbourne had risen 28.2 per cent since the start of the war; what had cost households 22s 7d soon after war was declared, cost 27s 6d twelve months later.[6] Poor nutrition and poor health combined with substandard housing created ideal conditions for the spread of a novel virus, in this case Spanish influenza.

Spanish influenza resulted in varied mortality peaks throughout Australia. According to the 1920 *Official Yearbook of the Commonwealth of Australia*, NSW experienced two disease peaks in April and July; Queensland just one in June; South Australia two in May and August; Tasmania one in September; and Western Australia one in August. Official statistics claim the virus in Victoria occurred in three waves,

causing about 3,561 deaths, a mortality rate of 24.1 per 10,000 (Figure 1). However, these figures are conservative, for cases were either not reported or the cause of death inaccurately registered. Mortality in Victoria was less than in NSW, where deaths were estimated to be 5,980, but greater than in more sparsely populated Western Australia where more died from phthisis (tuberculosis) than from pneumonic influenza.[7]

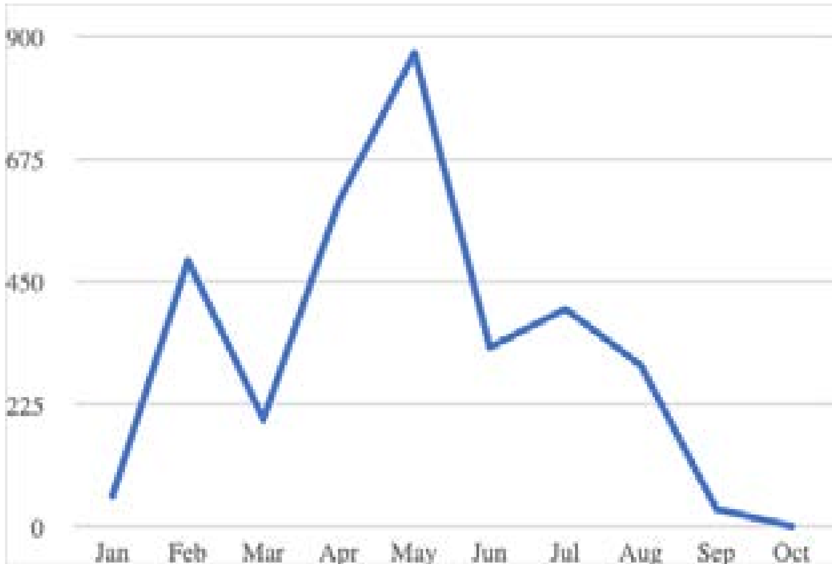


Figure 1: Influenza Mortality, Victoria, 1919 (Source *Report on the Pandemic of Influenza, 1918–19* (1920))

Melbourne's first wave occurred between January and early March 1919 when the virus was novel and highly contagious, placing sudden demands on public hospitals and compelling the creation of temporary or emergency hospitals. Then, when a remission occurred in early March, the government relaxed the Emergency Influenza Regulations first introduced in January. This was followed in late March by a recrudescence of greater magnitude that lasted until May, and it was during this period that case numbers skyrocketed and mortality rates soared, as demonstrated in the above graph. A third minor wave resulting in fewer cases and a smaller number of deaths occurred mid-winter in July. The increased case numbers bringing about this wave occurred in a climate of industrial unrest, protests by an escalating

number of unemployed, soldier discontent, and the gathering of crowds during the delayed peace celebrations on 19 July. After that the virus gradually dissipated until the pandemic was regarded as over at the end of September. The City of Melbourne—incorporating Carlton, North Melbourne and Flemington—recorded the greatest number of deaths, followed by South Melbourne, Richmond and Fitzroy (Figure 2).

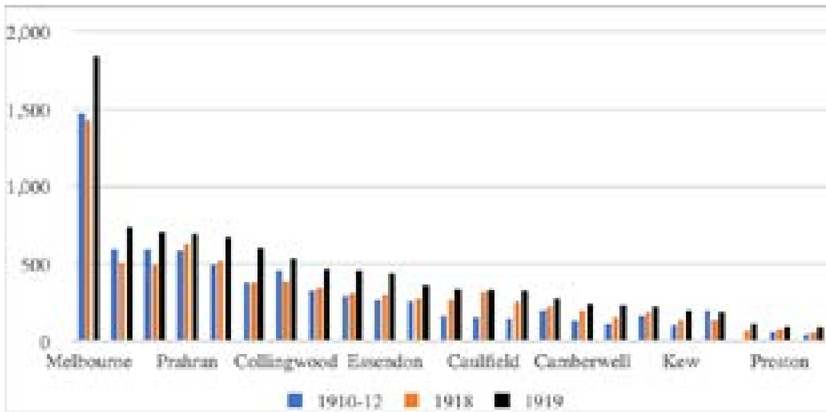


Figure 2: Melbourne municipal mortality per 1,000, 1910–12, 1918, and 1919
(Source *Victorian Year Book* 1919–20, Melbourne, Government Printer, 1920)

