CHAPTER SEVEN

THE CATHOLIC CHURCH’S RESPONSE IN THE 1940s

Introduction

The previous chapter indicated that the Australian Catholic Church resisted the introduction of Labor’s national health scheme in the 1940s. This chapter provides a detailed examination of that resistance. In particular it examines whether the Church’s stance can be explained by the ideas of Esping-Andersen, Castles, van Kersbergen, and Smyth. As outlined in Chapter Two, care of the sick and vulnerable is consistent with the mission of the Catholic Church and in accordance with Catholic social teaching. Early in the 1930s Philip Bernardini, the Apostolic Delegate, outlined to the Bishops of the Australian Province that:

the end which a Catholic Hospital sets before itself and for which it alone is sanctioned by the Church is a spiritual one, to be achieved especially through the free care and service of the sick call … No one should be debarred from our Hospitals because they have not the means to pay, nor should the poor be forced to seek the help they need in civil hospitals through the fact that beds are reserved in our hospitals for those only who can pay … It is … an institution of charity in the fullest and most Catholic sense of the word from which nothing is more abhorrent than any taint of commercialism or indeed of the spirit of the world in any form (SAA, Box L3314, File 2, No 21).

Certainly Catholic hospitals ‘must enjoy the confidence of the community (but) … the technical element must not be allowed to predominate to the detriment of the moral’ (SAA, Box L3314, File 2, No 21). Thus Catholic hospitals must control the appointment of staff, or have the power to veto appointments. Indeed this must ‘be regarded as a “sine qua non” condition for every hospital that wishes to be recognised as Catholic’ (SAA, Box L3314, File 2, No 21).

According to Bernardini, assurance of the charitable and moral status of Catholic hospitals rested upon the independence of Catholic hospitals; independence, presumably from dominance by the state, professional bodies or workers’ unions. The establishment of Catholic hospitals, like Catholic schools, however, was also informed by a fear that the Catholic community would suffer, if not disintegrate, if it was exposed to outside and hostile influences (Hehir, 1995: 19; Smyth, 2003: 21-22). Only institutions under the control of the Church, free from state interference, could
protect the souls of Catholics. Certainly patients and staff of any creed were accepted, but the hospitals were directed primarily towards the preservation of the Catholic community, a goal realised through mutual aid and support, not acceptance of government funds.

The rise of communism, both in Australia and overseas, made Church authorities even more wary of accepting government funds, and even more importantly, it inclined those same authorities to resist proposals, such as the national health scheme of the 1940s, which enhanced the role of the state. Indeed O'Farrell has argued that the ‘frontal conflict between Catholicism and communism … was to dominate, almost exclusively, the social thinking and apostolic energies of Australian Catholicism’ (O'Farrell, 1977: 389). In particular the Church feared that domination by the state would be an inevitable outcome achieved by indirect means, namely legislation and/or ‘benevolent despotism’ exemplified by the ‘Servile State’, or directly through a communist revolution. Support for the latter was provided by the communist infiltration, and the perceived takeover, of the Australian labour movement, and events in Europe (Duncan, 2001). The socialist rhetoric of the Labor Party, its efforts to extend and expand Commonwealth powers, and its attempts to nationalise various industries during the 1940s, including health, were cited as evidence that Labor was intent on the creation of a socialist state. Whilst the electorate was willing to tolerate centralisation of power and bureaucratisation of life during WWII, this did not extend to sanctioning Labor’s proposal to continue those same government controls beyond the War. Clearly the electorate believed that this ran the risk of producing a monolithic state, which would enslave the individual, a fear that resonated within the Church, particularly in view of the oppression of Christians in communist states.

The response of Catholic authorities to national health insurance, the concern of this thesis, then, rested upon the maintenance of the charitable status of hospitals, but it was also guided by a concern to preserve the flock against the tide of secularism and materialism, a concern heavily influenced by the fear of communism. Indeed, this thesis argues that the concerns of the time influenced the Church’s response to social and political events. Moreover, the fact that the Australian Church possessed a large economic stake in institutional health care also influenced that response. All in all this meant that the maintenance of independence, and thus the adoption of a position of
resistance, was a strong feature of the response to what Catholic authorities perceived as an attempt to curtail the operations of Catholic hospitals. It was not, however, simply a consequence of the Church’s social teachings, as suggested by Esping-Andersen, Castles and van Kersbergen, but a response conditioned by historical circumstances (Smyth, 2003).

The task of this chapter is to determine if Australian Catholic social teaching produced a ‘Catholic world of welfare’ that was conservative in approach and resistant to an increased role for the state as espoused by Esping-Andersen, Castles, and van Kersbergen. If it did, then, the response of Australian Catholic authorities to the Labor Party’s proposal to introduce a universal, national health scheme in the 1940s would be one of resistance. Indeed, this was the case, but was this simply a consequence of Catholic social teaching? Or was it also a consequence of the social and political context that framed the 1940s – a Catholic response to the ‘economic state’ (Smyth, 2003), and the rise of communism? Before addressing the Church response the chapter gives an overview of Catholic health care, particularly hospital care, prior to the 1940s.

**Church response in the 1920s and 1930s**

Church resistance to national insurance was evident prior to the 1940s. Indeed Catholic concern about funding access to health care first came to prominence when Catholic authorities opposed the introduction of schemes in the 1920s and the 1930s. In particular they voiced concern about the contributory nature of the proposed schemes, which in their view would force the individual to pay for their own care regardless of ability to pay. Instead, the *Catholic Worker*, the mouthpiece of the Campion Society, which was intent on building a ‘new Christian order based on Catholic social teaching (O’Farrell, 1977: 385), argued

> wages should be sufficiently high so that workers could afford to pay for their own medical care. Pending this happy outcome, health services and pensions should be universal and funded out of general revenue, not contributory national insurance (cited in Gillespie, 1991:108).

Compulsory health insurance, then, was second best, and if introduced, should be funded out of general revenue, not individual contributions. The antipathy voiced towards compulsory unemployment insurance illustrates the reason for Catholic concern, a concern also applicable to health insurance. Compulsory insurance would
be accompanied by all sorts of official tyrannies – nosing into people’s private life, directing workers to accept that work which the officials think suitable for them, dividing the population into two sections, the one which can look after itself and the one which the State must look after ... The capitalist State – the State with a vast number of propertyless workers – must end as a servile State. ... The owner of property has a right against everyone to that amount of property that is necessary for his present and future existence. To the surplus property he has a right which is good as long as the State considers it to be in the interests of the community. If there is no way of avoiding a slave State except by redistributing property, then the State must redistribute property for the common good (Catholic Worker, December 1940, No. 59: 3).

Government control, then, apparently threatened to enslave the individual, a situation that could only be redressed by ownership of private property. This was predicated on the belief that the ownership of private property would provide fathers with the means by which they could provide for their families. Until this could be achieved, protection should be provided through the payment of a family wage. The state would intervene only as a measure of last resort, an arrangement grounded in the idea of right order derived from natural law – mutual aid, charity, then, and only then, the state. A ‘Catholic view of welfare’, then, in very much the terms put by Esping-Andersen, Castles, and van Kersbergen was already evident in Australia, however, this thesis argues that the fear of communism inclined the Church to emphasise the principle of subsidiarity over the common good. Thus Australian Catholic social thought stressed the restriction of the role of the state even though its expansion would have assisted in the realisation of the common good. This view informed the response of Catholic authorities to Labor’s 1940s proposal for a national health scheme that enhanced the access of the poor and vulnerable to health care. The Church’s position, however, was not peculiar to the Church. Indeed, it was consistent with the view of the labour movement (Castles, 1985; Smyth, 2003).

