CHAPTER EIGHT

PROPOSAL TO POLICY

Introduction
As demonstrated in Chapter Six the Australian Labor Party in the 1940s tried to re-fashion the health care system so that all Australian citizens would have access to health care, regardless of ability to pay. This was to have been financed by a surcharge on taxable income. In practice, access to health care was absorbed into a national social security system that offered non-contributory cash benefits, and free hospital treatment for public patients. The Menzies Government, which replaced the Chifley Labor Government in 1949, reversed that practice. In particular, the Menzies Government restricted free hospital treatment to those who satisfied a strict means test and subsidised access for those who purchased private health insurance, many of whom were wage earners. The costs of the premiums and the standard of cover, however, left many with no or inadequate access to health services, a situation that the Whitlam Labor Government sought to redress between 1972 and 1975.

Following its election the Whitlam Government embarked on a wide-ranging program of health service reform that included the introduction of universal health insurance. Doctors and conservative politicians decried this as ‘socialised’ health care. The charge, however, was far from the truth. Labor in fact accepted ‘the entrenched system of private, fee-for-service practice’ (Gray, 1991: 102) but it sought to provide certainty for patients through the introduction of universal comprehensive coverage funded by government. Regardless, the scheme generated considerable opposition as doctors, private hospital providers, and conservative politicians worried about undue government interference. More importantly for this thesis, Catholic authorities, particularly those from Victoria, resisted the introduction of a scheme, which they feared threatened the independence and autonomy of Catholic hospitals. To this extent Catholic opposition mirrored Catholic opposition in the 1940s, prompting one to consider that perhaps the conservatism identified by Esping-Andersen, Castles, and van Kersbergen did predispose the Church to resist policies that enhanced the role of the state. That is, the Church was predisposed to the development of a conservative ‘Catholic world of welfare’. The task of this chapter, but especially the next, is to
assess the adequacy of the Esping-Andersen, Castles, van Kersbergen and Smyth account of the role of Catholic social teaching on the development of welfare policy. This will involve an examination of the social, economic and political conditions that framed the Catholic response to the introduction of a universal national health scheme in the 1970s.

As explained in Chapter Four, welfare and health provision in Australia up to the 1970s was largely residual in character, a practice supported by both Labor and non-Labor parties. There were, however, differences over the need for means testing, and whether the schemes should be funded by voluntary contributory insurance schemes managed by private organisations or compulsory non-contributory schemes administered by government. At its heart this debate concerned the role of the state. Doctors and private hospital providers, including Catholic hospitals, advocated a minimal role for the state. According to Sax, conservatives seek to restrict the range and degree of government intervention in market systems. This preference is derived from optimistic theories of economic growth which assume that benefits accruing to owners and rentiers will bring about an improved situation for the poor through ‘trickle-down’ effects, and that individuals will be able to provide for themselves for as long as governments ensure the maintenance of economic growth. Social welfare systems should then come into play only when the normal structures of the family and the market break down (1984: 100).

This view was not out of step with Catholic social teaching in the 1970s. At that time, in particular, such views were consistent with Church attitudes in the 1940s. On the other hand Labor, and the labour movement, opted for an increased role for the state. Thus the Whitlam Labor Government, Sax averred, held the view that the purpose of state intervention was to promote the welfare of all citizens. In particular, it promised greater commitment to the welfare of the poor, more government intervention in areas of health, education, housing and urban development, and some emphasis on social and cultural satisfaction (1984: 100).

It is fair to say that Labor saw that outlook as endorsed by the Australian public when it elected Labor to power in 1974.

In effect the Whitlam Labor Government sought to remove the stigma of charity, an attempt that echoed Labor efforts in the 1940s. Access to health services was a right that would be guaranteed by the introduction of universal health coverage. Catholic
hospital authorities, however, resisted the move. As noted in Chapter One this is somewhat surprising given the Church’s proclaimed commitment to the welfare of the poor. In an effort to understand the resistance to the Whitlam Labor Government initiative this, and the following chapter, examine the nature and circumstances of the resistance, and attempt to discern the similarities and dissimilarities with the 1940s. Before proceeding with the particular examination of the Catholic response, a task delegated to the next chapter, this chapter explores the social and political circumstances surrounding the introduction of national universal health insurance in the 1970s. Of necessity this commences with an examination of the health insurance arrangements that replaced the Chifley Labor Government’s scheme, a scheme the Whitlam Labor Government identified as in need of the repairs it proposed in the form of ‘Medibank’. It is now time to turn to a detailed discussion of the period leading-up to the scheme, however, it should be noted that this chapter draws to some extent on the work of Scotton and Macdonald, which at the time of writing provided the most comprehensive account of Labor’s scheme. Indeed, this book also provided the most detailed account of the Catholic response to Medibank, which this thesis seeks to extend.

The National Health Scheme

Following Labor’s defeat in 1949, the new Liberal-Country Party Government introduced its own national health scheme, in a sense tacitly admitting the need for significant reform. The Coalition’s National Health Scheme, colloquially known as the Page Plan, replaced Labor’s centralist, universal and compulsory scheme with a subsidised voluntary insurance scheme that required a ‘co-payment’. Voluntary insurance was ‘the Christian idea of mutual assistance’ (Fadden cited in Gillespie, 1991: 253), and as such would be ‘Australia’s answer to socialized medicine’ (Page cited in Gillespie, 1991: 254). Existing voluntary insurance organisations, including friendly societies, served as the administrative vehicles, a move that accelerated implementation, but also ensured market involvement. The Plan did not, however, remove state intervention. Universal fee-for-service benefits originally gazetted by the Chifley Government were enshrined ‘as the central principle of medical remuneration, but only at the expense of handsome subsidization by the taxpayer’ (Gillespie, 1991: 280). Fox aptly termed this ‘private practice publicly supported’ (1963: 875). In that sense, the amount of government support made a nonsense of any claims, prior to the
start of Medibank, that the system was based on ‘free market principles’. The market in fact was propped up by the state. Moreover, the Government subsidised hospital charges and premiums, and agreed to consider funding capital costs in order to ensure the expansion and quality of health care services. Finally, the Plan preserved the existing doctor-patient relationship. All Australians would receive good medical treatment ‘regardless of ability to pay the full price … without destroying or damaging beyond repair the freedom of the medical profession and the vital relationship between doctor and patient’ (Page in Fox, 1963: 876). Thus Page’s National Health Scheme reflected the government’s concern with individual initiative, market involvement, and limited state intervention, by replacing Labor’s centralised national scheme with voluntary subsidised insurance (Dewdney, 1972: 38-42; Sax, 1984: 75-78; Gray, 1991: 89-94; Scotton & Macdonald, 1993: 9-11; Crichton, 1998: 125-126). But the scheme required significant government intervention and, thus, tax payer support for the sanctity of the doctor-patient relationship and the discipline of the market.

