CHAPTER SIX

NATIONAL HEALTH INSURANCE IN THE 1940S

Introduction

The preceding examination of Catholic social teaching, European and Australian socio-political context, and theoretical explanations of the influence of religion on welfare state development has provided the background for an examination of the influence of Catholic social teaching upon welfare arrangements in Australia. In particular it has provided the framework for the examination of the response of Catholic authorities to Labor’s attempts to introduce universal, national health insurance schemes in the 1940s and the 1970s. This will help to explain the paradox identified at the outset of this thesis, namely the resistance of the Church to schemes that arguably would serve the vulnerable and marginalised members of society. This chapter commences that examination through a focus on health policy in the 1940s before proceeding to an examination of the Catholic response in the next chapter.

At the beginning of the 1940s access to hospitals largely depended upon personal initiative supported by mutual aid organisations such as friendly societies. Care for the indigent was subsidised by the state. This involvement of the state, however, was conservative, not radical, a response to the failure of charity and private providers to deliver adequate services and benefits. Moreover, it was strictly means tested, and ‘further hedged with an intimidating array of deterrent and intrusive conditions’ (Gillespie, 1991: 88). Ultimately this left some individuals without adequate access to care, a situation that prompted a search for alternatives. This included two attempts, one in the nineteen twenties and the other in the nineteen thirties, to introduce contributory national insurance. More importantly for this thesis, it also included moves by Labor to introduce a national universal health scheme in the 1940s. Each of these proposals raised questions about the proper role of the state, a role that vitally concerned the Catholic Church (Dewdney, 1972: 28-29; Thame, 1974: 241-258; Green & Cromwell, 1984: 178; Sax, 1984: 42-43; Gray, 1991: 50; Gillespie, 1991: 60-86).
The moves to introduce contributory social insurance in the nineteen twenties and thirties were underpinned by a belief in the importance of personal initiative, and a minimal role for the state, beliefs generally espoused by conservative and liberal politicians alike (Jones, 1983: 37). Others, most notably the Labor Party, opposed the contributory insurance principle. Anxious to remove the taint of charity they argued instead for non-contributory insurance, although they generally concurred with the dominant principles of self-help and individual responsibility (Thame, 1974: 274-275; Jones, 1983: 37; Ternowetsky, 1983: 13). Still others argued against the provision of cash benefits outlined in national insurance in favour of direct services. Comprised of a key group of Commonwealth and state public health doctors, including J.H.L. Cumpston, J.S.C. Elkington, and Sir Raphael Cilento, the national hygiene movement argued political and economic conditions were the social manifestations of medical causes. Only medically controlled scientific courses of treatment delivered through state-subsidised hospitals in urban areas and a chain of public health laboratories in rural areas, not the payment of cash benefits, would reverse the social causes of ill health. This would change the focus of health from curative to preventative medicine.

Whilst the national hygiene programme amounted to the nationalisation of health it was a consequence of medical paternalism, not socialism. Collective responsibility for public health, population policy, and preventative health care – the central planks of national policy were – ‘assumed for the protection of the welfare of the state and not because persons who thereby received care were considered to do so as a right’ (Thame, 1974: 241). Thus health responsibilities would be transferred to the federal government, thereby centralising coordination and planning, and subordinating “curative” private practice to “preventative” health. It did not, however, require the abolition of the market, or radical reform of access to services (Thame, 1974: 302, 307; Gillespie, 1991: 32). This thinking underpinned the deliberations of the Joint Parliamentary Council on Social Security (JPCSS), which was established by the then conservative government in 1941 to discuss the future of social services, including health. Following the defeat of the conservatives in 1941 Labor continued support for the JPCSS. Indeed, weighed down by the War and economic concerns, Labor was content to leave health to the JPCSS. In 1944, however, Chifley moved to take control of health policy resulting in the marginalisation of the Committee. In spite of the socialist rhetoric of some Labor politicians, the radical reorganisation of the health
system was not Labor’s intention. Certainly ‘free’ public hospital accommodation was introduced, but it did not constitute a national or nationalised health scheme. Rather it formed part of a system of comprehensive social security cash benefits that supported Labor’s main objective – full employment. Essentially this accorded with traditional Labor practice (Smyth & Wearing, 2002: 226-243; Smyth, 2003). Moreover, it largely accorded with the preconciliar view of the Catholic Church, which makes the resistance of Catholic authorities somewhat inexplicable. Why, then, did the Church resist Labor’s proposal that would have enhanced the access of the sick, poor, and vulnerable to health care? Rather, Catholic concern focussed on the recommendations of the marginalised and discredited JPCSS, which Catholic authorities believed threatened the very existence of Catholic hospitals. This chapter attempts to throw some light on this fear by extending the examination commenced in Chapter Four. In particular it seeks to explore the specific circumstances and history of health in the 1940s, beginning with a brief account of two earlier attempts by social liberals to introduce national insurance, before proceeding to an examination of the resistance of Catholic authorities in the 1940s in Chapter Seven.

Royal Commission on National Insurance

Reform of the health care system throughout the nineteen twenties and thirties was dominated by a preference for contributory insurance and the payment of cash benefits. The 1923 Royal Commission on National Insurance, established by the conservative Bruce federal government, recommended the introduction of a contributory national insurance scheme that would provide sickness, invalidity, maternity and superannuation benefits. It did not consider, however, medical benefits or national health insurance. Instead, the Commission accepted the medical profession’s argument ‘that any system of national health insurance should be strictly separated from social welfare or national insurance to ensure a strong medical voice in its control and that it was not eroded by pensions or sickness benefits drawing on the same funds’ (cited in Gillespie, 1991: 43). Thus it referred consideration of medical benefits and national health insurance to the 1925 Royal Commission on Health (Thame, 1974: 302; Sax, 1984: 36).
**1925 Commonwealth Royal Commission on Health**

The *Commission on Health* did not directly address the matter of medical benefits or national health insurance. Mindful of the lack of constitutional power over health provision, the Commission turned its attention to the relationship between curative and preventative health, which amongst other things required co-operative planning and research. Thus it recommended the establishment of a national health council and a national research council. Moreover, it recommended the establishment of an hierarchical national public health network under the direction of the Commonwealth Department of Health. As Gillespie explains, this would set general policy objectives to be implemented by state health councils and regional district administrations. Public and private practice would be integrated through publicly-financed pathology laboratories, radiology clinics, baby and child welfare centres. These regional centres would provide the focus for co-ordinating the work of general practitioners and medical officers of health to bridge the sharp line between curative medicine and preventative health (1991: 44-45).

