

CHAPTER NINE

THE RESPONSE OF CATHOLIC HOSPITALS IN THE 1970S

Introduction

On the 1st July 1975 Medibank, the Whitlam Labor Government's universal health insurance scheme, became operational despite the strenuous opposition of doctors, private insurers, and private hospitals, including Catholic hospitals. As indicated in the previous chapter, the DLP held the balance of power in the Senate. This meant that the government had to consider, and indeed placate, the interests of Catholic hospitals if it was to have any hope of enacting its legislation. The central question for Catholic hospitals in relation to the *National Health Insurance Program (NHIP)* was the survival and independence of religious hospitals whose future they argued depended on the maintenance of the dual system, freedom of patient choice, and the freedom of religious orders to continue their traditional apostolate to the sick and dying, all of which they contended were threatened by the *NHIP* (ARSC, A500/51: 1). Despite all the dire predictions, however, religious and charitable hospitals did not collapse following the introduction of Medibank. They were not forced, absorbed or incorporated into the public system. Moreover, they were not forced to perform treatments that were contrary to their philosophy or ethos.

Catholic hospitals did not oppose the idea of universal health insurance *per se*. To be more precise they opposed the universal health insurance scheme outlined in the Deeble and HIPC reports. Indeed, the Chairman of the NCMS noted the national policy of Catholic hospitals was predicated on concern that all, especially the poor, should have access to quality health care, but the question of medical ethics was also a matter of concern. In their opinion the objective of the proposed scheme was the economic management of health insurance, which took little or no account of the nature, delivery and practice of health care. Certainly there was a need for rationalisation of the health system in order to remove costly duplication of equipment, facilities and services, but Dr. Connolly, the Canonical Adviser to NCMS, argued this should not be the 'dominant and exclusive concern in formulating a national approach to hospital and health services' (ARSC, A502/67: (b), 1). Moreover, nationalisation did not obviate the need for religious and charitable

hospitals. In the NCMS's opinion the *NHIP* threatened the financial viability and independence of Catholic hospitals.

It is basically a National Health Insurance Scheme and embodies discrimination and a progressive denial of freedom of choice. There is basically allowed one system of health delivery and would tend to suggest a gradual elimination of Private Hospitals (LCMA 02, 1973).

Despite repeated government assurances that this was not the government's intention, Catholic authorities continued to voice the fear that they would be required to provide the same range of treatments as public hospitals. This included abortions and sterilisations. Consequently, Catholic hospitals remained resolute in their resistance to the introduction of Labor's universal, national health scheme. Yet to some extent this belies what was actually happening on the ground. Resistance, or at least the level of resistance, was not uniform across the Australian Catholic church.

As has been shown in previous chapters, the response of Catholic hospitals to the *Green Paper* was influenced by the events surrounding the Split, and the threat of communism, which effected the Church's relations with the ALP. In turn this impacted upon the Catholic response to Labor policy, including health policy. The most vehement opposition came from Victorian Catholic hospitals which, given the ferocity of the battle between the Victorian Branch of the ALP and the Victorian Church – a battle examined elsewhere – is hardly surprising. The antagonism in Victoria was fuelled by the anti-communist activities of the secret 'Movement', which drew upon Catholic social teaching, albeit a conservative interpretation. By way of contrast the much more pragmatic New South Wales Church expressed a measure of support for Labor's proposal. Unlike its Victorian counterpart, key NSW Catholic authorities, whilst gravely concerned about the threat of communism, were not prepared to sever their links with the Labor Party. In their minds the socialism of the ALP was not the socialism condemned by Church teaching. Nevertheless, they ultimately joined with the Victorian hospitals to frustrate Labor's attempts to introduce the *NHIP* but, in the short run at least, to no avail as Medibank was came into operation following protracted negotiations. What follows is a detailed examination of Catholic resistance to the *NHIP*.

Health Insurance Planning Committee Report (Green Paper)

The Health Insurance Planning Committee Report, or Green Paper, was released in May 1973 and soon evoked objections from Catholic interests. In particular they voiced concern about paragraph 3.41, which argued for ‘interim’ support to charitable and religious hospitals in order to avoid ‘any abrupt withdrawal of their services’; paragraph 3.43, which argued for possible integration into the public system; paragraph 3.44, which attached conditions to the payment of subsidies so that private hospitals might ‘assume a more public character’; and paragraph 3.56, which suggested ‘absorption’ and ‘incorporation’ of private hospitals into the public system (1973: 31, 33-34). Catholic authorities concluded the ultimate intent of the Government was the takeover of private hospitals. Moreover, the wide-ranging regulatory powers that the *Paper* conferred on the Minister, with no avenue of appeal, were viewed as a threat to the independence and freedom of religious and charitable hospitals (ARSC, A500/51: 9-10; ARSC, A500/15: para (3), 1).

A summary of the views of Catholic Hospitals in relation to the National Health Insurance Planning Committee Report

The release of the *Green Paper* prompted the Executive of the NCMS to produce *A summary of the views of Catholic Hospitals in relation to the National Health Insurance Planning Committee Report*, which defined the attitude of Australian Catholic hospitals. This was forwarded to the Bishops of Australia, the Minister for Social Security and all Federal Members of Parliament (Scotton & Macdonald, 1995, A731018: 36). Faithful to the mission outlined by Connolly it endorsed the view that all Australians in need should have access to the best possible health care. The statement, however, also expressed the fear that proposals outlined in the *Green Paper* ‘would lead to the decline and eventual disappearance of religious and charitable hospitals’, an end that would be avoided by the retention of the dual system of public and private hospitals. This would be ‘in the best interests of the total community ... (It would) safe-guard the continued contribution of religious and charitable hospitals to health care, and at the same time, permit the Government to provide the people of Australia with quality health services’ (Scotton & Macdonald, 1995, A731018, Paras (1), (3), (4): 1: 36). Verbal guarantees would not suffice. Rather, Catholic hospitals required legislated guarantees that enshrined the freedom of Catholic hospitals to set and control their own policies, appoint their own governing

bodies, and guarantee their autonomy in medico-moral matters, which was ‘essential to vocational fulfillment’ (Scotton & Macdonald, 1995, A731018, Paras (5-6): 1-2: 36). Furthermore, the hospitals argued against budget deficit subsidies for institutions. They regarded these as a threat to the autonomy of Catholic hospitals, as strings would be attached to acceptance of institutional subsidies. That is, Catholic hospitals would be obliged to use the funds as directed by government effectively making them public hospitals. Consequently they would lose their capacity to direct funds to other charitable works. As James Gobbo Q.C., adviser to the hierarchy on health matters put it:

in substance with the budget subsidy that you basically are a public hospital – all excepting you lose the capacity to obtain a surplus to pass it on to the other aspects of the charitable order – which are still an important work or to improve the facilities to have an autonomy in these matters’ (RSCA, A502/67: 3).

The NCMS argued this outcome would be avoided through the payment of a *per capita* entitlement. Finally, the Major Superiors called for a ‘breathing space’ between the release of the *White Paper* and the introduction of draft legislation in order to allow them to digest the content of the legislation and make submissions (Scotton & Macdonald, 1995, A731018, Paras (7), (9): 2: 36).

The Australian Association for the Defence of Religious Hospitals

Prior to the release of the *Summary of Views* the Melbourne based *Australian Association for the Defence of Religious Hospitals*, which proved to be intractable in its opposition, wrote to religious Superiors concerning the future of Catholic hospitals. Indeed, the letter from the *Association* encapsulated the heart of organised Catholic resistance to the universal national health scheme proposed by Scotton and Deeble. It highlighted ten ‘facts’, which warned of the effect of the proposed government scheme on the independence and survival of religious and charitable hospitals, and forecast the demise of the dual system of hospitals. The scheme would impose a financial burden – a point acknowledged by the Scotton/Deeble Report – that would result in the closure of Catholic hospitals or their integration into the public system. The latter would result in loss of autonomy and independence, as the Government would direct the hospitals. Ministerial assurances that the government did not intend to abolish the dual system were not convincing, given the *Green Paper’s* recommendations and the government’s refusal to provide legislative

guarantees. The objective, the *Association* claimed, was the economic management of health insurance, a criticism not without merit. Moreover, the *Green Paper* was prepared in haste, was inaccurate, and developed without prior consultation with religious and charitable hospitals and medical bodies. It took no account of differences in type of care, and would disrupt hospital services and decrease quality of care. Thus the *Association* called on Catholic hospitals to take a united stand against the proposed scheme, which impinged on ‘the Church’s organized apostolate of the sick’. Finally, the *Association* called on the Bishops to approach the Prime Minister, and ‘make a joint public statement in the defence of the right, of Catholic hospitals – and all religious and charitable hospitals – to continue their operations with due independence’ (LCMA 04, 1973: 1-3).

