CHAPTER TEN

ANALYSIS: UNDERSTANDING CATHOLIC RESISTANCE

Introduction
This thesis has covered a variety of views and themes – theological, historical, empirical and normative political theorising surrounding debates over welfare and health policies. Before summing up and drawing conclusions it would be good to acknowledge the original impulse behind the project. The research was driven by an apparent paradox: why in both the 1940s and the 1970s, did a Catholic Church with a mission to minister to the poor and needy in society, actively resist attempts to introduce a national health care system?

Historically the Catholic Church through its agencies and religious congregations has been a major provider of not-for-profit social services in Australia and overseas. The primary focus of scholarly attention in making sense of welfare and health provision, however, has been on the market and the state, which has left largely unexplored the role of the family and religious institutions such as the Catholic Church (Smyth, 2003: 17). More recently a growing, but not prolific, body of literature has attempted to redress this deficit by highlighting the impact of Catholic social principles on the development of welfare state provision. Much of this literature, however, is concerned with the European experience (Esping-Andersen, 1990; Castles, 1993a; van Kersbergen, 1995). The claims is that Catholic social teaching – most notably Rerum Novarum and Quadragesimo Anno – produces a conservative welfare state based on a corporatist ideology. This ‘Catholic world of welfare’, so the argument runs, is intent on preserving the role of the traditional family, finding an alternative to socialism and capitalism, maintaining harmonious class relations, and keeping power out of the hands of the state. Recently, however this research has been augmented by an Australian academic, Paul Smyth, who has undertaken an examination of the influence of Catholic social thought on Australian welfare policy. In particular he has highlighted ‘the neglected, historical role of the Catholic Church in promoting a “welfare society” over a “welfare state”’ (2003: 17). Religion is now formally on the agenda as a factor to be studied in explaining the behaviour of modern welfare states.
In a sense, following Smyth’s lead, this thesis has sought to extend and deepen the examination of the role Catholicism plays in the development of welfare policy. It focussed on the influence of Catholic hospital authorities and the Church hierarchy exerted on proposals to introduce national universal health schemes in Australia in the 1940s and the 1970s. Specifically it examined the apparently paradoxical resistance of Catholic authorities to the introduction of schemes that appeared to satisfy the Church’s commitment to the poorest and most marginalised groups in the community. Ironically their resistance was informed by Catholic social teaching, most notably the principle of subsidiarity. Even though the government proposals would have enhanced the access of the needy to healthcare, and arguably clearly benefited Catholic hospitals, Catholic authorities adopted a position of resistance. They insisted, instead, on the independence and autonomy of Catholic hospitals, which caused the respective Labor governments of both periods to modify their schemes. As in Europe, Catholic influence in Australia was conservative. So much so, in fact, that it appeared the Church was prepared to abrogate its responsibility to the poor and needy – to leave unsatisfied what is now understood as the preferential option for the poor – in order to preserve existing Catholic institutions intact.

Research in this particular area is not prolific, a deficit that is not assisted by the paucity of Australian documentation relevant to this thesis. Moreover, as indicated in Chapter One, some of the material was too difficult to access. Thus the conclusions drawn here are, of necessity, tentative, but this does not mean that the analysis is without value. On the contrary this thesis, which draws on the primary material contained in diocesan and congregational archives, represents a preliminary, but important foray into the study of the impact of Australian Catholic social thought on the development of health policy. This may be challenged or verified as other material comes to light. Moreover, it has provided an understanding of the principles that underpin and guide Catholic health care, which in the light of recent government moves to privatisate welfare provision, may assist religious and charitable providers to determine their role and place in the provision of health care.