Each state would be divided into health districts comprised of local authorities controlled by full-time district medical officers who had expertise in preventive medicine. The districts would offer a comprehensive range of preventive and curative services subsidised by the Commonwealth. Private practitioners working under the supervision of the district medical officer and paid by the local authorities would have prescribed duties in relation to preventive medicine and public health. This reflected the influence of the national hygiene movement (Thame, 1974: 304-305; Sax, 1984: 38). Constitutional constraints on the Commonwealth’s role in health, and the unwillingness of the States to hand over their health powers, however, prevented realisation of the recommendations by the government (Thame, 1974: 303-307; Sax, 1984: 37-38; Gillespie, 1991: 36-48).

**1928 National Insurance Bill**

Whilst the *Commission on Health* did not directly address the matter of medical benefits or national health insurance the Nationalist/Country Party Bruce Government eventually provided for contributory sickness, invalidity, maternity and superannuation benefits in its 1928 *National Insurance Bill*. Doctors, once they realised there was no provision for a national health scheme or medical benefits, directed their attention elsewhere (Thame, 1974: 307-308). Others, however, condemned the Bill. Predictably the national hygienists, who by now controlled the
Commonwealth Department of Health, opposed the scheme. In their opinion the payment of cash benefits merely confirmed the existing pattern of medical services. Employers, worried that unions would argue for a wage increase to cover the compulsory employee contribution, decried the scheme as an additional cost on employment. Unions and employees objected to the Bill’s contributory nature, which they perceived as a reduction in wages. Moreover, it broke from the tradition of non-contributory, means tested benefits funded by government. Friendly societies, which covered approximately thirty-two per cent of the population, saw it as a threat to their viability. Still others saw it as an excuse for malingering. Finally the proposal aroused the opposition of the Catholic Church, which expressed concerns over the contributory nature of the scheme, the suggestion that health and medical services would be nationalised, and the links of national hygiene with fascism. Efforts to introduce the scheme, then, faltered on the opposition of employers, employees, the Department of Health, friendly societies, and, to some extent, the Catholic Church. In the face of such widespread opposition it died along with the Bruce Government, assisted no doubt by the onset of the Great Depression (Dewdney, 1972: 20-29; Jones, 1983: 38; Ternowetsky, 1984: 1; Gillespie, 1991: 37, 87-89).

1938 National Health and Pensions Bill

The next attempt to establish a national health scheme occurred in the 1930s. The conservative Lyons Government, concerned about the ‘financial implications of a “free” social security scheme and the desire to preserve the dignity and self-respect of the recipient of benefits by removing any suggestion of “charity”’ (Dewdney, 1972: 30), sought to introduce the contributory principle into social security arrangements. Thus it requested the advice of Sir Walter Kinnear from the British Ministry of Health. He opted for the transfer of British national health insurance practices such as means-tested panel practice, and the exclusion of hospital and specialist benefits, to Australia with little acknowledgement of either Australian practice or local political considerations. Furthermore, his proposed scheme extended the reach of taxation to a group of people not previously liable for any federal income tax; limited the range of benefits; excluded the self-employed, old age and invalid pensioners, the unemployed, and farmers; and, contrary to the practice of friendly societies, excluded dependents (Thame, 1974: 311-312; Jones, 1983: 43; Ternowetsky, 1984: 1; Gillespie, 1991: 90-93). Despite these deficiencies the report became the basis of the 1938 National
Having recognised the need for some form of state intervention, and concerned about the possibility that a Labor Government, if elected, would nationalise health, the Federal Council of the British Medical Association (BMA) – now the Australian Medical Association (AMA) – agreed to a modified Kinnear scheme. It provided for capitation or free treatment for those on the lowest incomes; subsidisation of private insurance to cover the fees charged to those on middle incomes; and no subsidy for the wealthier members of the community. The specialists, who dominated the Federal Council, however, had little knowledge of lodge practice or capitation arrangements that underpinned general practice. General practitioners believed these afforded too much control to mutual aid organisations, a situation they had long sought to overturn. The similarity of the proposed scheme to lodge practice exacerbated their concern. Moreover, its inclusion of more individuals and services appeared to extend the reach of lodge practice, and thus the power of friendly societies. Consequently general practitioners through the state branches of the BMA forced the Federal Council to rescind its agreement (Scotton & Macdonald, 1993: 7; Gillespie, 1991: 102).

Resistance, however, was not consistent. The NSW branch of the BMA, whose experience of lodge practice was not wholly unfavourable, did not totally reject the scheme. Victorian rank and file doctors, however, were less happy. Some, like William H. Fitchett, adopted a radically anti-statist line arguing national health insurance was ‘the first step on the slippery slope towards socialism’ (Gillespie, 1991: 102), an argument that resonated down through the years. Others were prepared to accept greater Commonwealth intervention so long as it destroyed the operations of friendly societies (Thame, 1974: 313-314; Gillespie, 1991: 89-105).