The letter was followed by a statement, which was reproduced almost entirely in the November 15, 1973 issue of the *AMA Gazette*, and a pamphlet. The statement reiterated the claims made in the letter that the eventual effect of the *Green Paper* would be the collapse of religious and charitable private hospitals; the demise of the dual-hospitals system to be replaced by a single-system, government monopoly; and the denial of freedom of choice in hospital care (RSCA, A502/65, H4, undated: III #14, 4). These points were further developed in the pamphlet, which unlike the earlier statement assessed the effect of the *Green Paper* in the context of the essential functions of the Catholic hospital, namely commitment to the dedicated service of the whole person who is sick and dying, as a sign of Christ’s love. The pamphlet argued this function could only be realised in the Christian environment of the Catholic hospital operated and maintained by religious nursing congregations.

The Catholic hospital is above all a **corporate** witness to the reality of the charity of Christ, enhancing the value of the Church’s apostolate to the sick, in contrast to the witness of the individual Religious working in isolation (*The Australian Association for the Defence of Religious Hospitals*, 1973: 2, emphasis in original).

Individuals have a right to choose their hospital care, which is guaranteed by the existence of religious, charitable, private and public hospitals. Freedom of choice, however, will only be possible if Catholic hospitals ‘retain their autonomy in performing **all** their functions’ (*The Australian Association for the Defence of Religious Hospitals*, 1973: 3, emphasis in original).

On this reading, the *Association* was professing a view of mission that was closely tied to the independence and autonomy of Catholic hospitals to direct their own affairs. In effect it was predicated on the principle of subsidiarity that, as Esping-Andersen, Castles and van Kersbergen intimate, inclined the Church towards a view of welfare that restricted the role of the state. Moreover, charity is understood conservatively. That is, charity requires individuals to leave space in their lives to freely express – on a discretionary basis – acts of mercy towards the needy. Therefore government provision of social security and/or health care, may narrow, or even extinguish, the opportunities to act charitably. This may have been based on the erroneous view that charity, unlike justice, is not obligatory on all. Regardless, it reflects a preconiliar reading of Catholic social teaching.

What can be made of this? On the one hand the Church was expressing clearly and strongly its fears that the necessarily distinctive character of Catholic hospitals would be lost if they were absorbed into a homogeneous, state-run ‘monopoly’ on health care. This was by no means a baseless fear, as the *Green Paper* had indicated a desire to absorb private hospitals into a single state health care system. On the other hand, the Association’s statements could be characterised as alarmist, especially given Labor’s traditional preference for cash benefits, and its willingness to placate Catholic concern. First, the *HIPC Report* was a statement of proposals primarily based upon the research conducted by Scotton and Deeble, not a statement of government intent. Secondly, there was a degree of misrepresentation, intended or not, in the assessment of the proposals. For instance the effect of the suggested \$10 per occupied bed day applied to those private hospitals not offering diagnostic services. The amount increased to \$13 per day where private hospitals provided diagnostic services. Certainly, the *HIPC Report* did acknowledge that the benefit was less than the combined daily benefits available through voluntary insurance, which would ‘have a considerable effect on some private hospitals (HIPC Report, 1973: Para. 3.38, 30). Nevertheless, it argued, this

can be overstated. In the first place, the Commonwealth’s assistance to private hospital patients includes tax concessions on fees paid, the value of which could equal the additional amounts payable under the plan for full public hospital care. Secondly, net fees could, on average, be little higher than those proposed for private patients in public hospitals. If present trends continued, the average revenue of private hospitals would reach about \$32 per occupied bed day in 1974-75

which would leave an uncovered fee of \$22 per day, the same as that for the private patients in single rooms of public hospitals (*HIPC Report*, 1973: Para. 3.39, 30).

The *Association's* comments on Paragraph 3.56 of the Green Paper were also selective. Contrary to the *Association's* claims, 'absorption' or 'incorporation' into the public system was not mandated, but rather proposed as an alternative means for overcoming local shortages in public facilities. Indeed, incorporation, the second alternative, was

similar to that provided for by the Third Schedules of the Victorian and New South Wales Hospital Acts – would require little change in existing management and control, and the Committee recommends that this possibility be explored with State authorities if necessary (*HIPC Report*, 1973: Para. 3.56, 33-34, emphasis added).

Certainly, the flagging of 'absorption' and 'incorporation' as possible options could produce a reasonable apprehension that the government was intent on the creation of a single system, but as Hayden had already noted, the *Green Paper* was a proposal that was released for discussion, not government policy. Moreover, the report recommended government support for religious and charitable hospitals that provided short-term surgical and terminal care through the semi-autonomous incorporation model referred to above. Although it also allowed that they could be integrated into the public system in the long term. It was this provision that heightened the concern of Catholic hospitals. Finally, the concern expressed about the assumption of 'a more public character' (Para. 3.44) conditional upon the payment of substantial subsidies may be read as a threat, but it might also be read as highlighting the need for transparency in accountability for taxpayer funds, a move that accorded with Catholic teaching. A more serious charge, however, related to the *Association's* reference to the experience of Catholic hospitals under the Canadian national health insurance, a scheme similar to the proposed Australian scheme.

The Canadian experience

In defence of its claims the *Association for the Defence of Religious Hospitals* claimed that Canadian Catholic hospitals were subject to government supervision of hospital policy and administration, and required to offer the same range of services as public hospitals, which might include abortion. Religious nursing sisters had been reduced to the status of salaried employees with decreasing control of policy, had

their access to wards limited, and some were required to pay rent to the Government resulting in an exodus from religious life because they could no longer fulfil their religious vocation (1973: 5-6). Yet Donald McLeod, from the Canadian Department of Health and Welfare, who provided advice and statements on the situation of Catholic hospitals in the Canadian system, disputed these claims. He concluded that one can only speculate

on the source of this information. The Catholic Hospital Association of Canada has had no contact with this group, or with others claiming to represent the views of Catholic hospitals in Australia ... In general these statements can be discredited completely, as they are apparently intended to apply to all Catholic hospitals in "the Canadian system". In fact, each province has its own legislation regarding the operation of hospitals. Only Quebec has introduced legislation which could lead to these interpretations, and even there the interpretations may be challenged (Scotton & Macdonald, 1995, A731121, 1: 37).

Certainly, inclusion in the Canadian system had been accompanied by an increase in government involvement in hospital affairs, but 'in every province boards of hospitals operated by lay corporations or religious orders maintain considerable autonomy in establishing policy and administrative practice' (Scotton & Macdonald, 1995, A731121, (a), 2: 37). Religious were generally regarded as salaried because the salaries were shareable expenditures under the Act. Whilst much was returned to the hospital as an added source of general revenue, the orders retained the right to divert the income in whatever manner they saw fit.

Policy decisions continue to be made by the responsible governing authority. Participation of religious on boards varies from hospital to hospital, but the degree of participation has nothing to do with salaried vs. non-salaried status (Scotton & Macdonald, 1995, A731121, (b), 2: 37).

The right to refuse to perform abortions in Canadian Catholic hospitals was absolute; level of access to wards was a decision made by administrators or boards, not government; and payment of rent was either a congregational book-keeping exercise or a consequence of selling the property to the state. Finally, McLeod noted the decline in religious numbers could not be attributed to participation in the scheme alone, as falls in vocations began before its introduction (Scotton & Macdonald, 1995, A731121, (c-f), 2-4: 37). Put bluntly, the claims about the 'horrors' of the Canadian experience were based on misinformation.

