

CHAPTER EIGHT: STILL A ROCKY ROAD FOR MOTHERS

This research set out to add to the history of the mother and child welfare sector of public health in NSW by examining the services that Karitane, a voluntary organisation, provided for mothers and babies from 1923 to 2000. Conclusions are drawn together here firstly in relation to public health, then on Karitane's development as a voluntary organisation. Discussion about the professional interests of doctors and nurses follows and lastly there are overall comments about mothercraft and the funding of services for mother and child in NSW.

Contribution to public health

AMS developed because the community wanted its services; Karitane never lacked patients (or clients). Chapter two explains how organisations like the AMS were a community response to the problem of high infant mortality and how reducing infant wastage became a public health issue in Europe and Anglophone countries. The rationale at the time was variously; nationalism, imperialism, eugenics and scientific knowledge with people at the time often invoked more than one of those reasons. Throughout the twentieth century Australia's infant mortality rate fell steadily.

The study was unable to establish Karitane's direct contribution to public health because of the impossibility of establishing Karitane's direct effect on the State's infant mortality or morbidity rates, but it has estimated Karitane's contribution to mothercraft services in NSW. Numbers of clinic visits for Karitane peaked in 1947; metropolitan figures available for the previous year 1946, give Karitane approximately nineteen per cent of the metropolitan total of clinic visits. The years 1946-7 were also the years when Karitane had the highest proportion of admissions to mothercraft homes at thirty-nine per cent. At other times it cared for between twenty and thirty per cent of mothers admitted to homes for assistance with baby care. Comparing the numbers of nurses trained, Karitane consistently trained more than thirty per cent of mothercraft nurses but fewer Infant Welfare nurses, about fifteen per cent until the late 1960s when the proportion rose to about twenty-five per cent. The Department did not employ any Karitane or Plunket trained nurses until the 1960s and this probably affected the numbers choosing to train at Karitane. Even with allowances for the limitations in the way the numbers have been aggregated it is still reasonable to conclude that Karitane provided a significant contribution to the mothercraft care and supervision in NSW from 1923 to the 1970s. Since then information has not been comparable and the number and types of organisations involved in early childhood care have proliferated since the late 1960s when the

Department started to decentralise services.¹ The only comparison possible in 2000 was the number of beds available for mother and baby admissions, when Karitane had thirty per cent of available beds.

In service terms, Karitane in the 1920s gave NSW a new organisation and a choice of mothercraft care. In the 1930s and 1940s it provided additional capacity for mother and baby care at no cost to the State and in the 1950s and 1960s it was still filling the gaps in State care in new suburbs. In the 1970s and 1980s it was supporting women pressured to meet increasing social expectations and it provided ‘the holding environment’ that reduced anxiety and helped to allay depressive reactions. In the 1990s it provided secondary and tertiary care for families in South Western Sydney, a community identified by the Department as lacking family services. It was a desirable partner for the State because of the cost of dual residential facilities for mothers with their babies.

Karitane’s development clearly paralleled the periods of development that Baum identified in the development of public health in Australia.² It grew quickly through to the end of the 1940s, the ‘Nation-building’ stage. In the 1950s and 1960s its clinic work shrank when the era of ‘Affluence, medicine and infrastructure’ took the impetus from disease prevention. In the 1970s and 1980s ‘Life-style’ for women became complex with pressure to combine successful motherhood with career success. Karitane was overwhelmed by demand in this period; as President Gemmell-Smith observed in 1971, ‘We have entered the field of social work and mental health’.³ In the 1990s Karitane adapted to target its care to ‘those most in need’, who were being better identified by mechanisms developed through the ‘New Public Health’ population approach to health.⁴

Karitane had many of the characteristics of the ‘New Public Health’, aiming to engender confidence in mothers to enable them to manage baby feeding. It focused on knowledge, social support, behaviour and life-style, from the informal home style surroundings of the Karitane Home to the routines for baby care designed to allow mothers time for themselves. Karitane’s sisters encouraged mothers to care for themselves and its student nurses were taught not to criticise the mothers they helped in caring for their infants.⁵ Karitane’s philosophy of helping mothers to develop proficiency and confidence in infant care through information and practical supervision predated psychologist Albert Bandura’s work on self-efficacy based on knowledge and practice,

¹ In 1997 Karitane was providing one of 615 child abuse prevention programmes in NSW; Tomison, *Preventing child abuse and neglect in NSW*, 1997.