### Four pillars of the Page Plan

The Page Plan comprised four pillars: a subsidised scheme for pensioners; voluntary medical insurance; a pharmaceutical benefits scheme; and, voluntary hospital insurance. Ironically they were introduced using the sweeping regulation powers gazetted in Labor’s 1949 *National Health Service Act*. The first, the Pharmaceutical Benefits Scheme (PBS) introduced in August 1950, provided pharmaceuticals prescribed by a doctor, which, if listed on a formulary, would incur no charge. The defeat of Labor removed the fear of nationalisation so doctors somewhat disingenuously felt free to co-operate in a scheme that, whilst similar to the earlier scheme, did not contain the forms of financial control that doctors had claimed were abhorrent. Interestingly the costs of the scheme escalated rapidly, an escalation that was attributable to the rate of doctor usage, and the expansion of the formulary. Anxious to control the rising cost the government introduced a co-payment of five shillings, a measure justified by reference to the principle of self-help (Dewdney, 1972: 40, 42-43; Sax, 1984: 73; Gillespie, 1991: 256-260).

The Pensioner Medical Service (PMS), which was introduced in February 1951, covered the poorer members of Australian society, but it also enabled insurance organisations to charge lower premiums, and mollified doctors by limiting the number
of public patients to social security pensioners who satisfied a strict means test. Whilst this was relaxed in 1966-67, a ‘taper’ was introduced in 1969 reinstating eligibility restrictions. In part this was a response to fears about escalating costs, but it was also a response to the concerns of both the government and the medical profession. They feared that an unrestricted scheme would provide cover to patients capable of paying for their own treatment, and interfere in the right of the doctor to nominate who could be treated free of charge. Furthermore, there was discontent over the level of the concessional fee, which prompted some doctors to argue that they were forced into carrying a burden that was rightly the responsibility of the community (Dewdney, 1972: 46-48; Gillespie, 1991: 260-264; Scotton & Macdonald, 1991: 12; Crichton, 1998: 126-127).

The Medical Benefits Scheme (MBS) proved to be the most contentious of the four schemes. Its implementation was delayed by protracted negotiations with the BMA. Effectively the MBS divided the population into three classes, a division similar to that outlined in the 1938 scheme. Recipients of social security pensions (excepting unemployment) and their dependents would be treated free of charge. Individuals earning between £250-£550 and their dependents would be covered by subsidised lodge practice based on a patient contribution of between ten and twenty per cent. Those earning above £550 and their dependents would receive a lower government subsidy, on the proviso that they joined a private insurance fund. Whilst this largely accorded with the BMA’s 1949 Report on a National Health Service general practitioners feared that most of the population would receive care based on capitation arrangements. As there was no other effective network capable of administering voluntary insurance, the general practitioners feared the scheme would increase, not decrease, the power of friendly societies. Hence, through the state branches of the BMA, they waged a campaign that challenged the Federal Council’s support for the scheme. In fact the NSW branch gave notice of its intention to end all capitation agreements by the end of 1950 replacing them with fee-for-service arrangements, an action that was repeated across the country (Scotton & Macdonald, 1993: 9-10). Ultimately this forced the government into a private insurance scheme that reimbursed individuals on the basis of fee-for-service. Theoretically government and insurance benefits would provide up to ninety per cent of the cost of medical treatment leaving patients to fund the gap. In practice the amount depended upon the
extent to which doctors adhered to the notional “most common fees” and the willingness of government to raise benefit levels (Sax, 1984: 75; Gillespie, 1991: 264-276; Scotton & Macdonald, 1993: 12).

The fourth pillar was less contentious as the Coalition simply modified the general structure of Labor’s Hospitals Benefits Act in accordance with its own ideological stance. It reintroduced the means test and fees on public beds and encouraged voluntary health insurance through the introduction of two classes of hospital benefit. All were entitled to an ‘Ordinary Benefit’, but patients with health insurance were entitled to an ‘Additional Hospital Benefit’ plus their insurance fund benefit. In effect this replaced universal access with two-tier access to hospital services, which by the end of 1952 had been accepted by all States bar Queensland. Strongly committed to “free beds”, and at considerable cost, the Queensland Labor government refused to reimpose the means test. Tasmania too resisted the attempt to reimpose the means test, but it did not have the financial resources to hold out against its reimposition. The NSW and Victorian Labor Governments voiced concerns, but mindful of their earlier objection to their abolition, and persuaded by the promise of financial relief, they accepted the reintroduction of means testing and fees. Moreover, hospital administrators and providers, including Catholic providers who had opposed their removal in the first place, endorsed both measures.

Initially the ‘ordinary’ and ‘additional’ benefits did make a substantial contribution, but by 1956 it was evident that they were failing to keep pace with rising hospital costs, i.e. the real value of benefits fell. The fact that many individuals purchased some level of insurance in order to avoid large hospital bills exacerbated this trend by removing the pressure to maintain the real value of subsidies. Consequently, the Commonwealth share of expenditure fell. State governments, however, were forced to make increasingly larger, not smaller, contributions towards the upkeep of their public hospitals, whilst health insurance schemes were forced to raise premiums. Moreover, some patients were ‘excluded’ from receipt of benefits by pre-existing ailment, chronicity, and maximum fund benefit rules. Whilst designed to minimise the costs of premiums, and hence attract health insurance contributors, exclusions effectively debarred those most in need of assistance. Spurred by criticism, the Government introduced the Special Account System. This required funds to provide
a minimum benefit for its contributors regardless of the existence of exclusions, a requirement sweetened by Commonwealth reimbursement of deficits at the end of each financial year. The initiative, however, only partly solved the problem as the Special Account benefit scales were often set at less than the full benefit for which the individual was insured and less than medical and hospital charges. It was not until the beginning of 1969 that contributors were guaranteed the full rate of benefit for which they were insured, and this regardless of the length of their hospitalisation (Dewdney, 1972: 43-45; Gillespie, 1991: 276-279; Gray, 1991: 95).

**National Health Scheme: Failing the Australian public**

By the end of the 1960s it had become clear that Page’s National Health Scheme was not adequately addressing the health needs of the Australian population. Moreover, it was a source of widespread dissatisfaction, not the least because rising contribution rates and gaps in coverage meant patients were liable for one-third instead of one-tenth of doctor’s fees (Sax, 1984: 6; Scotton & Macdonald, 1993: 12, 19). As Sax explained, some

15 to 17 per cent of the population were found to lack insurance coverage either through the benefit funds or the pensioner medical service. Other groups were underinsured. Admission to public hospitals was not denied to uninsured persons, but they were frequently unable to pay the resulting bills. Either they deprived themselves of other goods and services in order to discharge their debts or the hospitals had to write off bad debts. Because insured benefits were roughly proportional to fees, high use contributors accumulated big out-of-pocket expenses (1984: 78).

Clearly these problems were having the biggest impact on those least able to fend for themselves: the chronically ill; the aged; and poorer Australians. Moreover, there were rumblings about the rapid growth in public expenditure, much of which was generated by suppliers, with little evidence of improved health outcomes (Sax, 1984: 71-72).

**The Wedgwood Committee 1968-1970**

The increasingly evident access and coverage problems emanating as a consequence of the National Health Scheme prompted the Labor Opposition to establish a Select Senate Committee on Medical and Hospital Costs, the Wedgwood Committee, in April 1968. Interestingly, two DLP Senators, Gair and McManus, members of a party
that for a time held the balance of power in relation to the introduction of Labor’s universal health scheme, supported its establishment. Whilst not restricted to consideration of voluntary insurance, the majority of the Committee in fact recommended improvements, some of which concurred with recommendations of the Government’s own Nimmo Committee, which is discussed below. Two Labor Senators, however, disagreed with these recommendations, arguing the deficiencies of the scheme could only be addressed by replacement with a new scheme funded by a surcharge on taxable income, a return to the proposal of the 1940s. If that was not acceptable then the number of registered organisations should be reduced, and state governments should assume control of existing registered organisations. There was then evidence of a search for an alternative to voluntary insurance, clearly linked to elements within the ALP. Indeed it harked back to earlier attempts to introduce national health insurance in the 1940s (Dewdney, 1972: 52; Scotton & Macdonald, 1993: 25-26).