One can only speculate on whether the tactics used by the *Association* in relation to the fears about the experience of Catholic hospitals in Canada may actually have undermined its credibility, and thus their case. The similarity with Santamaria's later criticism, which is discussed below, however, is remarkable. It is as if both the *Association's* contribution and Santamaria's were written by the same hand, or at least, shaped by the same mindset, a comment that also applies to criticism levelled by Breheny, Medical Director of the Mercy Maternity and Mercy Private Hospitals, and J.M. Lucas. Using language and arguments very similar to that used by the *Association* and Santamaria they characterised the *HIPC Report* as an attack upon religious and charitable hospitals that would result in the demise of Catholic hospitals as a consequence of direct or indirect financial pressure. They would be nationalised and therefore would no longer be free to direct and determine the type and quality of care, fees or medical appointments. Breheny and Lucas further complained that patients would lose their choice of doctors and accommodation, and bemoaned the fate of those families in which both husband and wife were forced to work, as both would be liable for the levy (ARSC, A500/7: 1-12; ARSC, A500/21: 3).

The tone of the commentaries by Breheny, and Lucas, however, is apocalyptic and based upon generalisations without reference to evidence. In particular they omit any consideration of the problems with voluntary health insurance arrangements, which were 'private but emphatically not competitive' (Scotton & Macdonald, 1993: 15), leading to growing dissatisfaction with both the rising contribution rates and gaps in coverage. Indeed, the protection afforded existing health insurance operatives by subsidies made it difficult for funds to work outside the system. The increase in the number and level of regulations encouraged the funds to adopt uniform tables, benefits and contribution rates, thereby making them uncompetitive, unaccountable and inefficient. Moreover, the industry 'was conditioned by the interests of the providers whom the system funded' (Scotton & Macdonald, 1993: 15). Consequently, many individuals were left with little or no cover. Breheny's commentary in arguing for the retention of the *status quo*, which appeared to serve the commercial interests of Catholic hospitals, ignored the needs of those least able to afford health care, let alone Catholic health care. Intriguingly, this view also accorded with the Bishops' response to perhaps the major issue of the day, needs based funding for schools discussed in an earlier chapter. Even more interesting is the parallel with

the few comments that Santamaria did actually make on Labor's health scheme, which are discussed below.

Championing the Principle of freedom

Underpinning the resistance of Catholic hospitals to the HIPC recommendations was the perceived threat to individual liberty. Breheny argued the religious would not be free to offer their services in the way that they would desire, and patients (who could afford to do so) would not be free to access private care. 'Neither private citizens nor private institutions should be conscripted to public service without unquestionably good cause and certainly not if there is a reasonable alternative' (ARSC, A500/7: 4), a claim reminiscent of the principle of subsidiarity. Moreover, the increase in demand resulting from the implementation of the recommendations contained in the *Green Paper* would reduce not only the patient's freedom to choose the type of hospital accommodation, but their own doctor. This would expose them to the risk of a lower level of care because the demand would result in busy, overcrowded and overtaxed facilities, and staff disgruntlement arising out of staff conscription, constitutional prohibition notwithstanding (ARSC, A500/15: paragraph 4, 1; ARSC, A500/13: paragraph 3.1(c), 3; ARSC, A500/7: 4).

Nationalisation

In essence private hospitals, including religious and charitable hospitals, viewed the *Report* 'as a proposal to achieve total economic control and the ultimate nationalization of all Private Hospitals throughout Australia' (ARSC, A500/15: paragraph 1, 1). They claimed that the ministerial assurances that the Government was not intent upon the nationalisation of private hospitals or desirous of forcing them into a more public role were undermined by the recommendations in the *Green Paper*. Moreover, many of the details regarding implementation had yet to be decided, but their major concern was the solution proposed by the *HIPC Report*, namely the 'absorption' or 'incorporation' of private hospitals into the public system (*HIPC Report*, 1973: Para 3.56). Whilst the total nationalisation of medical and hospital services may not have been the intent of either the authors of the *Report* or members of Government, Lucas voiced his concern that these arrangements awaited clarification after the passage of legislation. 'It is fair', he argued

to say that THE ESTABLISHMENT BY LEGISLATION OF THE MACHINERY TO ANY GOVERNMENT AT ANY TIME AND AS A MATTER OF BUDGETARY CONSIDERATIONS OR POLITICAL WHIM, TO NATIONALISE PUBLIC HEALTH IN THIS COUNTRY WITHOUT FURTHER LEGISLATION BY PARLIAMENT, AND WITHOUT REFERENCE TO THE COMMUNITY. “Socialisation with the cheque book” is an appropriate description of the situation (ARSC, A500/21: 3, capitalisation in original).

Moreover, the *Report's* proposals to close down inefficient, small private hospitals and encourage those private hospitals wishing to become public were seen as indicative of the Government's intent to dismantle the dual system, i.e. to nationalise hospitals.

The Minister replies

Hayden assured Catholic hospitals, personally and in writing, that the Government did not desire the demise of religious and charitable hospitals. Rather it was committed to the maintenance of the dual system; a commitment he stated was embodied in the forthcoming *White Paper*. The fears outlined in the *Summary of Views* and the *Australian Association for the Defence of Catholic Hospitals* pamphlet concerned what might, rather than what would, happen (Scotton & Macdonald, 1995, A731024a, 1: 36). Indeed, the Government had deliberately opted for the release of a *Green Paper* in order to

allow more thorough analysis of many policy and logistical issues to be undertaken, ahead of any government decision, both as a direct contribution to that decision and as a stimulus to outside bodies to provide inputs to it' (Scotton & Macdonald, 1993: 69).

In other words, as already noted, it was a statement of proposals put forward by advisers as distinct from a statement of Government intent. The final proposal would be informed by the views of interested parties. As the Minister for Health put it, the Government intended

to provide substantial financial assistance to non-public hospitals which seek it on terms which will not in any way compromise the autonomy or the character of these hospitals. The Government in fact will positively endorse the continuance of dual hospital systems in Australia. Moreover, it will provide for, with the total programme, opportunities for private insurance at favourable rates so that patients in private hospitals can receive benefits sufficient to cover them against the costs of most types of private hospital treatment and accommodation.

The Government's intentions as regards private hospitals, are, in short, to recognise that religious, charitable and community hospitals play an important role within the nation's health services and that in particular they provide an opportunity for freedom of choice which the Government not only accepts but endorses (Scotton & Macdonald, 1995, A731024a, 2: 36).

Hayden advised that the yet-to-be-released *White Paper* endorsed the dual system, and the independence of Catholic hospitals. Indeed, paragraph 4.32 of the *Paper* specifically guaranteed the right of religious and charitable hospitals to control their own policies free of unnecessary Government interference including the appointment of their own governing body. It also guaranteed autonomy in the medico-moral area (LCMA 05, 1973: #2, #3, #5, #6, 2-3), a guarantee reiterated at Hayden's meeting with the Executive of the NCMS where he gave his 'absolute assurance that there will be autonomy of management in the medico-moral area' (ARSC, A502/67: 2). Moreover, religious and charitable hospitals would not be forced into the public system. There was, the Minister said:

no proposal to assimilate your hospitals into the public sector by the Government. I would oppose any move – but no-one has suggested that. In regard to the autonomy of your Boards, we will take steps to guarantee that there will be no steps to intrude into the moral area. I appreciate your concern there. I would take steps to guarantee and preserve your independent right of independent Church hospitals (ARSC, A502/67: 4).

The Government, however, together with the states, would take appropriate steps to accommodate Catholic hospitals if they sought inclusion in the public system. This did not constitute a move to force the assimilation of Catholic hospitals into the public system. Rather, the Government recognised the contribution of charitable and religious hospitals and was anxious for their preservation. Indeed, the *White Paper*, by increasing the occupied bed day subsidy from the \$10 originally proposed by the Planning Committee to \$16, provided a concrete sign of the Government's desire to retain charitable and religious hospitals. Moreover, the Government would be willing to pay the subsidy as a *per capita* entitlement rather than a subsidy to the institution as requested by the NCMS. It should be noted, however, that the government, desirous of achieving the support of the DLP in the Senate, was anxious to placate the concerns of Catholic hospitals because of their close links with that Party.