² Baum, *The New Public Health*, 16-17.

³ KMS, *Annual Report*, 1971, 4.

⁴ KMS, *Strategic Plan, 1996-1999*, 4.

⁵ B Corry, personal communication, 2006

and the post war growth in the social sciences.⁶ It was multidisciplinary to the extent that the medical practitioners accepted the mothercraft nurses' expertise in infant feeding and Angel-Lord considered Karitane avant-garde in its use of social workers and psychiatrists to assist with the mother/child relationship.⁷ Community participation was most active up to the 1950s through the committees supporting the clinics and in 1990s the volunteer home visitors were another form of community participation. Karitane's focus was always disease prevention whether in response to gastroenteritis or maternal depression. It also aimed for equity in its work with mothers and babies, although with hindsight the limitations of the founder's middle class views of equity are easy to see; equity still remains a serious twenty-first century health challenge.⁸ Karitane was modelling many aspects of the 'New Public Health' well before the 1980s.⁹

Karitane as a voluntary organisation

Karitane's origins required unravelling; the Society's statement in their Annual Reports that it was started by parents whose babies had benefited from the Plunket Society did not shed any light on the chain of events that led to its start in 1923. As chapter two explains, RSWMB sought Truby King's advice in 1919 and the Plunket system of mothercraft nursing was set up at RSWMB's Tresillian with Plunket assistance. Harper did not agree with Plunket's feeding methods and sometime in 1922 differences arose between her and those who wanted to adhere to Plunket's systems of baby feeding. Given that there was no political counter weight to medical power in NSW like the Plunket Society in NZ, it was inevitable that RSWMB's Medical Superintendent would win that dispute. Harper was the sort of woman doctor whom Truby King had found antagonistic towards Plunket in NZ; one who 'looked askance at any invasion of what seemed to be their special sphere of action - they resented any intrusion by male doctors or the Plunket Society or even by trained nurses.'¹⁰ However not all supported Harper; the Assistant Medical Officer Raymond Green and a contingent of RSWMB supporters withdrew their services when McMillan was fired in 1923.

Just who was the driving force behind the new mothercraft organisation is not clear. McMillan had the skills but she was not a strong leader: so was it Earp who had led the NSW Public Health Association, Green who had been Secretary of RSWMB, Lady David with her involvement in a range of women's organisations or the Allens, Sir William McMillan's longstanding friends and lawyers? Green, Lady David and Ethel Allen all served as presidents in the first three years. It is

⁶ A Bandura, *Self-Efficacy: the exercise of control*, New York: W.H. Freeman, 1997, 302-305.

⁷ G Angel-Lord, personal communication, 2006.

⁸ S Leeder, 'A Din of Inequity,' *Australian Journal of Public Health*, vol. 15, no. 1, 1991, 2-4.

⁹ Baum, *The New Public Health*, 36.

¹⁰ King to Holman, 20 Jan 1920, Hocken Library: AG-007-005/036.

difficult to establish exactly what influence Truby King had on the process; he had no official role other than as a Patron, but he advised McMillan, he influenced the employment of the sisters at Karitane and he established and managed the short-lived KPS factory in Buckingham Street. His last visit was in 1931; his daughter Mary considered that he was a ‘broken man’ after his wife Bella died in 1927.¹¹ What is clear is that AMS was started by a group of Australians with connections to Plunket and Truby King, either as young parents from Tresillian in Sydney, or through contact in NZ or in England. Some members of the group had social connections, like McMillan and Elsie Greatrex. Lady David and Lady McMillan were both members of National Council of Women and the Feminist Club, which was known for its reverence for motherhood.¹² AMS was run by relatively affluent women; typical of the ‘maternalist’ model.

