CHAPTER ONE

NAMING A PARADOX

Introduction
In the 1940s, and again in the 1970s, faced with federal Labor Government proposals to establish a national universal health system, the Catholic Church in Australia fought protracted, sometimes fierce, campaigns against their introduction. How is this to be explained? The impetus for this thesis arises out of what was perceived as an enigma concerning the actions of a Church that proclaimed the dignity of the individual and the common good yet firmly resisted the introduction of national, universal health schemes on both occasions. To all intents and purpose these schemes were a practical embodiment of the Church’s mission to speak out and act for the poor, needy and vulnerable. Why, then, did Catholic authorities actively resist proposed social policies that *prima facie* appeared to be in accord with central Catholic teachings and principles? This thesis seeks to examine this apparent paradox by describing, analysing, and explaining Catholic resistance to national universal health care in the 1940s and the 1970s. Attention will focus on Catholic hospitals and the role of the state as espoused in the Catholic view of welfare, especially in the light of Labor proposals to introduce ‘free’ hospitals beds in exchange for the abolition of the means test.

The resistance of Australian Catholic authorities in the 1940s and the 1970s Catholic authorities, was at worst antagonistic, but even at best they were suspicious of government intentions, especially in relation to the survival of Catholic hospitals. Yet, by June 2003 that view had seemingly undergone a change. In that year Francis Sullivan, the Chief Executive Officer of Catholic Health Australia (CHA), the current umbrella organisation of Catholic health care, described Medicare, Australia’s national health scheme, as:

> the cornerstone of universal care with its fundamentals strongly aligned to Catholic social teaching. Medicare must be maintained as a universal insurance scheme and not turned into a safety net. Safety nets don’t work. They serve only to further marginalise the most vulnerable (2003: 21, 1).

In November of the same year Sullivan argued:
A good Medicare system promotes responsibility being taken by both individuals and the community. People can’t help the genes they are given or the predicaments life presents. They should look after their health but when they need care the lack of money should not be a factor. Health care is not just another commodity for sale like hairdressing or plumbing supplies. It is a social good we all deserve regardless of circumstance, background or social standing. The degree to which we regard each other is reflected in the support we offer each other. Medicare best represents that social pact (2003: 23, 2).

These statements raise several questions. Had Catholic teaching really changed so radically, that now a national universal health scheme was deemed compatible with the Church’s social teachings? Was Catholic resistance in the 1940s and 1970s contrary to the Church’s core teachings and its mission to the poor and the vulnerable, or is the Church’s teaching susceptible to various interpretations at different historical periods? On this view, the core teachings are comprised of several strands, each of which may properly be given an emphasis at different times and in different places. The task of this thesis is to grapple with these questions. Whilst it does not provide definitive answers, the thesis nevertheless makes a preliminary effort to untangle these fascinating issues at the intersection of theology and practical policy making.

Prior to the Second Vatican Council (1962-1965) Australian Catholic health care conformed to what Hehir describes as an ‘immigrant model of healthcare’. It was a product of ‘the ecclesial impulse to heal, teach and serve’, but it also evolved out of the need to protect and preserve the Catholic community (1995: 19). Thus the establishment of Catholic hospitals, like Catholic schools, was informed by a fear that the Catholic community would suffer, if not disintegrate, if it was exposed to outside and hostile influences. Only those institutions under the control of the Church, free from state interference, would protect the souls of Catholics. It is not surprising, then, that authorities, anxious to limit the role of the state, stressed the principle of subsidiarity, which was clearly articulated by Pius XI in his 1931 encyclical *Quadragesimo Anno*. The principle of subsidiarity stipulates that the family and local parishes are the preferred first choice for social functions leaving the state as the avenue of last resort. On this view the management and control of Catholic hospitals must reside in the hands of Catholic authorities, a position that could be compromised by acceptance of government funds. Catholic authorities,
then, preferred to rely on mutual aid and charitable support to build and maintain Catholic hospitals, a position that at times assumed triumphalist overtones. Bricks and mortar were tangible evidence of success over adversity (Hehir, 1995: 19; Smyth, 2003: 21-22).

A key aspect of Labor government attempts to introduce universal national health care in the 1940s and the 1970s, concerned access to hospitals, access that had generally been managed through charity, private payments, and various health insurance arrangements. The latter, however, is a market commodity, but health in crucial aspects is unlike other goods and services. The need for health care for individuals is largely uncertain, costs have largely outstripped the capacity of the individual to pay without some form of assistance, most consumers often do not have the knowledge to make informed choices, and illness restricts the experience of others either through the risk of the spread of infection, emotional and psychological suffering, or the loss of productivity (McClelland, 1991: 6). The community, then, has a vested interest in ensuring the access of all its citizens to health services in time of need, an interest that requires some degree of cross-subsidisation by the wealthy of the poor, and by the healthy of the sick. Thus in addition to protection against financial loss, health insurance does, or should, incorporate crucial normative elements, namely ‘the social objectives of access and equity’ (Scotton and Macdonald, 1993: 2). This is consistent with the mission of the Catholic Church: not because it makes good sense both for the economy and the community, but because it contributes to the common good. As judgements must be made as to the fairness of the distribution of resources, and the cost to be borne by various sections of the population, it has been argued decisions should not be entirely left to the market (McClelland, 1991: 6). This, however, is contentious, as attitudes vary over the extent to which individuals should be responsible for their own health. Moreover, opinions vary as to the appropriate level of state intervention. This was a key concern of Catholic authorities in the two periods under study. In particular they worried about the impact of government control on the management, organisation, and administration of their hospitals, particularly in relation to medico-moral matters. State intervention, to their minds, threatened the independence and autonomy of Catholic hospitals, a situation that they judged as being contrary to their mission and Catholic social teaching.
Catholic social teaching
The term ‘Catholic social teaching’, which dates from the release of Leo XIII’s 1891 encyclical *Rerum Novarum*, is commonly attributed to, but not confined to, the Church’s hierarchical documents, i.e. those documents handed down to the religious and the laity from the Pope. Their concern is social and economic issues, the guardian of which – at least in its own terms – is the Church. The teaching itself is based upon philosophical and theological principles that remain constant over time, but it adapts to take note of changing social, political and economic circumstances. Thus Catholic social teaching draws upon the traditional teachings of the Church and the traditional principles applied and taught by the Church, but it also develops in response to changing problems (Calvez and Perrin, 1961: xiv, 67). That is, the Church’s social teaching is an evolving ‘constant’ that takes cognisance of, and responds to, advances in thinking and changes in circumstances. The result is that – in different times and places – the Church may stress various specific aspects of its teachings over others.