Religion as a determinant of welfare policy
As shown in Chapter Five, a growing body of research challenges the orthodoxy that welfare state development is a consequence of social democracy. It argues that
concentration on this particular ‘secular’ factor has obscured the importance of other
determinants, not the least being the influence of religion. More importantly for this
thesis, the focus on ‘traditional’ social science concerns has obscured the influence of
‘the specific properties of Catholic social theory and the pro-welfare stance of the
Church’ (van Kersbergen, 1995: 7). In 1979 Stephens concluded that the anti-
capitalist aspects of Catholic social teaching and its generally positive attitude
towards welfare were conducive to the development of the welfare state. Later Whyte
(1981) demonstrated that the underpinnings of ‘closed’ Catholicism partly rested upon
a distinctive Catholic social teaching that promoted both personalism and solidarity,
characteristics cited as contributing to a conservative approach to welfare. More
significantly – in a series of scholarly pieces – Esping-Andersen (1990), Castles
(1993a, 1994) and van Kersbergen (1995) argued that Catholicism’s support for an
organic view of society; charity rather than rights enforceable by the state; ownership
of private property; harmonisation of class interests; acceptance of inequality
modified by the payment of a just wage; and the principle of subsidiarity; all
contribute to a distinctive ‘Catholic world of welfare’. Comprised mainly of Western
European countries, this ‘world’ rests on a corporatist ideology that is intent on
maintaining control of welfare at the level of the family and associations rather than
the state. Hence it favours the payment of generous social security benefits to assist
the family, whilst limiting or not expanding the role of the state. Indeed Esping-
Andersen argues Christian Democratic parties steered European social welfare
 provision towards social insurance schemes based on employer and employee
contributions, not schemes supported by taxation. More recently, Smyth (2003) has
argued that the Catholic principles identified by Esping-Andersen, Castles, and van
Kersbergen, have inclined the Australian Church to a preference for a ‘Catholic world
of welfare’, or ‘welfare society’, over a welfare state. This preference, however, was
also influenced by specific historical factors. This thesis has sought to extend the
examination of these scholars by assessing the conservative influence of the Church
identified by them, through an examination of the response of Australian Catholic
authorities to Labor’s proposal to introduce national health insurance in the 1940s and
the 1970s.
A theoretical reflection

The examination undertaken in this thesis is informed by the work of several scholars, notably Esping-Andersen, Castles, van Kersbergen and Smyth. The importance of the work of Esping-Andersen, Castles, and van Kersbergen arises from their examination of the influence of Catholic social principles upon the development of the welfare state. Crucially they argue support for the principle of subsidiarity inclined the Church towards a corporatist approach to welfare in which the state works not through individuals, but through social groups, the most important of which is the family – the basic unit of society. Acceptance of inequality is softened by insistence on the importance of full employment; the payment of a ‘family’ wage, which enables a man to support his family, and thus protect it against dependency on the state; and charitable provision for those unable to provide for themselves. But these scholars are concerned with the influence of religion on the development of the continental welfare state. Smyth, however, notes that the role of the Catholic Church on the development of social policy in Australia is largely untheorised, even though it ‘has long been a major non-profit service provider in Australia and, indeed, a more significant influence on Australian public policy than has been realised’ (2003: 17). His contribution to this present study derives from the identification of Catholic social teaching with a ‘welfare society’, at least until the 1970s at which time the papacy and Australia embraced the ‘welfare state’. Thus Australian Catholic social thought during the period of this study endorsed ‘the wage earners’ welfare state’, which offered social protection via the payment of a ‘just’ wage supplemented by ‘residual’ cash benefits. More importantly, it minimised the role of the state and thus protected the pre-eminence of the family and associations, an orientation also noted by European researchers. This enabled families and associations to manage their own affairs free from the excesses of capitalism and over-reliance on the State (Smyth, 2003). Catholic social teaching, at least until the 1970s, then, inclined the Australian Church towards a conservative view of welfare, a view that accorded with the observations made by Esping-Andersen, Castles, and van Kersbergen. This, however, requires qualification, as historically the attitude of Australian Catholic authorities was also a consequence of pragmatism rather than intellectual analysis. As Duncan observes

Catholics have a very rich inheritance of social thought but, … make very poor use of it, despite vast practical efforts in the fields of health,
education and social services … Although we have clearly identified a set of principles to guide our policies, we have barely begun to explore their implications beyond our immediate concerns (Duncan, 2004: 81(1), 30).

Australian Catholic policy, then, is the outcome of what is achievable, or practical, as well as Catholic social thought. Regardless, Catholic social policy during the period of this study was conservative in outlook, an outlook that was consistent with the view of the wider Australian population (Smyth, 2003). The question, however, remains – did the Church’s social conservatism compromise its mission to the sick, especially the sick poor?

Catholic Social Teaching

Catholic social teaching throughout the period of this study was grounded in natural law philosophy, which ‘refers to the eternal plan of God, discovered by reason and true for all times, places, and circumstances’ (Curran, 2002: 54). It was, then, classicist in outlook. It was also organicist and personalist. Consequently Catholic social teaching espoused eternal, universal, and immutable laws and principles, which resulted in a conception of society as natural, hierarchical, authoritarian, and unequal, an orientation that appears to support the research suggesting Catholicism is a conservative influence upon the development of the welfare state.