Karitane is an example of a voluntary organisation that moved along the private/public funding divide from being totally privately funded in 1923 to having its running costs met by the State at the end of the century. This path of development was characteristic of the pattern in Australia whereby the state progressively took more responsibility for health and welfare while some aspects like dental care remained private responsibilities.¹³ However, the difficulties Karitane encountered in getting a State subsidy in the 1920s were not characteristic of the pattern whereby voluntary organisations were subsidised to provide services for the poor. One reason might have been that Karitane’s services were not targeted at the poor but neither were those at RSWMB and it received State funds. Likewise Karitane’s services were not completely taken over by the State in the 1960s and 1970s as were those of other voluntary organisation like the Bush Nurses. It retained the ownership of the Residential Unit probably because mother and baby beds were expensive services for the State to provide.

AMS had its political supporters; until the 1950s these politicians tended to be liberal/conservative. From the 1950s when Karitane first received State funding it seems that the ALP was amenable to some services being provided by voluntary organisations. It acquiesced to some aspects of the neoconservative economic approach in respect of this area of public health; it was a Labor Premier who established the ‘Families First’ programmes in 1999 supporting volunteer home visiting organised by community organisations like Karitane. Towards the end of the twentieth century, voluntary organisations were being seen as an important part of social capital; the sum of the social responsibility and the trust that keeps communities connected. Karitane conformed to economist Putnam’s observations in the USA of a cohort of civic-minded people born

¹¹ King, *Truby King, the man*, 306, 337.

¹² G Griffith, ‘The Feminist Club of NSW, 1914-1970: a history of feminist politics in decline,’ *Hecate* vol. 14, no. 1, 1988, 56.

¹³ Crichton, *Slowly taking control?*

before World War Two sustaining the community's social capital through to the 1970s.¹⁴ The actual numbers of volunteers supporting Karitane is difficult to establish but there was a steady decline in the numbers of Council members from an average of twenty-nine in the 1930s to an average of nine in the 1990s.

Karitane was one of the voluntary organisations in the health sector that gained support with the rise of neoconservative economic ideals. The motives for the acceptance of these ideals are the subject of scrutiny and debate. In the USA Smith viewed the proliferation of voluntary organisations providing welfare services as a political strategy rather than a technical one resulting in requirements for increased control and higher standards.¹⁵ Karitane had many of the characteristics identified in the literature as arising from the greater accountability required of voluntary organisations receiving government funds. Karitane's operations became increasingly professionalised; by the end of the 1990s Karitane did not admit any self-referrals. Deprofessionalisation could also happen with shrinking resources. In the 1990s some of Karitane's community services were provided by non-professional volunteers rather than employing more professional nurses. In the UK Harris found voluntary organisations were expected to be increasingly sympathetic to government policy agendas; Karitane felt pressured to move to Western Sydney. Harris also mentioned problems arising when an organisation changed their mission to ensure funding flows.¹⁶ Karitane changed its mission three times in the 1990s and had difficulty with managerial appointees although it is not clear which was cause and which effect. Moreover its goals no longer expressed values; the constitution's statement of Karitane's function being 'promoting, advocating and disseminating material and information' to do with the 'development of family health' left a lot of room for interpretation.¹⁷

Australian writers were also expressing concern over the political strategy in Australia of increasingly using voluntary organisations to provide welfare services.¹⁸ Baldock gave the example of the Scandinavian countries where there was an absence of volunteers in the welfare sector. Her research in Western Australia identified class differences in volunteers along functional lines; the managerial positions tending to be middle class.¹⁹ This was the case at Karitane; in the 1990s the governing volunteers were professionally qualified people, the home visitors unqualified other than

¹⁴ Putnam, *Bowling Alone*, 15-28.

¹⁵ Smith, 'Contracting and the changing politics of need in the USA', 79-98.

¹⁶ Harris, 'Voluntary management committees: the impact of contracting', 73.

¹⁷ Karitane, 'Constitution of Karitane', 1.3 (b), 2005. See Appendix 1 for full text.

¹⁸ Baldock, *Volunteers in welfare*; Cox, *A truly civil society*; Mark Lyons, 'Non-Profit Organisations, Social Capital and Social Policy in Australia', in *Social Capital and Public Policy in Australia*; Oppenheimer, 'An overview of the voluntary principle in Australia'.