Prior to Vatican II, Catholic social teaching emphasised the natural law approach, which argued that men and women, by virtue of their capacity to reason, are able to identify the universal and unchanging characteristics of human nature and of society (Lebacqz, 1986: 67; Boyle in Komonchak et.al., 1987: 703-707; Calvez and Perrin, 1961: 43). This preconciliar teaching assumed a natural or organic order, in which the different parts of an organism work together for the good of the whole body, functions that other parts should not usurp. Thus the social order, governed and directed by the principle of subsidiarity, gave priority to the family, then intermediary groups and finally and only as a last resort, the state. The resistance of the Australian Church to the introduction of national universal health schemes in the 1940s and the 1970s is consistent with this view. Esping-Andersen (1990), Castles (1993a, 1994), and van Kersbergen (1995) concluded this teaching produced a ‘Catholic world of welfare’ that is conservative and corporatist in nature. Following Vatican II the Church modified the natural law approach thereby instituting a postconciliar teaching that highlighted the importance of the Gospels, and the place of Jesus and grace in the moral life of Christians. Thus the hierarchical documents, following Vatican II, more strongly emphasised the common good, solidarity, and a preferential option for the poor, which allowed for a more active, but not dominant, state. Put another way the preconciliar
Church teaching favoured resistance to the intervention of the state, which was to some extent replaced by postconciliar acceptance of greater, but still limited, state initiative.

It is therefore possible to argue Catholic social teaching has at least two key aspects. One minimises the role of the state, but the second allows for an active, albeit limited, state. Hence the seeming change in attitude evident in Sullivan’s comments does not discredit earlier responses by the Church, but rather highlights the importance of context, a situation that Smyth (2003) also highlighted in his examination of the influence of Catholic social teaching upon the development of Australian social policy. In particular he highlighted the Australian Church’s preference, at least until the 1970s, for a ‘welfare society’ rather than a ‘welfare state’, a preference that resonated within the wider Australian population. It is, then, possible to argue that the response of the Church in the 1940s and the 1970s – to be explained and analysed in Chapters Six through to Nine – whilst faithful to a particular ‘reading’ of Catholic social teaching, was conditioned by social, cultural, political, economic, and historical context. The conservative and corporatist ‘Catholic world of welfare’ identified by Esping-Andersen, Castles, and van Kersbergen, then, is not a necessary product of pristine Catholic social teaching, but rather Catholic doctrine historically conditioned by the world in which the Church operates – an ever-changing world. In other words, the resistance of Australian Catholic authorities to national, universal health in the 1940s and the 1970s was a consequence of a preconciliar reading of Catholic social teaching that inclined Catholic authorities to a conservative view of welfare.

The Catholic view

The essence of Catholic health care is spiritual, an expression of love of God through care of the sick that they might attain the fullness of God. Whilst this is to be developed more fully in Chapter Two, for the present it is sufficient to note that this view rests on four philosophical, and theological, principles that are derived from two God given and parallel sources – Revelation and natural law. First, individuals are created in the image and likeness of God. Thus they are gifted with an equal God given dignity. Secondly, they possess inalienable rights, which flow from their sacred nature, not the state or the community. Whilst indwelling they do not exist apart from duties, i.e. rights are correlative with duties (Moody, 1953: 51). Thirdly, individuals share the same Father, which means they are social by nature. Men and women are not
isolated monads, but rather need the support of the family, the church, and intermediary associations, in order to achieve their full development. In other words they need society, and by implication they need the state whose proper purpose is the pursuit of justice and the common good. Society, however, is broader than the state. Indeed the dignity of the individual assumes that the individual and the family are anterior to the state, an arrangement that implies a right order, often referred to as an ‘organic order’. Hence the role of the state, which is ‘natural, necessary, and good’, (Curran, 2002: 138) is limited by the principle of subsidiarity. Finally, the understanding that ‘the abundance of nature and of social living is given for all people’ (Lebacqz, 1986: 67), acknowledges that all have identical natures. Thus access to basic necessities that ensure the dignity of the individual ‘must apply to every human being, since all have the identical nature which grounds the right’ (Antoncich, 1987: 96). Crucially, all have a right to share in, and use, the goods provided by nature. Whilst these principles have remained constant over time this thesis argues that the emphasis on the principle of subsidiarity during the period that is the focus of this thesis obscured recognition of the final principle.