Concern was also expressed by other sections of the community. The ALP, and unions, argued health was a social obligation. Its cost should be borne by the community as a whole, not just employers and employees (Curtin cited in Commonwealth Parliamentary Debates, 1938, 155: 1329). Consequently they expressed concern about the regressive nature of the scheme, and its contributory nature. Nevertheless the Labor Opposition did not reject the proposed scheme. Indeed its reservations were minimised by the fact that the scheme ‘was national and
provided comprehensive services’ (Thame, 1974: 312, italics in original). In those States where hospital insurance schemes did exist, governments voiced concern that they would wither. This would then increase the demand upon state coffers. Friendly societies worried about the viability of their organisations. Employers and rural interests felt they had little to gain, yet they faced the prospect of increased costs. Moreover, the rural sector was concerned that its workers would join a union sponsored scheme placing them under the control of the powerful Australian Workers Union. Added to these concerns was the strong opposition of the Catholic Church, which attacked the contributory and centralising nature of the scheme. Underlying all of these concerns was a perception that centralisation of power in the state represented a threat to individual freedom, which the Government sought to placate through various means. Ultimately the Bill was passed into law, but events, including the outbreak, of World War II combined to defeat its implementation (Dewdney, 1972: 29-31; Thame, 1974: 312-318; Jones, 1983: 44; Sax, 1984: 39-42; Gillespie, 1991: 88-111).

**The 1940s**

During the nineteen twenties and thirties, then, Australia had witnessed two unsuccessful attempts to introduce national contributory insurance. Theoretically the emphasis on self-help and thrift in exchange for the payment of cash benefits underpinning the two schemes satisfied the demand for support during crises, whilst minimising the level of state responsibility. In practice both schemes provided inadequate access to care, especially for the poor who were forced to rely on a parsimonious state. Moreover, both were widely condemned by various interests, including Catholic authorities. In particular they expressed concern about the regressive and contributory nature of social insurance. At the same time the national health hygiene movement proposed a national health scheme administered and managed by government. The outbreak of the Second World and the election of the 1941 Labor Government provided the national hygienists with an opportunity to introduce an alternative to contributory national insurance. The scheme, however, became the focus of Catholic concern.
National Health and Medical Research Council

Although preoccupied with the war effort, the Menzies led coalition government commenced planning for post-War social reconstruction in 1941. At the instigation of Cumpston, now head of the Commonwealth Department of Health, the National Health and Medical Research Council (NHMRC) was given the task of planning a comprehensive health scheme independent of other government departments and agencies. This effectively separated health and social security policies. A draft report, *Recommendations of the National Health and Medical Research Council*, was forwarded to Cabinet in July 1941. It argued health care was a social duty not merely an individual responsibility. Therefore it recommended centralised planning and control, the provision of direct services under the control of the state, the replacement of private practice with a salaried service, and taxation of the whole community, not contributory national insurance, which merely subsidised illness. Essentially the report articulated the national hygiene agenda, arguing as it did for the re-organisation of health services to serve the aims of national policy, and the achievement of national efficiency. It was not, contrary to later assessments, an attempt to socialise medicine. Rather the NHMRC used the *Recommendations* in an attempt to shift planning and co-ordination of health services into the hands of government medical and public health officials, and subordinate general practice to the needs of centrally controlled public health policy. This would place national health policy on positive foundations, but would also avert the danger of health being subsumed into wider welfare schemes, a concern shared by the BMA (Gillespie, 1991: 131-142).

Joint Parliamentary Committee on Social Security

In an attempt to bolster support for the war Sir Frederick Stewart, an exponent of national insurance, recommended the introduction of a compulsory insurance-based comprehensive social security programme. On his advice Cabinet referred the matter to the JPCSS, which met for the first time in July 1941. It examined the introduction of a contributory social security programme as suggested by Stewart, but it also requested a costing of the NHMRC *Recommendations*. The ensuing report, *Outline of a Possible Scheme for a Salaried Medical Service*, reiterated the approach of the *Recommendations*, but contrary to the earlier report it defined the powers of the Commonwealth by nominating the Department of Health as administrator of the service (Gillespie, 1991: 142-143). Two months later the Curtin Labor Government
assumed office. It continued support for the Committee, but preoccupied with problems created by minority support, a hostile Senate, and a crisis in war finances, it left health policy to the NHMRC. Consequently the view of the national hygienists informed the JPCSS deliberations on health.

Three of the eventual nine reports of the JPCSS – the *Sixth* (1943), *Seventh* (1944), and *Eighth Reports* (1945) – related to health and hospital services, but the *Fifth* (1942) was also relevant. It dealt with social security in its broadest sense and strengthened support for planning for post-War reconstruction during the course of the War (Sax, 1984: 50). The reports moved debate away from reliance on individual responsibility that linked entitlement to benefits based on contributions – a characteristic of the national insurance schemes of the 1930s – towards an assumption of collective responsibility financed through the tax system (Gillespie, 1991: 142). Moreover, they legitimised the call for a network of public hospitals and clinics to support public health services. This was given a boost when Chifley, late in December 1942, requested JPCSS advice on what measures might be introduced during the course of the war. The task was delegated to Cumpston who proposed the formation of a joint NHMRC and BMA council to supervise the reorganisation of hospitals in remote regions, and the introduction of salaried services. He anticipated that planning would commence immediately, but the full-scale reconstruction of the health care system would be delayed until after the War. Some measures, however, were to be implemented in preparation for the post-War reorganisation. These included the establishment of a small expert committee to survey existing hospital services and report on the logistics of transferring the control of hospitals from the states. This would be necessary for the creation of a unified system, i.e. for the nationalisation of hospitals (Gillespie, 1991: 146).

**Medical and Hospital Survey Committee**

Cabinet, influenced by Chifley’s emerging concern over the independence of the JPCSS, reluctantly supported the establishment of the Medical and Hospital Survey Committee (MHSC) in March 1943. Headed by Dr Alan Lilley, the Committee comprised Sir Raphael Cilento, Director-General of Queensland Health, Arthur Brown a Victorian GP and supporter of salaried services, Frank McCallum from the Department of Health and Cumpston’s deputy, Agnes Walsh a West Australian
matron, and Herbert J. Goodes the co-ordinator of social security planning in the Treasury. The purpose of the Committee was to provide the factual data that would enable the JPCSS to consider proposals for comprehensive health services for Australia (NAA: A461/9, k347/1/2), which included a survey of the distribution and adequacy of hospital, medical and outpatient services. Furthermore, it was asked to provide an assessment of the ‘Practicability of introducing a Commonwealth wide hospital benefit scheme on grant-in-aid or subsidy under existing hospital facilities, or alternatively, what additional facilities would be necessary’ (NAA: A461/9, k347/1/2: 2). Whilst the Committee dealt with the development and integration of hospitals in some detail, the work on benefit schemes undertaken by Goodes was seen as less pressing. Even though he warned ‘free’ public ward accommodation would place strains on public hospitals, the Committee’s report simply noted the administrative difficulties of instituting a national scheme of hospital benefits and referred it to the States and Commonwealth for discussion (Gillespie, 1991: 144-150).