Whilst Catholic social teaching holds that men and women are first in the social order, it also acknowledges that their dignity can only be recognised and protected in the context of the community. Society, then, is necessary for the recognition and protection of human dignity and the realisation of a person’s ‘inalienable’ rights. The liberty of the individual, however, may be limited in order to secure the welfare of the community and the fundamental rights of the individual, understood as the common good. Society, then, assists individuals to realise their dignity in community. That is it is a source of help (Welty, 1960: 93; Calvez & Perrin, 1961: 119-122). Of special importance is the role of the state, which ‘is called to promote the authentic common good (by providing) those external conditions which are needful to citizens as a whole for the development of their qualities and the fulfilment of their duties in every sphere of life, material, intellectual and religious’ (Pius XII’s 1941 Message of Whitsun in Calvez & Perrin, 1961: 116). However, it too must be mindful of the right of lesser societies. Like society, the state also has a subsidiary role. Personal rights imply
social obligation therefore individuals and private or lesser societies must be free to 
exercise personal and social responsibility and thus contribute to the common good. 
Consequently the state must not usurp the function of the family or intermediate 
groups. Its task is to protect the common good by ensuring the conditions necessary 
for its achievement. But would this allow for the nationalisation of industry? The 
Church acknowledges that this might be considered if required by the common good. 
Indeed, Catholic authorities expressed a measure of support for the nationalisation of 
banks advocated by the Labor Government in the 1940s, an issue discussed in Chapter 
Four (Duncan, 2001: 112-121). The nationalisation of health, however, was opposed 
because Catholic authorities worried it would interfere with their medico-moral 
responsibilities, and threaten the integrity and independence of Catholic hospitals. 
Catholic social teaching, then, embodies both the principle of subsidiarity and the 
common good, but in practice, fears about first liberalism, then socialism, resulted in 
the subordination of the common good to the principle of subsidiarity – a preconciliar 
reading of Catholic social teaching.

Esping-Andersen, Castles, van Kersbergen, and Smyth suggest Catholic social 
teaching produces conservative policies that include resistance to expansion of the 
role of the state. In particular they cite the influence of *Rerum Novarum* and 
*Quadragesimo Anno*. Whilst *Rerum Novarum* condemned individualistic liberalism 
and socialism, Leo XIII also insisted on the precedence of the worker over economics 
and state protection of workers against exploitation. Like his predecessor, Pius XI 
bemoaned the plight of the poor, and the concentration of wealth and power in the 
hands of a few. But more importantly, he located the cause of injustice in the 
structure of society. Hence he went beyond Leo XIII’s call for reform of conduct to 
call for the reform of institutions, thereby articulating the notion of ‘social justice’ 
for social stability and harmony between classes, however, Pius XI argued for the 
formation of vocational groups, which would not only encourage the development of 
harmony both within and between groups, but would also act as a bulwark against 
both a rampant state and unrestrained capitalism. Like Leo he sought to protect the 
dignity of the individual through support for a natural order, and application of the 
principle of subsidiarity (*Quadragesimo Anno*, #95 cited in O’Brien & Shannon, 
1992: 63). The thrust of Catholic social teaching prior to Vatican II, then, favoured
the establishment of mutual help societies and private associations to provide care for the workman and his dependants in times of adversity (Rerum Novarum, #36 cited in O’Brien & Shannon, 1992: 32-33). Thus Leo XIII defended the establishment of distinctively Catholic hospitals so that they might provide support for the needy. In this view charitable provision was better than ‘a system of State-organized relief. But no human methods will ever supply for the devotion and self-sacrifice of Christian charity’ (Rerum Novarum, (#24 cited in O’Brien & Shannon, 1992: 25). Thus the Church favoured a limited role for the state and reliance on charity as the means of ensuring the welfare of the community. This preconciliar view, it is argued, had the capacity to blind the Church to the inadequacies of the levels of access to health care in the period under study.

As already noted, Catholic social teaching incorporates the principle of the common good. The principle of subsidiarity, however, achieved greater prominence in preconciliar teaching, an imbalance that was subsequently checked by the intervention of Pope John XXIII and the deliberations of Vatican II. Postconciliar social thought with its emphasis on correlative obligations, and social justice, implies that individuals, created in the image of God are entitled to an unspecified, but basic, minimum of health care. As adequate health care is essential for the common good one can presume society, as a whole, is responsible for access to health care. It implies, then, a role for the state, but it does not assume that the state is solely responsible. Welfare arrangements, then, are still governed by the principle of subsidiarity, but in the light of the common good, an insight assisted by the important – and in a crucial sense, radical – teaching on private property. Like all natural rights, ownership of private property applies to everyone, as all have the same nature which grounds the right. Hence ownership of private property is subordinate to the right of all to use the goods provided by nature. Superfluous property, then, must be used to provide for those who do not own property. This is not a matter of charity, but rather a matter of justice, as all persons have a right to all material goods (Antoncich, 1987: 96-102). Access to health care, then, is not absolute, but limited by the claims of others. Having said that, the demands of social justice require institutions, including the state, to ensure and maintain access to those rights deemed necessary for the development of the person. This includes access to health care (Hehir, 1992: 360-362; Lustig, 1993: 571-575). It can, then, be argued that – for
Catholics at least – access to health care cannot simply rely on individual effort and mutual assistance. Rather, it requires state assistance, especially given its complexity, and its importance for life, a point strengthened by the very real existence of glaring inequalities in access to health care for the poor and marginalised in society.