Taken together these principles provide the basis of the Church’s rejection of the extreme individualism of economic liberalism, and the state collectivism of socialism. Instead the Church advocated a path that acknowledged the dignity of the individual, their right to private property, the family as the basis of society, a role for intermediate groups, the limited but very necessary role of the state, and the need for harmony between the classes (Hales, 1958: 225-226). The organicist, classicist and personalist nature of Catholic social teaching which is explained in the next chapter, produced a particular view of welfare, a view highlighted by Esping-Andersen, Castles, van Kersbergen and Smyth, and detailed in Chapter Five. This Catholic view of welfare proclaimed

the principle of “subsidiarity”; an emphasis on the family as a fundamental unit of society; less emphasis on the rights of the individual citizen and more on the individual as a member of a social group with a need for the state to value the group; a view of some inequalities as natural and acceptable (Smyth, 2003: 18).

Inequality, however, is softened by insistence on the importance of full employment, the payment of a ‘family’ wage that enables a man to support his family, and ‘high levels of social spending to support families’ (Smyth, 2003: 18). Consequently the
Church favoured policies that supported the role of the family, but minimised the role of the state. It preferred a ‘welfare society’ to a ‘welfare state’ (Smyth, 2003).

The mechanism for the achievement of a ‘Catholic welfare society’ was corporatism, understood as a set of arrangements, which requires the state to work through existing social groups. Catholic social teaching, then, proposed a means of caring for individuals that protected the rights of the individual and families, supported but not dominated by the state. It resonated with a ‘residual’ approach to welfare, which argues

there are two “natural” channels through which an individual’s needs are properly met: the family and the market economy … (when these fail) a third mechanism of need fulfillment is brought into play – the social welfare structure. This is conceived as a residual agency, attending primarily to emergency functions, and is expected to withdraw when the regular social structure – the family and the economic system – is again working properly. Because of its residual, temporary, substitute characteristic, social welfare thus conceived often carries the stigma of “dole” or “charity” (Wilensky & Lebeaux, 1965: 139).

Whilst this approach may moderate the excesses of both the market and state, it is not without danger. At worst it may descend into a two-tier system of social support that fails to acknowledge the inability of some individuals to access the resources necessary to provide for the care of their families (Smyth, 2003), an outcome that would seem to contradict the mission of the Church. Moreover, reliance on safety nets runs the risk of stigmatising and further marginalising the poor, a situation acknowledged in Sullivan’s assessment of Medicare. The paradox then remains. Does Catholic social teaching suborn the mission of the Church? In answering that question it must be noted that the Church’s mission is not reducible to its social teaching. Rather the social teaching embodies, or proclaims that mission, however, particular historical moments shape the interpretation of the teaching and thus the approach to mission. It is, then, possible that the approach adopted by the Church and Catholic authorities may contradict what is understood as its mission, at least in the eyes of those who come after.

The Church and Welfare
The role of the Church in the development of social policy, and in particular health policy, has not received much attention although the recent work of Esping-
Andersen, Castles, van Kersbergen, and Smyth, among others, has begun to address this deficit. In particular they have identified and theorised a ‘Catholic world of welfare’ based upon corporatism. The issue of importance for this thesis is whether the Catholic view of welfare compromises the Church’s mission, a question that may be elucidated by the fledgling but growing work on the importance of religion as a determinant of policy. To date that research has focussed on the impact of Catholicism in continental Europe, but very little attention, with the exception of Smyth, has been directed to the impact of religion upon Australian social policy. Indeed, having noted the importance of Catholicism in their book, *Arguing about the Welfare State*, Beilharz, Considine and Watts devote only two and a half pages to that influence (1992: 40-42). This thesis seeks to redress the overall general paucity of scholarly work on the role of religion on the Australian social policy scene. Of necessity it is a preliminary and exploratory exercise. It is also tentative, as much of the documentation pertinent to the issue is generally not publicly available or accessible. Archival material from the Australian Catholic Health Care Association (ACHCA), now the CHA, is believed to be located in cardboard boxes under the Sacred Heart Hospice in Darlinghurst, but despite efforts on the part of the researcher and the voluntary officials of the NSW Chapter, which holds the material, access was not possible. While the conclusions drawn in this thesis can be justified on the basis of the evidence found in diocesan and congregational archives, and other sources used in the writing of this thesis, they may one day be challenged if access to the ACHCA material ever becomes available. Nonetheless, despite the limitations, it is argued that the topic – which seeks to further elucidate the impact of Catholicism upon the development of social policy – is crucial. This thesis, then, represents a preliminary, but necessary, step to understand that impact by examining the response of the Australian Catholic Church, in particular Catholic hospital authorities, to proposals to introduce national universal health schemes in the 1940s and 1970s.