Whilst the government was willing to provide verbal assurances in relation to the preservation and autonomy of Catholic hospitals, it was not willing to enshrine them in legislation. The Minister was of the view that the Government had given several assurances on the continuation of the dual system and independence of Catholic hospitals, which were also incorporated in the forthcoming *White Paper*. Moreover, at a meeting with Catholic authorities the Minister stated that autonomy in medico-moral matters would be guaranteed by ‘giving you autonomy at the Board level and at the administrative level. This can be established beyond all doubt’ (ARSC, A502/67: 7). Whilst the meeting accepted the Minister’s assurance, Dr. Breheny, who along with Father Duffy and James Gobbo led the resistance by Victorian Catholic hospitals, nonetheless persisted ‘that there will need to be in the legislation such safeguards as will in fact “preserve” and “encourage” the private hospitals’ (ARSC, A502/67: 6). He contended that acceptance of public funding would, and did, result in calls for private institutions to provide the full range of medical and surgical procedures, including those contrary to the beliefs of Catholic hospitals. Reliance on Ministerial guarantee would not remove the threat as another Minister or Government could revoke the guarantee, thereby placing Catholic hospitals in an invidious position. The threat would be removed only by the inclusion of a legislative acknowledgement of the ‘conscientious rights’ of the institution to refuse to provide those procedures contrary to Catholic beliefs (ARSC, A502/67: 7-8). This was a crucial point as the failure to provide legislative guarantees became a focus of Catholic hospital resistance. It was given force by the Church’s association with the DLP Senators holding the balance of power. Whilst Mr Hayden’s reluctance to enshrine the guarantees in legislation owed much to logistical difficulties, some Catholic authorities perceived it as an ominous sign in relation to the future of Catholic hospitals, a perception that appeared not amenable to persuasion. It appeared that many in the Church simply did not trust the Labor Government.

The other matter of contention was the Minister’s refusal to accede to the request for a ‘breathing space’. Catholic hospitals believed there had been insufficient consultation with institutions that would be directly effected by the introduction of the proposed scheme especially in relation to the use of private hospital beds for public patients. The *Australian Association for the Defence of Religious Hospitals* charged that there was ‘virtually no prior consultation of hospital and medical bodies. There was no

prior consultation at all of Catholic hospitals' (LCMA 04, 1973: (7), 2). Moreover, HIPC was totally dominated by economists and public servants whose main concern was the economic management of health insurance not the delivery and quality of care, which made it imperative that interested bodies had more time to discuss the proposal and make submissions. Hayden, however, believed that sufficient time for debate and submissions had elapsed and there would be more time between the release of the *White Paper* and enactment of legislation (LCMA 05, 1973: #9, 4; ARSC, A502/67: 2).

Signs of division

In reply to Hayden's letter following submission of the *Summary of Views*, Archbishop Cahill, secretary of the Australian Episcopal Conference, who had previously indicated that the NSW Church did not want to sever links with the ALP, advised the Minister that his comments 'SHOULD GO FAR TO DISPEL FEARS AND ANXIETIES ON THE PART OF THOSE RESPONSIBLE FOR THE HOSPITALS' (ARSC, A500/39, capitalisation in original). This assertion, however, was premature as signs of division within Catholic ranks were already emerging. Indeed, Hayden had been led to believe

in some respects from the understanding the Planning Committee had on the basis of information provided to it earlier this year, that Catholic Hospitals in some States at least were attracted to the advantages of operating as public hospitals within the general ambit of State legislation (Scotton & Macdonald, 1995, A731024a: 36).

Now faced with conflicting positions he requested that

a body representative of Catholic Hospitals be appointed to consult with my Department so that suggestions for changes to the system can be submitted for my further consideration' (Scotton & Macdonald, 1995, A731024a, 3: 36).

Archbishop Cahill agreed to that request and appointed the Executive of the NCMS. To that end Mother Mary Philomena, President of NCMS, formally requested working parties be established in each State to examine their situation and nominate one member to meet with government representatives to further discuss the national health insurance proposal (ARSC, A502/67: 2.15, 10; ARSC, A500/39). Their task included preparation of advice on the *White Paper*.

National Health Insurance Program (White Paper)

Up until this point resistance to Labor's national health scheme had focussed on the *Green Paper*. The release of the *White Paper* did not placate the concern of some Catholic authorities, notably the Victorians, even though it modified the recommendations of the Planning Committee, particularly in relation to private hospitals. Published in November 1973, the *White Paper* recognised the important role religious, charitable, and community hospitals played in the delivery of health services. It noted that they

provide an opportunity for freedom of choice by patients and also for the expression of high vocational motivation by those who work in and for them. The Government therefore endorses the continuance of the dual public/private hospital system and will provide financial support for private hospitals and the patients they treat in a way which will neither inhibit the autonomy of the hospitals nor restrict the services they provide. This means, for instance, that religious, charitable and community hospitals will be free to set and control their own policies without unnecessary Government interference and that they will retain the sole right to appoint the members of their governing bodies. A corollary of this is that they will retain autonomy of management in what has been referred to as the medico-moral area (Para 4.32: 52).

Thus the *White Paper* rejected the *HIPC Report's* recommendation that private hospital fees should be subject to the control of the Government. This was 'to make clear that the substantial financial assistance which will be provided to assist private hospitals and their patients will not involve interference in the management of the hospitals' (*The Australian Insurance Program*, November, 1973, Para 4.25: 50). Moreover, as noted above, the *Paper* increased the basic rate of benefit for patients in private hospitals from the \$10 recommended by HIPC to \$16 per day.

Whilst the Government provided assurances on the continuation of the dual hospitals system, it understood that some religious, charitable and community hospitals wished to care for hospital patients. Thus the *White Paper* included provision for negotiation of arrangements by which religious, charitable and community hospitals could accommodate and treat patients without charge on the understanding: that the arrangements were voluntary; the hospitals remained free to admit uninsured patients in accordance with their normal admission policies; the patients were treated by 'doctors engaged by the hospitals and remunerated on a basis to be agreed'; Government accepted responsibility for the agreed cost of accommodation and

treatment; and the amount to be reimbursed to hospitals was mutually agreed, based on the fee foregone in exchange for 'free' treatment, and, the method of payment was a *per diem* subsidy paid to the hospital on the patient's behalf. These arrangements would not lessen the hospital's control over admission, treatment and administrative policies (*The Australian Insurance Program*, November, 1973, Para 4.33-4.35: 52-54). The *White Paper* concluded these arrangements would expand the choice of hospitals offering 'free' treatment, and guarantee the role of religious and charitable hospitals (*The Australian Insurance Program*, November, 1973, Para 4.35-4.36: 54), a guarantee that did not, however, allay the concern of Catholic hospitals.

The National Health Insurance Scheme: The White Paper and Religious Charitable Private Hospitals, Memorandum

James Gobbo acknowledged the inclusion of 'useful concessions' in the *White Paper*. He worried, however, the guarantees did not have legislative status. Even if they were based in legislation, private hospitals were still 'being asked to exchange a system that, whatever its other defects, is for them entirely satisfactory for one which will make them financially dependent on the Commonwealth' (ARSC, A500/45: 2). This seems curiously at odds with a proclaimed mission to serve the poor. The present system was not serving the needs of the population as a whole, but especially not the needs of those seventeen per cent who were unable to afford insurance premiums. Moreover, Scotton and Deeble's survey of health service delivery and practice under voluntary hospital and medical insurance had concluded that there

is a strong welfare argument that the prime object of these government-sponsored and subsidized schemes should be to provide adequate cover for the expenses of high-use contributors, and that other objectives should be subordinated to this aim.

Neither scheme appears to achieve this objective satisfactorily. Medical benefits are paid only against expenses incurred, but this is not true of the hospital benefits scheme where over-insurance can produce substantial profits. Both schemes limit the benefits paid to certain high-use contributors, the effects being greatest for hospital users. These restrictions are directly contrary to the welfare objective particularly when other contributors obtain profits. On the medical side, the majority of members incur trivial annual expenditures, but a few are faced with very high costs. Both classes receive similar proportionate recoups under the existing system, but high-use contributors are left with substantial net expenses (Deeble & Scotton, 1968: 121).