**Catholic hospitals in the 1940s**

By the 1940s six religious congregations – the Sisters of Charity, the Little Company of Mary, the Sisters of St. Joseph, the Sisters of Mercy, the Sisters of St. John of God, and the German Sisters – owned and managed seventy-five public, private, intermediate, children’s and maternity hospitals, twenty-five of which were public hospitals. Several points can be made about these hospitals. First, they were located in fourteen different dioceses and thus were subject to the control of fourteen different
Ordinaries, ‘no one of whom is likely to take the initiative’ (Murphy, 1943: 21; SAA, L3314 File 1, No 36: IV, # 2) to establish a common voice. Secondly, the capital cost ran between five and six million pounds (AACG 01, 1944: 78). Thirdly, a significant proportion of recurrent and capital funds had to be found by the nursing congregations themselves in order to maintain and operate their hospitals. For example the twelve NSW Catholic public hospitals treated 26,650 in-patients and 133,216 out-patients in 1941. The total cost of this service was £230,399, including interest on building funds. The Government grants and patients’ fees account for £177,403, leaving a balance of £52,996 to be found, partly by the profits of the private hospitals and partly from charity. The patients pay about 10/- in the pound. In other words, half the patients are treated free of charge … Such, from the material side, is the enormous task our Sisters are doing and the heavy financial burden they are carrying (Murphy, 1943: 21).

Fourthly, the standard of care and equipment, verified by the MHSC, was high. Fifthly, the proportion of Catholic beds to total beds was ‘far higher than the ratio of Catholic to total population in the provision of beds in what are wrongly called private hospitals’ (AACG 01, 1944: 78).

Finally, some of the hospitals received government financial support. The NSW government subsidised all Catholic hospitals to varying levels, but not all were happy with this situation. Father Murphy, Chaplain to the Medical Guild of St. Luke, lamented that

our hospitals are practically mortgaged to the Government. By way of subsidy they receive annually about £80,000. With the exception of Lewisham, most of them would find it difficult, if not impossible, to carry on if the subsidy was withdrawn (SAA, L3314 File 1, No 36: II, # 3).

This situation, however, was unusual, as the Victorian and Queensland governments only supported one hospital each whilst the governments of Western Australia, South Australia and Tasmania provided no assistance to Catholic hospitals (AACG 01, 1944: 78-79). Thus Catholic hospitals to varying degrees relied on income derived from fees and donations, and the goodwill of those who staffed the hospitals. In spite of these constraints, however, the Church, through its congregations, controlled a strategic proportion of hospital beds. Moreover, whilst never able to deliver ‘the Catholic vote’ (Hogan, 1987: 65) the Church ‘claimed the allegiance of a majority of (federal) Cabinet ministers, and Catholics remained Labor’s largest single source of
electoral strength’ (Gillespie, 1991: 235). Consequently, Labor could not ignore Catholic views on health policy. Unlike education, however, the views of Church authorities on health and hospitals is under-researched, a situation that may be attributable to the lack of a united and consistent voice, but also to the lesser importance of health compared to education. It is now time to examine the 1940s in some detail.

The search for an equitable system of health care

The demise of the national health insurance schemes of the 1920s and 1930s – attributable to widespread opposition that included Catholic resistance and the outbreak of World War II – did not result in the abandonment of the search for a means of providing equitable access to health care. Indeed, the Labor Party and the labour movement, galvanised by the distress ensuing from WWI and the Depression, looked to implement its long held aim of access to health as a matter of right, not reliance on charity. Thus the election of the Labor Government in 1941 raised an expectation amongst some individuals that individual responsibility for health would be replaced by collective responsibility in the form of a ‘free’ and ‘complete’ non-contributory national salaried health service that stressed ‘positive’ health. This was not to be. As outlined in the previous chapter, health policy became a minor part of a wider social security programme based upon the payment of cash benefits. As has already been shown the opposition of the medical profession to Labor’s proposal was certainly important. But opposition also came from other quarters, such as the Catholic Church. Their opposition rested upon concern for the maintenance of the freedom and dignity of the individual, but it was also informed by a fear of state domination of morally sensitive areas. This precluded the nationalisation of medicine, and, more importantly for this thesis, the nationalisation of hospitals, although state assistance, at least for those unable to pay, was acceptable. As an article in the Catholic Worker put it:

Certainly medical and health services should be available to all in need of them. If our society cannot pay a living wage or effect an equitable distribution of property so that all men can pay for at least their normal medical expenses, then the State certainly must help ... But under the heading of medical treatment may be listed many matters which are not only medical but moral in significance ... contraception, euthanasia, abortion, and certain types of operations. On such matters people differ, and for this reason alone, apart from the desirability of preserving as much liberty as possible, the right of a person to choose his own doctor if he wants to is fundamental ... Similarly, the
voluntary and private hospital must remain independent. They must not be forced to do work which may be contrary to the consciences of their proprietors ... Nationalisation of medicine is not necessary, and it cannot operate without jeopardising some of the inalienable rights of the human person (March 1945, No 110: 2).

Condemnation of nationalisation, however, was not total. Whilst responsibility for the management of one’s own affairs, assisted by the payment of a just wage and/or the ownership of private property, was the ideal, Church teaching recognised that a situation could arise that would permit nationalisation. As already noted, however, it was a measure of last resort, acceptable only if the common good demands it. This is a question of fact in each case, and the Pope acknowledges that some production which affects intimately every person in the community and tends from its very nature towards monopoly, may, with justice, be owned and controlled by the State. There is not, however, in our view, a good case for the nationalisation of medicine (Catholic Worker, March 1945, No 110: 2).

Nationalisation of health either in the guise of contributory or non-contributory schemes, then, was not acceptable because first it threatened the spirit of charity, and the Church’s position on medico-moral issues, and secondly it compromised the freedom of the individual. Rather the ‘best work will be done by the combination of voluntary effort with government aid, not control’ (AACG 01, 1944: 79). Implicit in this stance is the principle of subsidiarity, which ensures an independent role for lesser organisation, such as a hospital, vis-à-vis the state. Catholic authorities, then, were guided by Catholic social teaching, but – and this point of qualification is important – the interpretation of that teaching was very much influenced by concerns about a rampant state, a concern fuelled by communist activities both in Australia and overseas. Examination of the Church’s resistance to the Labor proposal to introduce a national health scheme during the 1940s reveals both the influence of Catholic social teaching, and the influence of the social and political context.

**The Sixth Interim Report**

As indicated in the previous chapter, the Labor Government was initially happy to leave health policy to the NHMRC and the JPCSS while it concentrated on the war effort and the economy. Certainly it intended to introduce a national health scheme, but later circumstances revealed it was more inclined to absorb hospital benefits into a wider scheme for social security rather than totally re-organise the health system.
This in fact reflected traditional Labor practice. The national hygienists, who dominated the NHMRC and the deliberations of the JPCSS, however, had a more radical bent, an intention encapsulated in the *Sixth Interim Report* of the JPCSS. It argued

> that the ultimate solution will probably be found in a full-time salaried medical service with standardized uniform hospital provision, within which complete medical, hospital and public health services will be available to all and will be financed by a tax on incomes for this purpose (NAA; PP, *Sixth Interim Report*, JPCSS, 1943, #143: 15).

This goal, which Catholic authorities characterised as a threat to their hospitals, emerged as the focus of Catholic concern. In particular they worried that Catholic hospitals would be forcibly absorbed or incorporated into the public system, a move that would threaten the integrity and independence of Catholic hospitals. Dependency upon the state, or so it was feared, jeopardised the freedom of Catholic authorities to act and manage their own hospitals. This fear was compounded by the lack of an effective Catholic voice that could advocate on behalf of Catholic hospitals.

**The formation of the Australian Catholic Hospitals Association**

The lack of an effective Catholic voice was a result of the fragmented nature of Catholic health care. Father Murphy claimed that each Catholic hospital was only concerned with its own interest, not the needs of other hospitals, or the needs of Catholic hospitals in general. Moreover, their managers were in ignorance of the drift of affairs. As he put it:

> They are unmoved by the past encroachments of the Governments because these effect only their pockets … In N.S.W. our hospitals are practically mortgaged to the Government … if Nationalization comes, all the Hospitals will be financially dependent on Government. At least they will be so dependent that their liberty of action will be endangered if not destroyed (SAA, L3314 File 1, No 36: II, # 1-3).