Sixth Interim Report

Two JPCSS reports – the Sixth and the Seventh – and the MHSC survey, became the focus of Catholic resistance to Labor’s national health scheme, a response that is more fully developed in the next chapter. The Sixth Interim Report, which was tabled in July 1943, reached several conclusions that aroused the concern of Catholic hospital authorities. First, having noted the poor standards of most hospitals identified by the MHSC, the Report proposed the standardisation, classification and regionalisation of hospitals, improvements in facilities for the transport of the sick, and decentralisation of outpatient clinics (NAA; PP, Sixth Interim Report, JPCSS, 1943, #145-149: 16). Secondly, it recommended that the comprehensive health service should be controlled and financed by the Commonwealth, although it noted that a determination had yet to be made on the mechanism of control. Nevertheless, it suggested two options. In the event of a transfer of power from the States to the Commonwealth the latter could directly administer the scheme or delegate authority to the States. If power was not transferred, then the Commonwealth should establish the broad principles and standards necessary for a health service, which would be implemented by the States, and supported by the provision of Section 96 grants. The Government subsequently adopted this is option in December 1943 (NAA; PP, Sixth Interim Report, JPCSS,
Seventh Interim Report

Whilst the composition of the JPCSS remained essentially unchanged, relations with the Government, which are discussed below, had deteriorated to the extent that Chifley marginalised the Committee. Nevertheless, this did not prevent the JPCSS from tabling further reports, including the Seventh Interim Report in February 1944, the basis of which was the report of the MHSC. Although sceptical about the value of cash benefits the JPCSS recognised the changed political climate and acceded to Labor’s wish for a hospital cash benefit programme that would sit within the social security system (JPCSS, CPP, 1943-5: ii, 922; NAA; PP, Seventh Interim Report, JPCSS, 1944: 3-4; Gillespie, 1991: 160). The report, then, clearly signalled Labor’s departure from NHMRC and JPCSS plans for an integrated comprehensive national health service. Instead the JPCSS recommended ‘free’ hospitalisation in public ward beds for patients electing to be treated as public patients and reduced fees for non-public patients. Moreover, the report recommended an income support programme paid as tied grants to the States; an indirect patient subsidy of 6/6 per bed per day for all public; intermediate and private beds in return for free public hospitalisation; and reduced fees for intermediate and private patients. In order to prevent the absorption of this subsidy into state or hospital budgets, the States were required to abolish all means testing for public wards. In recognition of the deficiencies identified by the MHSC the report deferred the payment of the subsidy for the first year and required Commonwealth approval for the participation of hospitals in the scheme. Both measures were designed to raise standards. The deferred subsidy would be paid into a trust fund for capital expenditure on hospitals identified as below standard, which would be managed by a committee of experts. Commonwealth approval would depend on the raising of hospital standards, a strategy particularly designed to address standards in the private sector. Both these proposals raised particular concerns for Catholic authorities. Whilst these will be developed in the following chapter it is sufficient for the present to note that Catholic authorities objected to the lack of representation from religious or charitable hospitals on the committee of experts. Moreover, they feared the deferral would financially disadvantage their hospitals, as

Commonwealth co-ordination of hospitals and groups clinics, which integrated general practice, specialists and public health financed by a tax on incomes, provided the basis of the Committee’s Report (NAA; PP, *Sixth Interim Report*, JPCSS, 1943, #143: 15). Mindful of the opposition that such a proposal might arouse, the Committee advised that any changes should be ‘by evolutionary developments over a period of years’ (NAA; PP, *Sixth Interim Report*, JPCSS, 1943, #143:15). It did, however, recommend that discussion with interested parties should commence so that ‘as and when the war situation permits’, the agreed scheme could be ready for implementation, a recommendation picked up by Chifley and delegated to Cumpston. The request, however, exposed widespread discontent. The NHMRC executive raised concerns about the complexity of reconfiguring the health care system over the short time period suggested by Cumpston. Furthermore the Commonwealth’s constitutional powers were unspecified thus the survey of medical and hospital services, and the implied nationalisation of hospitals inherent in Cumpston’s request, were premature. The Council advised that no action should be taken until after the Constitutional Convention scheduled for later in the year. Conservative state governments opposed the transfer of power, whilst the BMA denounced Cumpston’s advice as a breach of the promise made by the Minister for Health that the Government would not precede with changes to medical practice until after the War (Holloway cited in Gillespie, 1991: 144). The need to implement as many aspects of its policy before the return of soldiers, however, saw the government introduce the hospital benefits scheme and a pharmaceutical benefits scheme (Sax, 1984: 50; Gillespie, 1991: 209-211, 146-147, 166-194). Catholic authorities, fearful for the existence of their hospitals, voiced strong concerns about the hospital benefits scheme, a concern that will be further examined in the next chapter.