The assurances welcomed by Gobbo related to what he termed ‘ancillary matters’ namely autonomy of management and freedom on medico-moral matters, issues that the *Summary of Views* had depicted as key. The *White Paper* did not, however, meet the ‘basic principle’, namely retention of the dual system of public and private hospitals. In particular it did not indicate how the independence of private hospitals would be maintained once the insurance system was replaced by the *per diem* subsidy supplemented by insurance schemes.

In any discussion of the Scheme, the critical question is inevitably the difficulty of combining the suggested subsidies to private hospitals with the independence of those hospitals ... (There must be) a clear guaranteed and satisfactory relationship between the amount proposed to be paid to private hospitals (as a per capita entitlement of the patient) and the running cost of public hospitals (ARSC, A500/45: 1, (2) 4).

Whilst the \$16 per bed day subsidy might initially reduce the fee to be covered and thus ensure affordable insurance premiums, there was no legislative provision for adjustment in line with rising hospital costs. Thus the cost of premiums would increase pushing private insurance and private hospital accommodation out of the reach of many. Consequently, private hospitals would collapse or be forced into the public system at the cost of their independence (ARSC, A500/45: 2).

Gobbo further warned that even if the modifications persuaded some Catholic hospitals to drop their opposition to the *NHIP* they should not endorse it. This would legitimate the argument to change a system, which whilst not perfect, served the interests of private hospitals. The defects did not warrant a total overhaul. Private hospitals were entitled to ask for the retention of existing private insurance arrangements. Moreover, they should be allowed sufficient time to consider the content of the legislation before its enactment. Whilst the immediate provision of free insurance cover would benefit the disadvantaged, private hospitals needed more time to put their case, as, once adopted, the effect of the scheme on private hospitals would be irreversible (ARSC, A500/45: (4), 5-7). It appeared, then, that Gobbo was putting the interests of the private hospitals above those of the disadvantaged who would be assisted by the introduction of Labor’s scheme.

The National Executive of the NCMS meets to consider the NHIP

Representatives from the State Conferences of Major Superiors and the NCMS met on the 23rd November 1973 to consider, and comment on, the *White Paper* with the intention of writing a report for the Episcopal Conference, a reply to Mr. Hayden, parliamentarians, and a press release. Discussion was limited to Items 4.1 through to 4.36 of the *White Paper*, the section dealing with hospital services. Comments included: requests that the development of new public hospitals include religious and charitable hospitals (4.24); payment be made to the patient not the institution (4.25); establishment of a link between the proposed subsidy and the costs of running public hospitals, and development of an adequate appeal procedure (4.26); extension of assurances in relation to private religious, charitable and community hospitals be extended to include their public equivalents and, that these be safeguarded in legislation (4.32). Moreover, there was considerable discussion of paragraph 4.33, which noted that many religious, charitable and community hospitals had indicated to the government their wish to participate in the scheme. The meeting acknowledged that there had been some general discussion, but this could not be construed as negotiations. Moreover, it concluded that 'we are unable to see how this can be achieved within the specific framework of the Government's proposal except by such hospitals assuming the essential character of being Public Hospitals' (LCMA 06, 1973: Item 4.33, 7). Sisters M. de Montfort and M. Marius L.C.M. from NSW, Mr Pendleton, representative of the NSW State Conference of Major Superiors, Mother M. St. Gabriel R.S.M. and Sr. Angela Mary R.S.M. both from Queensland, and Mr I.J. Morris also from Queensland, however, disagreed thereby reflecting division within the ranks of Catholic hospitals that was further exposed by the relation of the *White Paper* to the earlier *Summary of Views*.

The *White Paper* in relation to the *Summary of Views*

The meeting agreed that the modifications contained in the *White Paper* represented some progress. Some representatives, however, were firmly convinced that the *White Paper* would 'lead to the decline and eventual disappearance of religious and charitable private hospitals (LCMA 06, 1973: Principle 2, 8). Mother M. St. Gabriel and Sr. Angela Mary from the Mater Hospital in Brisbane, however,

stated quite definitely that their Governing Authority is in favour of the *White Paper*, as it was workable in their own situation. They made it

quite clear that they would have to disassociate themselves from any rejection of the *White Paper*. However, they stated they were presenting the views of their own Institution, and not necessarily those of the other Catholic hospitals in Queensland (LCMA 06, 1973: Principle 2, 8).

There was, then, a clear difference between these two representatives and the rest who argued that the *White Paper*, regardless of some concessions, did not satisfy the principles outlined in the *Summary of Views* (LCMA 06, 1973: 8-9). Nevertheless, the representatives agreed on a common response, which essentially was a recapitulation of the *Summary of Views of Catholic Hospitals* issued in October 1973.

In effect the response was a report card that scored the national health scheme against the nine nominated principles outlined in the earlier *Summary*. Essentially Catholic hospitals maintained the position outlined in their earlier opposition to the *Green Paper* while recognising that the government had introduced modifications that were acceptable. This response, unlike the earlier *Summary*, however, was framed in terms of the family, hospital, and region/State. The meeting argued that the ‘Government approach to this problem of Insurance is inflexible as it is orientated towards the individual and not the family’ (LCMA 06, 1973: 10). Consequently, the scheme discriminated against the family unit as the father, who might be satisfied with standard ward accommodation for himself, might prefer private accommodation for his wife and children; the levy was payable on the wages of both husband and wife even though both work as a matter of necessity; and all medical, personal, and payment details are centralised, thereby threatening the security of the family.

There is a need for devolution of authority to enable barriers to be erected between the Federal Government and the receiver of health care. There needs to be a means to break down the power of the Government purse through the payment of subsidies to various agencies, which in turn would be paid to the recipient of the health care to enable him to meet his costs’ (LCMA 06, 1973: 10).

Moreover, the Government should ‘leave alone those things which are functioning well within the hospital and ... provide support where there is any faltering’ (LCMA 06, 1973: 10), a principle that must also apply to those skills, services and traditions developed at the regional/State level of health care. ‘The National Health Insurance Program should not make individuals, families or institutions hostages in a desire for National uniformity’ (LCMA 06, 1973: 11). Clearly this position reflected the principle of subsidiarity, which had been identified previously by Esping-Andersen,

Castles, van Kersbergen and Smyth as leading to the development of a conservative welfare state.

The letter accompanying the response reiterated this discussion, but it also noted that the long history of service provided by Catholic, religious and other charitable hospitals entitled them to be heard on matters related to the care of the sick, impaired, dying and vulnerable. As disciples of Christ they

cannot but applaud and uphold the ideal of seeing to it that every member of the community, especially the less privileged and deprived, should have access to the best possible medical and health care at realistic and reasonable cost. It is the responsibility of the community as a whole to subsidize and, where necessary, provide this care free of charge' (ARSC, A502/69: (2), 1).

Interestingly, this comment appeared to be at odds with what amounted to the NCMS's rejection of the *White Paper*. Whilst the community must provide care to all its citizens, free care was a measure of last resort. In effect the response reflected the Church's social philosophy – the emphasis on family supported by intermediate associations, and then, the state. That is, it conformed to the 'Catholic world of welfare' identified by Esping-Andersen, Castles, and van Kersbergen.

The defeat of the *Health Insurance Bills*

Despite the fact that it was becoming increasingly evident that the Government could not achieve agreement with Catholic hospitals, Hayden continued to make efforts to reach an accommodation. 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, however, ended those efforts. Advice that the DLP would submit its own Bill sounded the death knell. Thus the *Health Insurance Bills* were defeated on the 12th December, 1974, on the combined vote of the DLP senators and the Opposition. This was not the end, however, of the Government's programme. Indeed, Whitlam continued to push for its implementation, a decision that ultimately meant the two *Health Insurance Bills* became double dissolution triggers, a situation examined in the previous chapter.