To address this problem Murphy called for an association of Australian Catholic hospitals ‘so that there will not be confusion resulting from the adoption by one hospital or congregation of a procedure which has been rejected by another as unacceptable in a Catholic hospital’ (LCMA 01, no date: #7, 2). He worried, however, that the number of congregations, their location in different and autonomous dioceses, and the distance between hospitals might derail its formation. Thus he called on Archbishop Gilroy, the primate of the Australian Catholic Church, to provide direction. The Hierarchy, he claimed
is the only competent body to move in this matter … besides having the authority to act, such action would indicate emphatically to the Hospitals and to the Government and public the Catholic and national nature of the Association, and the fact that behind it was the authority of the Hierarchy of Australia (SAA, L3314 File 1, No 36: IV # 3: 4).

Sufficiently concerned about the situation, Gilroy invited Bishops McGuire and Gleeson, respective bishops of Goulburn and Maitland, to a meeting to discuss the formation of a national association. Its establishment, however, was not without tension. Gleeson noted that

no one can guess +Dr Mannix’s reaction if he is not the beginning and end of all ideas. However one can hardly accept the position of always writing to him for permission to do anything (SAA, L3314 File 1, No 34).

Whilst Mannix co-operated in and eventually approved the formation of a national association, the obvious tension implied in Gleeson’s statement became crucial in the events leading up to, and including, ‘the Split’ in the 1950s. The fallout from this event ultimately coloured negotiations between Catholic authorities and Labor over the introduction of Medibank in the 1970s.

In part Murphy’s call was a response to the need for greater accountability. It was, however, also crucially driven by the recognition that the sheer scale of hospital provision was beyond the financial resources of both the individual and charities. If Catholic hospitals were to continue to function there must be increased government funds, but that must be accompanied by certain safeguards, a point Father McNally, secretary of the Australian Catholic Hospitals Association (ACHA), later reinforced in his evidence to the JPCSS. Government aid was acceptable ‘provided that the government that asked for co-operation protected the freedom of the Catholic Church to administer its own work and medical care, and that the control of nursing by the religious sisters were left in the hands of the Church’ (AACG 01, 1944: 81). In other words, Catholic hospitals would accept government funds, but only on their terms.

Charged with the task of establishing a national association Bishop McGuire advised the Australian Hierarchy in December 1943 of his intention to propose

that a committee (with power to add to its membership) be formed consisting of the Bishop of Goulburn as Chairman, and a priest in Sydney as Secretary, and the Major Superiors of each Order accompanied by a Hospital Superior of each of the Congregations of
the State that conduct Hospitals, to establish the Association … We are convinced that trends of administration require such a movement. We are also taking cognisance of probable changes in Federal and State powers of government (SAA, L3314 File 1, No 32).

At the same time he wrote to the religious congregations engaged in the conduct of Catholic hospitals in New South Wales inviting them to send representatives to a meeting, which would ‘take steps to form a Catholic Hospitals Association’ (ARSC, A521/37). In particular he voiced the Hierarchy’s fear that pending changes in health legislation based upon the recommendations of the JPCSS would not consider the “special problems” faced by Catholic hospitals. A national association would enable presentation of these problems ‘in a friendly way to obviate possible unhappy consequences’ (ARSC, A521/37).

**Catholic resistance to the JPCSS solution**

The first meeting of the ACHA was held in January 1944. The agenda included three items, the second of which requested the establishment of a sub-committee to prepare a submission to the JPCSS on behalf of Catholic hospitals (ARSC, A521/39). The JPCSS had argued its proposed solution would redress the lack of organisation and poor resources of smaller private hospitals. Catholic hospitals, however, believed the measures would result in excessive centralisation and bureaucratisation, finally leading to nationalisation of health, a major concern of Catholic authorities. Reflecting this concern, the Superior General of the Sisters of St Joseph, Mother Mary Cyril, argued

> that the Nationalisation of Hospitals, with complete Government control, would inevitably lead to the more, or less, tyrannical suppression of Catholic Hospitals as such. That Catholic Hospitals, as isolated units, would be powerless to defend themselves against the interference and encroachments of the State, and that a divided Catholic opinion would be fatal to their best interests, and to the sacred trust reposed in them (SAA, L3314 File 1, No 11).

Moreover, an article in the *Catholic Worker* declared

> its opposition to any compulsory form of national health insurance by employers and employees. Income Taxation should be scaled and graduated in such a way as to encourage and not penalise those workers who make some private provision through lodges and benefit societies against the contingencies of sickness and ill-health (No 94 November, 1943: 3, emphasis in original).
Nationalisation of the medical profession and the hospital system, then, was ‘utterly undesirable’. Rather, the Catholic Worker continued, all that was needed was more hospitals, and the money to meet the necessary fees and charges … The Government should subsidise on a really lavish scale all those groups of citizens who wish to combine for the purpose of being hospitalised, when the need for it arises, in an institution managed by people of their own faith and outlook (No 94, November 1943: 3).

This would remove the need for the nationalisation of hospitals. Breadwinners assured of their wage would be able to afford hospital fees kept manageable by the payment of untied government subsidies to all hospitals thereby ensuring the freedom and dignity of the individual, and the independence of hospitals from state control (Gillespie, 1991, 154; Catholic Worker, No 94, November 1943: 3).

Simmonds, the Coadjutor-Archbishop of Melbourne, whilst applauding the suggestions for the improvement of the health of individuals, deplored the materialistic viewpoint of the JPCSS solution, particularly in relation to hospitals, arguing that it inclined ‘too much towards State regimentation’ (Gillespie, 1991: 154). As Father Murphy noted in his earlier memorandum to Gilroy:

This is a matter on which Catholics should have something to say … We Catholics can never allow our hospitals to surrender their control to any authority that does not respect the principles for which they were founded … What concerns us gravely is that their Catholicity and their autonomous control must be maintained (SAA, L3314 File 1, No 36: I, # 4).

Catholic opposition to the recommendations outlined by the JPCSS, then, extended across the Catholic community. In particular that opposition resisted any suggestion that Catholic hospitals surrender their independence. Certainly Catholic authorities recognised the need to ensure access to adequate health care. But they also felt that the government should subsidise hospitals so that they could operate as autonomous units, and ensure the payment of a just wage that would enable individuals to finance their own access to a hospital of their choice, not nationalise hospitals. Catholic authorities believed that surrender to the state was not in the interests of either the individual or the Catholic hospital.

**Grounds of resistance**

As noted above the focus of Catholic anxiety was the Sixth Interim Report. It did not, however, directly refer to Catholic hospitals. Rather, it spoke briefly of private
hospitals, which were described ‘as business undertakings or as a form of denominational service (that required patients) to pay the full cost of the service provided’ (NAA; PP, Sixth Interim Report, 1943 #34: 5). This left the impression that denominational hospitals – many of which were Catholic hospitals – were businesses whose purpose was the generation of profit, a view rejected by Catholic hospitals. Bishop McGuire objected that: ‘No Catholic hospital will admit this as an adequate description of its function and purpose’ (SAA, L3314 File 1, No 18: # 1, 4). Fees and charges were levied not to generate profit for shareholders, but to serve the poor (McNally, 1943: 73). In all our hospitals, a large portion of the cost of the public portion is borne by the private section. In this connection it is well to point out that the private hospitals, whose charges can be met by the well-to-do, are a necessary portion of our Catholic hospital system. The profits that accrue from them do not go to the funds of the Order to which they belong. They are devoted to the upkeep and to the extension of the hospital service of the poor. In this way the private hospitals not only justify themselves, but confer a social benefit on the community. For by helping towards the cost of the service of the poor, they relieve by so much the public purse. Besides this social aspect of the private hospital, there is the religious side. The private, not less than the public, hospital comes within the scope of the apostolate of the Catholic nursing Sister. In both is sought the spiritual benefit of the patient, which is the inspiration of all Catholic hospital service. In the Private Hospital, as in the public, the spiritual work of the Sisters is beyond computation (Murphy, 1943: 40-41).