Two interpretations
In her study of the Australian party system, Overacker (1952) drew a useful distinction between the two main political parties in terms of ‘initiative’ (the ALP) and ‘resistance’ (the conservative side of politics) that may be fruitfully applied to the way in which Catholic social teaching is interpreted from time to time. As outlined in Chapter Two it is possible to discern at least two – perhaps antithetical – ways of interpreting Catholic social teaching. The preconciliar interpretation inclines the Church towards resistance, a feature of the debates in the two periods under study. The postconciliar approach inclines the Church to take the initiative in its engagement with the world. Each has implications for the role of the welfare state.

The preconciliar interpretation of the core social principles leads the Church to argue for a minimal role for the state in health and welfare provision, which resonates with a ‘residual’ approach to welfare. The role of government is to assist the family and intermediary groups in their normal functions, and be the avenue of last resort when they cannot fulfil their function. Consequently faced with government programs that threaten to subsume the ‘proper’ function of the family and intermediary groups – such as a proposal to introduce a universal health care scheme in order to tackle unequal access to health care – the Church is likely to assume a position of resistance. That is, it adopts a conservative stance. Indeed historically the Church has ‘acted as a conservative force arguing that State intervention was both morally wrong and practically inappropriate’ (Higgins, 1981: 74). Specifically, in the arena of health and welfare, as Smyth notes, Catholic social teaching inclines the Church towards a preference for a ‘welfare society’ over a ‘welfare state’ (2003).

The difficulty with residual welfare states, however, is they tend to provide meagre means-tested benefits tied to need, and force all others to contract private-sector welfare. Certainly they provide assistance to families in need, but the benefits tend
to be modest, and are usually coupled with notions of ‘deservingness’. Therefore they tend to be stigmatising and divisive. Moreover, ‘residual’ welfare states neglect the needs of those individuals on the margins, namely those individuals who earn too much to qualify for assistance but not enough to provide adequately for their needs or the needs of their families. Australian history leading up to and including the two periods under study revealed the inadequacy of this approach, which both the Curtin-Chifley and Whitlam Labor governments sought to ameliorate through their national health programs. The introduction of a basic, equal benefit, irrespective of prior earnings, contributions or performance, as proposed unsuccessfully by Labor in the 1940s, and successfully in the 1970s, satisfied at least the basic requirements for health care. Thus – it was argued – they would contribute to the well being of all citizens, and ultimately society. This appeared to be in accord with the Church’s proclaimed mission to the sick, and its commitment to the common good. Yet in the 1940s and the 1970s the Church resisted the introduction of the very schemes that were designed to achieve that end.

There is, however, another view of the Church’s social teachings, the postconciliar interpretation, which inclines the Church to take the initiative in the areas of health and welfare. In particular liberal or progressive elements in the Church are open to consideration of the value of the ‘institutional’ welfare state. It is then conceivable that welfare services provided by the state are not necessarily contrary to the Church’s social teaching, and indeed could assist the Church to achieve its proclaimed mission, as well as contributing to the achievement of the common good. Rather than being an avenue of last resort, the state, through the provision of social services, recognises that society is marked by social inequalities that are both structural and complex, and thus difficult to address at just the level of the individual. In this reading, the social teaching impels the Church actively to seek social justice by proposing and supporting measures to assist the needy and vulnerable in society. Given the structured and interlocking nature of inequality, the achievement of social justice requires support for an active, but not dominant, state. Hence support for government programs such as the national universal health schemes proposed by Labor in the 1940s and the 1970s, and whose purpose was the reduction of health inequality, would be desirable. It does not, however, compromise the Church’s own efforts to assist the needy. Having acknowledged that families and associations alone cannot address the level and extent
of inequality, the Church, in this view, opts for co-operation with the state in order to address the inequality that prevents the realisation of a just society. On this reading of Catholic social teaching the role of the state complements the role of lesser units without ruling out the prospect of greater state intervention, i.e. the operation of the principle of subsidiarity is realised in common with the principle of the common good.