Catholic Hospitals Association for the State of Victoria

A meeting of representatives from practically all Catholic hospitals in Victoria was held on the 18th July, 1974, the same day that the Senate rejected the two companion *Health Insurance Bills* for the third time. Its purpose was the establishment of the Catholic Hospitals Association of Victoria (CHA (V)) that would represent the common interests of the apostolate, with particular reference to the proposed *NHIP*, and medico-moral issues (ARSC, A502.3/1: Item 2: 2). Fr. Paul Duffy, S.J., Dr. Breheny, and James Gobbo assumed leading roles in CHA (V), which produced an analysis on *The Future of Catholic Hospitals: Independence and Survival*. It postulated that the main concern of Catholic hospitals was the maintenance and enhancement of

their long tradition of serving the sick and the needy through quality medical care for the whole person. The many doubts and unanswered questions about the *NHIP* frustrate these ambitions of service (ARSC, A502.3/5: 1).

The dispute, they insisted, was not about the provision of health insurance for all in the community, but the means to achieve that objective. In particular the CHA (V) questioned whether coverage should be achieved by the implementation of a compulsory government scheme or private voluntary insurance, or a combination of the two (ARSC, A502.3/5: 3).

Doubts about the scheme were sincerely held and several. Whether they were also consistent with the Church's mission is, however, a matter of contention. Regardless, the new organisation rehashed their previous objections, not swayed by government assurances. Rather the CHA (V) argued the *NHIP* threatened the survival and independence of religious and charitable hospitals, public and private, and raised questions about the future of the nursing congregations. CHA (V) contended that Catholic private hospitals had only two alternatives. They could either close their doors or be absorbed into the public system. In the case of the latter this would mean they would be dependent on Government funds, which would entitle the Government to direct hospitals on how they would spend the money, and the provision of services. As the legislation contained no guarantees to protect the medico-moral position of Catholic hospitals they might be directed to perform procedures contrary to their belief. They alleged they would be subject to the uniform control and administration already apparent in the Canadian system, a claim that had been disputed, however, by

a Canadian authority (ARSC, A502.3/5: 14-17). ‘The evidence, despite protestations, points to the nationalisation of health by informal means’ (ARSC, A502.3/5: 19-20). The Victorian opponents of the Government scheme argued that preservation of voluntary insurance and the dual-hospitals system made possible genuine freedom of choice, and was part of that diversity of services and functions that comprise democratic societies. They claimed:

Without the alternatives which these systems offer the patients, ‘freedom of choice’ becomes an empty propaganda slogan.

The elimination of private institutions of health insurance and hospital care, and their replacement by a single system Government monopoly, will have a wider effect on Australian society. A further step will have been taken towards the collapse of that diversity and independence of local institutions that are the essence of democratic living (ARSC, A502.3/5: 20).

Although there was an element of stalemate surrounding the debate – both parties going over and over the same ground of objections and response – events were nonetheless coming to a head.

Dissent within the ranks

In response to the Government’s intention to re-introduce the *Health Insurance Bills* at a joint sitting of Parliament, and having received an indication from the Government that it would be prepared to consider amendments to the legislation – including the offer of a right to ‘opt out’ of the scheme – Catholic hospitals met to consider their position. Essentially the meeting reaffirmed its earlier objections (LCMA 07, 1974: 1-5). Nevertheless, James Gobbo was deputised to discuss the minutes of the meeting with Dr. Breheny with a view to formulating a submission for the Minister. In Gobbo’s view there were two basic statements of principle, namely the maintenance of the dual system of hospital care, and the maintenance of the viability of private insurance funds in order to preserve private hospital care for a wide cross section of the community. In a subsequent letter to Mother Mary Philomena, he argued Catholic hospitals should lobby for the right to opt for the levy or private insurance; the relation of the daily bed subsidy to average public hospital daily bed cost; access to an independent tribunal composed of a Federal Judge in the event of a dispute over the amount payable; and the provision of legislative guarantees to safeguard autonomy of management and freedom in medico-moral matters (LCMA 08, 1974: 1-2).

More importantly, Gobbo made several other suggestions, which exposed the tension between Catholic authorities. First he suggested that Norris, the Chairman of the St Francis Xavier Cabrini Advisory Board, be asked to write to the Prime Minister. The purpose of his letter would be to advise Whitlam that Catholic hospitals had made substantial progress on modifications to the *NHIP*, that ‘Catholic hospitals will “carry” all the private hospitals’ (LCMA 08, 1974: 3), and request a meeting with the Prime Minister and Hayden. Secondly, he suggested Catholic hospital associations in each State be asked to confirm both the principles and points outlined in the letter as the basis of negotiations. Thirdly, the deputation should be comprised of a religious, Norris, Breheny and/or Gobbo, a representative from hospitals in Queensland and/or NSW. Alternatively the deputation could in the first instance be restricted to Breheny and Norris who strongly advised that Gobbo also be included in the deputation. In a postscript Gobbo advised that the meeting should be held after the joint sitting of the two federal Houses of Parliament. This would make it unnecessary, indeed undesirable, to have a national consultation with State Catholic hospital bodies, which might lead to the premature disclosure of the views of Catholic hospitals (LCMA 08, 1974: (1-3), 3-4). In reply Mother Mary Philomena stated it was her understanding that the National Executive of the NCMS would write to the Prime Minister and/or the Minister requesting a meeting. Whilst the Executive was mindful of Norris’s interest in their problems, the Conference felt that the deputation, in line with previous discussion, should comprise Bishop Perkins, Mr. Gobbo, Dr. Breheny, Mr I. Morris from Queensland, Mr. D. Pendleton, Sister Marie, a hospital administrator, and herself (LCMA 09, 1974: 1). Relations between the Victorian Catholic hospitals and the rest, most notably NSW Catholic hospitals, then, were tense.

The tension between the States was sufficient to be noticed by members of the Government. In a memorandum to Hayden, Deeble noted that Breheny had rung him to ask how discussions might be facilitated. He had asked specifically if Norris’s letter to Whitlam could form the basis of the negotiation, and whether the ‘opting-out’ proposals were still a possibility. In the course of that conversation, however, Breheny criticised

Mother Philomena and her “Labor party advisers” meaning, of course, Mr. O’Dea. I formed the impression that Dr. Breheny was conducting

an operation to ensure the he remained a major spokesman (if not the major spokesman) for the Catholic hospitals, and that there was some conflict within the Catholic hospital group about the course which they ought to follow (Scotton & Macdonald, 1995, A740701c: 44, emphasis in original).

Following that conversation Deeble rang O’Dea to make clear he had told Breheny no more than he had told him. Moreover, he reiterated the view that the Minister would prefer to talk with the official representative of Catholic hospitals. O’Dea, then,

confirmed that there was a rift within their organisation. Apparently one group (Breheny’s?) had already met and Mother Philomena, as Convenor of the National Conference was annoyed, and would take some action at Wednesday’s meeting. He also said that the New South Wales hospitals had taken advice from a senior counsel, so as to counteract the weight of Mr. Gobbo on the Victorian side.

Overall, it seems that the Catholic hospitals are so divided that there is little chance of their formulating firm proposals for some little time (Scotton & Macdonald, 1995, A740701c, 2: 44).

In a hand written note, Deeble stated that O’Dea had told him in confidence that NSW hospitals had arrived at a number of amendments to the Act ‘including the inclusion of a separate section of the Act to deal with religious and charitable hospitals’, but they had received legal advice not to outline them in detail. Rather they should limit their advice ‘to a general statement of aims for Government consideration’ (Scotton & Macdonald, 1995, A740701c: 44).