Catholic hospitals, as seen by their supporters, then, provided both an economic and social benefit (relief of the public purse) and a religious benefit (the spiritual well being of the patient realised through the provision of charitable health care). This second aspect was crucial to the operation of any hospital that called itself Catholic. This understanding of charity, however, is voluntary and as such the obligation can be ignored. Clearly, this had the capacity minimise access to health care, particularly for those individuals who were unwilling to ask for assistance, or for those individuals who were judged to be ‘undeserving’. Nonetheless, Catholic authorities worried that the Sixth Interim Report appeared to be in ignorance of the charitable aspect of Catholic health, a concern that was not alleviated by the JPCSS recommendation to provide access to hospital care as a matter of right.
The spirit of charity

In essence, Catholic authorities believed that the socialisation of health proposed by the *Sixth Interim Report* challenged the Church’s belief that care for the sick poor was a matter of Christian charity understood as love and service of God, not legislative provision. Indeed, the fact that Labor held substantial majorities in both Houses of Parliament underscored Catholic concern as it would enable Labor to implement JPCSS recommendations. Catholic authorities feared this would lead to an expansion of a socialised national medical service for Australia … Unfortunately, the Service of God finds little mention in discussion of Social Services and Social Security to-day, and there is a danger of the real character of the Catholic Hospital being forgotten in public discussion (McNally, 1943: 68-69).

Like education, health care ‘was to be free, secular and compulsory’ (McNally, 1949: 61), with hospitals controlled by a Federal Director of Health and administered by State Departments. This would not only threaten the independence of Catholic hospitals, it would also lead to the loss of choice of doctor, and ethical control of medical practice, other than what the State approves. State Medicine will travel the same road as State Education, and will raise parallel difficulties for the Catholic citizen, the Catholic home, the Catholic Hospital and the Catholic Church (McNally, 1943: 70).

Loss of control, then, was a dominant concern.

Adoption of a stance of resistance, however, presented a difficulty for Catholic hospitals, as Labor’s scheme would enable Catholic hospitals to expand their apostolate. Was acceptance of government aid possible without compromising the essential character of Catholic hospitals? As one overseas commentator put it:

The question which should be raised and faced is, will this relative affluence have a deteriorating effect upon the spirit of charity. If it does, then this relative wealth will prove a curse rather than a blessing. It is imperative that our Catholic hospitals be made aware of the situation and be urged to take steps to re-examine the whole concept of charity in hospital service. Catholic charity cannot be measured in terms of economics. The Catholic hospital cannot sympathise with the mere economic viewpoint for the simple reason that charity in hospital service means the wholehearted and unselfish self-sacrificing devotion to the interests of every patient, whether that patient comes to the hospital clad in tatters or silks. In the light of to-day’s economic conditions it is important that our institutions should re-examine this fundamental approach to the needs of the patient and to the ability of the Sisters to meet those needs (Schwitalla cited in McNally, 1943: 74).
Whilst Schwitalla was speaking of American Catholic hospitals, this dilemma had already arisen in Australia with the passage of the 1929 NSW Public Hospitals Act. It provided an annual grant for the maintenance of denominational hospitals, which raised concerns in the minds of some Catholic spokespersons about the nature, independence, and autonomy of Catholic hospitals especially in relation to medico-moral issues and the employment of staff, concerns later echoed by McNally. Some argued that the acceptance of public funds diluted the act of charity and threatened both the independence of Catholic hospitals, and their essential character. Others argued that Catholic hospitals provided a valuable service to all, regardless of creed, and thus deserved government support. Indeed, it was argued, this would promote the common good (Sax, 1984: 115; Carey, 1991: 23-24; Gillespie, 1991: 150-154; Scotton & Macdonald, 1993: 112-113).

As already noted, the charitable aspect of the work of Catholic hospitals at this time was considered vital, but it is the linkage to correct practice – a moral question – and the supervision of the Bishop that is of interest. The love and service of God extends to right practice and relations hence the spirit of charity is impugned if actions offend morality. As health care relates to the dignity of individual and the sanctity of life, it involves questions of morality. Thus the voice of the Church, the authoritative voice, must be respected if a hospital is to call itself Catholic. Moreover, the responsibility for the Church’s teachings rests in the local Bishop who has the right of visitation and supervision of the moral administration of the Catholic Hospital. Not only must the hospital subscribe to the teachings of the Church if it wishes to be known as Catholic but, and this point is crucial, those who operate it must also submit to the supervision of the Bishop. If the acceptance of government aid required the rejection or marginalisation of the Church’s teachings, or the surrender of episcopal supervision, then, the hospital could no longer be Catholic. For that reason Catholic hospitals would stand outside any government scheme that threatened the freedom of the Catholic Church to administer its own work, the medical care provided by the hospital, or its control over those who operated the hospitals (AACG, 1944: 81). This, however, is a thin line. What is the demarcation between moral and technical administration, and when does discussion of the financing and operation of the hospital move beyond the competence of the Church as guardian of morality? In the 1940s fear of state intervention, which was interpreted as loss of Catholic control of
Catholic hospitals, appears to have coloured the answer. Put another way, so concerned were Catholic authorities with the maintenance of the independence of Catholic hospitals, a concern informed by the rise of communism, that they ignored Labor assertions that the Party was not intent upon taking over Catholic hospitals.

**Government failure to consult Catholic authorities**

In addition to concerns about the threat to the essential character of Catholic hospitals, Catholic authorities were incensed by what they perceived as the failure of the JPCSS to consult the Superiors of Catholic hospitals or someone competent to speak on their behalf, and the Report’s peremptory treatment of private hospitals (SAA, L3314 File 1, No 31). Father McNally worried that the Report was based on the findings of a survey conducted by a body known as “The Medical Survey Sub-Committee,” and consisting of the nominees of State Departments of Health exclusively. … The denominational hospitals, … do not owe their existence to State departments; they have not been under the control of State officials. No official of a State department has either the competence or authority to speak for them. Governments cannot reasonably complain about hesitant co-operation, on the part of … these bodies, in the working out of a policy in the framing of which they have not been consulted (1949: 61-62).

Failure to consult the Superiors, which McNally intimated was influenced by the fact that not one member of the JPCSS was a Catholic (McNally, 1943: 69), resulted in ‘costly, laborious, inadequate and inaccurate’ information. Moreover, the Committee’s work and the recommendations were not credible because its establishment had not been approved by parliament (McNally, 1949: 61).

The failure to consult was rebutted by Dr. Lilley, Chairman of the MHSC. He advised Gilroy that the Committee had obtained information ‘regarding every hospital in Australia – public, semi-public and private, including denominational hospitals’ (SAA, L3314 File 1, No 31). Indeed, the committee had visited and inspected nine NSW Catholic hospitals, two Victorian, three Queensland, one South Australian, four hospitals in Western Australia, and one Tasmanian Catholic hospital. Whilst Gilroy eventually acknowledged that these visits had occurred, he diverted the Church’s attack to the lack of direct contact between members of the JPCSS and Catholic hospitals. The Archbishop maintained that:

My complaint was, and it stands, that a Parliamentary Joint Committee, appointed to make a report on a most important matter did
not seek nor obtain information from a very skilled and efficient sector of the community competent to give advice and vitally interested in the report made to Parliament … the reference to private Hospitals attributed to the Parliamentary Joint Committee is little short of insulting (SAA, L3314 File 1, No 28).