Officially known as 'pneumonic influenza', the disease was formally recognised in Melbourne on 28 January 1919. Yet the virus had begun to affect the population before its presence was formally acknowledged. The virulence of the disease became obvious to 57-year-old Dr Abraham Haynes, Richmond's local medical officer since 1908, when, on 10 January, he visited the Lacey family in Type Street, Cremorne, where four members showed signs of the disease, along with their next-door neighbour and her two daughters.[8] Then, four days before the disease was formally announced, Haynes received another message advising him that a girl living in Murphy Street, Cremorne, had been exhibiting progressively marked symptoms of the virus since 14 January. Within days of the girl becoming ill her mother had begun to show symptoms, as did her father soon afterwards; and another member of the family became so seriously ill that she was sent to St Vincent's Hospital. These patients were among Melbourne's first Spanish influenza cases, which began to appear in the first weeks of January.

Meanwhile, until the virus was formally recognised, local municipal health officers and the general public were receiving confused messages. On the one hand newspapers reported increasing hospitalisation of cases, confirmed by Melbourne Hospital's medical superintendent Dr Ralph McMeekin.[9] On the other hand, Victoria's chief medical officer Dr Edward Robertson, in consultation with the Commonwealth director of quarantine Dr J.H.L. Cumpston, delayed officially declaring the disease active in Melbourne for nearly three weeks until microbiology reports were received.[10] This reluctance to acknowledge the presence of the virus delayed implementation of containment strategies and compromised management within the already flawed health system.[11]

Victoria's Health System

A flawed two-tier public health system that divided health responsibility between central and local health boards was in place when Spanish flu began to wreak havoc in Melbourne. The legislative health framework in Victoria dated from the 1850s and had been created by the newly formed colonial government to allay fears of an epidemic following the discovery of gold and consequent population influx. The *Health Act 1915*, under which the pandemic was managed in 1919, evolved from the 1850s legislation, and responsibility for health and welfare was devolved to local councils designated by the legislation as local boards of health.[12]

The *Health Act 1915* empowered Victoria's municipal councils to make orders and by-laws subject to the approval of the Board of Public Health and ratification by the governor-in-council, and their widest powers concerned the control and prevention of epidemics and contagious diseases. In addition, the Act mandated the employment of local health officers such as Dr Abraham Haynes. Hospitals were the declared responsibility of municipalities, and councils were required to contribute financially to the public hospitals operating under government grant schemes, as well as partly fund temporary hospitals in an emergency.

The administrative head of public health in Victoria was the chief health officer, who in 1919 was Dr Edward Robertson. Robertson was an old hand in the role, for he had been with the department since 1901 and had held the position of permanent head for six years. By the time Spanish flu took hold Robertson was 49 years old and an experienced

chief health officer. But, in common with health officers throughout the world, he had no experience dealing with a pandemic of the magnitude of this novel influenza virus. Robertson was initially confident the health crisis could be managed in the same manner as the meningitis outbreak in 1915–16, in which 468 deaths occurred throughout Victoria. He was therefore ill-prepared for the challenges of Spanish influenza. In the aftermath of war and amid reports of unrest throughout the world as well as alarming local newspaper reports of a 'mystery' disease, Robertson declared he was 'more anxious [about] the effects of a panic' in the community than the pandemic itself. As a result, he publicly played down the severity of the disease.[13]

Edward Robertson was not only chief medical officer for Victoria, but also chairman of the state's Board of Public Health, a body that somewhat vaguely shared power with local councils. Since the minister of health appointed the board, members were accountable to him alone and had no authority over the chief medical officer who was appointed under the terms of the *Public Service Act 1915*. The board comprised seven local representatives elected by municipal districts, plus an engineering inspector and the chief medical officer. When Spanish flu infected Melburnians in 1919, Robertson was the only board member with any medical knowledge. Thus the Department of Health was effectively run by just one person, and that person was not answerable to the board. Robertson was therefore entrusted with sole responsibility for the state's health administration, as well as the overall supervision of the campaign against influenza, a gargantuan task. Effective management of the pandemic was further impaired by the lack of power assigned to the board. Because members were essentially required to simply rubber stamp the chief health officer's decisions, the board became riven by internal dissent and squabbling. This led to their complaints of being 'credited with [making] recommendations of which they knew nothing', and that 'they knew no more than what was in [news]papers'.[14] But their indignation and objections went unheeded.