Naming the tension

Despite efforts to achieve a unified voice, then, there were cracks in the façade of Catholic hospital resistance that were first evident on the release of the *Green Paper*. As already noted the lack of a united Catholic voice had prompted Hayden to request the establishment of a representative body of Catholic hospitals. Indeed, entries in Scotton’s diary during October and November 1973 record a variety of responses. On the 19th October Scotton wrote ‘Victorian hospitals bitterly opposed but NSW not so resolutely against’. The entry for the 1st November records Hayden had met with Archbishop Rush (Brisbane) ‘who is very pro’ whilst the 9th November entry records that Hayden and Deeble met with the Sisters from St. Vincent’s and ‘They are happy’. On the 15th November Scotton wrote ‘Other favourable news – Mons McCosker says NSW is OK – but Jim Breheny says no good’. Scotton had already concluded on the 14th November that they ‘must isolate Victorian private hospitals – Breheny will not

be satisfied with anything'. Moreover, Catholic authorities themselves highlighted the lack of unity, which led the *Association for the Defence of Religious Hospitals* to warn wavering hospitals that

separate negotiations with the Government will have a divisive effect that can be exploited politically. Such divisiveness can only contribute to the ultimate destruction of the Catholic hospitals system (LCMA 04, 1973: 3).

This warning appears to be related to the guarded expressions of support for the *NHIP* that emanated from Queensland and New South Wales hospitals. As a meeting attended by Catholic private hospitals stated:

The impressions of those present varied, from those who were reassured by the Minister that they would not find insoluble problems in adjusting to the new National Health Insurance Scheme to the majority who were of the opinion that although not an object of the Scheme it was implicit that the end result would be the absorption of Catholic private hospitals into the public hospital systems in various states. This would evolve through the necessity to accept subsidy if the institutions were to remain financially viable in the long term.

It was also evident from discussions among members that the relationship between Catholic private hospitals and the statutory health authority in each State influenced attitudes of individuals within the hospitals and covered a wide spectrum over various States. Hence, the role of the Catholic private hospital was viewed from different perspectives from some States. In Western Australia, where there are no Catholic public hospitals, the private hospitals make a very significant contribution towards the State hospital services. There is inherent in these private hospitals a strong desire to maintain complete independence whilst serving all sections of the community. At the other end of the spectrum in New South Wales, the Catholic public hospital makes a significant contribution towards the State hospital services whilst the contribution made by the private hospital quantitatively speaking is much smaller. In this State there has been a long history of cooperation with the State authority irrespective of the political party in power and any minor loss of autonomy has not been seen as a significant deterrent (LCMA 03, 1973: 1-2).

There was, then, division over the approach to the Government's scheme that ranged from rejection by the Victorian Catholic hospitals to the more moderate position adopted by some Queensland and NSW hospitals, which it is now appropriate to discuss.

A NSW perspective

Generally speaking, NSW Catholic hospitals supported voluntary health insurance, but by the 1970s the opposition of at least some hospitals appeared to have been tempered by its ineffectiveness. Archbishop Freeman took his advice from Monsignor McCosker, a supporter of the scheme. Mother Mary Philomena, the president of the NCMS, and Cecil O’Dea, a member of the North Sydney Mater Misericordiae Hospital Board, were inclined to negotiate over the introduction of the program.

In the *Golden Jubilee Annual Report 1906-56* the Chairman of the Mater Misericordiae Hospital, North Sydney argued for the education of the people of NSW so that they might make weekly contributions to guard against illness.

No hospital can in justice close its doors to anyone just because they are poor, friendless or improvident. Their care is a duty of Christian charity. But should not the ordinary man and woman who are earning see the necessity for an insurance against adversity and so help others as well as themselves’ (McClemens, 1956).

In the face of the inadequacy of the then current system of financing hospitals he argued not for increased levels of State support, but mutual assistance realised through voluntary insurance. By the 1971 Report this had been moderated by recognition of the need for some centralisation, but not excessive centralisation. Access to health care was a right, not a privilege based upon ability to pay that required integration of the various segments of the system, and assurances of access when men and women needed it. Moreover, access should be affordable, not invite abuse, and most importantly respect the dignity of individuals. Whilst circumstances necessitated change

it is to be hoped that these changes will preserve what is good, foster a rational degree of independence, loyalty and team spirit in Hospitals and Institutions and will be based solidly upon the idea that the Hospital exists to serve men and women as part of a community (McClemens, 1971: 4).

The acknowledgement for change moved to recognition of the need for, indeed dependence upon, government assistance in the *Sixth-sixth Annual Report*. The Chairman, however, did reiterate his earlier concern that change, taken to its extreme would

result in a standardised system from which aspiration is largely removed ... In a modern society there is a need, and one may think it

an ever-increasing need, for hospitals founded on spiritual values, ideals of service and self-dedication' (McClemens, 1972: 8).

The 1973 Report did not comment on the desirability of Labor's national health insurance proposals. McClemens, concerned about the future of the Mater, emphasised, however, the need to preserve what 'was best and most idealistic in our existing hospital system (McClemens, 1973: 10). By the 1970s, then, the NSW hospitals, or at least the Mater, acknowledged the need for change which – reading between the lines – included a greater role for government if Catholic hospitals were to meet their goals. At the same time they were mindful of the dangers inherent in that increased role, not the least being a threat to their autonomy, coming not so much from the NHIP but from the formation of the Health Commission of N.S.W. (*AGM, New South Wales Catholic Hospitals' Association, 24/11/72 and adjourned to 23/3/73*).

The view from Brisbane

Clearer support for the Government's proposals came from Queensland no doubt a consequence of Queensland's retention of the free in-patient services introduced by Labor in the 1940s. In delivering his Annual Report for the Brisbane Mater Misericordiae Public Hospital, John Kelly, the Chairman, lamented the conflict over Labor's new scheme. Moreover, he argued that the Government's willingness to inject more funds into health and hospital services

placed an obligation on all of us to see that this laudable purpose should be achieved for the benefit of those who most need it and there can be no question that those who most need it are to be found, not in the single rooms of private hospitals, but in and about the ward and out-patient areas of large over-crowded public hospitals (Scotton & Macdonald, 1995, A731019c, 1: 36; emphasis added).

He further noted the striking similarity between the recommendations of the Nimmo and HIPC reports, including the establishment of standard bed accommodation for all patients. Kelly went so far as to conclude that the Nimmo recommendations, which had been favourably received by those with interests in health, formed the basis of the *HIPC Report*. Interestingly those same interests now opposed the recommendations contained within the *Green Paper*. Kelly lamented that

Worse still, from the point of view of these hospitals, is the fact that the times have brought into existence an organisation known as "The Australian Association for the Defence of Religious Hospitals". The purpose of this body appears to be to justify a claim which is

unequivocal and baldly stated that the implementation of the National Health Deeble Health Scheme will, in fact, destroy the Catholic Hospitals system. This claim, in our view, is complete nonsense and the bodies associated with this organisation would be better employed examining the scheme with constructive criticism rather than to indulge in this sort of provocative controversy (Scotton & Macdonald, 1995, A731019c, 7: 36).

In Kelly's view the Scotton-Deeble proposal correctly identified that private hospitals were in the main nursing homes and not hospitals, which could not

provide the sophisticated services provided by public hospitals. This problem must be faced as it is one of great urgency. The standard of medical and hospital service available in a private bed (apart from the crockery) must be equal to that available in the wards and out-patient clinics of a public hospital. The report, with its insistence that private hospitals must accept responsibility for much more sophisticated services is not to be regarded as a threat to the future of private hospitals but rather is to urge for their integration into a system where the same standard of medical and hospital care and services is available to all irrespective of the capacity of the patient to demand and to pay for the extras (Scotton & Macdonald, 1995, A731019c, 7-8: 36).

Quite clearly Kelly was not of the same mind as those behind the *Association for the Defence of Religious Hospitals* or their sympathisers who in the main hailed from Victoria.

The Victorian perspective

The core of Catholic resistance came from Victoria, the heartland of the DLP, and the political and religious home of probably Australia's most influential yet controversial Catholic figure, B.A. Santamaria. Though not overt in the campaign of resistance, his influence cannot be underestimated especially given the fact that the view of Victorian Catholic authorities prevailed in the debate over the *NHIP*. In a 1958 speech entitled *The Place of the Catholic Teaching Hospital in the General Mission of the Church*, Santamaria outlined the principles that governed the Catholic approach to health care – 'the government of God, the primacy of human personality, and the exercise of social controls through vocational groups' (Santamaria, 1958, 3(6): 17). Together they constituted a Christian "way of life" whose existence is reliant upon the entire Christian medical community, but especially on the Catholic medical community made up of all who serve and care for the sick and dying. These apostles breathe "life" into the "way of life", but there are 'no apostles without institutionalised training' (Santamaria, 1958, 3(6): 19-20) provided in a Catholic

teaching hospital unified by nursing congregations who ensure Christian philosophy and spirituality permeate the hospital (Santamaria, 1958, 3(6): 17).