**The transfer of powers**

The chance to implement a national health scheme appeared to improve with a request for the transfer of state powers to the Commonwealth, which included the transfer of health powers. Its absence had been identified as an impediment to the implementation of a national health scheme (NAA; PP, *Sixth Interim Report*, JPCSS,
Resistance, however, forced the Commonwealth to compromise. In December 1942 a Constitutional Convention failed to produce the voluntary transfer of power. Moreover, the power in respect of national health was referred to the Commonwealth ‘in co-operation with the states’, a referral that would not allow the institution of the NHMRC scheme. A year later the Commonwealth and State Ministers for Health agreed to proceed with the national health scheme in which the Commonwealth would ‘lay down the broad principles of a health service and general hospital standards, and subject to acceptance of these principles and standards, will finance the States under a system of grants-in-aid, in order that uniformity in health services and hospital standards may be established generally throughout the whole Commonwealth’ (NAA: PP, *Eighth Interim Report*, JPCSS, 1945, Appendix A, #16: 22). This included the administration of hospital benefit schemes (Gillespie, 1991: 156). Whilst this moved some of the way towards a national health scheme, it left the states in control, a position that also held true in relation to the other powers sought by the government. Thus the Government called the 1944 Post-War Reconstruction and Democratic Rights referendum to authorise the extension of the government’s constitutional authority up until five years after the end of the war (Gillespie, 1991: 156). The transfer of powers, however, was perceived as socialist in intent. Consequently the referendum was defeated along with efforts to implement the national health scheme (Sax, 1984: 52; Gray, 1991: 63).

**A change in direction**

As has been shown the Labor Government, preoccupied with the demands of the War, was initially prepared to leave health to the JPCSS and the NHMRC. In October 1942, however, Chifley combined his duties as Treasurer with the Ministry of Post-War Reconstruction thereby providing Treasury with considerable power over welfare policy, and ultimately health. Under the influence of Treasury it ‘became incidental to wider fiscal and social goals’ (Gillespie, 1991: 155). Medical programs became one part of a comprehensive social security scheme funded by the extension of taxation to the working class. Cash benefits would supplement the incomes of those most in need, deliver minimal costs for consumers, and enable government to control costs. Labor, then, opted for income support, a clear contradiction of the NHMRC recommendations. Little attention was directed to the organisation and control of health practice, an omission attributable to several factors.
First, the payment of cash benefits reflected Labor concern with questions of access rather than addressing the causes of inequality. Traditionally Labor supported the payment of a decent minimum wage that would enable individuals and communities to provide for their own needs leaving the state to provide a safety net: to be the place of last, not first, resort (Smyth & Wearing, 2002: 226-234). Secondly, there was general support for costly cash benefits that involved little planning or threat from government interference. Generally speaking the Australian population welcomed the payment of cash benefits despite their cost because they did not disrupt private supply agencies such as the medical profession. This may partly be explained by the historical dislike of state intervention, which – together with the increasing weariness of government rations and control – may explain the later resistance to the proposed extension of government control beyond the War, especially over banking, employment, and housing (Jones, 1983: 54). Thirdly, the locus of control had shifted from the Department of Health and the NHMRC to Treasury, which was more concerned with the need to dampen inflationary pressure arising from consumer demand in the overheated war economy. Extension of income tax to the previously untaxed working class, although at odds with traditional ALP opposition to regressive contributory insurance, would ostensibly achieve that end (Sax, 1984: 50; Gillespie, 1991: 130, 145, 155).

Importantly, Smyth notes, Labor was preoccupied with the achievement of full employment, which was perceived as the route to social security. A lessening of the demands of war, and a change in political circumstances, allowed Chifley to concern himself with the direction of social security policy and post-War reconstruction. Contrary to criticism, the government was not intent on the total reorganisation of the health system or the socialisation of health. Rather it was intent upon the creation of full employment supported by social security benefits. Its preference was for the ‘economic state’ in which the economy was managed to eliminate unemployment with redistribution through the ‘wage’ system ‘backed by nationally provided cash social service benefits’ (Smyth & Wearing, 2002: 230). For Labor, then, the purpose of social services was to ‘plug the gaps in full employment’ (Smyth, 1994: 54).
1945 Hospital Benefits Act

Anxious to expand equity of access without causing financial chaos, Labor opted to retain existing arrangements, and improve access through the provision of income support, which it articulated in the Hospital Benefits Bill. Thus it endorsed the subsidy recommended by the JPCSS, but reduced it to 6/- per occupied bed day for all patients who elected public ward accommodation, whether located in public or private hospitals, on condition the States abolished the means test. The health ministers from Queensland, Tasmania and West Australia supported the provision of free public-ward care, the South Australian minister agreed to present the proposal to his government, and the NSW minister, worried about the heavy demand for free care, argued for the retention of the means test, a position held also by Catholic authorities. Chifley dismissed this request on the grounds that the ‘better off’ would continue to opt for intermediate and private accommodation, and indeed would use their subsidy to support that accommodation. Only the Victorian minister failed to endorse the agreement. Further discussions were held at the August 1944 Premiers’ Conference where NSW and Victoria again expressed opposition. NSW had little to gain financially, but Victoria was opposed to the principle of the scheme, no doubt influenced by its greater reliance on fees. Despite objections the Hospital Benefits Bill became law in 1945 and the scheme became operational in 1946 (Gillespie, 1991: 196-203; Gray, 1991: 72-73).

Chifley was not intent on the nationalisation of health, but rather the subsidisation of access to health care for all citizens. Catholic authorities, however, were not convinced by government declarations of support for the dual system of hospital provision. Indeed they were convinced that the payment of the public bed subsidy and the removal of the means test compromised the viability of intermediate and private beds. So strong was this concern that the government extended the subsidy to private patients to counter the concern. This, however, was not the extent of Catholic concern. Rather Catholic authorities, along with the states, were also concerned about the loss of control over fees and admissions policies; the inadequacy of the bed subsidy to meet the necessary level of hospital services (let alone improve and expand those services); an expected fall in charitable donations that would not be fully compensated by the Commonwealth; and, the demise of hospital contributory

The introduction of ‘free’ public hospital accommodation did not survive the end of Labor rule. Nevertheless it was the only part of the Government’s scheme that came into operation during its time in office. Despite the lack of constitutional power, Labor was, via the provision of a subsidy, able to enter into agreement with the States to provide for free hospitalisation for patients admitted to public beds in public wards in exchange for the abolition of the means test. Although Thame’s claim that it ‘finally destroyed the charitable basis of public hospital care’ (1974: 292) goes too far, as the subsequent re-introduction of fees and the means test would reveal, the Act did seriously challenge the basis of access.