The Nimmo Report
The Government countered Labor’s move by establishing a three-man Committee of Enquiry into Health Insurance headed by Justice J.A. Nimmo. His brief included the examination of a compulsory insurance scheme proposed by John Deeble and Richard Scotton, health economists from the Institute of Applied Economic Research, which later formed the basis of Labor’s national health insurance scheme. The Enquiry, however, was constrained by the requirement that it be conducted within ‘the context of both a voluntary health insurance scheme, and the obligations at present accepted by the State Governments’ (Commonwealth Committee of Enquiry into Health Insurance cited in Scotton & Macdonald, 1993: 26). In effect this meant that the Committee was ‘nobbled’, because it could not make any recommendations compelling universal coverage. Tabled on the 25th March 1969 the Nimmo Report confirmed that the system of voluntary health insurance was ‘beyond the comprehension of many’ (cited in Dewdney, 1972: 75). Not only was it unduly complex, expensive, and incomprehensible, but fund rules disallowed or reduced claims for particular conditions, which created undue hardship for individuals and their families. Whilst the Committee could not recommend compulsory coverage, their Report did expose the difficulty of providing universal coverage of sufficient standard within a voluntary insurance scheme. In particular the Committee
recognised that the means test and fees created barriers to access to hospitals. Thus they recommended ‘the negotiation of agreements with states to provide for standard, all-inclusive fees (to be matched by benefits) and entitlement of all patients to standard ward accommodation, regardless of means’ (Scotton & Macdonald, 1993: 30; italics in original). Public ward accommodation, however, had the potential to deprive doctors and private hospitals of income from private patients, a concern not lost on doctors and private hospitals (Dewdney, 1972: 52-67; Sax, 1984: 79-86; Gray, 1991: 96-99; Scotton & Macdonald, 1993: 29-31; Crichton, 1998: 127-128). More importantly it also aroused concern among Catholic hospitals, a position that became evident during negotiations over the introduction of Medibank to be discussed in the next chapter.

**Gaps in coverage**
Both the Wedgwood and Nimmo reports documented the problems with, and the level of disquiet surrounding, voluntary health insurance. The ‘universal’, but doomed, scheme proposed by Labor in the 1940s had been replaced by a three-tiered health system comprising eligible pensioners who were entitled to free treatment, those who could afford to pay for health insurance, and those carrying inadequate insurance or none at all. As noted above the uninsured, most of who were low-income earners, comprised approximately seventeen per cent of the population (Scotton & Macdonald, 1993: 13). This by itself raised questions about the desirability of a scheme in which the costs fell most heavily on those least able to afford services, a situation that most clearly fell within the ambit of Catholic concern for the poor. Moreover, there was a contradiction within Page’s scheme between protection against the financial costs of illness, and the existence of unregulated medical fees and support for fee-for-service treatment. Resistance by doctors to any attempts by third parties to regulate their fees exacerbated by their insistence on fee-for-service payments meant there could be no certainty or predictability about the cost of treatment. The linkage of benefits to fees set by others left government and insurance organisations financially vulnerable; thus there had to be some measure of regulation. Doctors, however, could not be compelled to comply with restrictions on fees as they were protected by the ‘civil conscription’ clause in the Constitution. Consequently many patients were left with out of pocket expenses as benefits supported by patient contributions were fixed. There was, however, no restriction on charges.
The situation of low-income earners was further compromised by incentives within
the hospital benefits scheme for state governments and public hospital administrators
to increase the number of private patients. As well as deriving more revenue from the
privately insured, they had no obligation or budgetary incentive to adjust the means
test for admission to public wards. Consequently, ineligible low-income earners were
forced into taking out private insurance or risk loss of access to hospital services.
‘By the mid-1960s as many as a quarter of entitled pensioners were medically insured
and a third insured for hospital benefits’ (Scotton in Scotton & Macdonald, 1993: 14).
Their position was further compromised by the fact that they were required to
contribute the same proportion of their medical costs as the less needy. Moreover,
many were denied their fund benefits by rules relating to maximum benefits and
chronicity. Whilst the Special Account System was instituted to overcome these
exclusions, it was only partly successful because the incentives offered to health funds
to improve their financial results encouraged the funds to act in a way that actually
reduced members’ benefits (Scotton & Macdonald, 1993: 13-14, 22).

By the end of the 1960s, then, it was evident that voluntary health insurance,
supported by regulation, subsidies and income tax concessions, did not deliver
sufficient benefits or provide equitable coverage. Indeed, it unduly burdened low-
income earners. Moreover, the system was increasingly complex, uncompetitive,
expensive, overly bureaucratic and unaccountable. Quite clearly the Commonwealth
would have to act. But it was also evident that doctors and private providers would
continue to support the maintenance of voluntary insurance, a position not consistent
with the Coalition’s own ideological stance. Even more interesting for our purposes
is the support of Catholic authorities for the retention of a scheme that seemingly
contradicted the Church’s mission to the poor, a position examined in some detail in
the following chapter.

**Rescuing voluntary health insurance**

As a consequence of criticism, the Liberal/Country Party government moved to
simplify the National Health Scheme. In 1969 it amended the *National Health Act* to
provide free insurance for recipients of unemployment, sickness or special benefits,
new migrants, and low-income families whose income was slightly in excess of the
minimum weekly wage. The amendment entitled recipients to full medical benefits
and hospital benefits equal to the cost of treatment in a public ward, the cost to be borne by the Commonwealth. That is the government, far from radically changing health insurance arrangements, subsidised hospital and medical services for those unable to afford insurance. This Health Benefits Plan assisted ‘those members of the community who would otherwise suffer hardship in the payment of contributions at the usual rate, while not extending the “concessional fee” principle nor departing very far from the “voluntary insurance” concept’ (Dewdney, 1972: 75). Rather than opting for a universal scheme, the Coalition addressed the criticism through a selective and targeted scheme.

The Health Benefits Plan

The Health Benefits Plan became operational on the 1st July 1970. Based on the Nimmo Report, it included two contentious proposals – ‘most common fee’ lists and differential benefits. The latter referred to the payment of two levels of benefits for many services, depending on whether they were provided by general practitioners or specialists. Opponents, most notably doctors, characterised the former as a step towards nationalisation because it interfered with the right of the doctor to set fees, and thus threatened medical autonomy. The latter recognised specialist skills, but threatened the income of general practitioners, as patients could receive the same service from a specialist with no apparent increase in cost (Scotton & Macdonald, 1993: 15-16; 29-31). In addition to these difficulties, the Plan could not institute the rationalisation of health insurance proposed by Nimmo, as it required the introduction of comprehensive fees, a move that depended on the agreement of the States, which was by no means certain. In fact hospital insurance was not restructured until July 1972 by which time all states had agreed to confine benefit tables to three levels equivalent to one of the three levels of public hospital charges (Dewdney, 1972: 68-76; Bates, 1983: 109-111; Sax, 1984: 91-92; Gray, 1991: 100; Scotton & Macdonald, 1993: 36-41). The Health Benefits Plan did eliminate many of the inefficiencies identified by the two earlier reports, and benefits did improve for high use and subsidised contributors. Nevertheless it soon became evident that it was not going to deliver an adequate national health scheme.
The Labor alternative

