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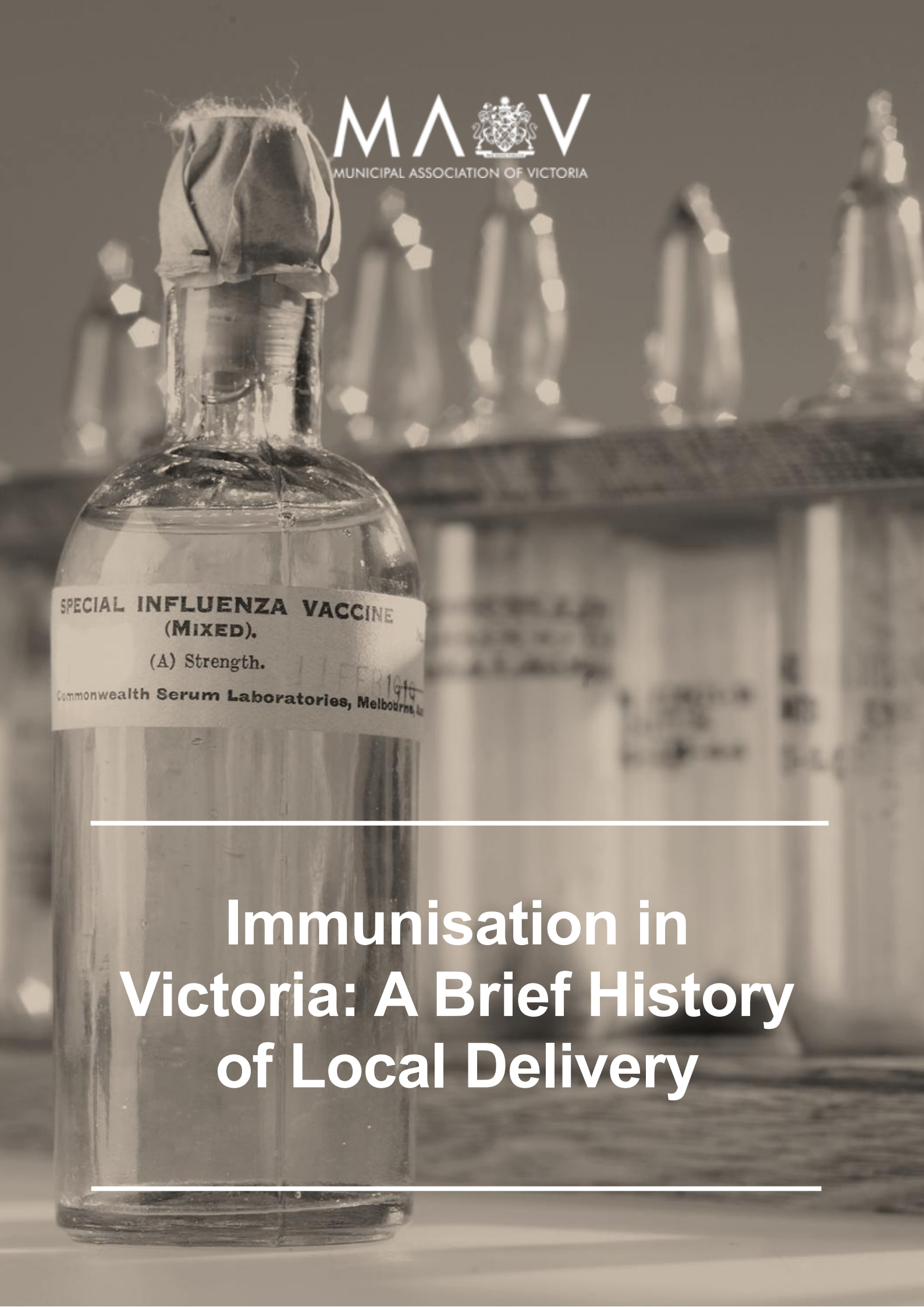


# Immunisation in Victoria: A Brief History of Local Delivery

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# Contents

# Executive Summary

In Victoria, immunisation is delivered through a system that combines state coordination with local implementation.

This approach is shaped by the design of the state's public health system, which has evolved since the nineteenth century. Unlike more centralised models, responsibility is shared, with the state providing legislative authority, policy direction and oversight, and local government delivering many frontline services within communities.

Victoria's model emerged in response to rapid population growth, urbanisation and the spread of infectious disease in the 1800s.