Whilst a more detailed discussion of the work of Esping-Andersen, Castles, van Kersbergen and Smyth is contained in Chapter Five, it is appropriate to introduce their work at this point. Esping-Andersen notes that because ‘the welfare state has generally received scant conceptual attention’ (1990: 18) the literature privileges the social democratic view of the welfare state. This ultimately obscured the impact of other influences, including ‘the Christian ethic, based on the religion of love and
universal brotherhood’ (Robson, 1976: 13). As early as 1979, Stephens offered the tantalising observation that ‘it seemed possible that anti-capitalist aspects of Catholic ideology – such as notions of fair wage or prohibitions of usury – as well as the generally positive attitude of the Catholic church towards welfare for the poor might encourage government welfare spending’ (1979: 100), a view developed by other researchers. In 1981 Higgins concluded religion ‘established the rationale for many social welfare activities and to the extent that there is an ideology of social policy in different societies it has often provided it’ (Higgins, 1981: 74). Whyte (1981) noted religion was an important basis of political cleavage, and consequently a determinant of social policy. Wilensky went even further by arguing Catholicism constituted a more important determinant of welfare statism than the power of parties of the left (1982). Indeed Esping-Andersen later demonstrated that welfare state development is not simply reducible to the influence of social democracy. Rather, religion, in particular Catholicism, produced a distinctively ‘Catholic world of welfare’. In 1990 he linked Catholic social teaching to welfare arrangements in the ‘corporatist’ state, a position also supported by Castles (1993a). van Kersbergen concluded ‘that the specific properties of Catholic social theory and the pro-welfare stance of the Church’ lead to ‘a distinctively Catholic type of welfare state’ (1995: 7). Finally, Smyth (2003) noted the influence of Catholic social teaching principles, which the previous researchers had identified in European welfare arrangements, also applied to Australia. However, the Australian Church’s close ties to its mainly working class constituency modified the conservatism of European policy.

Taken together these authors demonstrate that religion, and more importantly for this thesis, Catholicism, impacts upon the evolution and development of the welfare state. In particular Esping-Andersen, Castles, van Kersbergen, and Smyth all assert that Catholicism’s emphasis on the principle of subsidiarity, the organic order of society, the fundamental role of the family, and responsibility for one another incline the Church towards a system of social support that rests upon the family as the first provider assisted by intermediate organisations, and, only then, finally the state. Rather than relying on social rights guaranteed by the state, social reform rested upon Christian charity supported by the maintenance of ‘right’ relations. Generally speaking health and welfare services provided by individuals, families and associations were perceived as superior to those provided by the state, as reliance on
the latter ran the risk of producing a ‘servile state’ (Esping-Andersen, 1990: 61). Preference for the ‘welfare society’ understood as reliance on individual initiative and mutual assistance, then, prevailed over the ‘welfare state’, which favoured state-guaranteed social rights (Smyth & Wearing, 2002: 226-232). This orientation only changed with John XXIII’s support for the welfare state and the deliberations of Vatican II. Both recognised that the increasing complexity of economic and social life meant that the Church and its agencies must interact with the state in order to provide for the needs of welfare, education and health.

Preference for the ‘welfare society’, then, is not a necessary consequence of Catholic social teaching, but rather a consequence of an interpretation shaped by a particular historical, cultural and political context. Whilst not diminishing the importance of the common good preference for a ‘welfare society’ had the capacity to overemphasise the principle of subsidiarity. Catholic social teaching is a living body of doctrine. It is thus capable of being interpreted by individuals with their particular needs and agendas in ways that – in stressing one aspect of it – obscures other nonetheless core aspects. Consequently elements of Catholic social teaching, in this case the primacy of the family and the principle of subsidiarity, may be emphasised at the expense of the common good. The task of this thesis, then, is to extend the examination of the hypothesis that Catholicism produces a distinctive, and conservative, ‘Catholic world of welfare’. This will be done through an examination of two key events in Australian history, namely Labor’s proposal to introduce national health schemes in the 1940s and 1970s. Moreover, the thesis seeks to determine if the Australian Church’s resistance to the proposals was faithful to, or in conflict with, the Church’s social teachings and mission. That is, it seeks to explain the paradox identified at the outset.

**Explaining Catholic resistance**

The resistance of the Australian Catholic Church to national universal health schemes in the 1940s and 1970s occurred within an historical context, which is examined in Chapters Four, Six, and Eight. For the present it is sufficient to describe briefly the events surrounding the development of health care policy in Australia. From the time of white settlement Australia’s governments have played a role in the provision of health care services (Jones, 1983: 24; Sax, 1984: 35). The size of the
colony and its convict origins, especially in the early years, meant there were no significant family bonds or parish support networks to care for those who fell ill. Thus the state, from the time of white settlement, was the source of help, but at best it was always a reluctant provider. Instead it encouraged self-reliance through the establishment of mutual aid or friendly societies for those capable of providing for themselves, and subsidised voluntary and charitable, or public, hospitals for the poor (Sax, 1984: 3-26, Scotton & Macdonald, 1993: 4-6). Throughout the nineteenth century the emphasis was on self-help and limited government intervention, but the remoteness and isolation of first the colonies and then the states did not allow complete state withdrawal.

Advances in therapeutics and technology enhanced the profile of the public hospital during the nineteenth century and demand for its services expanded to include the emerging middle and respectable working class. Public hospital efforts to accommodate this demand, however, highlighted the limitations of philanthropic provision. Instead of being places of charity, public hospitals were now the preferred place of treatment for classes other than the poor (Thame, 1974: 259-292). This prompted a debate about who could be treated free of charge as doctors, administrators, and Catholic operators looked to the ‘non-poor’ for funds to supplement income derived from government subsidies or private sources. In an effort to maintain income, public and denominational private hospitals, particularly in the capital cities of NSW and Victoria, erected separate intermediate and private wards for paying patients supported by systematic contribution schemes. Thus demand for public hospital services was satisfied, whilst limiting access to means tested public wards.