The Australian Socio-political Context

Whilst the resistance of the Australian Catholic authorities to the introduction of national health insurance was, as indicated above, a consequence of a conservative, or preconciliar, reading of Catholic social teaching, it was also influenced by the unique social and political context that was Australia. First, although not as anti-liberal as its continental counterpart, the Australian Church was suspicious of liberalism, but this was moderated by the need for acceptance in a pluralist society. Secondly, unlike Europe the Australian Church was closely tied to the working class and hence supported proposals designed to improve their pay and conditions. This included support for the Australian Labor Party whose socialism Moran judged was not the socialism condemned by the papacy. Thirdly, the Church was guided less by intellectual thought than by pragmatism. Somewhat isolated from the rest of the world it concerned itself with practical and achievable goals to support and develop Catholicism in Australia. Thus considerable stress was placed on practical tasks such as protecting the faithful and building schools and hospitals. Fourthly, the Catholic view of welfare resonated with the view of the wider Australian community. Support for the payment of a just wage, the right to manage one’s own affairs free from state interference, and the existence of a residual safety net for those unable to provide for themselves or their families were dominant concerns not just within the Church, but also within the wider Australian society (Smyth, 2003). Fifthly, the fear of communism fractured the Labor Party, but it also fractured Labor’s relations with the Church, and the Church itself. Australian Catholicism, then, during the period of this study exhibited aspects of Whyte’s ‘open’ and ‘closed’ Catholicism. Whilst aspiring to social integrations it nevertheless built a segregated society that kept the flock faithful at the expense of a narrow outlook that was staid, reactionary, inflexible, and pragmatic. More importantly, it adopted a position of resistance to policies proposed by the ALP.
Explaining resistance in the 1940s

As revealed in Chapters Six and Seven, the failure to introduce a ‘free’ national universal health service in the 1940s was influenced by several key factors, including the resistance of Catholic authorities, and the fear of communism, which opponents exploited in order to derail the programme. Communist influence, especially in the industrial area, was certainly a major concern not assisted by Labor’s attempts to nationalise the banks, growing concern over the centralisation of power in Canberra, and extension of wartime powers beyond the War. They fanned the flames of anti-socialism and thus opposition to Labor’s national health scheme (Sax, 1984: 58-59). Indeed, the fear of communism obscured the fact that the Curtin and Chifley Labor governments were committed to the introduction of a ‘free’ national health service that addressed the question of inequality through the generation of full employment, albeit co-ordinated by government (Crichton, 1990: 40-41; Gray, 1991: 62; Smyth, 1994, 54; Smyth, 2002: 429). Nonetheless, the labour movement and the ALP generally concurred with the dominant principles of self-help and individual responsibility (Thame, 1974: 274-275; Jones, 1983: 37; Ternowetsky, 1983: 13). Radical reorganisation, despite socialist rhetoric, was not Labor’s intention. Rather the government opted for a scheme of low-cost, means-tested, non-contributory cash benefits, a strategy that accorded with traditional Labor practice, and ‘free’ public beds. Nevertheless the implicit centralisation and bureaucratisation provoked criticisms from interested parties, including Catholic authorities (Gillespie, 1991: 182-185).

What emerges from the available documentation during this period is a serious concern that federal government intervention would remove or severely alter the essential character of Catholic hospitals. Co-operation with Labor was possible, but only if Catholic hospitals retained their independence and autonomy. Nationalisation held particular fears for Catholic hospitals in so far as they would fall under the control of ‘an authority that does not respect the principles for which they were founded’, as Gillespie put it (1991: 153-154). Catholic authorities, then, portrayed the scheme as an attempt to abolish the free market, undermine individual freedom and choice, and destroy the relationship between doctor and patient by making both servants of the state. In particular, they expressed concern about the centralisation of control over medico-moral issues in a Godless state, and the abolition of private
hospitals consequent upon the introduction of the scheme. A scheme that sought to replace the spirit of charity, understood as love and service of God, and which imposed practices contrary to Catholic teaching, was unacceptable. Moreover, the tumultuous social and political context of this period reinforced Catholic suspicion of government intervention, so much so that Catholic hospital authorities rejected government assurances that it was not intent on the demise of religious and charitable hospitals. Instead Catholic authorities argued access to hospital and medical services should be financed by private contribution – voluntary health insurance – and the maintenance of subsidised philanthropy for those unable to provide for themselves or their families. As both strategies had already failed to deliver adequate access to health care this position prompts the unhappy conclusion that the Church was willing to ignore the needs of those very people it was bound to serve in the interests of maintaining the independence of Catholic hospitals.