Again in a letter to the Honourable J.A. Beasley M.P. he stated: ‘We felt we had a right to expect that a Parliamentary Joint Committee seeking information for the betterment of Hospitals would have done well to obtain evidence from the Superiors of Catholic Hospitals’ (SAA, L3314 File 1, No 26). In an effort to address this situation a meeting between Mr. Barnard, the Chair of the JPCSS, and representatives of Catholic hospitals, was convened at which Barnard requested a statement of evidence from Australian Catholic hospitals to be presented at the Sydney hearings of the JPCSS (SAA, L3314 File 1, unnumbered; SAA, L3314 File 1, No 18: 6-7).

**Statement of Bishop McGuire to a meeting of the Hierarchy, 24/4/1944**

Bishop McGuire delivered a statement on the *Proposed Federal Legislation on Hospitals* to the April 1944 meeting of the Hierarchy in which he discussed concerns about the *Sixth and Seventh Interim Reports*. In particular he expressed concerns about the MHSC’s inclusion of Catholic hospitals under the heading of ‘private hospital’, which, as noted above, did not adequately describe the function or purpose of the Catholic Hospital. Secondly, he voiced concern about the financial disadvantage arising out of the replacement of patient fees by a government subsidy, and the accompanying increase in state intervention.

McGuire argued that Catholic hospitals would be financially disadvantaged because it was proposed that the subsidy to hospitals for the first year of operation of the scheme would be diverted into a trust fund for the improvement of hospital standards. A body of three experts, whose composition contained no representative of either Catholic, voluntary, or private hospitals, would control the distribution of funds.

As the fund is to be administered by the “Commonwealth in cooperation with the States” State instrumentalities such as The Hospital Commission of N.S.W. and the Charities Board of Victoria will continue to function with enlarged powers and funds. Catholic hospitals will have to depend on the goodwill of those bodies to secure even a fair share of the distribution and expenditure of monies earned in Catholic institutions. But Government appointees will always tend to put the interests of governmental and semi-governmental institutions first (SAA, L3314 File 1, No 18: # 3, 4).
Moreover, Catholic access to the trust funds would be compromised by the better conditions and levels of efficiency already evident in Catholic hospitals when compared to their secular counterparts, a condition verified by the MHSC. In other words the standard of the Catholic hospitals vis-à-vis state hospitals would place them at a disadvantage because their need for improvement would be less urgent than the state hospitals.

A great portion of this money will be earned by the work of our Catholic hospitals, but its expenditure will no longer be controlled by them; they may not get fair consideration in its distribution, also, unless strong and accurate representation of their claims be made in time (SAA, L33314 File 1, No 20).

McGuire argued Catholic Hospital authorities should detail the sacrifices and debts incurred by the religious congregations in order to achieve that high standard as this ‘sacrifice and these debts are a just charge on the funds available’ (SAA, L3314 File 1, No 18: # 3, 4).

Despite these concerns, McGuire believed that Catholic hospitals were in a good position to extend and consolidate their hospital apostolate, as he believed that the Government had acknowledged the right of Catholic hospitals to a fair share of the trust money. He also advised the hierarchy that the Government was anxious to win the co-operation of the Catholic hospitals.

Consequently the Government is ready to consider on a friendly basis, any reasonable representations that will secure the continuance of their work. The aim is to build on existing services, not to destroy and replace them (SAA, L3314 File 1, No 18: # 7: 7).

Indeed, Barnard, the Chair of the JPCSS, advised McGuire that the Government welcomed the prospect of co-operation from the Catholic authorities. Moreover, Catholic authorities

would receive every consideration and acknowledgment of public service in the findings of the Committee.

He also expressed publicly the hope that the unfortunate consequences of the nationalisation of education would not be repeated in the attempt to nationalize health services and that a way would be found for complete cooperation between Church and Government in this field (SAA, L3314 File 1, No 18: 6).

Chifley also expressed his willingness to make himself, or Treasury officers, available to discuss the legislation (SAA, L3314 File 1, No 18: # 5-6, 6-7). Paradoxically, McGuire’s statements to the hierarchy, together with government assurances of
support for Catholic hospitals, actually contradicted the prevailing view that Catholic hospitals were under threat.

Despite Catholic concern, the JPCSS and the government were not intent on to re-organising relations between doctors, the state and patients, or threatening the independent and charitable status of Catholic hospitals. Instead, Chifley and the government wished to integrate health services into a consolidated programme of social security benefits that included health as a way of satisfying Labor’s traditional concern, namely removing the stigma of charity whilst relieving the costs of hospital and medical services (Gillespie, 1991: 197). Anxious about Catholic resistance, the government moved to assuage the concerns of Catholic authorities by promising money for the improvement and expansion of Catholic hospitals following the adoption of the JPCSS recommendations. That is, they promised the means whereby there could be an expansion of the Catholic hospital apostolate. These moves prompted McGuire to advise the Hierarchy to seek the insertion of clauses in the proposed legislation

that will preserve the essential character of our hospitals without excluding them from government aid. (This task should fall to) a Federal Catholic Committee of experts in this field, Religious and Medical, to work under the direction of the Bishops and in collaboration and co-operation with the Commonwealth authorities (SAA, L3314 File 1, No 18: #7, 7).

The Church, then, was not averse to state assistance, so long as it retained control of its hospitals. Catholic social teaching, then, did not forbid co-operation with what had been characterised as ‘socialised health care’. As indicated in an earlier chapter, Australian Catholic authorities, had reached an accommodation with socialism, which Moran earlier declared was not socialism in the communist sense.

Submission of the ACHA Statement of Evidence to JPCSS

Following its establishment, the ACHA, with Bishop McGuire as chair, and Father McNally, Lewisham Hospital’s chaplain, as Secretary, moved to prepare the Catholic statement of evidence for presentation to the JPCSS. A hospital questionnaire proposed by the JPCSS was deemed unsuitable. Consequently the executive, in consultation with representatives of the Bishops, religious in charge of hospitals, and medical advisers in each state, developed its own questionnaire, which the Bishops
subsequently sent to all Catholic hospitals. The answers became the basis of the statement of evidence (SAA, L3314 File 1, No 16; SAA, L3314 File 1, No 18: 1-2). Of particular interest is the level of control exercised by the Hierarchy. Not only did it retain the right of approval and veto over any submission on behalf of Catholic hospitals to Government, it also constituted the Association under episcopal supervision and clerical control, a move related to the nature and status of Catholic hospitals. At the same time debate, which was dividing the Church, was proceeding over the nature and reach of episcopal control of Catholic Action. This debate ultimately divided the Victorian Church, which was advocating lay control, from the NSW Church, which imposed episcopal control.

Bishop McGuire presented the ACHA statement of evidence on the 18th September 1944 to the JPCSS. Following discussion on the need for charity, the statement focused on the JPCSS recommendations on hospitals, namely the establishment of an expert body to establish uniform standards for hospitals; the establishment of a central trust fund to provide money for the improvement of hospital standards; the regionalisation of hospitals in cooperation with State hospital authorities; the hospital benefits schemes; and the consolidation of social legislation (AACG 01, 1944: 77). It argued that the MHSC Report was neither factual nor accurate, rejected the implication that Catholic hospitals were a commercial enterprise run for profit, opposed the abolition of the means test, and worried that government control and interference would hinder the work of Catholic hospitals. Moreover, it voiced concerns that the state scheme would be indifferent to moral issues in medical and hospital practice, destroy the spirit of charity, freeze voluntary effort, and destroy individual initiative and hinder progress (AACG 01, 1944: 79).