The position of religious hospitals was exacerbated by the lack of government subsidy. Up until the 1920s Catholic hospitals had to rely on fees, and the support and goodwill of lay people through public appeals. Increasing costs and declining income from public appeals and donations, however, forced them to look elsewhere for income, which included a push for government funds. In 1929 the NSW government enacted legislation that provided denominational hospitals with about half the money needed to fund their operations, the remainder coming from private sources. The level of government support, however, varied across the States. For instance in 1944 the
NSW government subsidised all Catholic hospital to varying levels, but the Victorian and Queensland governments subsidised only one hospital each, and the Western Australia, South Australia and Tasmanian governments provided no assistance to Catholic hospitals (AACG 01, 1944: 78-79). Even this varied, but limited subsidisation, aroused concern among some Catholics who worried that partial reliance on government financial support would dilute the spirit of charity and compromise the independence of Catholic hospitals especially in relation to medico-moral issues and the employment of staff. Others, however, argued that Catholic hospitals were providing a valuable service to all regardless of creed and hence deserved government support (Carey, 1991: 23-24). Indeed it could be argued that the government was promoting the common good by providing assistance to religious organisations for the care of the sick and indigent.

Prior to the twentieth century there was a belief that poverty was inevitable, an accepted part of the human condition, relief of which was largely limited to charitable assistance for ‘deserving’ individuals. The resulting gaps in care prompted social reformers to seek alternative means of financing access to services and benefits, including consideration of schemes based on self-reliance and collective responsibility. Social insurance, a compromise between private voluntary insurance and state relief, drew upon the notion of self-reliance (Jones, 1983: 37). Efforts to introduce such schemes in 1928 and 1938, however, faltered as they broke from the Australian practice of providing non-contributory, but means-tested pensions funded from general revenue (Gillespie, 1991: 88). By way of contrast the Australian Labor Party (ALP), long opponents of charity and the ‘means test’, and galvanised by the social and economic distress of the Great Depression, argued for collective responsibility. Instead of contributory national insurance, it argued for enhancement of the role of the state, and universal social and health services funded by a surcharge on taxable income (CPD, Vol. 155, 24 May 1938: 1329-30). Not only would this remove barriers to services, but it would also acknowledge the responsibility of the whole community for the well being of all citizens.

The 1940s
By 1949 a clear line had developed between the advocates of self-reliance and collective responsibility. On the side of the former were an increasing number of
doctors, supported by conservative politicians, who argued for fee-for-service medicine financed by private contribution – voluntary health insurance – with the maintenance of subsidised philanthropy for those unable to provide for themselves or their families (Crichton, 1990: 40; Gillespie, 1991: 186). On the other side some workers supported the ALP’s platform, but others sought the replacement of the capitalist system by communism. In between were members of the Catholic working class, who sought a solution in the corporatism of Catholic social teaching (Duncan, 2001: 9-11). Thus Catholic authorities argued for a system of social support that rested upon the family as the first provider, assisted by intermediate organisations, and then finally the state, a relationship predicated upon the principle of subsidiarity.

Efforts in the 1940s to introduce a national health scheme, initially based on the idea of direct services not cash benefits, generated opposition that notably included Catholic authorities. This together with the increasing weariness of the electorate of wartime rations and control, and Labor ineptitude at this time, was sufficient to derail the proposal. Instead government opted for traditional practice by electing to pay cash subsidies for hospital accommodation, a practice that accorded with the ambivalent attitude of the electorate towards the role of the state. Jones argued social services

that give cash to people are tolerated – even welcomed – because they are non-disruptive of private supply agencies, such as the medical profession and the housing industry. There seems to be a large difference in the public mind between the government’s granting people money to be able to compete in the market [government wholesaling] and actually interfering in, and even controlling, the supply processes in a particular industry [government retailing] (Jones, 1983: 54).

Thus the government opted for free hospitalisation for patients admitted to public beds in public wards, subsidised by an indirect cash benefit in exchange for the abolition of the means test by the States. These arrangements, however, were not popular with doctors, the States, hospital administrators, and Catholic providers, who feared for the independence and charitable nature of Catholic hospitals. Indeed, the Chifley government, concerned about entanglement in a sectarian fight, extended the hospital benefits subsidy to private and church hospitals at the same level as public hospitals to placate Catholic concerns. ‘Free’ access to public beds, however, died along with defeat of the Labor government in 1949.
The 1970s
Throughout the nineteen fifties and into the sixties internal Labor Party politics was dominated by what became known as the ‘Split’, which kept federal Labor on the Opposition benches for twenty-three years. Concerned that the secret Catholic anti-communist ‘Movement’ led by B.A. Santamaria was intent upon assuming control of the Party, the Victorian Branch of the ALP expelled those members who it believed were exerting undue outside influence, which by implication meant Catholic influence. Consequently Catholics in the Victorian branch, but not NSW, left the ALP and joined non-Labor parties. Against this backdrop the conservative coalition Menzies led government introduced voluntary health insurance. The scheme, however, resulted in a return to uneven protection and poor access to health services, especially among those deemed in most need. Labor’s attempt to regain the policy initiative improved when under the leadership of Gough Whitlam the Party adopted the *Scheme of Universal Insurance* proposed by two health economists, Richard Scotton and John Deeble. Among other things, it proposed universal access to free treatment and medical care as a public patient in a public hospital or outpatient clinics financed by consolidated revenue and a levy on taxable income. Following Labor’s election in 1972 the Party refined the Scotton/Deeble proposal and presented it to Parliament for enactment. Despite setbacks and strong opposition the legislation, with the exception of the levy Bills, received the assent of a joint sitting of both Houses following a double dissolution election. The passage of what was now known as the ‘Medibank Bills’, however, was not helped by the actions of Catholic authorities, whose influence was enhanced by the hold the quasi-Church party, the Democratic Labor Party (DLP), had over the balance of power in the Senate. As in the 1940s, Catholic authorities voiced concerns about the impact of the scheme on the independence and charitable nature of Catholic hospitals, concerns that Labor sought to address until it was clear that the DLP would vote against the legislation (Gillespie, 1991: 198; Scotton & Macdonald, 1993: 87-89). Catholic opposition, however, was not unanimous, a situation to be discussed in Chapter Nine. Indeed some Catholics voiced concerns that opposition to the scheme was coloured by the anti-Labor bias of the hierarchy of the Victorian Church, the influence of the Australian Catholic social thinker, B.A. Santamaria, and fears of loss of control over important economic institutions under the guise of religious concerns.
Aspects of Catholic resistance