Early centralised approaches proved insufficient to manage health risks across dispersed and fast-growing settlements. In response, successive reforms placed responsibility within local structures, culminating in the transfer of key public health functions to municipal councils in the late nineteenth century.

Over time, this produced a system grounded in proximity, local knowledge and community connection. While hospitals and acute care became increasingly centralised through the twentieth century, public health functions remained largely localised.

This distinction continues to shape the delivery of prevention and population health services in Victoria.

This paper provides a historical overview of this model, tracing how public health responsibilities became embedded within local government and how immunisation developed within this framework.

Immunisation offers a clear example in practice. From early vaccination efforts through to contemporary programs, delivery in Victoria has relied on local systems to translate policy into action. Councils have played a central role in organising clinics, engaging communities and supporting uptake.

As immunisation programs have become more nationally coordinated and supported by advances in data systems and policy settings, the underlying delivery approach in Victoria has remained consistent. Local government continues to play a key role, particularly in childhood and adolescent immunisation, including through school-based programs, community clinics and targeted outreach.

This history shows that the effectiveness of immunisation in Victoria reflects not only scientific and policy advances, but the strength of a system operating across both state and local levels. It highlights how local capability, community trust and accessible delivery have contributed to immunisation practice over time. More broadly, it reinforces the role of local government as a key partner in protecting and promoting population health in Victoria.

# Introduction

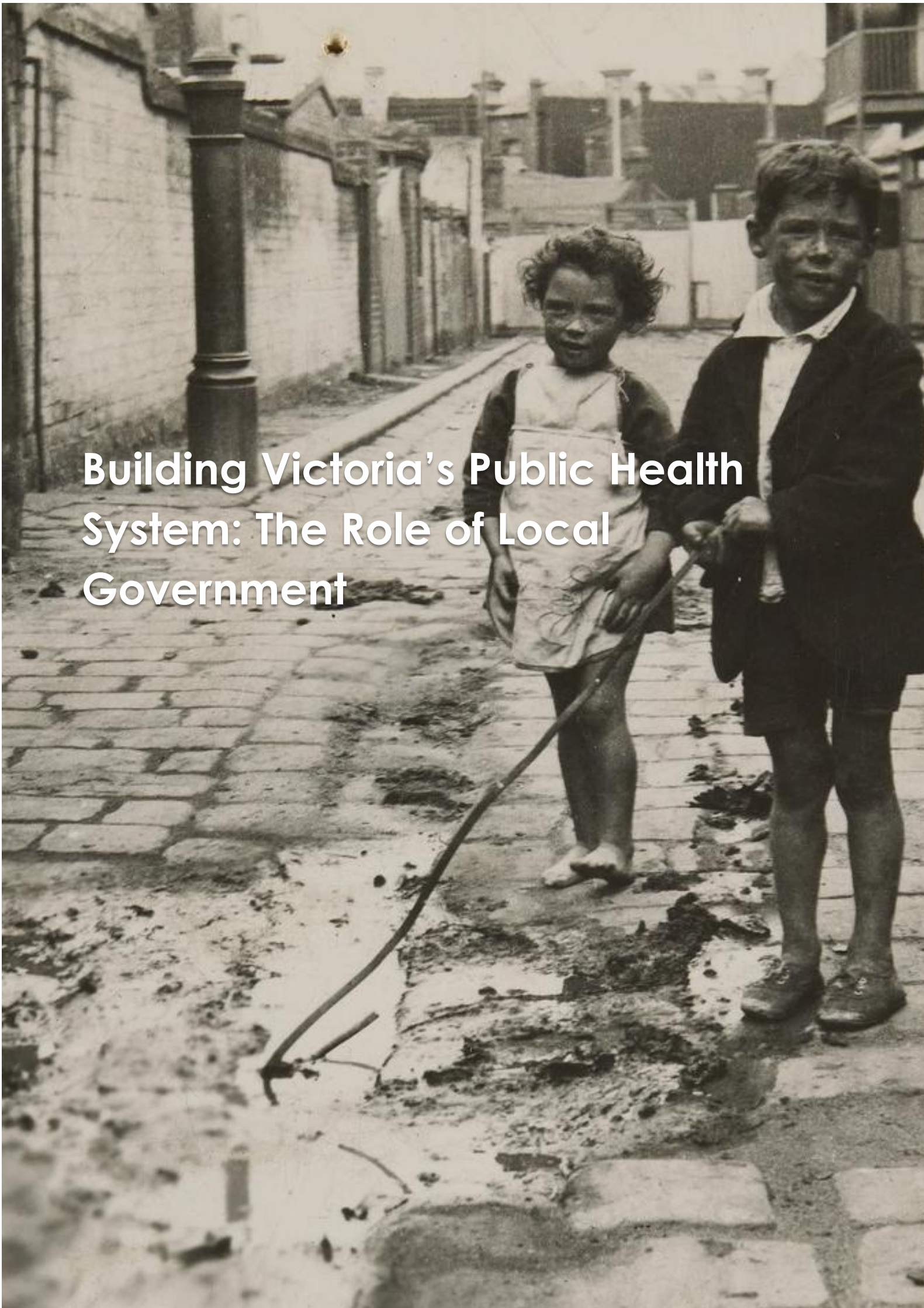
Few jurisdictions rely on local government for immunisation delivery to the same extent as Victoria.