Santamaria's views rested upon a conservative or preconiliar reading of Catholic social teaching, one which emphasised a corporatist view of social organisation. Men and women are made in the image and likeness of God. He endowed them with personality that is distinguished by possession of free will, and rights that cannot be violated by the state or any other organisation. If men and women are to be truly free the organisation of society must facilitate that freedom by ensuring choice. This 'has led Catholic sociology along a road which ends in opposition to both private and public monopoly; a demand for the personal ownership of the means of production; and a thorough-going policy of decentralisation of ownership, of political and economic power of government and of administration' (Santamaria, 1958, 3(6): 18). Consequently, the Church supports the independence of the individual and the exercise of social controls by voluntary and professional organisations, not the state, which should only act to assist individuals and intermediate groups. Catholic principles, Santamaria averred,

favour the control and administration of hospitals by voluntary bodies rather than the State ... Since positive action needs to be taken to help families meet the crippling costs of serious illness, it is far better that this be done by an extension and perfecting of the insurance and friendly society principle rather than by means of a so-called "free" medical service, which is not only not "free" but involves the creation of an all-powerful medical bureaucracy. The role of the State is to assist these private and voluntary enterprises – never to substitute itself for them – and to exercise its own unchallenged and primary jurisdiction in the field of public health (Santamaria, 1958, 3(6): 19).

The role and function of the state, then, is a subsidiary one, an approach that led Santamaria to argue for the importance of Catholic hospitals supported by voluntary insurance and against "free" health care.

When contacted by the researcher, Santamaria, through Michael Gilchrist, replied that he was unable to assist in the research for this thesis as it was an area that he had not 'had much to do with' (Personal communication, 25/1/96). Certainly, there is little evidence to dispute this claim. Nor is it possible to ascertain what informal role – if any – Santamaria had through conversations and counsel. Nevertheless, his high profile as a Catholic thinker, and his association with the DLP, mean that any

statement made by him is important. Moreover, there are times in reading the arguments against the introduction of Labor's national health scheme that one feels that Santamaria's influence is not far away. Indeed it is worth noting that *News Weekly* was widely read among the more conservative Catholics, lay and hierarchy, so any comments that he did make in that forum would have had an influence. Indeed, Scotton recorded in a diary entry for the 25th November 1973 his concern about Santamaria's criticism of Labor's scheme (Scotton & Macdonald, 1995). Santamaria had argued that in the event that the Hayden scheme was introduced it

would have three most serious consequences:

- It would result in the establishment of an expensive bureaucracy, the cost of which would greatly add to an already serious inflationary situation in Australia.
- The Hayden scheme would also destroy the present dual system of public and private hospitals by attacking the autonomy and independence of private hospitals, religious and charitable, forcing them to accept tied government grants.
- Finally, the Hayden scheme would penalise single income earners.

Under the present scheme single income earners make up 40% of the present contributor membership.

Together with families, where both husband and wife are forced to work, they would generally pay more for health insurance, under the Hayden scheme (Santamaria, 7/11/73: 5).

Instead, Santamaria supported the DLP's proposal to amend the *National Health Act*, which 'avoids the many problems that would be created by the introduction of a socialised health scheme, such as Mr. Hayden's' (Santamaria, 7/11/73: 5). Regardless of the lack of public comment, Santamaria's views, in particular his emphasis on freedom and autonomy, and its apocryphal tone, are evident in the commentaries of Dr. Breheny and Mr. J. Lucas on the *HIPC Report*, the deliberations of the *Community Hospitals Association of Victoria*, the *Catholic Hospitals Association (Victoria)*, and *The Australian Association for the Defence of Religious Hospitals*. It is worth noting that James Breheny, along with Fr. Paul Duffy S.J., was involved in most, if not all of the above organisations.

There was, then, division in the ranks of Catholic leaders, both lay and hierarchy, about the proper response to the plans for a national health scheme. In the long run Catholic resistance to the introduction of Medibank, however, proved fruitless. The

Government – by means of the double dissolution, and then the joint sitting of the two houses – was able to successfully manoeuvre the passage of the two companion *Health Insurance Bills* into legislation. Despite dire prediction this did not precipitate the demise of religious and charitable hospitals. Indeed, Catholic hospital authorities eventually threw their support behind Medibank’s successor, Medicare. The question then remains – why did Catholic hospitals resist the implementation of a scheme that to all intent and purposes satisfied the Church’s mission to the sick and vulnerable?

Conclusion

The *White Paper* endorsed nearly all the recommendations contained in the *HIPC Report*, but faced with opposition from the states, the medical profession, private hospitals and private insurers, the Government modified those recommendations causing concern. This did not placate Catholic hospitals, but there were signs of support, particularly from NSW and Queensland whose hospitals had already reached an accommodation with the public system. As already noted Archbishop Freeman took his advice from Monsignor McCosker, a supporter of the scheme. Moreover, Mother Mary Philomena, the president of the NCMS, and Cecil O’Dea, a member of the North Sydney Mater Misericordiae Hospital Board, were inclined to negotiate over the introduction of the program. However, the deeply conservative forces entrenched in the Victorian Church, whose members included Dr. Jim Breheny, James Gobbo QC, and B.A. Santamaria’s close associate Fr. Paul Duffy S.J., still mounted considerable resistance. Victorian Catholic hospitals opposed any contractual arrangements that might impede their autonomy. Voluntary insurance arrangements had provided Victorian Catholic hospitals with growing amounts of Commonwealth benefits and tax concessions for the subsidisation of the payment of private patients’ accounts. As Scotton and Macdonald note, Catholic authorities believed these could be removed or reversed by the Labor program. This in turn would drastically reduce admissions and threaten the viability of Catholic hospitals, or so they believed (1993: 111). Moreover, the Victorian Church and her advisers still harboured feelings of deep animosity towards the Labor Party arising out of the disputes over Catholic Action that had plagued the Australian Church during the 1940s and 1950s. Its close allegiance with the DLP, the holders of the balance of power in the Senate, did not bode well for the future of Labor’s national health scheme, a situation described in the previous chapter.

It is fair to say that the Victorian Church through its Catholic hospitals made the running on the debate about the *NHIP*. Its resistance rested upon a conservative, preconiliar interpretation of Catholic social teaching, that this thesis argues inclined them to sacrifice the needs of the most vulnerable in order to maintain control over Catholic hospitals and to live out their mission of charity, which arguably was perceived as voluntary. This was also true of the Victorian response to needs based funding for education discussed in an earlier chapter. In the 1970s the resistance related to the maintenance of the dual system of hospitals and the retention of charitable health care. In large measure this rested upon conservative Catholic social teaching, but it was also driven by the anti-communist forces led by Santamaria. Whilst not arguing that Medibank was without flaws, it is fair to say that the scheme did address the needs of the poor and vulnerable by enabling them to access health care, access that for around seventeen per cent of the population had largely evaporated during the 1950s and the 1960s.

On the basis of the material contained in this chapter it is, then, possible to argue that Australian Catholic social teaching did incline the Church to a conservative view of welfare as identified by Esping-Andersen, Castles, van Kersbergen, and Smyth. However, it was also modified by local conditions and events, which blinded elements of the Australian Church to the need to include consideration of the common good, and not just the principle of subsidiarity, in its response to Labor's initiative. This does not argue that Catholic social teaching is simply amenable to circumstances. Rather it is suggested that historical context inclined the Australian, and indeed the European, Church to stray from consideration of its entire body of core principles, a situation that Vatican II attempted to correct. The Church's resistance to Labor's proposal with its insistence on the principle of subsidiarity, the maintenance of charitable care conservatively understood, and insistence on independence, then, compromised the principle of the common good. It is now time to draw some final conclusions based upon the material contained in the previous chapters before suggesting possible implications for Catholic health care in the future.