Yet another layer was added to the public health system in 1919, causing further affront to the board. Members of the British Medical Association were appointed to a separate Influenza Advisory Committee comprising 'leading medical men' tasked to provide advice to the government, but their advice was not always acted upon, and thus, like the board, the committee lacked power.[15] Such disjointed handling of the

health crisis was aggravated by absences of the minister of health, John (later Sir John) Bowser, who was also chief secretary, a role that embraced prisons, police administration, mining and goldfields administration, and other diverse functions. Bowser was a 63-year-old skilled politician in 1919, albeit also without experience in dealing with a health crisis of the magnitude of Spanish influenza. Born in 1856, he entered parliament in 1894 as representative of the Wangaratta and Rutherglen electoral district and, for a brief period as leader of the Economy Party, was premier (November 1917 to March 1918). When his government was defeated by Harry (later Sir Harry) Lawson's Nationalist government (1918–23), Bowser took on the dual portfolios of chief secretary and minister of public health. Plagued by ill-health and said to be shy and introverted, Bowser was forced to take sick leave for several weeks amid the health crisis. During his absence, John (later Sir John) McWhae became the acting minister. He retained the acting role when Bowser returned from leave, and, after Bowser's resignation in June 1919, McWhae was formally appointed minister of health. Bowser's multifaceted roles during the early period of the health emergency militated against effective ministerial leadership in containing the disease and managing the crisis.

Local Government and the Health System

Susan Gallagher was 39 years old when influenza invaded her tiny house on narrow Vale Street in one of North Melbourne's notoriously unhealthy districts. Susan was pregnant with her eleventh child in seventeen years—by then she had also buried six of her children. Her husband John was a 'general hawker' or peddler but had worked only irregularly since Spanish influenza was formally declared. The Influenza Emergency Regulations, introduced soon after the disease was officially declared, closed hotels, theatres, concert halls and public buildings, banned race meetings, and threw at least 1,500 out of work, greatly reducing prospects of a liveable income for unskilled casual workers like John Gallagher.[16] When he became seriously ill with influenza in the first week of March, he was admitted to the temporary hospital in Carlton's Exhibition Building. This left the eldest surviving Gallagher child, fifteen-year-old Johanna, as the sole source of income for this impoverished family, the youngest member of which was just three years old. But, since Johanna brought home just 15s a week and rent on the Vale Street home was 10s, the

family was very soon destitute. Melbourne City Council's assistant health inspector, Mrs Kemp, visited the house in response to Susan's request for welfare help and, in a gross understatement, described Susan to be 'not very healthy'. Rent was paid, and food coupons were provided to help the family through the crisis.[17]

Susan gave birth to a girl they named Kathleen in July. Kathleen died the following year. Susan delivered another child in 1920, her thirteenth live birth. This baby survived just six months. Susan herself died in 1924. Her early death at the age of 43 was hastened by multiple pregnancies, poor nutrition and substandard living conditions, exacerbated by circumstances inflicted by the Spanish flu pandemic. The Gallagher family's plight gives weight to the contention that communicable diseases spread more easily where there is poverty and high-density living.[18] The vulnerability of John and Susan Gallagher and their family to the influenza virus was characteristic of many poor people living in the inner-city suburbs of Melbourne. Residents of these suburbs were the worst affected by the pandemic and bore the state's highest mortality burden.

Municipal councils, particularly those in inner-city suburbs, struggled to deliver appropriate health services and welfare support to those like the Gallagher family. Prior to the advent of the virus, Footscray Council complained it was 'practically at its wits end for money' to maintain roads used by very heavy traffic from outside the municipality 'from which they [could gain] no revenue'.[19] Similarly, as Janet McCalman noted in her history of Richmond, *Struggletown*, Richmond Council could ill afford to carry out essential roadworks, let alone bear the financial burden of the pandemic through the city's rate income.[20] Rates were municipal councils' principal source of income but were capped by the *Local Government Act 1915* at around 2s 6d in the pound of the net annual value of a property. Since land valuations were generally lower in inner-city areas, the income derived by these councils severely challenged capacity for infrastructure development as well as for health and welfare services, and their financial burden greatly increased during the pandemic.

In November 1918 the Health Department reminded councils that, under the terms of the *Health Act 1915*, municipalities were obliged to provide hospital care for residents, including emergency hospitals. Unlike Western Australia where, as historian Bev Blackwell has shown,

the government reimbursed all costs to municipalities, Victoria shared the costs of hospital and welfare equally between the government and councils.[21] However, the Victorian government did pay the full cost of the vaccine serum prepared by the Commonwealth Serum Laboratory and inoculations performed by municipalities, as well as printing costs associated with the influenza information flyers and posters distributed throughout the state.