The abolition of the means test – a crucial issue of contention
In addition to the more general fears about loss of autonomy, Catholic authorities feared the charitable nature of Catholic hospitals and their financial position would be threatened by the proposed abolition of the means test. They argued its removal would discourage individuals from making provision for themselves, thereby undermining thrift and independence, and lead to an increase in demand on public beds as people realised they could be treated free of charge regardless of their income. Secondly, it would threaten hospital income, as patients who had previously
paid for a public bed would no longer be required to pay for that bed, a concern also shared by State governments (SAA, L3314 File 1, No 2: 4). Thirdly, the bed subsidy to be paid in compensation for the abolition would not maintain existing services let alone allow for an expansion of demand. Nor was it augmented by capital funds leading to further problems with access and quality. Fourthly, Catholic authorities argued the abolition of the means test would not only ruin Catholic hospitals, it would also compromise the health status of the poor. If it means that we shall have to admit a patient into a public ward without regard to his means and that we shall no longer have control over who shall go into public, private and intermediate beds, we shall be ruined, because we should not be able to accommodate all the people who would want to occupy public beds without cost. Free treatment at hospitals is given only to those who cannot afford to pay. There are plenty of mean rich people who would cry “poor mouth” in order to obtain free treatment. We have to have an Almoners Department to prevent the exploitation of the out-patients Department by rich people who come to the hospitals in chauffeur-driven cars. That is why we cannot open our public beds for occupation without applying the means test. If the abolition of the means test means that we shall have to throw our beds open to all without question, we shall lose control over admission to the hospitals … We quite agree that every taxpayer is entitled to get his money back, but we cannot accept a policy which will rob us of control over admissions (SAA, 1944, Box L3314, File 1, No 3, Item 243: 8).

The concerns were dismissed by the JPCSS, which argued that the extension of the bed subsidy to intermediate and private beds would relieve the pressure on ‘free’ beds as the more affluent members of the community would seek non-public beds. That is, there would be an expansion of intermediate and private accommodation. In fact the Committee advised

While public hospitals would receive the same rate of subsidy for all patients, it would be in the interests of the hospital to decrease public beds which now make a loss and increase other types of beds which provide a small profit. This would have the effect of reducing State expenditure on public hospitals and of increasing the income of private hospitals (NAA; PP, Seventh Interim Report, 1944 #35: 7).

The Government argued that the abolition of the means test was not the means of reorganising the health care system. Rather its purpose was relief of the costs of hospitalisation and removal of the stigma of charity, which involved a form of universalism, not the removal of the hierarchy of access. Indeed Goodes, the Treasury Officer responsible for the Government’s health scheme, assured McNally
that the authority to decide on who should be admitted to public beds would remain with the hospital (AACG 01, 1944: #244, 82). Despite these assurances Catholic authorities remained unconvinced, a position influenced by concern over government interference in medico-moral matters. They insisted that this

is a moral question. In hospitals many problems are of a moral nature. The church claims the right to teach and to legislate on questions of morals and discipline. We do not subscribe to the fallacy that “freedom of religion” means “freedom from religion” in matters affecting social security. For that reason abortion, birth-control, sterilization and illicit operations are all condemned by the Catholic Church. Hence a hospital claiming to be Catholic must submit to the church’s teaching in this respect (AACG 01, 1944: 78).

ACHA Principles of co-operation

Despite the Church’s concerns, the ACHA statement did not rule out co-operation, provided the control of Catholic hospitals, and the appointment of staff, was left in the hands of the Church.

A Catholic hospital is a work of religion. If the Government is prepared to co-operate with religion or allow religion to co-operate with it, the Catholic Church will be freely co-operative (AACG 01, 1944: 81).

Indeed, the ACHA statement spoke favourably of those States that provided assistance to Catholic hospitals. As already noted the pattern was chequered, which the ACHA statement attributed to a reluctance to support the work of religious congregations. Willingness or unwillingness to provide support, however, may have been the consequence of the nature, size and geographical spread of each settlement rather than religious bias. For example Victoria, which had a strong tradition of charitable provision, and South Australia, which was colonised by “free” settlers who were reliant on their own resources, had higher numbers of non-government beds, 37.5 per and 42 per cent compared to 28.1 per cent in NSW. Combined Catholic/private beds in Western Australia accounted for 36.4 per cent of its total, attributable to the size and geographical spread of the state. Tasmania with 25.1 per cent, like NSW, had a history of state support for hospitals that originated in their penal foundation. Queensland had the least number of non-government beds, 9.5 per cent, attributable to its embrace of public hospitals (AACG 01, 1944: 78).

Having acknowledged the Church’s willingness to co-operate with the Government, the ACHA submission outlined the conditions necessary to ensure the co-operation of
Catholic authorities in the implementation of the national scheme. These included safeguarding the administration of public money, the preservation of the essential character of Catholic hospitals, and the interests of the medical profession especially in relation to staff appointments and the needs of teaching hospitals (AACG 01, 1944: 79). McNally, in his evidence to the JPCSS added that Catholic authorities were also concerned that acceptance of government aid risked increased government interference. As the bed subsidy, which covered a portion of the total cost of hospitalisation, was payable only under certain conditions, Catholic hospitals were concerned that the Commonwealth would seek to extend its control over total hospital expenditure, even over that portion not provided by government.

There should be provision inserted in any legislation governing this matter that the Government shall have no right of control of expenditure but shall have the right of inspection in order to ensure that the subsidy is expended in the way intended. But that does not give the Government the overriding right to control the expenditure of all moneys that come into the hospital … We have experienced that in Victoria (AACG 01, 1944: 82).

To lessen the possibility of state interference the ACHA asked that Catholic hospitals be represented on any board or public body appointed to regulate and administer the proposed scheme. The ‘special circumstances’ of Catholic hospitals, and the size of their commitment to health care warranted separate representation. Not only would this extend the pool from which information and advice was sought, but it would also remove the possibility of undue, or unwarranted, interference in the operations of Catholic hospitals. ‘The best work will be done by the combination of voluntary effort with government aid, not control’ (AACG 01 1944: 79).

**Concerns about the Seventh Interim Report**

The concerns of Catholic authorities were exacerbated by the release of the *Seventh Interim Report*. McNally advised Gilroy that in the event that the Government withheld the proposed trust money for one year

Catholic hospitals will have to make serious representation of their claims based on accurate and certified record of public service, to avoid having to allow the monies earned by them being expended exclusively on Governmental and semi-governmental institutions (SAA, L3314, File 1, No 20).

Interestingly, he went on to advise treating the
proceedings confidentially and with great prudence (because of the) possibility of arousing sectarian and bigoted united opposition to Governmental measures that will enhance greatly the economic strength of Catholic hospitals (SAA, L3314, File 1, No 20).

In other words, far from absorbing or incorporating Catholic hospitals they stood to gain, prompting one to question how seriously the Church perceived the threat of Labor’s proposed national scheme. It would appear, then, that the religious character of Catholic hospitals was not a bar to co-operation with the Government, a position acknowledged by McGuire in the statement of evidence to the JPCSS. Certainly the Church had concerns about the Government’s intentions, but one cannot help wondering whether these were exaggerated to ensure that Catholic hospitals entered the scheme on its own terms.

By the time that the ACHA made its submission to the JPCSS, Catholic grounds for resistance were strongly in evidence. The proposals outlined in the Sixth and Seventh Interim Reports were perceived as a threat to the charitable status of Catholic hospitals and their independence. Moreover, the abolition of the means test and the payment of the bed subsidy were perceived as means to extend Commonwealth control over Catholic hospitals. Against the backdrop of the rise of communism, Catholic authorities turned to Catholic social teaching, but also to more secular arguments, notably the diminution in funds as a consequence of the abolition of the means test. This, it was argued would disadvantage, not advantage, the poor as the funds previously derived from fees would no longer be available to subsidise public patients in Catholic hospitals. Nevertheless, Catholic authorities were not totally dismissive of the scheme, but rather sought to shape it to their own interests. The influence of the JPCSS, however, was rapidly coming to an end.

**Hospital benefits scheme**

Following Chifley’s marginalisation of the JPCSS in 1944 the Government shifted its support from the radical national hygiene scheme to medical and hospital programs embedded in a comprehensive social security cash benefits scheme. It would supplement the incomes of those most in need, deliver minimal costs for consumers, and enable government to control costs. Faced with this pressure, a reluctant JPCSS proposed a hospital benefits scheme that would provide an indirect subsidy to patients to alleviate hospital costs and their economic impact. In fact this reflected traditional
Labor practice in so far as it addressed questions of access rather than the causes of inequality. Despite the marginalisation of the Committee in the larger debate, Catholic concerns still focused on the findings of the JPCSS reports. In 1945 McGuire noted that the purpose of his earlier statement had been
to emphasise the essential religious character of the Catholic Hospital;
to point out the danger to that essential feature from an unlimited Government control and interference; and to suggest principles of co-
operation between the Federal Government and the Catholic hospitals,
and ways of avoiding conflict in the planning of Health Care in the Social Security Programme (AACG 02, 1945: 1).