The failure of voluntary health insurance moved the Labor Opposition to search for an alternative means of ensuring access to health care services. Labor’s 1972 election policy on health contained three planks: the establishment of an Australian Hospitals’ Commission that reflected ‘the “old” socialist preoccupation with the public hospital system and the grafting on of “new public health” objectives emphasising preventive health services delivered in community settings’ (Whitlam cited in Scotton & Macdonald, 1993: 51); a free five-year dental program for all Australian children; and, a universal health insurance scheme. Despite election rhetoric, the universal health insurance scheme was not a socialised health system, but a modification of the Deeble-Scotton plan previously examined by the Nimmo Committee. Indeed, a medical member of the Labor Caucus Health and Welfare Committee decried it as ‘little more than a mechanism for subsidising private fee-for-service medical practice and private hospitals’ (cited in Scotton & Macdonald, 1993: 42). Dr. Moss Cass, also a member of the Committee, ‘described Medibank as the very antithesis of a genuine health service for the community. He wanted community health centres staffed by salaried doctors, although he did concede that such a scheme would be attacked by the medical profession and the conservative parties as ‘socialist medicine’ which they would say was, therefore, bad medicine’ (Stubbs in Scotton & Macdonald, 1993: 42). In effect it was a compulsory national health insurance scheme run by government. The medical component required extensive changes in Commonwealth administrative structures, including the introduction of direct or ‘bulk’ billing whereby doctors directly billed the insurer and accepted the benefit calculated as a percentage of the schedule fee as full settlement. This provoked considerable political opposition, but ultimately there was little effect on the delivery of health services. By way of contrast the hospital component did not extend Commonwealth administration because it was implemented through the provision of conditional grants to the states. It did involve, however, ‘substantial changes in Commonwealth and state government roles, in the internal organisation of public hospitals, in the terms on which doctors were paid for hospital work, and in the balance between private and public treatment’ (Scotton & Macdonald, 1993: 152). Consequently its formulation was complex and its implementation difficult, not the least being because of the need to undertake extensive negotiations with a range of stakeholders, including the Catholic Church (Scotton & Macdonald, 1993: 152).
The key to the introduction of universal health insurance was the leadership of Whitlam, and the work of two health economists – Richard Scotton and John Deeble. Whitlam focussed on the provision of health care through the public hospitals, a position that reflected Labor tradition, but he also sought an increase in the level of Commonwealth intervention in the planning, management and organisation of health services. Thus he instituted a substantial review of health policy, which included examination of the operation and outcomes of voluntary health insurance, which brought him into contact with Scotton and Deeble. They had undertaken a statistical analysis of the functioning, financing and costs of health services, and an examination of the National Health Act. In the course of that work they examined the Canadian federal hospital insurance programme, which was informed by the thinking of the Canadian Royal Commission on Health’s conclusion that voluntary insurance disadvantaged low-income earners because they did not have the capacity to afford the premiums. Moreover, they were required to pay fixed premiums, which consumed a larger proportion of their income compared to high-income earners. The means testing necessary to overcome these deficiencies was ineffective, administratively complex, and expensive, all of which meant the system was inefficient. Finally, the Commission concluded that the costs associated with the actual operation of voluntary insurance, and the accumulation of reserves necessary for the scheme to function, were too expensive, especially when compared with the operations of a single insurer (Scotton and Macdonald, 1993: 19-24).

Scotton and Deeble’s research confirmed these findings, which were further strengthened by the Australian Government’s limited capacity to control health costs and the tendency of several major funds to shift their costs onto government (Scotton & Macdonald, 1993: 23). Voluntary insurance was costly, complex and did not deliver its promised social outcomes. Late in 1967 Scotton and Deeble submitted a plan for compulsory insurance in draft form to Whitlam, and to the Coalition’s Minister for Health whose officers concluded the proposal had no practical application. The Labor Party, however, adopted the Scotton/Deeble plan as Party platform. Scotton and Macdonald argue adoption was assisted by the publication of reports on Scotton and Deeble’s research in the Australian Financial Review in 1968, which called for an overhaul of the health system. The adoption by the Australian Council of Social Services (ACOSS) of a highly critical report on the cost and
coverage of voluntary insurance, and its recommendation for the establishment of a system of compulsory health insurance, further heightened the mood for change (Gray, 1991: 133; Scotton & Macdonald, 1993: 23-24).

**A Scheme of Universal Insurance**

Scotton and Deeble’s 1968 proposal, *A Scheme of Universal Insurance*, set out a virtual blueprint for health reform that was directed at the problems identified by the both the Wedgwood and Nimmo Committees. Funded by a 1.25 per cent levy on taxable incomes and general revenue, the scheme provided for: universal medical benefits paid at 85 per cent of a schedule fee; universal access to free treatment and medical care as a public patient in a public hospital or out-patient clinic; the establishment of a national health insurance commission to administer the program; and, Commonwealth grants to states to fund free treatment of public patients. It did not suggest all services would be free, nor did it propose the centralisation or nationalisation of health care, the curtailment of private arrangements, or the restriction of freedom of choice of doctor (Sax, 1984: 79). Indeed, it retained fee-for-service but ‘changed the way in which people paid for insurance and received reimbursement’ (Gray, 1991: 134-135). That is, doctors could either charge their patients directly or bulk-bill the Commission. Contrary to criticism the scheme was far from being socialist, a point acknowledged by Hayden, who reflecting on his time as Minister of Social Security, later declared Medibank ‘was middle-class welfare reform and it favoured the medical profession. It was based on private medical practice, fee-for-service payments, and patient’s choice of doctor. What it did more than anything else was to efficiently collect and distribute funds for medical and hospital care’ (1996: 213). Two elements, however, threatened relations with the medical profession and private providers, namely the introduction of bulk-billing linked to a formally negotiated schedule of fees, and the re-introduction of universal access to public care (Scotton & Macdonald, 1993: 26-27). Whilst both measures threatened to reduce the size of the private market (Gray, 1991: 135), it was the introduction of public ward accommodation that most concerned Catholic hospital authorities. They feared increasing numbers of patients would elect to be treated as public patients thereby threatening the viability of medical practices and, in particular, private hospitals.
From Proposal to Policy
Following Labor’s election in 1972, Bill Hayden, the new Minister for Social Security, assumed responsibility for the Department of Social Services and the Health Insurance and Benefits Division of the Department of Health. His task was to transform Scotton and Deeble’s academic proposal into a legislative program for implementation. To that end he opted for the development of a Green Paper, which would enable the Government to gauge and consider the responses of interested parties prior to making a final decision. This task was delegated to the Health Insurance Planning Committee (HIPC) the core of which consisted of Deeble, Scotton, and two members from the new Department of Social Security – Laurie Daniels from the Health Insurance and Benefits Division, and Ray Williams, the First Assistant Director-General.