On 28 January, the day Spanish influenza was officially declared present in Melbourne, the department informed councils that, because of overwhelming demand, only serious cases would be admitted to public hospitals. Councils were therefore directed to make arrangements without delay to receive influenza cases in emergency hospitals.[22] The number of the seriously ill quickly mushroomed. On 1 February, 540 cases had filled the 1,449 available hospital beds; two weeks later there were 1,075 in Melbourne's public hospitals.[23] Robertson became the target of criticism for being slow to concede that escalating numbers of those hospitalised were due to Spanish flu. Local and interstate newspapers criticised the health authorities' delay in declaring the virus, saying 'nothing worthwhile [had been] done to check the progress of the scourge in Melbourne'.[24] Robertson's confidence in the management of the 1915–16 meningitis epidemic as the model for the 1919 health emergency had been critically misplaced. Yet, in all fairness, while the delay in recognising the disease was remiss, Robertson and his department were not entirely responsible for the scarcity of hospital beds. Not only was the magnitude of the disease unexpected, the Australian Department of Defence had also withdrawn the promised use of the No. 5 Base Hospital in St Kilda Road.

Emergency Hospitals

Civilian patients suffering from Spanish flu began to be admitted to the No. 5 Base Hospital on 24 January 1919. Six days later, on 30 January, there were 112 sufferers in the hospital. Then, despite the earlier promises to make 500 beds available, the military authorities abruptly refused to accept any more civilians.[25] As Acting Prime Minister William Watt declared in a letter to the Victorian premier, accommodation had been 'taxed' at the Caulfield and Mont Park military hospitals, and, because the return of a large number of troops was expected, St Kilda Road's

Base Hospital had to be kept in reserve. He went on to explain that 'influenza had broken out among the Commonwealth forces', and, since a recrudescence was possible, it was considered essential to retain the Base Hospital for military purposes.[26] Whatever the influences on this decision, Robertson and Victoria's Health Department were forced to act hastily to make alternate arrangements.

Negotiations took place with the Victorian Division of the Australian Red Cross to use the Red Cross No. 1 Rest Home at Wirth's Park (now the site of the Melbourne Arts Centre) as a makeshift measure, despite conditions in this temporary facility being far from suitable. Wards were located on the second floor of a wooden building, and 'all water had to be carried up [the stairs] and all refuse carried down' by hand.[27] Within ten days of taking over on 30 January, 135 beds had been taken up and 39 patients had died already.[28] Coode Island quarantine station was another inadequate facility the Health Department was forced to use to care for escalating numbers of cases. By 6 February, 36 male patients occupied beds on the island, some of whom were seriously ill. Finally, arrangements were made to take over Carlton's Exhibition Building, which was to become Melbourne's largest emergency facility. However, the decision was not made before consideration was given to using the Flemington Racecourse, Carlton's Grattan Street Drill Hall, and the Royal Melbourne Showgrounds at Flemington.[29] Premier Lawson admitted the Exhibition Building was chosen 'on the principle of any port in a storm', despite awareness that it was 'very unsatisfactory for the purposes of a hospital'.[30]

For all their efforts, the emergency facilities established by the department were not sufficient to care for the rising number of seriously ill. Accordingly, during February 1919, municipal councils throughout Victoria were obliged to create more than 50 temporary or emergency hospitals in drill halls, kindergartens, and public halls. However, school buildings were the places most frequently taken over and adapted for use as hospitals, for schools remained closed for about six weeks after the summer holidays. Examples were to be found in suburbs such as Armadale, Brunswick, Caulfield, Camberwell, Footscray, Kew, Malvern, Melbourne, Port Melbourne, Richmond, St Kilda and Sandringham, as well as in country towns (Figure 3).

Nearly 700 women lined up at Red Cross Australia's Victorian Branch premises offering to care for patients in these emergency

Figure 3: Richmond Influenza Emergency Hospital Staff, 1919, assembled before the Central State School kindergarten building in Gleadell Street (Courtesy John Young Collection, National Library of Australia)

hospitals and usually volunteering for a maximum period of ten weeks. A little more than 80 were registered trained nurses accredited by their professional body, the Victorian Trained Nurses Association; they were few in number because so many of their colleagues were still serving overseas. Greater in number were Voluntary Aid Detachment (VAD) nurses, described by historian Melanie Oppenheimer as generally young upper- or middle-class women of 'independent means'.[31] They were likely to present with first aid training and home nursing certificates awarded by St John Ambulance. Although a small number (about 50) were described as 'partly trained', the majority who volunteered (337) had no formal training and were simply keen to help in a time of community crisis, including those who offered their help as cooks and laundry assistants.[32]