Given the fact that Catholic hospitals had no representation on the expert body established to advise the Government, and their reliance on the goodwill of Government bodies for equitable treatment, Catholic authorities feared their hospitals would be at a disadvantage. The findings of the *Eighth Interim Report* to some extent alleviated these concerns in so far as it allowed for Catholic and denominational hospital representation on the advisory body (NAA; PP, *Eighth Interim Report*, 1945, #13: 7), but its effect was nullified by the marginalisation of the JPCSS.

The Government did not abandon the plans outlined in the JPCSS reports. Rather it sought to mould the Committee’s findings to its own purpose. To that end it accepted the recommendations of the *Seventh Interim Report*, which had largely been determined in response to Government pressure. Hence the national salaried service was replaced by a system of cash benefits, which included the subsidisation of access to existing hospital services, a departure from the radical overhaul proposed by the JPCSS. The subsidy was extended to Catholic and denominational hospitals payable at the same rate as that applied to public hospitals. The Government believed subsidisation of access to Catholic hospitals would placate a Church already expressing concern over the socialistic tendencies of the state. The fact that they controlled a strategic proportion of hospitals, and the Party was culturally Catholic if not a Church Party, meant that the Government was anxious to avoid conflict (Gillespie, 1991: 198, 235). Despite this the *Hospitals Benefits Act* aroused if not outright opposition then certainly concern among Catholic hospitals, as Catholic authorities worried that Federal support for the expansion of hospital facilities would not extend to Catholic hospitals.
The ACHA statement on the Australian Social Security Legislation 1945/46
The ACHA statement on the Australian Social Security Legislation 1945/46, which included the *Unemployment and Sickness Benefits Act* and the *Pharmaceutical Benefits Act*, and the proposed *Federal Hospital Act* and the *Medical Benefits Acts*, maintained the focus of Catholic authorities on their hospitals, but it was the last two Acts that raised most concern. In particular Catholic authorities feared that the medical benefits legislation would compromise their control over staff appointments, which they regarded as essential if the teachings and practices of the Church were to be safeguarded. In order to avoid embarrassment McGuire advised that ‘any contract of service and appointment … (must be) submitted to the Bishop for perusal and amendment if necessary … The Church, through the Bishop, must control appointments in Catholic hospitals’ (AACG 02, 1945: 5).

A Question of Status: *The Federal Hospital Benefits Act*
The effect of the proposed *Federal Hospital Benefits Act*, however, was more worrisome. Chifley and Goodes had assured McGuire that the *Hospital Benefits Bill* would not affect the administration and control of any Catholic hospital, and the subsidy would be provided for all beds of the requisite standard. Nevertheless, Catholic hospitals faced the prospect of increased state control because the Federal law assumed that the state was responsible for any difference between the daily bed-cost and actual cost. The state, however, had never been responsible for the difference in Catholic hospitals. Rather, Catholic hospitals funded the gap through donations and fees. This enabled them to provide equivalent hospital services for those unable to pay; an ability, they argued, which would be compromised by the abolition of the means test on public beds. Registration, then, became another source of concern.

Under the terms of the Bill federal benefits were only payable to patients treated in hospitals registered by their respective State government. This meant Catholic hospitals had to choose to be registered as public or private institutions as there was no allowance for registration as ‘Separate Institutions’, a practice adopted in some states. ‘Public’ registration required hospitals to abolish the means test, which as already noted, concerned Catholic authorities, as they believed it threatened the financial position of Catholic hospitals, and their control over admissions. Moreover,
abolition of the means test left Catholic hospitals open to state interference and control, particularly if the state assumed responsibility for the gap between the benefit and the actual cost of each bed.

The authority that is responsible for total cost must be the hospital authority. If Government finds (sic) the whole cost Government must control, and nobody wants that (ARSC, A502.2/9: 2, underlining in original).

Chifley and Goodes assured McGuire that the new scheme would not change the administration and control of Catholic hospitals. This included the right to classify patients, but once patients were admitted to public wards Catholic hospitals would not be able to charge fees. McNally, however, countered that the abolition of fees in public wards was only possible if and when the state agreed to cover the gap between the actual bed-cost and the amount received by the hospital.

Until the State recognises the “actual bed-cost” in a Catholic hospital as distinct from the apparent bed-cost it may be necessary for us to register all our hospitals as “private hospitals” for the purpose of the Federal Act (SAA, L3314 File 2, No 45: 2, underlining in original).

‘Private’ registration, however, was also fraught with problems. In NSW only three hospitals were registered as ‘private hospitals’ with the remainder being registered as ‘Separate Institutions’. This gave them ‘public hospital’ status without government control, a situation that also applied to St. Vincent’s Hospital, Melbourne and the Mater Public Hospital, Brisbane. All other Catholic hospitals were registered under State Acts as ‘private hospitals’ with the exception of Tasmania’s St. Vincent’s Hospital, Launceston and Calvary Hospital, Hobart. After some lobbying Federal authorities amended the definition of ‘private hospital’ in the Federal Private Hospital Benefit regulations to classify these two hospitals as ‘exempt hospitals’ for the purpose of Federal private hospital benefits. That is, they were exempted from registration or obtaining a licence.

To complicate matters even further ‘private hospital’ registration was not an option for Catholic hospitals in NSW or the Mater in Queensland. As already noted, classification as ‘Separate Institutions’ provided these hospitals with ‘public hospital’ status without government control, but it also enabled them to access special grants for building and equipment and thus the expansion of their work. ‘Private hospital’ registration would remove that entitlement. Therefore Catholic hospitals lobbied for,
and won, ‘exempt hospitals’ status, which ensured their access to the state subsidy for maintenance whilst enabling them to receive the federal benefits. Catholic authorities were not so much concerned with the benefits themselves, but rather with the status of their hospitals. At issue was the question of control and hence the freedom of Catholic hospitals to operate their hospitals in accordance with the Church’s teachings, free of state interference. They argued this could be achieved by reviewing and amending the Federal Hospital Benefits Act ‘so as to contain within itself provisions, which would secure to the Sisters the complete control and management of their respective Hospitals, and which would reduce to a minimum the records to be kept and the returns to be submitted to Government Departments’ (SAA, L3314 File 1, No 4).

The concerns flowing from registration requirements, including the abolition of the means test, were further compounded by what was perceived as the Government’s failure to acknowledge that authorities other than government operated in the health field.

The Hospital Benefits Bill now before the Federal Parliament is intended to create agreement between State and Federal authorities in Health legislation. It is necessary to emphasise that there are other authorities besides Government in the field now – Religious and Medical. The Catholic Hospital is still in danger of being merged in a general scheme that ignores its special and essential features. The abolition of the Means Test involves loss of control of admission of patients; free treatment for all in public wards is possible only when the State contracts to make up the difference in daily bed cost to the hospital; and the suggested Joint Authorities are exclusively governmental. The definition of “public hospital” is completely inconsistent with the judgements of the Full Court of the Supreme Court of New South Wales, confirmed in the High Court (AACG 02, 1945: 7).

Catholic authorities, then, formed the view that the Medical Benefits Act and the Hospitals Benefits Act increased centralisation and bureaucratisation. As Cardinal Gilroy explained:

It appears that the Parliament has, by its legislation, placed upon the Hospitals and their staffs the burden of distributing to the sick (indigent and otherwise) the benefits under the Governments scheme. At the same time, the Parliament, fearful that those controlling the Hospitals may not act lawfully in that regard, places upon those in control the burden of proof of the right of each sick person to benefit, and consequent proof of the right of the Hospital to collect a refund.
corresponding to the benefit, necessitating the keeping by the Hospital of additional records, the filling up of additional forms and the compilation and submission of additional returns … The vocation and function of the Sisters is to nurse the sick, and to ensure that those committed to their care receive the best possible attention. In that they are assisted by many charitable people who are pleased to contribute financial and other aid.