This approach is not accidental. It reflects a long-standing public health structure that has evolved over more than 150 years. While vaccination is often framed as a technical or policy achievement, its success has depended on the institutions responsible for reaching communities. In Victoria, that role has consistently been performed by local government.

This paper examines how and why this model developed, and what it reveals about the role of local government in public health. It argues that councils have functioned not simply as delivery agents, but as the operational backbone of immunisation, translating policy into practice across diverse and changing communities.

Tracing this history highlights three defining features of Victoria's approach. First, public health responsibilities, including vaccination, were deliberately assigned to municipal authorities through legislation, establishing a clear expectation of local involvement. Second, councils developed the capacity to adapt programs to local conditions, shaping how immunisation is experienced on the ground. Third, the model has been shaped by the interaction between central coordination and local flexibility, particularly during periods of system change.

This paper provides a historical overview of Victoria's public health system, with a particular focus on the role of local government. It traces how responsibilities came to be located within municipal structures and how this model developed over time. Immunisation is used as a key example, illustrating how policy has been translated into practice, from early vaccination efforts to contemporary programs.



# Building Victoria's Public Health System: The Role of Local Government

## The Emergence of Local Government (1837-1854)

Local government in Victoria began to take shape in the early 1840s, before separation from New South Wales in 1851, with the incorporation of the City of Melbourne in 1842. Municipal bodies were subsequently established across the colony, with legislation including the Municipal Institutions Act 1854 and the Local Government Act 1874 formalising councils as the primary level of local administration.

Local government was not originally designed for public health. However, as population growth and disease pressures increased, local government became the framework through which responsibilities could be delegated, shaping the model that would remain in place to this day.

## Foundations of Public Health in Colonial Victoria (1837-1854)

Public health activity began in the late 1830s as a narrow, largely reactive function of the colonial medical system. The appointment of an Assistant Colonial Surgeon in 1837 and Melbourne's first public hospital in 1839 marked the beginnings of organised health services.

These early services focused on government responsibilities, including the care of police, prisoners and immigrants, with limited preventive measures largely confined to quarantine at ports.

Health was seen as episodic and external, managed at borders or within institutions, with little attention to the environmental and social factors shaping health across growing settlements. As the colony expanded, these limitations became increasingly apparent.

## Responding to Rapid Growth: The Public Health Act and Local Boards (1854-1865)

The gold rush rapidly transformed Victoria's population, economy and living conditions. Overcrowding, mobility and poor sanitation created persistent public health risks that central institutions could not manage alone.

The Public Health Act 1854 responded by establishing a Central Board of Health and a network of local boards. This marked a decisive shift toward distributed responsibility, recognising that many risks needed to be managed locally.

Local boards oversaw infectious disease control, sanitation, drainage, food safety and housing conditions, requiring ongoing monitoring and rapid local response. This early system acknowledged that effective public health depended on proximity to communities.

## Embedding Public Health in Municipal Governance (1865-1890)

Victoria strengthened this distributed model in the following decades. Public health legislation progressively expanded councils' responsibilities in sanitation, disease control and local regulation, while municipal bodies also took on a growing role in service provision, including establishing and supporting hospitals, either independently or in partnership with neighbouring districts.

The Public Health Act 1889 marked the decisive shift, abolishing local boards and transferring these responsibilities directly to municipal councils. Public health became a core function of local government, with council staff forming the frontline workforce for enforcement and service delivery, supported by state oversight.