¹⁹ Baldock, *Volunteers in welfare*, 43.

having had children. Research on institutionalizing practices might explain some of Karitane's difficulty maintaining cohesion in the 1990s. It had lost many of the practices that had maintained its identity like training nurses; the students were an important institutionalizing mechanism, doing things the 'Karitane way'.²⁰

This study unravels something of Karitane's origins and explains its place as a voluntary organisation in the field of mothercraft in NSW. Karitane's history gives the volunteer perspective on the 'moving frontier' between the State and private organisations, in this instance providing mother and child services in the public health sector. However, it is also a cautionary tale about the destabilising effect on a voluntary organisation of dependency on a single funding source and of other external forces like nursing regulation.

Medical professional interests

Although AMS operated with the mothercraft methods developed through Truby King's professional interest in preventive medicine, ironically Karitane owes its existence and survival to the personal medical ambitions of Harper and Morris. As explored in chapters two to five, their actions are open to more complex interpretation than previous writers have put forward in relation to Karitane's operations. Historian Brian Harrison found similar complex influences in relation to the improvement in women's health in Britain 1840-1940; one of his conclusions was that 'there is a strong case for giving detailed study to the personalities involved'.²¹ Harper wanted to make Tresillian hers rather than it being identified with Plunket methods and the RSWMB aims that emphasised 'saving baby life' were to her advantage; she overcame prejudice against women doctors to be an acclaimed paediatrician. Morris's intransigence towards Karitane probably ensured its ongoing existence. Had he followed Campbell's advice in her 1930 *Report on maternal and child welfare in Australia* to be inclusive then Karitane may well have merged with RSWMB at some point.

There were many contradictions about Morris; even if he was ideologically opposed to assisting the privileged in any way, not recognising Plunket or Karitane trained infant welfare nurses reduced the pool of nurses available to extend the State's BHC services. Although he was sceptical of the value of mothercraft he supported RSWMB until he died. He accused the Plunket nurses of 'rigidity' in their baby care methods while insisting on State wide 'uniform' teaching by the State's

²⁰ C McDonald and A Mutch, 'The future of volunteering as institutionalising practice', in *Volunteers and volunteering*, 125-139.

²¹ B Harrison, 'Women's health and the women's movement in Britain: 1840-1940', in *Biology, medicine and society 1840-1940*, edited by C Webster, Cambridge University Press, 1981, 71.

BHC Sisters.²² Morris was known as a demonstrative Quaker but the Australian Dictionary of Biography states that he was from a Russian Jewish family and only a twenty-one year old medical student when he was married in Sydney's synagogue to thirty-year old Alice Cashmore from Melbourne. Alice died in Tasmania nine years later. He then joined the Australian Imperial Force Medical Corps in 1918, serving in the Middle East. Public health might have been one of few career options open to him; he had worked initially in psychiatric hospitals. Knowing more of these early events might help in understanding Morris as they would have shaped his social attitudes to some extent.²³

Morris' sustained vehement denunciation of Truby King and the AMS seems somewhat out of proportion with his experience of Plunket and Plunket Nurses. As suggested in chapters three and four, it may have been more about competition for State health funds. Morris did not have the total support of his public health colleagues and the majority of medical practitioners would not have supported his advocacy for State employed salaried medical practitioners. The Public Health Act endowed the DG's position with unassailable authority over public health matters. Morris was able to stop Karitane from receiving State funds by maligning AMS to successive Ministers. He could refuse to employ Plunket and/or Karitane trained infant welfare nurses and he wrote the reports that left Karitane and other voluntary services out of any Government record of NSW services for mother and child. Throughout he appeared not to differentiate between public health and State funded health care. It took a new generation to reach the DG position in the person of Cummins for change to happen in the relationship between the Department and Karitane.