Whilst Catholic resistance alone was not sufficient to derail either Labor’s scheme in the 1940s or the 1970s, it was significant enough to cause the ALP to modify both schemes. In both instances several aspects influenced the resistance. First, the resistance was predicated on, even if not always explicitly stated, the Church’s social teachings. This teaching, however, was deeply influenced by a preconciliar reading that preserved the role of the family and intermediate groups whilst restricting the role of the state. To a large extent this accorded with the historical opposition of Australians to state provision of welfare, and their support for the payment of a decent minimum wage that would enable individuals and communities to provide for their own needs supported by the payment of cash benefits. Secondly, the exaggerated but nonetheless real threat of communism in both periods under study also informed the reaction of Catholic authorities to Labor’s national universal health schemes. In particular Church leaders feared that the nationalisation of health would impose practices contrary to Catholic moral teaching on Catholic hospitals. Thirdly, the response was informed by the Church’s significant investment in health care institutions. In the course of fulfilling her mission to the sick, the Church in Australia had by 2003 assumed responsibility for around thirteen per cent of health and aged care (Sullivan, 2003: 21, 2). Consequently the Church, through her congregations or agencies, had accumulated a large economic investment in institutional health care in the course of fulfilling her mission. Whilst this may be necessary if the Church is to fulfil its mission, there is a risk that ownership may compromise mission – a risk that even now concerns Catholic health care providers. The Church’s mission clearly points to responsibility for care of others, most notably those suffering disadvantage, but a Church worried about the future of its institutions may act to limit the role of the state, in order to preserve those institutions. Finally, the Church’s response was influenced by the animosity and cultural differences between Sydney and Melbourne, the two senior Australian Church hierarchies. Their different cultures and traditions produced different styles of Catholicism, which ultimately influenced their attitude to the ALP and its policies, differences that will be discussed in Chapters Four, Seven and Nine.
Methodological considerations

At this point it would seem reasonable to note that there are a couple of methodological considerations that must be taken into account in the writing of this thesis. The first methodological consideration concerns the selection of a commencement date for the examination and analysis of the response of Catholic authorities, and the periods to be the focus of the study. Why commence with the 1940s, and why study the debates in the 1940s and the 1970s? There are good reasons to do so. Both periods were enmeshed in what McSweeney identifies as the stage of competition between Catholicism and major secular forces (McSweeney, 1980). This stage commenced with Leo XIII’s assumption of the papal throne and concluded with Vatican II. During this time the Church competed with the world for the souls of Catholics, a strategy that was characterised by the establishment of separate Catholic institutions, including Catholic hospitals. Moreover, considerable papal attention was directed to relations between the individual, the family and the state, and the organisation of society, relations at the very centre of welfare policy. Clearly this period included the 1940s, but the proposal to introduce Medibank came after the deliberations of Vatican II. The influence of the Council, both overseas and in Australia, however, was slow to permeate Church policy and practice. Thus it is possible to argue that the 1970s, along with the 1940s, was conditioned by competition with the world and preconciliar social thought. So by comparing the two periods, it may be possible to discern the nature and degree of that influence, and thus an explanation of Catholic resistance to the ‘welfare state’, which since Vatican II no longer seems to apply.

A further reason for studying the 1940s and the 1970s relates to the fact that both periods were subject to the rule of the ALP, and both experienced social crises – the Second World War in the first period and economic recession in the second. Communism too influenced the debate. Nevertheless each period also possessed a peculiar spirit, atmosphere and problems. By adopting a comparative approach it may be possible to discern what influences informed the response of Catholic authorities. Moreover, it may be possible to judge whether the response was the same in the 1940s and the 1970s, and, more importantly whether it was in keeping with the Church’s mission. The intention is not to discern “unworthy motives”
on the part of individuals, the Church, congregations, religious authorities, or politicians. Rather it is acknowledged that decisions about doctrine, organization or discipline in the Church are inescapably decisions about power and politics, and one does not have to impute unworthy motives – or even political awareness – to the decision-makers in order to explain their actions as the outcome of social and political factors (McSweeney, 1980: xi).

Hopefully the choice of this issue – the conflict around government attempts to introduce national universal health care – along with the selected starting point, and the two nominated periods, will bring sufficient perspective to enable examination of the influence of Catholicism upon social policy. In particular it is hoped to determine whether the resistance of Australian Catholic authorities to national universal health care was a ‘necessary’ or ‘foreordained’ product of the Church’s social teachings that risked contravening the Church’s proclaimed mission to the poor and vulnerable. This task is given some urgency within the context of debates in the literature over the role of religion in the formation of the welfare state.