The Green Paper was tabled in Parliament on the 2nd May 1973, followed by wide dissemination. Much of the reaction was hostile, but came largely from organised medicine, voluntary insurance organisations, private hospitals and the Opposition. The concerns of the general public had largely been assuaged by the earlier changes to the National Health Act. As Sax put it, most Australians participated ‘only as puzzled spectators’ (1984: 114). In coming to understand the criticisms it must be borne in mind that government funding significantly underpinned the activities of the medical profession and the health funds. Yet somewhat disingenuously complaints voiced by doctors and health insurance organisations centred on the implementation of what they saw as socialist, nationalised health care that would rob patients of their right to choose their own doctor (which extended to choice of insurer), and interfere in the doctor-patient relationship leading to a lower standard of care. The Federal Council thundered that the proposals ‘would lead to regimentation of the public, a lessening of free choice, a deterioration of health care standards by encouraging a uniform mediocrity. In the broad, the Committee’s report is a blueprint for the rapid nationalisation of health care’ (AMA cited in Gray, 1991: 138; Scotton & Macdonald, 1993: 78). Private hospitals argued it would threaten both their viability and operations, and the states worried about the loss of income from fees and loss of control over admissions (Sax, 1984: 108-115). Catholic opponents echoed these views. Whilst medical assistance proved to be the most formidable opposition, this thesis is primarily interested in the response of the Church, especially given her
relations with the quasi-Church aligned Democratic Labor Party. As in the 1940s Catholic authorities focussed largely on the impact upon Catholic hospitals, a concern that is examined in some detail in the next chapter.

**Dissent within the ALP**

Whilst dissent over the introduction of the universal national health insurance scheme was particularly fierce amongst doctors and elements within the Catholic Church, the ALP itself was not united in its endorsement. As already noted members of the Caucus Health and Welfare Committee had voiced concerns about the scheme. Indeed, they were concerned that the plan ‘was open to abuse and overservicing by private doctors’ (Stubbs in Scotton & Macdonald, 1993: 42). Moreover, some argued it was nothing more than subsidisation of private provision of health services, and as such diverted the Party from the establishment of a socialised health system. Even Hayden had reservations about the cost of the program (Murphy cited in Scotton & Macdonald, 1993: 41), but saw it as preferable to the existing scheme. Despite these reservations, however, planning proceeded and the *HIPC Report*, or *Green Paper*, was eventually presented to both the ministry and the caucus for their approval. Again the Caucus Health and Welfare Committee expressed reservations with its chair, Dr. Dick Klugman, opposing the extension of medical benefits for PMS pensioners to specialist services fearing that this would reduce demand on outpatient services and hence the demand for the services provided by salaried practitioners. Following a series of intense meetings, the Report was finally approved, subject to modest amendment, and preparation commenced on the drafting of the Government White Paper (Scotton & Macdonald, 1993: 86-87).

**The defeat of the Bills**

The resulting legislation consisted of a set of associated bills the centrepiece of which was the *Health Insurance Bill*, tabled on November 29, 1973. Their production, along with the *Green Paper*, was an administrative success especially given the short time frame and the inexperience of the new Government. Implementation, however, depended on the passage of legislation through a Senate over which the Government did not command a majority. The balance of power was held by the DLP, the ALP’s nemesis, a situation not likely to change until the half-Senate election due mid-1974. Whilst the popularity of both the Government and the health insurance program
would be important considerations when it came to the vote, it also depended upon (as Scotton and Macdonald put it):

the extent to which organisations with vested interests in the voluntary insurance scheme could be placated by negotiated concessions. These included health insurance funds, the private hospitals and the AMA and other medical organisations. Of the private hospitals, the Catholic hospitals might be considered the most significant, in the light of their previous history and their links, through the church hierarchy, with the DLP (Scotton & Macdonald, 1993: 75).

It was conceivable, but highly improbable, that the five DLP Senators would vote to accept the legislation. They had split over the appointment of the Wedgwood Select Committee, and they had failed to keep Labor out of office, but it was not clear whether this would influence their vote, especially in the light of the Government’s clear mandate to introduce its program. Hence negotiated concessions, especially involving groups with interests in common with the DLP, was regarded as a necessary step to secure passage of the legislation. To that end the Government was forced to consider the impact of free access to public beds in Catholic hospitals, but ultimately to no avail as the Health Insurance Bill, along with the companion Health Insurance Commission Bill, was defeated in the Senate on the 12th December 1973 on the vote of the DLP. Relations, then, between the DLP and Catholic hospitals proved crucial in the defeat of the Bills.

**Organised medicine’s campaign**

DLP relations with the medical profession were also important, especially relations between the DLP and an informal group of NSW members of the executive of the AMA and the secretariat comprising Keith Jones, George Repin, Lionel Wilson and Nicholas Lloyd, all of whom had a long history of opposition to government health initiatives. Together with Bill Arthur they orchestrated a campaign for the defeat of the universal health insurance proposal. Backed by the authority of the Federal Council, which had declared its total opposition to the proposals outlined in the Green Paper, but contrary to the more conciliatory views of the Federal Assembly, the group lobbied the Opposition and DLP Senators in their quest for an amended voluntary insurance scheme and the defeat of universal compulsory health insurance (Scotton & Macdonald, 1993: 96-99). Negotiations with the DLP, however, were not facilitated by the inner sanctum’s location in Sydney, as the DLP’s power base was in Victoria not NSW. Moreover, efforts to garner support were compounded by indications of
support for Labor’s program that emanated from both the NSW hierarchy and NSW Catholic hospitals, indications that will be further explored in the next chapter. For the moment it is sufficient to say that medical lobbying of the DLP added weight to the campaign of Victorian Catholic hospitals.

Medical lobbying against Labor’s proposal was accompanied by a publicity campaign financed by increased subscriptions and the creation of a Freedom Fund whose purpose was to prevent the ‘socialisation’ of medicine. Whilst deeply political, the message somewhat ironically maintained that health and politics did not mix. Doctors were enjoined to ‘say NO to Nationalised Medicine’ (cited in Scotton & Macdonald, 1993: 99) understood as ‘the total or near total dependence on a government for our income and as a result of this the establishment of a master-servant relationship in the responsibility for the delivery of health care’ (Jones cited in Scotton & Macdonald, 1993: 105). The campaign argued the scheme would reduce patients to a number in a computer, an image reinforced by Nazi allusions. Although initially stunned by their 1972 electoral defeat, and indeed even critical of the AMA publicity campaign, the Opposition eventually sided with the medical profession and declared its opposition to the Government’s health insurance legislation. Among the reasons listed for this position was the claim that the program would lower the quality of patient care, and move Australia down the path to nationalisation of health and medical care. Having secured the support of the Opposition the defeat of the legislation depended upon the support of the DLP (Scotton & Macdonald, 1993: 96-110).

Throughout 1973 the AMA, and the more extreme General Practitioners Society in Australia (GPSA), engaged in public and private attacks upon the health insurance proposal, which included personal attacks on Hayden. Eventually the Government was moved to engage its own publicity campaign, which was structured around the release of an information booklet entitled *The Plain Facts*. Developed as a series of questions and answers its purpose was to redress what it perceived as the misrepresentations being directed at both the public and patients. The AMA responded by publishing comments on the Government’s ‘answers’, the GPSA published a parody under the title *The Plain Truth*, and the Community Hospitals Association published a look-alike booklet containing what were deemed corrections to the ‘answers’. The later was quickly withdrawn when the Government indicated
that it might sue for possible breach of copyright. Despite the Government’s attempts to promote its scheme it was largely unsuccessful, a fact confirmed by a market research poll of public attitudes to the then current health insurance arrangements and the government’s publicity (Scotton & Macdonald, 1993: 101).