On 4 March 1919 Alice Gibson died in Richmond's emergency hospital. 'Cardiac arrest' was recorded as the cause of her death, although in all probability pneumonic influenza was primarily responsible.[33] Seventeen-year-old Alice, the third daughter of Catherine and the late James Gibson, was from Green Street, Cremorne. A number of other Cremorne residents were also diagnosed with influenza at this time, including a 58-year-old man and his daughter in Dover Street. It was early in March too that local medical practitioner Dr Gerald Baldwin visited eight-year-old Keith McFarlane in Duke Street, Cremorne. His

condition was described as serious. Keith's mother was also ill and no one else was available to care for them.[34] Cremorne had become an influenza hotspot. A highly industrial suburb, it included poorly ventilated houses in narrow, equally poorly ventilated streets where the virus would become especially virulent. Similar areas of virulence, or hotspots, developed in North Richmond in the neighbourhood of Elizabeth and Lincoln streets, dubbed 'the valley of death', as well as in North Melbourne in the vicinity of Vale Street, in Yarraville's south ward, and in other areas of metropolitan Melbourne where congested living was common.[35] Yet, although mandatory reporting of influenza cases had been ordered, the absence of efficient and reliable data collection prevented the accurate identification of these hotspots, or a comprehensive understanding of the extent of the disease in metropolitan Melbourne.

Mandatory Case Reporting

In accordance with the *Health Act 1915*, influenza was formally declared an infectious disease in November 1918. The declaration was a legislative prerequisite before a compulsory reporting order could be published in the *Government Gazette,* a further requirement of the Act. However, when the mandatory reporting notice concerning influenza was published on 28 November 1918, it contained a significant variation from the usual reporting procedure for other declared infections such as diphtheria and scarlet fever for which doctors were to report to the Board of Public Health *and* local councils. The November 1918 notice *omitted* the need to report to both local council and the board; the latter task was devolved to town clerks who were required to report daily to the board.[36] Thus, in early 1919, confusion reigned among doctors busy with greatly increased patient loads. As Camberwell's town clerk Robert Smellie admitted, some doctors continued to report to both the board and town clerk, while others followed the variant procedure published in November 1918, and some failed or refused to report altogether.[37] Adding to the confusion, on 1 February the *Age* and *Herald* newspapers published notices announcing the traditional procedure used for infectious diseases: namely, reporting to the board *and* local councils.[38] Consequently, after the commencement of the outbreak in Melbourne in January, the case numbers reported to the board were considerably

lower than they should have been, thus challenging the health authority's ability to accurately determine the incidence and distribution of the disease and efficiently manage the health crisis.

Remission

The three waves of influenza that arose in such rapid succession in January, March and July 1919 were unprecedented and offered only the briefest intervals of respite. The bewilderment of the scientific and medical community was reflected in an article published in American journal *Science* in 1919 that admitted the difficulty in understanding a virus that 'comes, spreads, [and] vanishes with unexampled suddenness'. The author, Major George Soper, was an American sanitation engineer credited with tracking down 'Typhoid Mary' in 1907 in New York. He claimed this new disease 'possesses such terrific energy that little time is afforded during its visitations in which to study it in a careful and painstaking manner'.[39] Victoria's Premier Lawson reflected the bewilderment of politicians in his remark that the government had not expected the outbreak to last so long, nor that the Emergency Influenza Regulations would remain in force for such a lengthy period or cause such levels of destitution.[40]

The regulations threw many out of work and, as a consequence, industry groups lobbied the government to relax the rules and thus relieve hardship. One was the Liquor Trades Employees Union acting on behalf of members, including bartenders and waitstaff as well as coopers, carters and drivers, all of whom were thrown out of work when the regulations closed more than 300 metropolitan hotels. The Theatrical Employees Union was another that lobbied on behalf of an estimated 1,500 members who lost work when theatres closed. These people were especially affected by the regulations, since many had been touring country districts when entertainment venues were closed and became stranded.[41]

Labor Party members formed a deputation to the premier requesting the government provide temporary wage relief. Footscray member George Prendergast (MLA 1900–27) echoed the deputation's views in declaring that the restrictions 'affected a very large class of working people'. They would have included non-union, unskilled casual workers like Andrew Motherwell.[42] Motherwell was the father of five children, all under eight years of age, and none of whom were eligible to earn money. Before the emergency regulations banned race meetings, he earned a tenuous

income selling fruit and frankfurt sausages at race meetings. Motherwell did not qualify for either union support or friendly society assistance and, in the absence of unemployment benefits, he was reliant on limited municipal handouts or the rapidly dwindling funds of private charities.[43] Presented with examples like this family, it is understandable that, when case numbers declined in early March, Premier Lawson, politicians and union leaders were keen to believe the virus was 'dying out' and it would be safe to relax the regulations.[44]