This reform established a system combining statewide coordination with place-based delivery, anchoring public health within municipal structures.

## Consolidation and State Coordination (1890-1944)

In the early twentieth century, central coordination was strengthened while local delivery continued. The Health Act 1919 created a Commission of Public Health to provide regulatory, advisory and research support, offering guidance, technical expertise and model by-laws to councils.

Hospital services, historically locally established, began to centralise as demand and complexity grew. Responsibility for hospitals shifted progressively to the State, culminating in the creation of a unified Department of Health in 1944, enabling more consistent planning and oversight.

This period reinforced a defining feature of Victoria's system: hospitals and acute care became state-led, while public health and prevention remained locally delivered.

## A Shared System for Modern Victoria (1944-Present)

Subsequent reforms focused on coordination, efficiency and system integration, including the Health Commission of Victoria in 1978 and later departmental restructures.

Despite structural changes, including the 1993-1994 consolidation of over 200 councils into 78 larger municipalities, the role of local government in public health has remained consistent.

Today, Victoria has 79 councils delivering environmental health, disease prevention, and supporting community-based services. The Public Health and Wellbeing Act 2008 formalises this arrangement, establishing the state's public health responsibilities, empowering councils to take a role in disease prevention, and requiring local authorities to implement strategies to protect the health of their communities.

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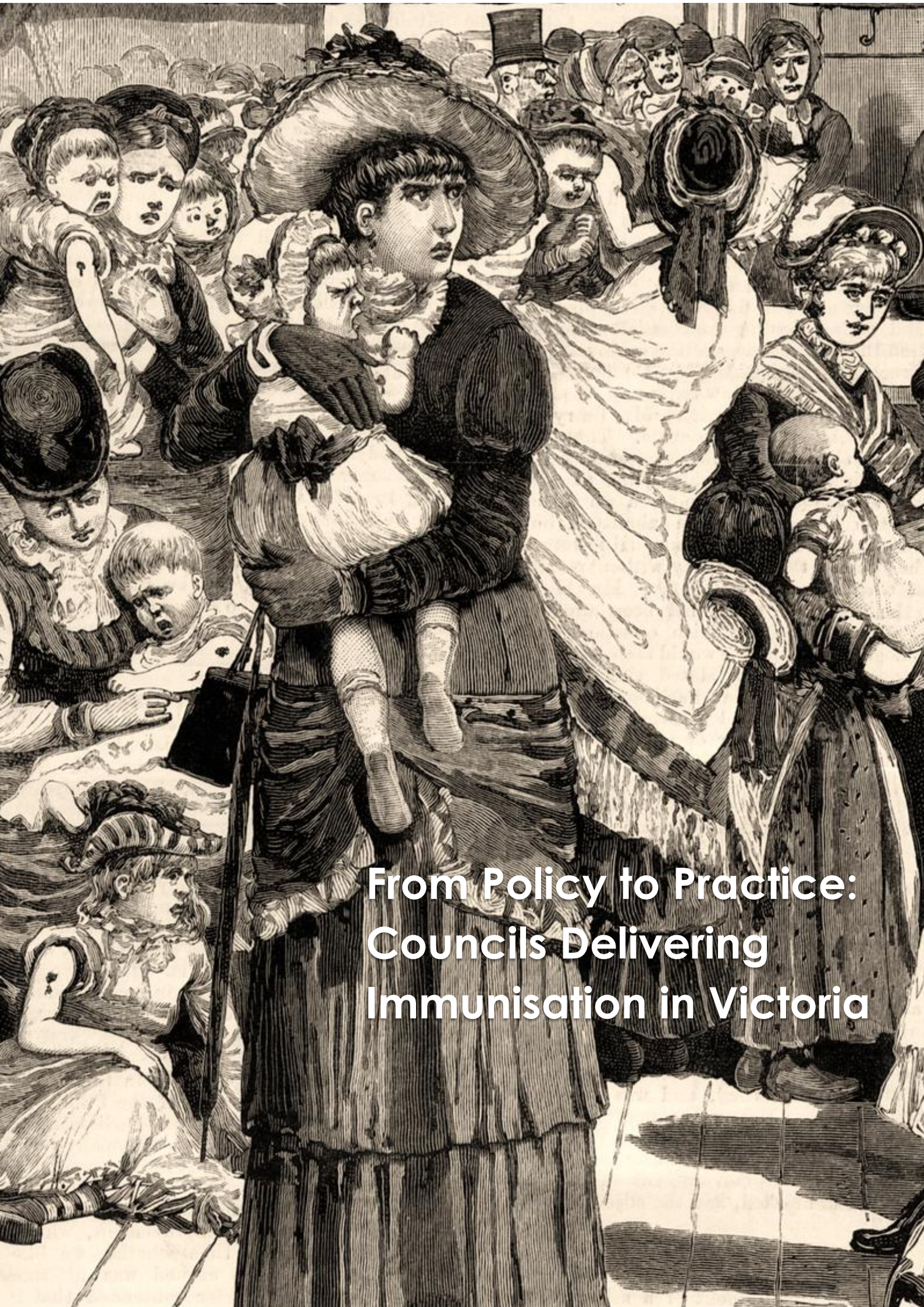
Adapted from:
Public Record Office Victoria, *Health, public*, https://prov.vic.gov.au/archive/VF125#:~:text=The%20Central%20Board%20of%20Health,appointed%20on%2021%20February%201855