Despite having failed to convey its message, the survey did reveal that the Government had reason for some hope as it concluded the AMA campaign had not achieved its desired end. Rather, it had discredited doctors in the eye of the public, which viewed the campaign as biased and dishonest. Moreover, there were signs that the profession itself was divided over the campaign. The Federal Assembly had earlier indicated a desire for a more conciliatory tone, but was overruled by the federal executive. Now many of the members responded by resigning their membership. Whilst this was not wholly attributable to the publicity campaign, it was influential with the strongest reaction coming from Victoria, interestingly the heartland of the DLP. Despite this the leadership continued to defend its tactics, arguing it was designed to provoke the man and woman in the street into asking questions, but, paradoxically, despite succeeding in getting their nationalisation message across, more people expressed support for, rather than opposition to, ‘nationalised’ medicine. Nevertheless fifty-four per cent of the population maintained their support for the rejuvenated voluntary insurance system. Victoria was the only State to record majority support for the government program (Scotton & Macdonald, 1993: 96-109), an interesting response given the most trenchant criticism of Labor’s proposal emanated from that State’s DLP Senators.

The DLP to the fore
The AMA’s failure to garner public support strengthened the position of Catholic authorities, and thus Catholic hospitals, in relation to the passage of the insurance Bills because of their close association with the DLP. As the Split precluded formal negotiations with the DLP, Hayden adopted a more roundabout way of influencing its Senators in the hope of securing their support, and the support of the hierarchy. The HIPC Report had recommended the payment of interim operating subsidies shared equally between the Commonwealth and state governments to private hospitals subject to a presumption that they would ‘assume a more public character’ if the size of these subsidies became ‘substantial’ (HIPC Report, paras. 3.41-3.44). Catholic
hospitals objected that this, among other things, would require them to engage in morally repugnant practices. In an effort to alleviate their fears, the White Paper increased the private hospital daily bed subsidy from $12 to $16, and made allowance for religious and charitable hospitals to negotiate for beds to be made available for the treatment of hospital patients free of charge without surrendering their right to determine admission, treatment, or administrative policies. These still did not placate Catholic concern (Sax, 1984: 114-115; Gray, 1991: 135; Scotton & Macdonald, 1993: 87-89). As Sax put it, Catholic hospitals

alleged that the availability of free care in public hospitals would reduce the demand for private care in private hospitals, that increased demand for public beds would lead to increasing pressure on religious and charitable hospitals to admit ‘hospital patients’ thereby forcing these hospitals completely or partly into the public sector, and that they would be compelled to allow the performance of operations contrary to their moral beliefs (Sax, 1984: 115).

This fear was inflamed by the publication of The National Health Insurance Plan and the Future of Catholic Hospitals, a pamphlet written by Fr. Paul Duffy SJ, the Canberra based Director of the Catholic Centre for the Study of Social Issues and a close associate of B.A. Santamaria, but published by the virtually unknown Australian Association for the Defence of Religious Hospitals discussed in Chapter Nine.

National Conference of Major Superiors: A Statement of Principles

As a consequence of attacks by the Church Hayden did not expect to receive support from the DLP, a concern that was not assisted by receipt of A Statement of Principles from the National Conference of Major Superiors (NCMS), which purported to represent the views of the Australian Catholic hospitals. After affirming support for the preservation of the dual system of public and private hospitals, the Principles argued for the inclusion of several guarantees in the legislation, which included the preservation and encouragement of the dual system of public and private hospitals, the right of religious and charitable hospitals to set and control their own practices without unnecessary government interference, the retention by religious and charitable hospitals of the sole right to appoint the members of their governing bodies, and maintenance of the autonomy of Catholic hospitals in the medico-moral area. Moreover, the statement argued for per capita reimbursement of religious and charitable hospitals, not institutional subsidies. Finally, it called for a delay between
the release of the White Paper and the introduction of legislation in order to allow some ‘breathing space’.

White Paper
The NCMS was not successful in obtaining a deferral of the release of the White Paper, which endorsed nearly all the recommendations contained in the HIPC Report, but modified those recommendations causing concern among the states, the medical profession, private hospitals, private insurers, and more importantly, Catholic authorities. In particular Hayden responded to the NCMS Statement of Principles. He assured the NCMS of the government’s commitment to the dual system and the autonomy of Catholic hospitals in the medico-moral area, promised an increase in the per diem payment, and announced affordable private insurance to cover private patients for private hospital treatment and accommodation, but he refused to delay the introduction of the legislation. However, he did invite Catholic hospitals to submit suggestions for improvements to the Department for consideration. The response of Catholic authorities will be developed in the following chapter. Suffice it to say here that the government’s modifications did not entirely placate Catholic hospitals. There were, however, signs of support for the government, particularly from the NSW and Queensland Churches, whose hospitals had reached an accommodation with the public system.

Signalling opposition
The DLP had yet to make its position clear, but Hayden’s assurances and promises to the NCMS came too late. The Victorian Frank McManus had replaced Gair, and Jack Little, another Victorian, became the spokesman on health. Both were unwavering in their opposition to the Government’s scheme. On the 6th November the DLP signalled its lack of support for Labor’s programme by announcing its intention to introduce its own National Health Bill, followed the next day by an attack by McManus on the cost of the Government programme and a statement that the Government’s concessions were not sufficient. He advised the government on the 28th November that the DLP would vote against the Government Health Bill if it is based on the Hayden White Paper. Such a Bill is a form of Health conscription and cannot function without the co-operation of the forces opposed to it – the medical profession, private hospitals, health benefit funds and

On the day before the second reading in the Lower House the DLP introduced its Bill in the Senate, which ‘provided for replacement of the subsidised health benefits plan and (progressively) the PMS by a system of subsidising the contributions of low-income families and pensioners to health benefit funds’ (Scotton & Macdonald, 1993: 94; italics in original). The defeat of the Government’s legislation in the Senate was now a foregone conclusion.

Despite the inevitability of the result, Hayden continued to make efforts to reach an accommodation with Catholic hospitals. The receipt of a letter from the Major Superiors that included new demands for the subsidised expansion of Catholic hospitals and per capita benefits equal to public hospital costs, ended those efforts. Not long after, Peter Norris, the Chairman of the St Francis Xavier Cabrini Advisory Board, wrote to Whitlam arguing that the only barrier to securing the agreement of Catholic hospitals was the lack of an indexation provision in the per diem payment. If agreement could be reached on this it might be possible to arrange an amendment that the DLP might support in the Senate. The amendment did not eventuate and on the 12th December 1974 the DLP senators joined with the Opposition to defeat the health insurance bills. Scotton and Macdonald described the defeat as attributable to the efforts of a small group of highly motivated people within the AMA leadership, who had dedicated their considerable talents and energy to that end. They had the support of strategically located opinion leaders in the private hospitals and health funds, and most importantly, in Catholic organisations with links to DLP senators. These people had widely varying degrees of financial and professional interests in the outcome, but their commitment to a common purpose was sustained by strong convictions which left no room for deals and compromises (1993: 96).