By financing the scheme from consolidated revenue funded by progressive income tax, the government was upholding the redistributive principle that each member of the community should provide according to his means for the health needs of his fellows and that each had the right to receive such hospital care as was considered necessary, irrespective of cost. Finally, by providing care for the whole community the state was assuming responsibility for the treatment of all varieties of disease and all groups within the population rather than for only those diseases which constituted a direct threat to progress or for those persons whose welfare was of particular value (Thame, 1974: 292-293).

Nevertheless, the Act did deviate from NHMRC and JPCSS advice, particularly as articulated by the Sixth Interim Report. It was also limited by the lack of constitutional power and Treasury’s opposition to increased capital expenditure.

By retaining the existing structure, and opting for improvements in access through the reduction of financial barriers, Labor compromised the achievement of the goals espoused by the national hygienists. Capital and recurrent expenditure was left in the hands of the States, which overcame constitutional impediments, but removed the possibility of a national co-ordinated approach to the delivery of hospital services. The Act did not result in the administrative co-ordination of hospitals and group clinics, the integration of ‘curative’ and ‘preventative’ health, or the introduction of a salaried medical scheme. Rather it reflected Labor’s traditional practice: the payment of cash subsidies to improve access, in this case the payment of indirect income subsidies for beds, and the removal of the hated means test. According to Gillespie,
far from seeking the re-organisation of the health care system, the Act ‘was part of a
more general Labor commitment to universalism, towards eliminating the taint of
pauperism by dismantling restrictive means tests, extending access to the public
hospital system to all: “only one phase of a wider matter [as] the whole trend of
opinion today is leaning towards abolition of the means test in all the social services”’
(Gillespie, 1991: 199). It was, then, concerned with the creation of a ‘welfare
society’, not a ‘welfare state’, an approach consistent with the findings of Esping-
Andersen, Castles, van Kersbergen and Smyth outlined in Chapter Five.

Medical Planning Committee
Despite the growing rift with the Government, the JPCSS convened a Health Services
Conference in December 1943 at which it established a joint Medical Planning
Committee (MPC) to report on the general principles of a comprehensive health
service. Its status, however, was ambiguous. Not only was it not approved by
Parliament, but it also reported directly to the JPCSS, not the Health Services
Conference. Despite these irregularities the MPC presented a report, approved by the
Federal Council of the BMA, in March 1944. It recommended the establishment of
experimental group practices in each state staffed by part-time salaried private
practitioners as a precursor to the introduction of a national scheme. More
importantly it recommended that government should control non-medical
administration and finance, supply the clinics, and pay sessional fees, but, contrary to
Government policy, the medical profession should control the clinics and group
practices. It made no recommendation as to whether services should be accessed free
of charge or on a fee-for-service basis (Thame, 1974: 324-325; Sax, 1984: 52-53;

Eighth Interim Report
By the time the Eighth Interim Report was published in June 1945 it was obvious that
relations between the Government and the JPCSS had soured, so much so that the
JPCSS delivered a rebuke to the Minister for Health in its conclusion (NAA; PP,
Eighth Interim Report, JPCSS, 1945, #71: 17). The Report did not further debate but
simply summarised the findings of the MPC. It did, however, upset the Government,
not the least because it recommended medical control, a view contrary to the
Government’s decision to nationalise the medical profession, albeit by evolutionary
means. Contrary to the claims of critics this was not driven by socialism. Certainly, the government was guided by the principle of redistribution, and it supported the non-contributory principle, but it was not intent upon the complete reorganisation of social relationships. Nor was it intent on the creation of a socialist state (Thame, 1974: 326). Rather, the government intended to introduce a complete and free medical service that would allow every person access to doctors and other ancillary services without direct charge or regard for his/her economic status. Its successful introduction required not only control, but also regulation of medical incomes, both of which would be realised through the establishment of a national salaried medical service. The Federal Council of the BMA, however, argued for the provision of a medical service funded by a voluntary, state subsidised, but not controlled, insurance scheme, ostensibly in the interests of maintaining the doctor-patient relationship. It would be based upon the retention of private practice, and medical control. Thus services would be available to all, but be controlled by doctors (Thame, 1974: 320-321; Sax, 1984: 47-49; Gillespie, 1991: 166-185). The JPCSS support for this position sealed the fate of the JPCSS. Chifley, and the Treasury, armed with the identification of procedural irregularities in the formation of the MPC, moved first to discredit, and then end, its influence (Thame, 1974: 324-327; Gillespie, 1991: 160-161).

At the same time as relations between the JPCSS and Government soured so too did relations between the Government and the BMA, which was not helped by the Minister for Health’s statement at a conference called to discuss the implementation of a national medical benefits scheme in June 1944. Alan Fraser, the then Minister, declared whatever the conference decided ‘the Government, intends to give a free medical service to the people of this country. That is a basic principle. Therefore, we can dispense with discussion in regard to the subsidizing of medical practices (Fraser cited in Thame, 1974: 326). Chifley compounded the situation by stating the Government would ‘have to seek for other means to achieve our object’ (Chifley cited in Thame, 1974: 326) if faced with medical intransigence. The doctors countered that the Government’s intention to establish a full-time salaried service, albeit an evolutionary process, contravened assurances that the government would not proceed with any major changes until the end of the War. It was ‘the “thin end of the wedge”, which would lead to a socialist system of medical care’ (Sax, 1984: 54). Whilst this
was not Labor’s intention, the BMA charge highlighted the differences surrounding the merits of supporting access to health care via the payment of contributions or government provision. Supporters of contributory insurance, which included Catholic authorities, argued the payment of contributions encouraged self-reliance, thrift and independence. Supporters of the latter, most notably the Labor Government, argued contributions unduly burdened low-income groups. They, and the community, would be better served if ability to pay was taken into consideration and benefits derived from general revenue (Thame, 1974: 322-323; Sax, 1984: 50-51, 53; Gillespie, 1991: 145-147, 186-194; Gray, 1991: 66).