# From Policy to Practice: Councils Delivering Immunisation in Victoria

## Early Vaccination in a Developing System (1837-1854)

In its earliest years, vaccination in Victoria operated within a public health system that was narrow and largely reactive. Efforts focused on quarantine and institutional care, with limited capacity to deliver preventative measures across the broader population.

Access depended on the availability of individual practitioners and ad hoc arrangements rather than organised programs.

As settlements expanded and living conditions deteriorated across urban and goldfields communities, the absence of a system capable of delivering vaccination widely and consistently became apparent.

The challenge was not simply the availability of vaccines, but the lack of structures to reach communities effectively.

## The Emergence of Local Delivery (1854-1865)

Victoria mandated compulsory vaccination against smallpox in the 1850s through the Compulsory Vaccination Act of 1854, marking a turning point that prioritised mass immunisation to control outbreaks that ad hoc arrangements could not manage.

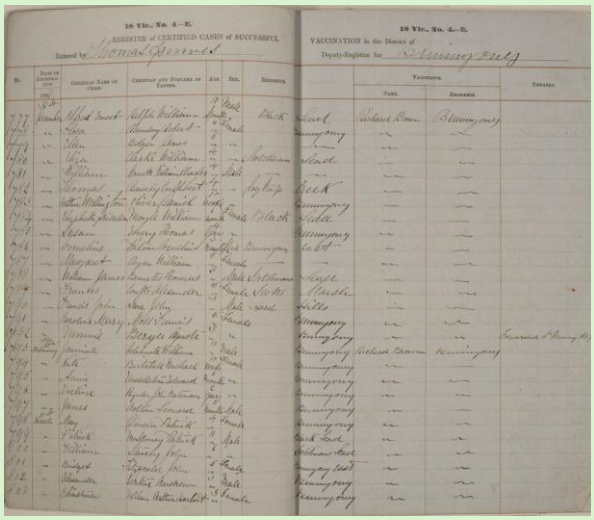
Implementation relied on the emerging network of local boards of health. Local registrars monitored compliance, public vaccinators delivered free services, and communities became the setting in which vaccination occurred.

Early opposition to vaccination highlighted the need for local engagement. Vaccination was not only delivered; it was explained, negotiated, and integrated into community life. This period established a defining dynamic that persists: policy could be set centrally, but its effectiveness depended on local delivery and community trust.

**Early Campaigns: Smallpox vaccination in the 1880s**

During smallpox outbreaks, councils were responsible for organising vaccination at the community level. Municipalities established vaccination depots, advertised clinic times and provided free access to vaccinators.

These responses demonstrated the strength of local systems, enabling rapid mobilisation using existing community infrastructure.



Register of Vaccination Buninyong

## Councils Assume Responsibility (1865-1890)

As Victoria's public health system matured, councils assumed increasing responsibility for vaccination alongside sanitation, disease control, and broader community health.

Vaccination became part of a place-based approach to prevention, with local authorities acting as the interface between policy and population, ensuring programs were accessible, trusted, and responsive to local conditions.

## From Outbreak Response to Routine Programs (1900s-1940s)

By the early twentieth century, vaccination began transitioning from reactive outbreak response to a routine public health service. Interwar diphtheria programs illustrate this shift, Councils established regular clinics, maintained records, and undertook public education, integrating vaccination into everyday service delivery.