The DLP, by virtue of its balance of power in the Senate, and the Victorian Catholic Church, by virtue of its links to the DLP, then, had the power to thwart Labor’s scheme. Influenced by the fall out from ‘the Split’, the DLP used its position to stall, but ultimately not to prevent, the introduction of a scheme that would assist the needy and vulnerable, a scheme that was not too different from its own policies.
Looking for a way out: The ‘opting out’ proposal

Following the Senate defeat of the Health Insurance Bills, Hayden began to explore other options, which, whilst substantially in accord with the objectives of the Labor programme, would also secure the support of the DLP by taking sufficient account of medical and Catholic hospital interests. This included consideration of an opting-out scheme, which would allow people contributing to private health funds to offset their levy liability against their contributions, and a Government administered fund that would provide income-related coverage of low income earners and ordinary membership for others. Late on the 4th March 1974, however, Whitlam advised that the Government would re-introduce the Health Insurance Bills to establish the grounds for a double dissolution. Initially Hayden advised against this because of concerns over the cost of the program, but finally accepted that the Bills would be reintroduced in their original form. Nevertheless he thought they could be amended successfully in the Senate and thus proposed a meeting to discuss both compromise programs.

Although Hayden was not convinced that the opting-out program was any better than the Health Insurance Bills, Deeble raised the prospect of Catholic support for such an amendment. This was premised on a second letter from Peter Norris to Whitlam in which he advised that religious private hospitals might be prepared to withdraw their objections. As passage of the legislation could only be assured by the support of the DLP Senators, Hayden asked Deeble to meet with Norris. Consequently Deeble held a series of confidential meetings with the convenor of the National Standing Committee of Private Hospitals (NSCPH), and Catholic and private hospital administrators to discuss the opting-out compromise. Agreement appeared within reach when Hayden gave approval for the offering of concessions ‘without prejudice’ to the Major Superiors and the NSCPH. Cecil O’Dea advised Deeble on the 26th March that representatives of the Victorian Catholic hospitals would support the compromise, but only in private. Deeble, then, was hopeful that the Major Superiors and the NSCPH would endorse the opting-out proposal at meetings to be held the next day. Private hospital representatives, however, indicated lack of support and requested more time to take advice from their members, which prompted Corrigan, Assistant Director-General of the Hospital Insurance and Benefits Branch, to issue an ultimatum about the consequences of slow acceptance of the Government’s
compromise. This resulted in a walkout by NSCPH representatives some of whom took the confidential papers before Corrigan could ask for their return thereby removing the guarantee of confidentiality. The papers subsequently fell into the hands of the health funds and the Liberal Party who used them to discredit Labor’s compromise. Now the only hope of success was to secure the assent of the Catholic hospitals, and thus the support of the DLP. Norris and Mother Mary Philomena, the chairperson of the NCMS, however, made it clear that any chance of a negotiated compromise lay in the hands of a higher authority. On Norris’s advice Deeble tried to contact Duffy, but despite frequent phone calls, was unable to do so (Scotton & Macdonald, 1993: 123-128).

The Gair Affair
On the 2nd April 1974 Whitlam announced the appointment of Vince Gair as ambassador to Ireland. This move was intended to create a casual vacancy, which would mean that Queensland would have to elect six Senators, not the usual five, at the next election. Because this would reduce the size of the quota it was then feasible that three, rather than two Labor Senators would be returned in Queensland. In the event that the other states returned equal numbers of Labor and Coalition Senators, Labor would have an extra Senator in Queensland, which would secure the Party’s position in the Senate, and thus its legislation. Bjelke-Petersen, the Queensland Premier, however, immediately issued the writs for the election of Queensland senators thereby foiling the ploy. Furthermore, the Coalition capitalised on the surrounding furore and accepted the recommendation of the Leader of the Opposition, Billy Snedden, to reject the supply bills in the Senate. This would force a general election. Whitlam retaliated by threatening to dissolve both houses. In anticipation of that eventuality the Health Insurance Bills were reintroduced and guillotined through all stages in the House of Representatives then pushed through to the Senate where they were again rejected for the second time. This provided Whitlam with the double dissolution trigger, a trigger that he activated on the 10th April following the announcement that the DLP, even though it stood to lose most of its representation, would support the rejection of supply. Norris made one further attempt at compromise by requesting the reopening of negotiations with Catholic hospitals. He intimated they would support the government if it introduced the opting-out scheme. Hayden, who perhaps had his fingers burnt by the NSCPH debacle and citing election
pressure, declined any further discussions until after the election (Scotton & Macdonald, 1993: 116-124).

The Joint Sitting of the House of Representatives and the Senate

The Labor Government was returned with a reduced majority in the House of Representatives. It was, however, the composition of the Senate that was, and soon would cause, the most concern. The election returned twenty-nine Labor, and twenty-nine Liberal/Country Party Senators. An Independent Liberal who subsequently rejoined the Liberals was also elected, as was a Liberal Reform Senator whose vote would not assure the passage of Labor legislation, but could assure its defeat. The health insurance program could, however, be passed at a joint sitting of the two houses in the event that the disputed legislation was again rejected by the Senate, which it subsequently did on the 18th July 1974. The lead up to the sitting was plagued by Opposition delaying tactics. Furthermore it decided to reject the supplementary bills to impose the levy, terminate redundant voluntary health insurance subsidies, and regulate private insurance under the new scheme. These had not been the subject of the double dissolution thus they could not be presented at the joint sitting, but were required for the implementation of the new program.

The double dissolution changed the tenor of negotiations with the AMA, but also with Catholic hospitals. As the DLP had been defeated, the government no longer needed the support of Catholic hospitals to ensure the passage of its legislation. Consequently the government now maintained that an opting-out compromise would be acceptable if it avoided a fight with the AMA. The necessary legislative amendments, however, would have to be formulated by its supporters in a form acceptable to the Senate. This was far from assured as indications had begun to emerge that there were clear differences between NSW and Victorian Catholic hospitals and their advisers. Norris had indicated on the 10th June that the Major Superiors were about to adopt a firm position on the opting-out proposal but later wrote the ‘the hospitals, or at any rate, a significant section of them, are reluctant to make any such approach … on the grounds that it … would probably be treated as an endorsement of the government’s scheme’ (cited in Scotton & Macdonald, 1993: 129; italics in original). By this time it was already too late for amendments. Moreover, Hayden had formed the opinion that Norris was not a conduit to the Catholic hospitals
and advised against further contact. The joint sitting took place on the 6th and 7th August 1974 and the Health Insurance Bills were passed into legislation in their original form. As the supplementary levy bills were not a double dissolution trigger the government was forced to proceed with the implementation of only those elements of the new program covered by the Health Insurance and Health Insurance Commission Acts. The timing, however, was not auspicious as Labor was forced to deal with a downturn in the economy, and a revitalised political opposition (Scotton & Macdonald, 1993: 128-131).