In the 1920s infant feeding nutrition was a body of knowledge that was still evolving and a source of medical contention. Truby King's mothercraft methods and formulae for 'humanising' cow's milk had supporters and critics amongst Australian doctors although the groups are not easily characterised. However, Karitane never lacked honorary medical services. Clements, Australia's internationally known nutritionist, quietly contributed to Karitane's nursing education programme and did his share of being just one of the honorary medical staff. He achieved what Truby King could not; agreement on feeding guidelines for artificially fed infants on both sides of the Tasman. He was a champion of the infant welfare nurse as an agent for nutrition education; he found a correlation between mothercraft and the physical health of infants and was a forerunner of the later emphasis on mental health. However, a question remains about Clements. Why did he never refer to Karitane in any of his publications? Was it to do with medical politics or was it tangled up

²² Department of Health, *Annual Report*, 1929, 32; 1930, 33; 1931, 38.

²³ Morris probably encountered Quakers in Tasmania. It was the base for the Religious Society of Friends in Australia. Religious Society of Friends in Australia, *Australian Quaker history*, viewed 25 October 2008, <<http://www.quakers.org.au/displaycommon.cfm?an=1&subarticlenbr=5>>

somewhere in trans-Tasman rivalry and contention over Truby King's status in paediatrics? It is for some future research to tease out how trans-Tasman rivalry might have fed into these conflicts because in the first two decades of the twentieth century NZ's relationship with Australia changed markedly after Federation.²⁴

Mothercraft in the early twentieth century provided a difficult juxtaposition for the medical profession in relation to remuneration, professional boundaries and the public/private divide. In NSW the profession's difficulties also left a legacy of alienation amongst the community groups working in mother and child care.

Nursing professional issues

It was Hester Maclean, nurse Inspector of Hospitals in NZ, who advised the Plunket Society in 1907 that it would be more politically acceptable to use trained nurses rather than volunteers to advise mothers on baby feeding.²⁵ Plunket Nurses became well-regarded health professionals at a time when women's career opportunities were limited and a powerful Plunket Society defended their autonomy. In NSW the medical profession was opposed to nurses advising on baby care and the State's BHCs all had local medical supervision, 'to see difficult feeding cases.'²⁶ Notwithstanding, Clements considered that the BHC sisters were the biggest influence on household nutrition in NSW.

The nurse in charge of the Karitane Home was crucially important. McMillan was good at teaching baby care but she had difficulty retaining staff. MacLean had considerable managerial ability and the systems she set up continued to the 1950s; for example, the 'Dream Book' that was the Karitane Nurses' infant feeding manual. Warneke's strengths were care and hard work; one Karitane student observed that she never seemed to sleep. In the 1950s there were three relatively short-term appointments and Caldwell-Smith provided some needed stability between 1954 and 1958. In 1960 Wilson, coming from the Department, had the advantage of knowing how the Department's systems operated. Working with Clements she widened the nurses' curricula and achieved an upgraded status for mothercraft nursing with State examinations and registration. Erlanger reinforced teaching and learning in every aspect of Karitane's work. She was energetic and she fostered the therapeutic atmosphere identified by the doctors through the 1970s and 1980s.

²⁴ Belich, *Paradise reforged: a history of the New Zealanders*, 46-52.

²⁵ The founders of the Plunket Society in Dunedin in 1907 had initially planned for volunteers to visit mothers at home. LS Milne, 'The Plunket Society: an experiment in infant welfare', BA Hons, Otago, 1976. McLean was an Australian nurse and a friend of Dr Agnes Bennett, the target of Truby King's comments above about women doctors. PA Sargison, 'Maclean, Hester 1859 - 1932', *Dictionary of New Zealand Biography*, viewed 14 May 2008, <<http://www.dnzb.govt.nz/>>

²⁶ Department of Health, *Annual Report*, 1929, 33.

Kocken in the 1990s had to cope with the sweeping changes to nursing education that 'gutted' mothercraft nursing and Karitane. When she left in 1992 Kocken expressed her dissatisfaction with her exclusion from the Council meetings. The formality and lack of inclusiveness on the part of the Council towards the Matron were a recurring comment. This distance could have been a contributing factor to the difficulties that resulted in the turnover of nursing management in the 1990s and the change to an executive general manager.