## Post-War Expansion and Community Reach (1940s-1960s)

Post-war population growth and the expansion of Maternal and Child Health services in local government provided a universal platform for engaging families in immunisation efforts.

Councils' existing infrastructure reinforced their role in prevention and early intervention. Mass vaccination campaigns demonstrated the system's capacity to respond at scale, leveraging local knowledge and community trust.


**Mass Immunisation at Scale: The polio campaign**

The introduction of the Salk polio vaccine in the 1950s triggered one of the largest immunisation efforts in Australia's history.

Victorian councils organised clinics in schools, town halls and community facilities, vaccinating large numbers of children in a short period.

These efforts translated national policy into rapid local delivery, supported by infrastructure and relationships already established within communities.

## Coordinated Delivery with Local Foundations (1970s-Present)

From the 1970s, Victoria's immunisation programs participated in national campaigns, including measles, rubella, and DTP.

In 1988, responsibility for running vaccination programs was formally transferred to the states and territories, creating some variation in schedules until the National Immunisation Program was established in 1997, unifying standards and coordination nationally.

Systems such as the Australian Immunisation Register support coordination, data collection, and monitoring, while the Australian Immunisation Handbook provides consistent guidance on vaccine schedules, administration, and best practice across the country.

Victoria has retained a multi-level approach to immunisation delivery: national policy sets standards, the state provides oversight, and local providers translate programs into practice. Councils continue to contribute significantly, particularly in childhood and adolescent programs, including school-based vaccination.

The Victorian Public Health and Wellbeing Act 2008, formalised immunisation explicitly as a function of local government under Part 3, Division 3, Section 24:
"The function of every council under this Act is to seek to protect, improve and promote public health and wellbeing within the municipal district by … (f) co-ordinating and providing immunisation services to children living or being educated within the municipal district."

Policy measures such as "No Jab, No Play" demonstrate that even where compliance settings are strengthened, effective implementation depends on local systems that connect policy to communities, build trust, and sustain uptake.

**A Modern Mass Campaign: The Meningococcal C vaccination rollout (2003-2004)**

The National Meningococcal C Vaccination Program, launched in 2003, was one of the largest immunisation efforts undertaken in Australia, targeting almost 6 million children and adolescents aged 1 to 19 years.

The program combined a new routine vaccine for infants with a time-limited catch-up campaign for older children.

In Victoria, local government played a central role in delivery. Councils utilised established school-based immunisation infrastructure to vaccinate secondary school students, and in many areas also supported younger age groups at community-based clinics.

Early progress in Victoria was noted at the national level. In June 2003, the Commonwealth Minister for Health and Ageing, Kay Patterson, publicly recognised that all Victorian councils were already well underway with implementation, highlighting the state's strong early rollout compared to other jurisdictions.

High coverage was achieved across the target population, contributing to a substantial and sustained reduction in meningococcal C disease in Australia.

The rollout reinforced a key feature of the Victorian system, the ability to rapidly deliver large-scale immunisation programs through established local government networks.