Not all were convinced the regulations should be relaxed, however. The Influenza Advisory Committee claimed that case numbers were not 'sufficiently good to justify relaxation of restrictions' and instead advocated that infected areas should not be regarded as 'clean' until seven days after the last case recorded a normal temperature.[45] Committee members argued too that: 'It was not wise to decrease hospital accommodation' by closing emergency hospitals created in schools, declaring 'everything should be in readiness for reinstitution of an abundance of beds for influenza patients' in the event of a recrudescence. Brighton Council also advocated for the number of emergency hospitals to be maintained and wrote to the director of education registering its objection to reopening schools as 'inimical to the interests of the public'. Footscray's *Advertiser* echoed the local council's view and cautioned against 'a false sense of security', warning that the virus could break 'forth again with redoubled energy'.[46]

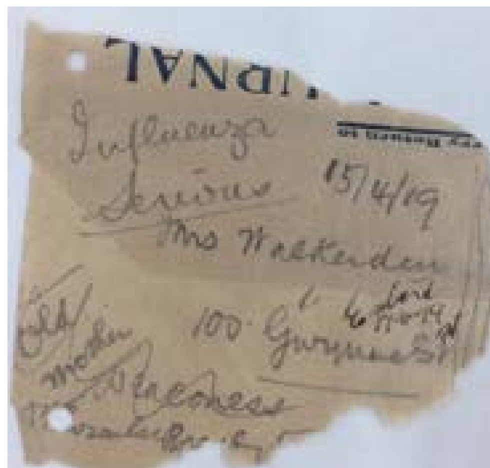
Notwithstanding the cautionary advice, the regulations were relaxed. Councils were directed by the Education Department to reopen schools on 10 March. Those schools used as emergency hospitals were permitted to delay opening but were ordered not to admit any more patients. Thus, in the first weeks of March, at least sixteen emergency hospitals closed in the metropolitan area, including at Armadale, Footscray, South Melbourne, St Kilda and Fitzroy, and remaining patients were transferred to the Exhibition Building's emergency hospital.[47]

Other emergency regulations were also eased. On 4 March hotel bars and wine saloons reopened, and on 8 March race meetings were again permitted, as were special excursion trains to country racecourses. On 10 March, five people were allowed to play at a billiard table, and on the same day live theatres as well as picture theatres opened again, albeit with performances restricted to one a day. Workplace excursions

resumed too, and on 12 March Bryant & May employees crowded onto the *SS Courier* and travelled to Mornington for their annual picnic. At Port Melbourne pier on 26 March, 1,600 people packed on board the *Weeroona* and another 1,100 jammed onto the *Hygeia* before steaming down the bay to Sorrento for the annual grocers' picnic. Large crowds also flocked to the Oakleigh Plate at Caulfield Racecourse on 13 March and again on 22 March to Flemington for the final day of the Autumn Racing Carnival.[48]

Recrudescence

On 15 April 1919, as another surge of Spanish influenza was causing numerous deaths, Abraham Haynes, Richmond's local medical officer, scribbled a note describing one of his patient's condition. During the previous week 77 cases had been reported in Richmond, one-third of which were considered seriously ill.[49] That the brief description of Mrs Walkerden's condition was reported on a scrap of paper suggests Haynes was very rushed, and probably harried too (Figure 4). He was then one of many overworked and exhausted local medical officers treating patients in their own homes, for the closure of emergency hospitals had resulted in a drastic shortage of beds.



Influenza
Serious 15/4/19
Mrs Walkerden
100 Gwynne St

Figure 4: Note scribbled by Richmond's local medical officer Dr Abraham Haynes to describe Mrs Arthur Walkerden's condition (Courtesy Victorian Public Record Office, Pneumonic Influenza, April–July 1919, VPRS 16668 20)

Rising case numbers caused excessive workloads among over-extended health workers with no immediate prospect of relief. The situation was aggravated by the Board of Public Health's dictum that, since more than 100 serious influenza cases were awaiting admission to hospitals, no more names would be added to any waiting lists.[50] By the third week of April there were 1,234 people in hospital, a number that rose to 1,404 in the first week of May. Patient numbers in the Exhibition Building's emergency hospital skyrocketed in the first two weeks of April, from 168 to 600.[51] Delays meant that patients were often seriously ill when finally admitted to hospital, increasing the burden for nurses and doctors. Dr Wickens, the medical superintendent of the Exhibition Building emergency hospital, complained to the Board of Health. Medical officers, he said, were unable to gain adequate sleep and nurses were working ten-hour shifts with only four hours break.[52] In utter desperation Wickens notified the board that no further patients would be received at the Exhibition Building until additional staff became available.[53]

It was at this time that seriously ill Joseph Kennedy was unable to gain hospital admittance. A barman by trade, the 29 year old was at the time living with his wife and young son in his father's house in Balmain Street, Cremorne. There he was seen by Dr Gerald Baldwin and assessed as a 'seriously ill case urgently needing hospital treatment'. But, despite Baldwin's valiant efforts, Kennedy died before a hospial bed could be found.[54] Local medical officers were forced to continue caring for an increased patient load and to offer what treatment they could for their patients in often unhygienic and crowded homes, with only occasional help provided by a small pool of trained nurses.