But to be fair, Catholic concern about Labor’s ‘free’ and ‘complete’ national health scheme related to the spiritual nature of health care work, the expression of charity through care of the sick, and observance of ‘right order’. Satisfaction depended upon Catholic control of the administration and management of Catholic hospitals, many of which were private, and the maintenance of control over the appointment of staff. Non-interference by outside bodies was then a defining principle for the operation of Catholic hospitals, justified on the grounds of safeguarding the moral and spiritual status of Catholic health care. Father McNally, however, conceded that government aid could and did assist the work of Catholic hospitals, which was ‘all to the good, if it can be continued and enlarged without endangering the essential character of the Catholic Hospital, that sees in the service of the sick neighbour the Love and the Service of God’ (McNally, 1943: 72-73). Efforts to extend government planning and control beyond the War, especially in the light of the rise of communism, were perceived as a threat to the autonomy of Catholic hospitals. Thus Catholic authorities viewed Labor’s proposal as an attempt ‘to reduce [Catholic hospitals] to “public utilities” within a national scheme’ (Gillespie, 1991: 198). As Catholic hospitals occupied a strategic position in health care provision, the Government could not ignore their criticism. Whilst the provision of benefits satisfied traditional Labor practice, the Government also rightly concluded it would also placate Catholic concern. It is almost certainly going too far to argue that the efforts of the Church and Catholic
authorities prevented the introduction of a national health service. Nonetheless, their influence was by no means insubstantial in providing systematic resistance to the efforts of the Labor Government at that time. As the Church saw it, it was not in the interest of the Catholic Hospital to become a mere instrument of the State. Thus the resistance of the Church proved a heady ally for powerful vested interests – for instance in the medical profession – seeking to halt the programme. Certainly Catholic authorities drew on the Church’s social teaching, but the socio-political environment of the 1940s, not the least being the threat of communism, mediated Catholic resistance. Similar comments can be made about Catholic resistance to Medibank in the 1970s.

Explaining resistance in the 1970s

By the 1970s there were signs that welfare provision in Australia was moving away from a ‘welfare society’ towards a ‘welfare state’ (Smyth & Wearing, 2002; Smyth, 2003). The move, however, was accompanied by strident criticism, which echoed the anti-socialism aired in the 1940s (Gray, 1991: 135-136). Indeed the debate was driven by an ideological tussle over the concepts of 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 is not level therefore, as a matter of justice, the community as a whole must bear the responsibility for the health of all of its citizens. Access is not a privilege, but a right, and this is best achieved by a compulsory scheme (Sax, 1984: 95-96).

Doctors, insurance organisations, private providers, and conservative politicians tended to support the concept of freedom. Thus they argued that the incoming Whitlam Labor government’s scheme would compromise the freedom of doctors and their patients, lead to standardised treatment directed by government, and lower the quality of care. Catholic authorities, most notably Victorian Catholic hospital authorities, generally concurred with this criticism. Freedom of choice and non-interference could only be guaranteed by a voluntary system. Hence they resisted the introduction of a scheme that seemingly was in accord with the mission of the Church. Again, Catholic hospital authorities, informed by a preconciliar ‘reading’ of
the Church’s social teaching, resisted the expansion of the role of the state. The fact that the DLP held the balance of power in the Senate meant the government had to take account of the views of Catholic hospitals. Thus it sought to ameliorate Catholic concerns by including measures to placate the hospitals. Whilst these moves did not secure Catholic support, the changed political makeup of the Senate after the 1974 election rendered Catholic opposition pointless, as the Government was able to legislate for the introduction of Medibank at a joint sitting of parliament. Catholic resistance, however, again raised a question concerning a preference for the principle of subsidiarity over the achievement of the common good.

The central question for Catholic hospitals in relation to the NHIP – at least as the Church perceived the issue – 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 (ARSC, A500/51: 1). Labor’s scheme, it was argued, particularly by the Victorian hospitals, would result in the demise of Catholic hospitals. Despite all dire predictions, however, religious and charitable hospitals did not collapse. The introduction of universal, national health care did not force, absorb or incorporate Catholic hospitals into the public system, nor were the hospitals forced to perform treatments contrary to their philosophy or ethos. Despite the socialistic rhetoric of some within the ALP, it was not Labor’s intention to nationalise health care. Rather it sought to restructure health care so that access was not reliant on charity, but a matter of right. Given the complexity of health care and funding arrangements, this would best be achieved through a government managed national health care scheme. Whilst elements within the ALP would have preferred public provision, the dominant pragmatism inclined the Party to the introduction of a scheme that included private and not-for-profit providers, including Catholic providers.

**Grounds of Catholic resistance**

Catholic hospitals did not so much oppose the idea of national universal health, but rather the specific programme outlined in the *Deeble Report* and *Health Insurance Planning Committee Report (Green Paper)*. Indeed, in 1973 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 (ARSC, A502/67). 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 as Dr. Connolly noted, this should not be the ‘dominant and exclusive concern in formulating a national approach to hospital and health services’ (ARSC, A502/67). Nor did the need for rationalisation obviate the need for religious and charitable hospitals. The NHIP, they argued, would threaten the financial viability of Catholic hospitals, their independence, and their freedom to manage and direct their own affairs. ‘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). Moreover, Catholic authorities feared that Catholic hospitals would be obliged to provide the same range of treatments as public hospitals, including abortions and sterilisations, a position that was abhorrent to the Church and clearly antithetical to the ethos of Catholic hospitals.