Karitane's nurses were disadvantaged by the Nurses Registration Board's Chair being the Department's DG for so long. The NRB was not acting in the interests of the public when it did not question Morris's action to exclude Karitane as a nurses' training school in 1926. Again in the move of nursing training to the education sector the NRB did not appear to have examined the public's interests in mothercraft nursing. Matron Erlanger's concerns about the future of mothercraft nursing were borne out in the changes of the 1980s when mothercraft nurses were downgraded to being enrolled nurses. The nursing profession's interests seemed to be centred on the registered nurse. Registered nurse training went to the University but enrolled nurses did not escape the apprentice model of nurse education, remaining a student nurse workforce with their tuition in the technical skills sector, the TAFE. They no longer gained the specialist skills to manage well baby care independently. Although there had still been a demand for Karitane Mothercraft training in the 1980s and there was an increasing demand for mothercraft nurses in the community in the 1990s, the systems of nurse education and regulation were beyond Karitane's control, and not in the best interests of mothers.

NSW's investment in mother and child care

An underlying theme in the development of AMS/Karitane is the continuing parsimony of the State towards women and children in spite of a demonstrated demand. For all the words about the value of motherhood, the money has not followed. In 1925 Harper told the Royal Commission on Health that NZ had twice the ratio of baby health nurses to population than was the case in NSW. Competition for funds was a plausible reason for the Department's attitude towards AMS; both Morris and Cuthbert-Browne complained about insufficient funds to increase their services. The Department saw itself ideally as the monopoly provider of mothercraft supervision and it successfully removed any competition from AMS to ensure that the bulk of moneys available for mothercraft services were directed to its own services and those of its quango, RSWMB, until the late 1950s. In the midst of government spending cuts in the 1980s the State's parsimony resulted in Karitane moving to South West Sydney rather than allowing the establishment of a second residential Home. There are some economic analysts that argue that there was no welfare funding

crisis and who point out the irony that the rhetoric about reducing government expenditure came from the relatively low spenders like the UK or US and Australia.²⁷

In NSW health services are dependent on ‘the needs of financial and other resources available to the State’.²⁸ It is the politicians who interpret the priorities for ‘financial and other resources’ that in turn determine the resources available for health services. The conclusion therefore is that politicians rate the services for mother and baby below many other priorities. For all the criticisms levelled at the ‘maternalists’ of the early twentieth century as champions of middle-class values they were an effective lobby.²⁹ They were most successful in NZ, where the Plunket Society gained control of the bulk of well baby services. In NSW doctors were firmly in control of mothercraft and it was the Department’s doctors who co-opted the only large organised women’s group in NSW, the CWA, into their plans for monitoring baby care. At the beginning of the twenty-first century, the position is worse; there is no large lobby group for women as mothers, and women’s lives are taken up in paid work in addition to their unpaid labour as mothers. ‘Mothercraft’ became ‘parenting’ and ‘gender neutral’ although women still do most of the ‘parenting’. The State, faced with evidence of gross failures of parenting in some community sectors, has targeted its funds to train volunteers. Karitane has gone from being an identifiable community provider of mothercraft teaching to being just one amongst many voluntary groups that the State funds to support needy families.

In 1974 when Douglas Gordon, Professor of Social and Preventive Medicine at Queensland University, said that Australian health services were hindered by the ‘weighty albatross’ of the nineteenth century attitude that medicine was ‘a gigantic exercise in community charity’, he advocated a realistic assessment of the monetary value of health care and an expectation of efficiency as antidotes. In the last quarter of the twentieth century, ‘cost’ and ‘efficiency’ were the watch words of the health services. However, in 2000 his ‘albatross’ still hung around mother and child care; it was still being viewed as an ‘exercise in community charity’.³⁰

²⁷ M O’Higgins & R Klein, *The future of welfare*, Oxford: Blackwell, 1985, 18.

²⁸ *Health Administration Act 1982* (NSW).

²⁹ Griffith, ‘The Feminist Club of NSW, 1914-1970: A history of feminist politics in decline’.

³⁰ Gordon, *First National Seminar organised by the Federal Council of the Australian Public Health Association*, 30.