The second methodological consideration relates to the organisation of the Catholic Church. Whilst all Catholics owe allegiance to the Pope, Christ’s vicar on earth, the Church is in fact comprised of autonomous dioceses for which an ordinary, a Bishop, is responsible. In other words, the local bishops, as authentic vicars of Christ, exercise power over their local Church. Whilst ultimately controlled by the supreme authority of the Church, so long as he does not transgress the official teachings, the word of the bishop in his diocese is determinative. Hence different interpretations of Church teaching may be placed on the same question, a situation that allowed for local responses to Labor’s proposal to introduce national universal health schemes in the two periods under study. Indeed the government in the 1970s bemoaned the fact that there was no one Catholic or Catholic authority that could or would make decisions in relation to their scheme, a situation that clearly frustrated the then Labor government (Scotton: 1996, personal communication). This diversity makes generalisations difficult, perhaps even tenuous, in their relevance to particular issues. But some degree of generalisation is required in order to achieve a theoretical understanding that may help explain the response of Australian Catholic authorities in the 1940s and 1970s. Official Catholic social teaching provides the possibility of a general description and explanation (McSweeney, 1980: xi-xiii). Either implicitly
or explicitly, the teaching permeated the responses of Catholic authorities in both periods. This did not, however, mean responses were in accord. Indeed, as mentioned above, the hierarchies of the NSW and Victorian Churches, influenced by their own social, political and cultural contexts, differed in the intensity of their response to the health schemes of both the 1940s and the 1970s.

The third methodological consideration is both ontological and epistemological in nature. The approach adopted in this thesis acknowledges that examination of the past is influenced by the perspective of the researcher, i.e. it is influenced by assumptions and preconceptions derived from the experience of the researcher. Whilst recognising the importance and value of this insight, however, this thesis postulates that there is an historical reality that can be known, albeit imperfectly, through examination of the past. This is not to argue for absolute truth, but rather for a version of reality that is knowable through investigation that may in fact be subject to revision and reformulation. To quote Fay ‘To be true to itself, the discipline of history must invoke both its scientific dimension and its rhetorical dimension’ (Fay, 1998: 8). Insistence on either undermines the raison d’être of history. Whilst this thesis is not an historical thesis it does use an historical perspective. Thus it postulates that there is a past reality, but it also acknowledges that the researcher has made a deliberate choice in selecting the topic, the study commencement date, and the two nominated periods, which colours the analysis. This, however, does not discredit the conclusions, but rather provides a perspective that may be challenged, revised and reformulated in the light of new information and new perspectives. To borrow from Fay – ‘there is a knowable reality but also that rhetoric is a means to ascertaining truth about this reality’ (Fay, 1998: 10). Thus this thesis, whilst not engaging in a philosophical debate about the nature of history, does contend that it is possible to reconstruct ‘a past reality on the basis of factual research and discuss the adequacy of these reconstructions; at the same time it must elucidate the fact that these discussions seldom lead to a consensus and that therefore pluralism is a basic characteristic of history as a discipline’ (Lorenz, 1998: 366).

Four further points should be noted before drawing this chapter to a close. First, this thesis focuses on the Roman Catholic Church. Time and space does not allow for an examination of the influence of Protestantism on health policy. Consequently that subject remains the focus of another research project. The word ‘Church’ as it is
used in this thesis, then, refers to the Roman Catholic Church. Moreover, it refers not to the community of people as stipulated in postconciliar teaching, but to the leadership of the institutional Church. That is, it refers to the pope, bishops, clergy, religious and lay individuals invested with specific religious and pastoral responsibilities. Secondly, the language of much of the source material referred to in this thesis is not gender neutral. This is attributable to the time period that is the focus of this study in which ‘man’ or ‘men’ was often used when today more gender inclusive language would have been preferable. Nevertheless, where possible this thesis has used gender-neutral language. Thirdly, in an effort to ensure that the thesis flows smoothly the thesis does not include end-notes or footnotes, but rather in text references.

Finally, this thesis rests on incomplete, therefore imperfect, data sources. Even so, the research reported here hopefully adds, even if only to a small extent, to what is known about the two periods under study. It tackles deeply contentious issues on contested terrain, the reading of which is dependent upon the perspective adopted by the researcher. Whilst acknowledging the necessarily tentative nature of the conclusions drawn on the basis of the evidence, and the necessarily personal nature of the interpretation of that evidence, the thesis nevertheless takes a position that may be justified on the basis of the available evidence. The concern is to render an account of both periods that rests upon, and is faithful to, and quotes extensively from, the available archival material. Moreover, it invites readers to assess whether the interpretation is realistic, and to draw their own conclusions.

**Purpose of the thesis**

Arbuckle notes ‘that there are now two languages in healthcare, that of economic rationalism and the holistic ethic, and they are fundamentally at odds’ (Arbuckle, 2000: 76). This, he concludes, makes it imperative for Christian reformers to ‘deepen their understanding of the vision, mission, and values of the healing Jesus, which must influence all decisions in healthcare; without this understanding it will be impossible to resolve the tension between mission and business’ (Arbuckle, 2000: 76). The importance of the present research lies in both what it tells us about two crucial periods in the history of health care, and what it might say about the future of Catholic health care in a climate that is increasingly driven by economic rationalism. Clearly access to
health care is now beyond the means of individuals. State involvement, then, is essential if access to health care, especially access for the poor and vulnerable, is to be assured. It is not enough to institute ‘safety nets’. As Sullivan indicated at the beginning of this chapter: ‘Safety nets don’t work. They serve only to further marginalise the most vulnerable (2003: 21, 1).