Councils in Footscray, Richmond, Coburg, Prahran, South Melbourne, Brunswick, Essendon, and Preston were permitted to reopen their emergency hospitals, but still there were not enough beds.[55] In the absence of adequate medical and nursing care mortality rates escalated, with about 600 deaths recorded in April and almost 900 in May.[56] The health crisis was the unwitting outcome of the premature closure of temporary hospitals in March and the associated discharge from service of VAD nurses and other volunteer carers initially engaged by the Red Cross.

The Victorian government imposed more restricted times on live performances and picture theatres but did not implement the full array of emergency regulatory measures imposed earlier. There were also

attempts to play down the spread. In a circular to all municipalities, the department stated the influenza virus that was then prevalent was 'similar in character to the disease which has occurred every year for years past', the only difference being that this time it was 'more widespread'. The statement seemed to be shaped by circumstances, for an announcement was simultaneously made that, 'owing to the lack of nurses', it was 'not possible to treat every case in hospital'.[57] Instead, a new set of regulations was released targeting individual behaviour rather than public gatherings and requiring infected patients to stay at home or risk fines up to £25.[58]

Local medical officers were advised that, 'where patients have homes where reasonable isolation can be secured, they should be kept there if the necessary attention is available'.[59] But confining them to their poorly ventilated houses on narrow streets in the inner-city suburbs militated against any success in isolating the sick or containing the disease. South Melbourne's visiting nurse complained of the struggle she encountered treating influenza sufferers in their homes, declaring it an 'absolute impossibility isolating cases' from other family members and neighbours and claiming all attempts were farcical. The futility of attempting to isolate cases was also noted by Footscray's *Independent* when describing the widespread extent of the disease. As the paper declared, 'every doctor in the district can cite cases where every member of a household—sometimes seven or eight persons—is down [with the disease]'. The *Richmond Guardian* complained about the uselessness of isolation too, claiming 'the influenza epidemic [was] out of bounds', and that 'nearly every house has held a sufferer'.[60]

New Leadership

Ill-health forced Health Minister Bowser to take sick leave when the recrudescence was at its height. Prior to leaving, he convened a meeting on 26 April at Melbourne Town Hall attended by mayors, town clerks and health officers representing 40 metropolitan councils. Overburdened with responsibilities and seemingly unaware of the demands on municipalities' limited resources, Bowser, instead of offering leadership, continued to devolve responsibility for coordinating containment of the disease and crisis management to municipalities. He reprimanded councils for their 'lack of co-ordination' and failure to 'secure consistent municipal action in grappling with the disease', but his failure to offer

leadership did nothing to encourage action. The meeting was adjourned for ten days until 6 May, and in the interim John McWhae was appointed acting minister of health.[61]

Formerly a leading member of the Melbourne Stock Exchange and involved in a broad range of commercial activities, McWhae, unlike Bowser, was able to devote his ministerial attention exclusively to management of the pandemic. He quickly applied his organisational and diplomatic skills to restructuring management of the health crisis, providing desperately needed central leadership. McWhae was aware that funds were a major issue for councils. He therefore arranged with the State Savings Bank for councils to borrow money on generous terms to cover liabilities incurred by the pandemic, and this arrangement was announced at the May meeting. He also announced the creation of a Central Emergency Influenza Committee of medical experts to ensure the 'proper organisation of forces to combat the epidemic'. This freed Robertson from sole responsibility for all health matters in the state because, as McWhae said, 'one man could not possibly conduct health administration and supervise the campaign against influenza too'.