It will not accord with their religious vocation that they should be instruments of State distributing Government relief, subject to a Departmental control, and dependent entirely upon Departmental funds (SAA, L3314 File 1, No 4).

Ultimately this threatened the autonomy of Catholic hospitals. Thus the Superiors of Sydney’s St. Vincent’s, Mater Misericordiae and Lewisham hospitals, and their legal advisers, concluded the proposals were not acceptable. However, they were willing to co-operate in the formulation of amended proposals, which must provide for the recognition of the Catholic hospitals as ‘separate institutions’, preserving to the Sister the control of the management and the appointment of staff (SAA, L3314 File 1, No 4).

Clearly financial considerations were a major stumbling block, especially if they threatened the independence of Catholic hospitals.

Conclusion

What emerges very strongly from the various documents is concern that government intervention would remove, or severely alter, the essential and distinctive character of Catholic hospitals. Co-operation with Labor’s national health insurance scheme was possible, but only if the Catholic hospital retained its independent and autonomous status. A scheme that sought to replace the spirit of charity, understood as love and service of God, and to impose practices contrary to Catholic teaching, was unacceptable. The tumultuous social and political context outlined in Chapter Four meant that the Church in Australia was suspicious of government intent. Consequently, Catholic authorities and the Church persisted, despite assurances, in their calls for Catholic hospitals to remain outside government control. Whilst reference to the principle of subsidiarity is not evident in the primary material on Catholic health care in this period, its influence was evident in the wider social context, particularly in the social justice statement, Pattern for Peace. It did not discuss the national health plans, an omission that McNally attributes to the likelihood that the authors did not have the detailed
proposals. Nevertheless, an inkling of the Catholic attitude to the health proposals can be deduced from the statement’s reference to education. It argued:

There can be no real freedom in the modern world unless the rights of the individual and the family are safeguarded against the absolute power of the State and the economic system (Pattern for Peace in Hogan, 1990: 39).

Relations, then, between the individual and the state must be guided by the principle of subsidiarity. Indeed, McNally in posing a question about the rights of the individual and the family in the proposed health legislation concluded that the question could not be answered ‘until these proposals have been examined expertly in the light of Catholic social principles’ (McNally, 1943: 71).

Nationalisation held particular fears for Catholic hospitals in so far as they would fall under the control of ‘an authority that does not respect the principles for which they were founded’ (Gillespie, 1991, 153-154). Whilst Catholic social principles are not opposed to nationalisation, a view articulated in the 1948 social justice statement Socialisation, McNally, the secretary of the ACHA, maintained it must be subject to safeguards in order to prevent the enslavement of the individual to the state, and assure the common good. This view was supported by reference to American and Canadian Catholic support for national hospital and medical benefits. American support rested upon the hope that the principle of the responsibility of the individual for his own acts will be safeguarded; that the principle of co-operation between public and private agencies will be maintained … that the betterment of human society will be effected through a sound regard for the elevation of the individual through his moral responsibility rather than that of semblance of betterment be attained through palliative patronage seeming to facilitate the solution of society’s problems (Schwitalla in McNally, 1942: 72).

Canadian Catholic support was subject to the inclusion of safeguards against the socialisation of medicine. So long as freedom of choice in relation to doctors, hospitals, and nurses was observed the Council agrees that a Health Insurance Act does not socialise medicine. On the contrary, it helps the poor to get medical services and the hospital and doctors to be better remunerated (Bouvier in McNally, 1943: 72-73).

Safeguards, however, did not remove apprehension. Indeed, the religious in Canada fear that the government will interfere with the hospitals, doctors and nurses, that conditions will be unfavourable to them; for the fact
remains that they have not been considered on an equal footing with lay hospitals (Bouvier in McNally, 1943: 72-73).

Consequently McNally concluded that government aid was all to the good, if it can be continued and enlarged without endangering the essential character of the Catholic Hospital, that sees in the service of the sick neighbour the Love and the Service of God (McNally, 1943: 72-73).

Of importance, then, was right order, an order that was threatened by the nationalisation of health. An article in the March 1945 Catholic Worker summed up the situation for the Church admirably.

One of the fundamental principles of Catholic social thought is that of subsidiarity, which means that a large unit should not undertake work which can be efficiently handled by a smaller unit. Naturally, a society in which responsibility and control and property is widely distributed is one in harmony with the essential dignity of man. His rights – derived from God – are more effectively guaranteed in such a state than in one dominated by the State or monopolies.

Therefore, no industry should be nationalised unless the common good demands it … Certainly medical and health services should be available to all in need of them. If our society cannot pay a living wage or effect an equitable distribution of property so that all men can pay for at least their normal medical expenses, then the State certainly must help… But under the heading of medical treatment may be listed many matters which are not only medical but moral in significance. Thus, contraception, euthanasia, abortion, and certain types of operations. On such matters people differ, and for this reason alone, apart from the desirability of preserving as much liberty as possible, the right of a person to choose his own doctor if he wants to is fundamental.

Similarly, the voluntary and private hospital must remain independent. They must not be forced to do work which may be contrary to the consciences of their proprietors … Nationalisation of medicine is not necessary, and it cannot operate without jeopardising some of the inalienable rights of the human person (Catholic Worker, No 110 March 1945: 2).

Clearly, then, resistance to the introduction of a national health scheme was aided and abetted by deeply held and strongly voiced fears of nationalisation and socialisation. Moreover, it was assisted by the Church’s concern that the abolition of the means test would compromise the financial status of Catholic hospitals, and thus their ability to continue their apostolate.
Catholic concern about the ‘free’ and ‘complete’ national health scheme, then, related to the spiritual nature of health care work, the expression of charity through care of the sick, interference in the life of the individual and the technical proficiency of Catholic health care work. However, economic concerns were also a consideration. Protection of the interests of the Catholic hospital required Catholic control of the administration and management of the Catholic hospital, including the maintenance of control over the appointment of staff. Non-interference by outside bodies, then, was a defining principle for the operation of Catholic hospitals, justified on the grounds of safeguarding the moral and spiritual status of Catholic health care. This attitude permeated the Church’s response to Labor’s national health scheme in the 1940s. It was perceived as an attempt to extend government control. Consequently, it was regarded as a threat to the autonomy of Catholic hospitals, a view informed by Catholic social teaching. Whilst it is too simplistic to argue that Catholic resistance to Labor’s ‘socialistic tendencies’ predicated on the principle of subsidiarity ‘nobbled’ the scheme, its influence was not insubstantial. It was not in the interest of the Catholic hospital to become a mere instrument of the state. Having said that, it should be noted this response was not a necessary consequence of Catholic social teaching. Rather, the emphasis on the principle of subsidiarity in the interests of maintaining the charitable status of Catholic hospitals was very much influenced by the times that saw the Church adopt an attitude of resistance to an expansion of the role of the state. This period, then, provides support for the claim of Esping-Andersen, Castles, van Kersbergen, and Smyth that Catholicism does incline towards a conservative view of welfare. However, it also supports the view that Catholic resistance is also shaped by socio-political events and circumstances.

The Catholic Church actively resisted the introduction of the Labor Government’s national health initiatives in the 1940s. Yet it is reasonable to argue that the scheme would have improved health care in Australia, especially for the poor. On this occasion the resistance of the Church frustrated the government’s proposal. But the Labor Party cherished its several social welfare objectives, notably in health care. Although it remained in the federal political wilderness for twenty-three years, a national health scheme remained on its agenda. It is now time to turn to the introduction of Medibank, and then the Church’s response to its introduction.