Does Catholic social teaching, then, have anything to say that may inform the involvement of the Church in health care, or should it be left to the state? It is hoped that this thesis will provide some thoughts in relation to this matter. Nonetheless, the degree of Church influence is not the concern of this thesis. Rather it is the Church’s resistance itself, which is the focus. After all, national universal health appeared to be in accord with the proclaimed mission to the sick, especially the sick poor, and the teachings of the Church. Did Church resistance contravene that mission? In raising this question the thesis will not simply ask how policy was derived, but it will also consider the impact of Catholic social teaching principles upon the identification, justification and defence of a particular policy, and opposition to other policies. In that sense this thesis is concerned with the intersection of ‘Normative’ and ‘Empirical’ or ‘Positive’ political theory (Weale, 1983: 8). That is, the thesis is concerned with not only how and why events turned out the way they did, but also with an evaluation of the policies and positions assumed by the protagonists.

The purpose of this thesis, then, is threefold. First, it offers a contribution to the debate over the role of religion – in this case Catholicism – in the formation of social policy. Thus, like Smyth, it extends the focus of Esping-Andersen, Castles, and van Kersbergen from Europe to Australia in an effort to determine the nature of the influence of Catholicism on the development of welfare policy. Secondly, it seeks to explain what appears to be a paradox; that is, it seeks to explain why the Catholic Church resisted the introduction health policies that to all intents and purpose were designed to enhance the access of the poor and vulnerable to health care services. Surely, it may be asked, the Church’s mission is to care for the poor and vulnerable? Yet in the two periods under study, the Church resisted such efforts prompting one to question the Church’s rationale. Thirdly, by examining Labor attempts in the 1940s and the 1970s to establish national health schemes from the perspective of the
Catholic Church, it is hoped to extend the understanding of these two particularly fascinating periods of Australian social welfare history.

**Conclusion**

Historically the Church has ‘acted as a conservative force arguing that State intervention was both morally wrong and practically inappropriate’ (Higgins, 1981: 74), a view grounded in preconciliar Church teaching. Organicist in nature, it argued for the family as first provider assisted by intermediate groups and finally the state. The Church could and did, however, support the idea of a residual welfare state because, in such arrangements, the state intervened only in the event of family or market failure. In other words a residual welfare state satisfied the Church’s principle of subsidiarity. An institutional welfare state was less attractive despite the fact that it aims at personal and social relationships which permit individuals the fullest development of their capacities and the promotion of their well-being in harmony with the needs of the community” … (It) implies no stigma, no emergency, no “abnormalcy”. Social welfare becomes accepted as a proper, legitimate function of modern industrial society in helping individuals achieve self-fulfillment … The inability of the individual to provide fully for himself, or to meet all his needs in family and work settings, is considered a “normal” condition; and the helping agencies achieve “regular” institutional status (Wilensky & Lebeaux, 1965: 138-139).

The increased role of the state implicit in this view, however, threatened the role of the family as the source of social provision. However, on the above reading the institutional welfare state would appear to satisfy the Church’s mission making even more inexplicable the strategies of resistance adopted by the Australian Catholic authorities in the 1940s and the 1970s. Residual welfare states, which include Australia, provide meagre means-tested benefits tied to need leaving the rest of the population to purchase services and benefits. Certainly they provide some assistance to families in need, but the benefits are meagre, and entailed by notions of ‘deservingness’, and divisive. Moreover, they neglect the needs of those individuals on the margins, namely those individuals who earn too much to qualify for assistance but not enough to provide for their needs or the needs of their families. Moreover, in dividing citizens into unequal classes of recipients one is left pondering about the realisation of the common good. The introduction of a basic, equal benefit, irrespective of prior earnings, contributions or performance as proposed unsuccessfully by Labor in 1940, and successfully in 1970, would satisfy at least the
basic requirements for health care, and thus contribute to the well being of all citizens, and ultimately society. Yet the Church resisted their introduction, a position that this thesis attempts to explain. What, then, lies ahead?

Plan of the Thesis
The thesis is divided into ten chapters. The opening introductory chapter has presented an outline of the research question, the methodological approach, and the significance of the problem that is the focus of this thesis. Chapter Two, the next chapter, discusses the role of health care as an expression of mission through an examination of Gospel foundations and the Church’s social teachings. It includes discussion of natural law, the dignity of the human person, the common good, and the principle of subsidiarity. Chapter Three examines the social, political, and economic context that framed the response of the Church in Europe whilst Chapter Four examines those contexts in Australia. Chapter Five examines in some detail the theoretical literature on Catholicism and welfare. In particular it highlights the arguments of Esping-Andersen, Castles, van Kersbergen, and Smyth. Chapters Six through to Nine draw on primary and secondary sources to outline the position of the Church on national, health insurance in the debates and conflicts of the 1940s and the 1970s. Chapter Ten analyses and discusses the material before drawing conclusions. This last chapter also discusses the implications of this research for the future of Catholic hospitals. The discussion turns first, though, to consideration of health care and the mission of the Catholic Church.