# Conclusion

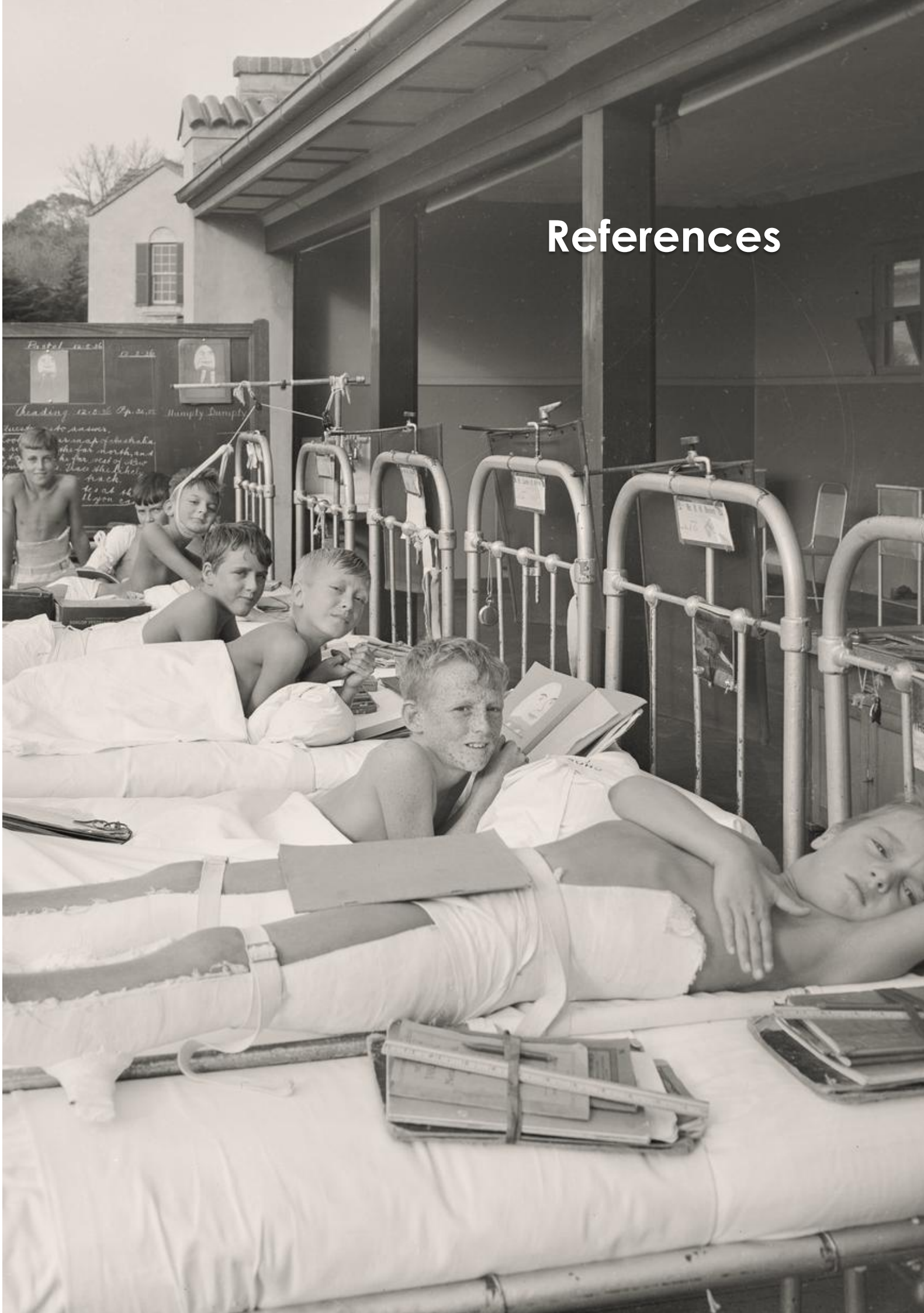
Victoria's approach to vaccination reflects a deliberate design choice, one that places local government at the centre of delivery, supported by state coordination. Over time, this model has proven its value not only in responding to outbreaks, but in sustaining routine immunisation and reaching communities effectively.

What this history demonstrates is not simply continuity, but capability. Local government has built the infrastructure, workforce and relationships required to deliver immunisation at scale. These are not incidental features of the system, they are what enable it to function.

As immunisation becomes more complex and public health challenges continue to evolve, these local capabilities are increasingly important. National policy and data systems provide structure, but they depend on local delivery to achieve impact.

This has clear implications. Maintaining effective immunisation in Victoria requires more than program design, it depends on recognising and sustaining the role, experience and workforce of local government. Erosion of this capacity risks weakening the connection between policy and community that underpins coverage and access.

Victoria's vaccination history therefore offers a clear lesson. Immunisation systems are only as strong as the mechanisms that deliver them. In Victoria, that strength has long been grounded in local government, and sustaining this capability will be critical to maintaining effective immunisation into the future.

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**Page 6**
*Carlton. Entrance to a slum pocket.*
Photographer unknown, ca. 1930.
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**Page 9**
*Small-pox precautions: vaccination "from the calf"*
Photograph, 6 May 1882.
State Library of Victoria.
https://handle.slv.vic.gov.au/10381/256597

**Page 10**
Register of Vaccination Buninyong 1868 -1904
Public Record Office Victoria
https://prov.vic.gov.au/archive/VPRS3654

**Page 11**
*Diphtheria Poster*
Unknown photographer
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**Page 13**
*North Melbourne. Group of children in Erskine Place.*
Photographer unknown, ca. 1935.
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**Page 15**
*Boys with polio taking lessons on outdoor verandah at Children's Orthopaedic Hospital, 33 Jacksons Road, Mt Eliza.*
Photograph by Lyle Fowler (1891–1969), 12 May 1936.
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