The response of Catholic hospitals to Medibank was no doubt influenced by the Cold War, the events surrounding ‘the Split’ and the threat of communism, which affected relations with the Labor Party. Despite repeated Government assurances and denials that it did not wish to force religious and charitable hospitals into the public system, or force them to assume a public character, Catholic hospitals, at least in public, remained resolute in their resistance. Yet in a crucial sense, this belies the complexity of what was actually happening on the ground. The most vehement opposition came from Victorian Catholic hospitals, but Queensland hospitals expressed a measure of support and Catholic hospitals in New South Wales occupied the middle ground. In part the explanation of the different positions is found in relations between the Church and the ALP. The Church in Victoria was antagonistic towards Labor. It had its roots deep in preconciliar Catholic social teaching, but it was also informed by anti-communism, especially as espoused by the Movement and its later incarnations. Their links with the DLP meant the Victorian Church became a significant force in the debate over the implementation of Medibank. The Church in New South Wales and Queensland, however, had reached an accommodation with Labor in their
respective states that made them a little more open to persuasion. Nevertheless they
did not publicly distance themselves from the position articulated by the Victorian
hospitals in their campaign to frustrate Labor’s attempts to introduce the NHIP.
Whilst the life of Medibank was short, the idea of national health did not die,
eventually being resurrected as Medicare. In the long run, then, Catholic resistance to
national health was largely fruitless, but interestingly, the Church now supports
national health. Indeed, the current umbrella organisation for Australian Catholic
health care, the CHA, is at the very forefront in support.

The impact of Catholic social teaching on health care provision in the 1940s and
the 1970s
Having examined the resistance of the Australian Church to Labor’s proposals for
national health insurance, it is now possible to discern an explanation of the paradox
outlined in the opening chapter: why a Church, apparently committed to the care of
the poor and needy, resisted attempts to establish a national health scheme in the
1940s and 1970s. In 1973 Catholic authorities argued ‘that all, without exception,
should have access to quality health care. It is the right and prerogative of the poorest
in the community to receive the best possible care (ARSC, A502/67: 1-2). The
available primary documentation, however, reveals a pragmatic preoccupation with
the status of Catholic private hospitals, and associated health insurance funds. In
particular it reveals a concern that the introduction of a national health scheme in the
1970s would spell the end of charitable and religious hospitals. At the same time
Catholic authorities expressed concern about the increasing centralisation of power in
the State.

The resistance of the Church to the introduction of a national health scheme in the
1940s related to concerns over the charitable nature of Catholic hospitals, the
independence and autonomy of Catholic hospitals especially in relation to medico-
moral matters, and the economic survival of its hospitals following on the abolition of
the means test, which – it was argued – would deny Catholic hospitals the fees
necessary to subsidise the care of the poor. The tone of Catholic resistance, however,
was not exclusive in that there were declarations that Catholic authorities could work
with Labor’s scheme provided Catholic hospitals received guarantees in relation to
their independence and control over staff appointments. Resistance in the 1970s, however, was sharper and less accommodating, in part due to the events of the 1950s.