The final hurdle
Following the passage of the two companion Bills, opposition to Medibank assumed a spoiling character with the Opposition and private sector interests denying the support of those organisation that were considered to be crucial to implementation of the scheme. The medical insurance side of Medibank could proceed, but the Government had yet to secure the support of the states for the hospital side of the program. Prior to the double dissolution, the AMA had worked loosely with private hospital interests, but this rearguard strategy required co-ordinated action. Consequently, in the second half of 1974, opponents of the scheme that included the AMA, the Voluntary Health Insurance Association of Australia (VHIAA) and the NSCPH established the National Joint Health Advisory Committee (NJHAC). Fr. Duffy and Dr. James Breheny, Medical Director of the Mercy Maternity and Mercy Private Hospitals, represented Catholic hospitals. The establishment of a formal organisation to oppose the implementation of Labor’s scheme, however, appears to have fractured, not cemented, relations between the constituent members. Instead it raised tension between for-profit and Catholic hospitals, as the former sought to take advantage of their association with the latter. Moreover, it was now evident that the elimination of the DLP in the Senate, and the passage of the Health Insurance Act, had undermined the significance of private hospital interests. Whilst the major health insurance funds intensified their opposition, they were now nothing more than an irritant, as ultimately the Government did not need them to implement their program. This left the medical profession and the states. Despite the earlier signs that it was prepared to reach an accommodation with the Government, the AMA now hardened its position. In association with its NJHAC colleagues it urged the states to resist negotiations with the Commonwealth over the Medibank hospital agreements, and warned the states
that they could not expect the co-operation of doctors. Their rearguard strategy, however, faltered as recruitment for the Health Insurance Commission (HIC) gathered pace, the Pharmacy Guild agreed to enter into agency arrangements despite pleas from the AMA not to do so, and Tasmania announced that it would sign a hospital agreement. The final barrier to implementation was removed when Malcolm Fraser, the new leader of the Liberal Party, announced that the Opposition would not block supply. Consequently the AMA resolved that it must live with Medibank despite its opposition to the program.

Conclusion
Despite at times fierce opposition Labor, unlike in the 1940s, was successful in introducing a universal national health insurance scheme that commenced operation on the 1st July 1975. The debate leading up to its introduction concerned an ideological tussle over freedom and compulsion that had been discussed, and at times hotly contested, in the nineteen twenties, thirties and the forties. The supporters of ‘freedom’ argued for individual initiative and responsibility, which was best guaranteed by voluntary insurance. The advocates of compulsion argued that the playing field was not level therefore as a matter of justice the community as a whole must bear the responsibility for the health of its citizens. Access was not a privilege, but a right, and this was best achieved by a compulsory scheme (Sax, 1984: 95-96). Doctors, insurance organisations, private providers, and conservative politicians tended to support the former arguing that compulsory insurance would compromise the freedom of doctors and their patients, lead to standardised treatment directed by government, and lower the quality of care. The G.P. Society News argued that:

It is well known that he who pays the piper calls the tune … By the same token, he who pays the money wields the stick. He who pays the doctor determines the quality and frequency of medical services and to some extent the place where the service is given (cited in Gray, 1991: 136).

The discouragement of individual responsibility and the encouragement of government paternalism that are inherent in a compulsory health insurance scheme are retrograde moves which have no place in a prosperous and progressive community (Turner cited in Sax, 1984: 95).

Moreover, it was said the proposed scheme would lead to over-utilisation of free services, demoralise the medical profession, and deliver less funding for hospital
construction and maintenance. The maintenance of freedom of choice and non-interference could only be guaranteed by a voluntary system, a view also held by many of the Catholic authorities.

The introduction of national health insurance conflicted with these ‘traditional liberties, privileges, and responsibilities of providers and the requirements of justice’ (Daniels, 1985: 16). Indeed, much of the criticism of Labor’s compulsory scheme described it as ‘socialist’ (Gray, 1991: 135-136). So for example the director of Australia’s largest fund, the Medical Benefits Fund argued that some ‘of our socialist economists and politicians want an income-tax-supported health service bought at the Government shop disguised as a Commonwealth Health Insurance Commission. Karl Marx’s theories have never been wanted by Australians in the past, and they are needed even less today’ (Jack Cade cited in Scotton & Macdonald, 1993: 28). The NSCPH charged that the national health scheme was designed to achieve total economic control and the ultimate nationalisation of all private hospitals throughout Australia. This is at variance with our understanding of the Government’s expressed policy of the continuance of a parallel system of private hospitals. The proposed plan reduces the freedom of choice presently available to the majority of patients in regard to hospitalisation (Letter from A.K. Brierley, Convenor of NSCPH cited in Scotton & Macdonald, 1993: 112).

Frank O’Keefe, a member of the Opposition, decried the National Insurance Bill in terms that appeared to lose sight of patients’ interests. He declared it was ‘a nationalistic, socialistic piece of legislation … I am not interested in a socialised scheme or a nationalised scheme, but in a scheme that keeps free enterprise going in Australia’ (O’Keefe cited in Gray, 1991: 135). Paying for Health Care, the AMA’s case against compulsory insurance somewhat disingenuously, given its frequent appeals to the high ideals of the medical profession, identified health care as just another commodity, which should not be controlled by the state. It is only one of life’s basic necessities. We all buy bread and butter from the shop and all pay the same price. No one seriously suggests that because our incomes differ we should queue up at a tax-supported shop for free bread (cited in MJA, 1969: 783).

These criticisms conveniently obscured the heavy burden of health care costs, borne by the taxpayer by way of government subsidy of private insurance, and by the individual consumer, a reality recognised by Labor.
The whole community shares the cost of the community’s health; the whole community bears the cost of the community’s ill-health. It is Labor’s objective simply to optimize the arrangements through which this interdependence is expressed, providing greater opportunities and wider choices for doctors and patients alike (MJA, 1969: 783-784).

Labor’s scheme, whilst short lived, recognised collective responsibility for health. To that end it challenged the dominance of voluntary insurance in order to provide access to all Australians to health care regardless of their ability to pay. Certainly, as a core principle, this addressed the needs of the poorest and sickest members of the Australian community by ensuring their access to health care. But it was not, despite criticism, socialised health. Rather it was a compulsory national health insurance scheme run by government, which some detractors described as middle class welfare.

Unlike the 1940s Labor did implement its national universal health scheme. Like the 1940s it faced opposition from the same opponents who argued again against the introduction of socialised health. Concern on both occasions was fuelled by the fear of communism, its rise leading up to the 1940s, and its expansion following the end of the Second World War. Consequently an expanded role for the state generated considerable concern. Nevertheless there were clear problems with access to health care, especially for the poorest and most vulnerable members of society which Labor sought to address through both its schemes. In the 1940s, however, the scheme was reduced to the payment of cash benefits, as an adjunct of Labor’s economic state in which the situation of the wage-earner was assured by full employment boosted by social security (Smyth, 2003). By the 1970s, Labor had replaced this welfare society with its vision of a welfare state in which Australian citizens accessed health care as a matter of right, a view that could be argued was broadly in accord with post-Vatican II social thought. Having said that, it could be argued both the scheme in the 1940s and the 1970s appeared to fit the mission of the Church. Regardless, Catholic authorities resisted both proposals. It involved association, if not engagement, with politics that forced the governments of the time to modify their proposals. Indeed, the passage of the 1974 Labor Government national health proposal was narrowly carried in the face of fierce opposition. The Catholic Church – as has already been shown – was prominent in its opposition, both direct and indirect, to the idea of a national health scheme. Having established the social and political circumstances leading up to and including the introduction of Medibank in this chapter, it is now necessary to
examine in more detail the Church’s resistance in the 1970s. Was it a necessary consequence of Catholic social teaching as claimed by Esping-Andersen, Castles, and van Kersbergen, or a response that over-emphasised the principle of subsidiarity at the expense of the Church’s mission to the poor and vulnerable, or both? The next chapter addresses these questions through an examination of both the response and the reasons for Catholic resistance to Medibank.