The Pharmaceutical Benefits Scheme
As a consequence of government mishandling of the medical profession, the failure to secure constitutional power over the regulation of fees, and increasing worries about the inflationary impact of large spending programs, the Chifley Government repeatedly postponed the introduction of its medical benefits scheme. Its introduction was further delayed by the acrimonious dispute with the BMA over the introduction of the Pharmaceutical Benefits Scheme (PBS) in the latter half of the nineteen forties (Gillespie, 1991: 233-234). Its purpose was to provide patients with ‘free’ medicines, materials and appliances listed on a government formulary. The BMA, however, was concerned that the scheme was the precursor to a national salaried medical service. Thus they opposed the introduction of the PBS. Fearful, however, they would face political isolation if they campaigned against the provision of free medicine; the Federal Council adopted an anti-socialist stance. It highlighted Commonwealth control of the scheme, bureaucratisation, and the threat to the freedom of doctors by interfering with their prescribing rights. Moreover, Government tactical blunders fuelled medical opposition. Whilst the introduction of the PBS would enable the government to make a start on the introduction of a ‘free’ national health service before the end of the War it lacked the technical expertise, staff, and resources necessary for its introduction. It also underestimated the level and breadth of resistance, preferring instead to railroad the profession into acceptance of the scheme by adding even stronger regulations. Finally, the Government ignored a warning that the Bill went beyond the Commonwealth’s constitutional power. This eventually proved the undoing of the scheme when the High Court ruled in 1945 that the Commonwealth did not have the constitutional power to provide or finance health services. Together these factors
heightened concern about the Government’s centralising tendencies, a concern that was of vital interest to Catholic authorities.

**1946 Constitutional amendment**

Fearing that other social security benefits might also be ruled unconstitutional, Labor called a referendum in 1946 to seek a constitutional amendment to empower the Commonwealth to make laws with respect to ‘the provision of maternity allowances, widows’ pensions, child endowment, unemployment, pharmaceutical, sickness and hospital benefits, medical and dental services (but not so as to authorise any form of civil conscription), benefits to students and family allowances’. In effect it gave the Commonwealth wide powers in relation to health. Not only did it allow cash benefits, benefits in kind and the direct provision of services, it also enabled the Commonwealth to determine the form of administration of any scheme designed to provide benefits or services and the method of financing. Furthermore it enabled the establishment of health institutions by the Commonwealth (Sax, 1984: 55; Gillespie, 1991: 164, 222-223; Gray, 1991: 64). The success of the referendum question, however, was not without its drawbacks. Whilst the amendment enabled the Commonwealth to provide a wide range of welfare services, these either had been or could be, implemented in co-operation with the States. The bracketed words, however, formed the basis of the case against the Labor Government’s Pharmaceutical Benefits Act described above (Dewdney, 1972: 34-35; Thame, 1974: 330; Sax, 1984: 53-55; Gillespie, 1991: 164, 223; Gray, 1991: 63-65).

**Mounting opposition**

By 1944 the electorate had begun to show signs of disquiet over government controls. Prepared to accept controls during wartime it became progressively concerned about centralisation of power in the hands of the Commonwealth, and the proposed extension of controls beyond the War. Support for radical reform, which was linked to socialism, fragmented in the face of opposition that included the Catholic Church. Moreover, it was not assisted by the ineptitude of government handling of the medical profession. Largely preoccupied with economic concerns, the Labor Government misread the changed political context, which enabled the profession to capitalise on what was perceived as the totalitarian intent of Government policy. Although ‘socialised medicine’ peppered Labor Party discussions, the reality was far from
practice. Rather Labor opted for traditional practice, the payment of cash benefits not
direct services, an option that was also influenced by the Government’s desire to
control costs. Ultimately the Government abandoned its national salaried medical
scheme introducing instead the National Health Service Act.

Attempts to introduce the PBS were played out against the Government’s 1946 advice
to the BMA that it would introduce ‘a complete medical service … to every person
without any direct charge and without regard to his economic status’ (cited in
Dewdney, 1972: 36). Whilst the BMA rebuffed initial invitations to discuss the
proposal, they did accept an invitation to attend a conference in 1947. Senator
McKenna, the new Minister for Health, proposed a national health scheme based on
capitation fees and salaries for doctors. Whilst representatives of the BMA agreed to
attend, they made no commitment to co-operate in the implementation of the scheme.
No doubt their position was influenced by the Minister’s declaration that the
Government’s ultimate intention was to abolish private practice. Instead the
profession reiterated its opposition to government control, confirmed their support for
fee-for-service and freedom of choice, and argued for contractual relations between
doctor and patient not doctor and government (Dewdney, 1972: 36; Thame, 1974:
335; Sax, 1984: 57-58). In this, the Catholic Church supported the medical
profession.

A month later the profession established the NSW Medical Benefits Fund based upon
the professions’ belief that individuals should retain some responsibility for the
financial costs of their treatment. Approximately two-thirds of the fee was
recoverable, but benefits were determined by a schedule. As no control was exercised
over fees set by doctors, the level of benefit could not be assured, thus undermining
the effectiveness of the scheme. Its popularity did not increase until the introduction
in the 1950s of a subsidy by the recently elected Liberal-Country Party Government.
Other States soon followed the NSW example. Doctors were thus able to assuage a
community denied ‘free’ national medical services by instituting their own scheme or
convincing others, most notably Friendly Societies, to introduce similar schemes
(Thame, 1974: 335-336). Such schemes emphasised the notion of “deservingness”,
rewarding those who were thrifty and independent. The Government noted that it was
possible to provide against short periods of economic stress by personal endeavour
but, contrary to the profession’s view, argued that the individual could not provide against the crippling costs of prolonged illness (Gillespie, 1991: 233). Unable to achieve a negotiated agreement the Government enacted the *National Health Service Act* two months prior to its demise.