McWhae was also conscious of the importance of accurate data collection and aware that it was critical to know 'where the disease was worse, so that doctors, nurses and ambulances could be rushed [to a hotspot] without delay'. Hence on 8 May the mandatory reporting of cases, rescinded on 5 March, was reintroduced. A medical controller was also appointed to supervise hospitals, thus freeing the secretary of the Board of Public Health to focus on data collection. [62]

McWhae's influence insured more effective management of the crisis, and probably reduced the number of deaths too. By early May he had successfully negotiated the use of a 70-bed ward at the Broadmeadows Hospital, easing demand and providing immediate relief for the many sick previously denied hospital care. He also gained assurance that 450 beds would be available for civilians at the St Kilda Road Base Hospital.[63] The Exhibition Building was visited by a medical team and its closure discussed. But before the temporary hospital could be closed another wave of the virus arose, and it was not dismantled until mid-September.[64]

In addition, McWhae eased the demands of caring for patients in their homes by encouraging the involvement of 'public-spirited women' who, he said, had not previously been given the 'opportunity to

organise forces against the disease'.[65] A scheme was adopted to 'educate the women of the community' in caring for influenza sufferers. Lectures on combatting the disease were delivered, the first at Melbourne Town Hall on Friday evening 3 May.[66] After that, demonstrations by matrons and lectures delivered by doctors occurred in suburban town halls, including at Caulfield, Port Melbourne and Prahran. Their addresses were frequently printed for distribution; Essendon scouts, for example, delivered about 8,000 information leaflets to local residents offering advice on home nursing.[67]

McWhae also appointed a controller of transport and distribution of food. Volunteers were organised to transport District Nurses Society members (from 1966 Royal District Nursing Service) to the sick and to distribute food prepared by volunteers. Kitchens were set up in Port Melbourne by various groups including the City Mission, and women were organised to prepare and distribute food to the sick. At Richmond, the local Red Cross branch prepared soup and light food in a kitchen established in the Central School, and volunteers distributed the food to homes. The general secretary of the Australian Boy Scouts Association encouraged the utilisation of local troops to provide assistance, often involving food distribution to the homes of the sick. At Essendon, scouts were also employed as orderlies and stretcher bearers in the emergency hospital and generally helped by delivering messages.[68]

Inspired by McWhae's encouraging words and under the auspices of local councils, Welcome Home committees now also turned their attention to helping the sick. What aided the speedy creation of a strong network of women in communities was the pre-existence of wartime patriotic societies able to quickly adjust and redirect their attention to epidemic relief work. Volunteers were divided into teams and arrangements made for some to visit homes, and others to patrol districts and report any sick people to the town clerk. Port Melbourne residents were advised that, in order to gain help, they should 'project through a window in front of [the] house or over the front gate a large white cloth as a distress signal'. [69]

At Yarraville, where a hotspot arose, woman adopted the 'distinctive block system' organised in Wellington, New Zealand, and described by Geoffrey Rice in *Black November*.[70] The south ward was divided into fifteen sections, and a 'captain' was appointed to each section in order to arrange for streets to be patrolled. SOS signs were created and delivered to houses with instructions to place them prominently in front windows

if help was needed. Two tents were set up in a local reserve. One was used to prepare soup for those in need, local businesses donated produce and the municipal council provided financial support. Wash coppers were set up in the second tent to launder bed linen and clothes of the sick (Figure 5).[71]

Figure 5: Members of the Yarraville Women's Influenza Relief Committee, some of John McWhae's 'public spirited' women, arrayed before their soup kitchen (left) and laundry (right) (Courtesy Footscray Historical Society)

When another recrudescence arose in July, it was in a milder form and accounted for fewer deaths. Although the virus remained prevalent in inner city areas, doctors attending the sick reported most cases were able to be cared for in their homes. By then, too, accommodation in hospitals was equal to the demand. In August, case numbers began to decline, and the emergency hospitals in schools that had remained open, or reopened, were ordered to close and the equipment sold. The influenza outbreak was regarded as over in the middle of September. The last case officially reported to the Board of Public Health occurred on 1 October 1919, and in the same month the obligation to notify cases was discontinued. The attention of municipal councils then turned to wrangling with the government over cost recovery, and Melburnians began adjusting their postwar lives free, at least for the time being, from disease outbreaks.

Conclusion

A fine-grained microhistory of the 1919 pandemic in Melbourne discloses the risks associated with delayed recognition of a new virus and flawed legislation in accomplishing efficient management of the ensuing crisis. Inept and inefficient data collection, inconsistent reporting, and the premature relaxing of the Emergency Influenza Regulations also greatly challenged containment of the disease. But, besides revealing organisational flaws, a consideration of Spanish influenza from the single viewpoint of public health delivery makes it possible to gain insight into the impact the disaster had on people's lives and the conditions they endured. History viewed from the grassroots level also exposes the often-hidden distress and suffering that result from a cataclysmic event like a pandemic. It reveals too, the generosity and altruism of individuals who sought to help the sick and destitute, and the dedication and selflessness of health care workers. In this way a more comprehensive understanding is offered of the effects disasters generally have on communities and individuals.

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(Courtesy State Library Victoria, H93.23/92)