**The National Health Service Act, 1948**

The *National Health Service Act* was wide-ranging in its provisions although its implementation would take several years. It required the co-operation of the states and doctors, but enunciated the Government’s long-term objective to assume administrative control over the organisation and management of medical and hospital services in exchange for increased funding. Universal availability would be accompanied by increased state control. The proposed Medical Benefit Scheme, however, abandoned salaried practice in favour of a modified fee-for-service scheme, although a schedule of fees would be instituted to control costs and abuse. Contrary to earlier plans, patients would be required to make a co-payment amounting to one half of the medical fee. Thus the Government succumbed to opposition by conceding salaried service and accepting the demand that individuals bear at least some of the financial responsibility for their treatment. In spite of these concessions doctors, buoyed by the success of their campaign against the PBS, remained steadfast in their opposition to the introduction of any national scheme controlled by the state. Whilst the *Act* retained Government administrative control, in effect it removed the redistributive elements of Labor’s wartime policy, reducing it to a subsidised fee-for-service scheme. Doctors had acknowledged that some form of state subsidisation was necessary, but they held out for, and won, a scheme that accorded with their interest. Access would not be ‘complete’ and ‘free’, but dependent upon individual initiative and thrift. Rather than universal coverage, individuals would be ‘free’ to provide for their own health needs (Dewdney, 1972: 37; Thame, 1974: 336-338; Sax, 1984: 58; Crichton, 1990: 39-41; Gillespie, 1991: 233-249). So ended the period of attempted reform by the Labor Governments of Curtin and Chifley. The failure of the reforms was a consequence of several factors, including medical opposition, constitutional constraints, economic concerns, and Government ineptitude. More importantly for this thesis it was, to some degree, also a consequence of Catholic opposition, a stance that will be discussed in the following chapter.
Conclusion

Plans for a national health service based on salaried practice, and the integration of curative and preventative health, despite Government rhetoric, were effectively abandoned during 1943 and 1944 in favour of the payment of social security cash benefits. In the process the radical, but non-socialist critique of medical practice, expounded by first the NHMRC and then the JPCSS, fell into disrepute. Labor’s decision to base the health scheme on cash benefits embedded in a wider social security programme reduced state intervention to the improvement of access only. As Gillespie puts it, this fitted ‘squarely in a long Labor tradition of concern for the material well-being of the sick by establishing equality of access to medical care, destroying the stigma of charity, and providing income support for those temporarily incapacitated through illness (but it failed to recognise) that equality of access involved more than the destruction of financial barriers’ (Gillespie, 1991: 131).

Nevertheless the centralisation of power contained in the JPCSS reports continued to arouse dissatisfaction, a concern that was not dissipated by the introduction of ‘free’ public ward accommodation, a matter of particular concern for the Catholic Church. The failure to introduce a ‘free’ national health service in the 1940s was influenced by several factors. First, the Commonwealth lacked the constitutional power to impose a national solution. This power rested with the States and, jealous of their rights, they were prepared to co-operate only on those matters that did not threaten their power or their rights. Secondly, doctors had successfully aligned the profession with conservatism. Together the profession and the Opposition played on the widespread fear of communism, a concern that was also expressed by other powerful groups including the Catholic Church. Attempts to nationalise medicine added fuel to anti-socialist sentiment, which was not helped by Government attempts to nationalise the banks, growing concern over the centralisation of power in Canberra, the proposal to extend wartime powers beyond the War, and the growth of communism within the labour movement (Sax, 1984: 58-59). Thirdly, blunders by the Chifley Government, and its failure to counter the tactics of the medical profession enabled doctors to block any changes that would threaten their control of the health care system (Crichton, 1990: 40, 233-249). Indeed their influence was extended through the 1946 Constitutional amendment.
Fourthly, rhetoric surrounding the development of a national health service obscured the fact that the Labor Party, which held office from 1941 to 1949, was advocating a series of national services – a national medical service, a national hospital service, and a national pharmaceutical and dental scheme – not a comprehensive national health care scheme. Indeed Labor was committed to an ‘economic’ or ‘welfare society’ that sought to address the question of inequality through the generation of full employment, which would expand access to the economic cake (Crichton, 1990: 40-41; Gray, 1991: 62; Smyth, 1994; Smyth, 2002: 429). Social ‘services … were but complementary to Labor’s primary policy for social security, full employment – to be achieved through bringing the private economy under effective government management’ (Smyth, 1994: 54). Despite calls for the introduction of a national health scheme funded out of general revenue, the Government instead opted for low-cost, means-tested, non-contributory, cash benefits (Jones, 1983: 50-51), and the introduction of ‘free’ public beds, a strategy that accorded with previous Labor practice. Nevertheless, the centralisation and bureaucratisation implicit in the scheme – and the location of control in a government department – provoked criticisms from interested parties, including Catholic authorities, which will be explored in the next chapter (Gillespie, 1991: 182-185).

By 1949 the Government’s term of office was rapidly coming to an end, as was Labor’s plan for the introduction of a ‘free’ national and comprehensive health care system. It fell, along with the Government. Conservative politicians and doctors, along with Catholic authorities, deemed Labor’s plan to be a communist plot to abolish the free market, undermine individual freedom and choice, and destroy the relationship between doctor and patient by making both the servants of the state. Moreover it would centralise control over medico-moral issues in a Godless state, and abolish private hospitals. Instead opponents argued for hospital and medical services financed by private contribution – voluntary health insurance – and the maintenance of subsidised philanthropy for those unable to provide for themselves or their families. Chapter Four examined the social and political context that framed Labor’s attempt to introduce a national universal health insurance scheme, a task furthered by the specific focus on the 1940s adopted in this chapter. It is now time to turn to an examination of the resistance of Catholic authorities to Labor’s national health scheme in an effort to
establish the rationale for that resistance, a rationale that Esping-Andersen, Castles, van Kersbergen and Smyth argue is conservative.