The attitude of Victorian Catholic hospitals was crucial. Their use of language remarkably similar to Santamaria and NCC denunciations of Labor government sponsored schemes such as needs-based funding for schools, clearly suggest that resistance to Medibank was prejudiced by relations between the Victorian Church and the ALP. After the Split, Victoria became the heartland of opposition to the ALP. Here the Church maintained its rage against a Party it judged to have sided with the communists. Thus Labor’s proposal to introduce the Scotton-Deeble national health program was characterised as the ‘nationalisation’ of health. Rather Labor sought to consolidate services and centralise administration in order to facilitate planning and access. Whilst sectors within the Party would have preferred more, the pragmatism of Labor politics did not overturn private fee-for-service medicine or absorb private hospitals. Nevertheless, the Victorian Church through its national representatives and the DLP unsuccessfully resisted the introduction of Medibank, a resistance that had parallels with the resistance to the implementation of needs based funding for education contained in the Karmel Report, and discussed in Chapter Eight. Reliance on charity as the basis of social provision, however, was increasingly unfeasible. Yet the Victorians, conditioned by pre-Vatican II thinking that itself was very much influenced by the Church’s fear of capitalism and, in particular, socialism, opted for the maintenance of the status quo. Moreover, their resistance was sufficient to override the expressions of support, albeit largely pragmatic, emanating from elements within the NSW and Queensland Churches. In the end, Catholic opponents, although right to question and suggest refinements of Labor’s two programs, were inclined to conservatism by their reading of Catholic social teaching, a reading that compromised the achievement of the common good, in this instance, a socially just outcome of significantly improved access to health care for the poor and vulnerable. These positions, however, were influenced by relations with what the Church perceived as an antagonistic world that threatened to diminish the influence of the Church and enslave the individual, a view subsequently modified by Vatican II. Consequently, the Church exaggerated the threat to its hospitals, a position supported by the fact that Catholic hospitals did not disintegrate following the introduction of Medibank. Nor were they absorbed or incorporated into the public system.
The Catholic response, then, was partly informed by the concern that loss of independence would compromise the Catholic hospital in medico-moral matters, and the appointment of staff. It was, however, also informed by material and political concerns. The fact that both the Church in the 1940s and in the 1970s concentrated its attack on documents that were superseded by later material, namely the *Sixth Interim Report of the JPCSS* in the 1940s, and *Green Paper* in the 1970s, also suggests that the Church’s response was ideological. It could, then, be argued that the Church adopted a protectionist stance; one if not contrary to the common good and social justice, which compromised their achievement. This is not to imply that Labor’s schemes were without flaws. Indeed, as Catholic authorities rightly noted, the Scotton-Deeble proposal, was an economic program designed to manage access to health care. Thus it ran the risk of neglecting other factors impinging on the delivery of health services. Nevertheless, the vehemence of opposition, especially in the 1970s, even in the face of government assurances, prompts speculation that the Church, or at least sections of it, were prepared to sacrifice the needs of the most needy members of Australian society in their efforts to minimise the role of the state in general and the influence of the ALP in particular. In that sense, the resistance of the Catholic Church to the implementation of a national health scheme was two-fold. On the one hand the opposition was grounded in a particular ‘reading’ of the Church’s social teachings. On the other hand, resistance was promoted by self-interest in which retention of control of ‘its’ hospitals was a crucial factor.

**Conclusions**

The emphasis of Catholic social teaching, at least up until the 1970s was upon charity in preference to social rights enforceable by the state, and the principle of subsidiarity, which highlighted the role of the family and associations over the state. In Smyth’s view Australian social teaching opted for the ‘welfare society’ over the ‘welfare state’. Whilst the Australian Church was more accommodating of liberalism and socialism than its European counterpart, it was not immune to the reaction of the European Church that influenced papal social thought, but neither was it immune to the influence of secular politics. Australian society, which included Catholics, and the Australian state, favoured family provision and mutual aid supported by residual
cash benefits. Consequently, Catholic resistance to the Labor proposals of the 1940s and the 1970s was a product of religious and socio-political influences.

According to scholars like Esping-Andersen, Castles, and van Kersbergen, Catholic social teaching produces a conservative social policy that focuses on the family, the principle of subsidiarity, and a degree of inequality as being natural. Examination of the response of the Catholic Church in Australia in the 1940s and the 1970s to proposals for a national health care system, appear to support that hypothesis. It is, however, possible to argue that this is not an inevitable outcome. Rather a postconciliar reading of Catholic social teaching provides support for a more active role for the state. The resistance of Catholic authorities in the 1940s and the 1970s, whilst mindful of Catholic social teaching, particularly the principle of subsidiarity, appeared to be more concerned with the maintenance of independent and autonomous Catholic hospitals. Whilst this would ensure their charitable status and their autonomy over medico-moral matters one cannot help drawing the conclusion that material and financial concerns also informed the resistance.

Esping-Andersen, Castles, and van Kersbergen established the crucial role played by religion in the development of social policy. In particular they argue that Catholic social teaching leads to a distinctive ‘Catholic world of welfare’ that is conservative and corporatist in nature. This ‘reading’, however, is conditioned by a preconciliar understanding, one that emphasises the principle of subsidiarity, but downplays the importance of the common good, an essential aspect of Catholic understanding of the social order. The conclusion that there is a corporatist welfare regime type, however, is predicated on evidence from continental Europe. In response to the fear of secular liberalism and the rise of an omnipotent state, the papacy emphasised the dignity of the individual, the importance of the social group, the importance of the family and intermediary groups, and the principle of subsidiarity. Smyth extends the insights of Esping-Andersen, Castles, and van Kersbergen by highlighting the importance of the socio-political context on the development of a Catholic understanding of Australian welfare provision. Whilst he notes that this inclined the Church to opt for a ‘welfare society’ over a ‘welfare state’ this was not a necessary, but rather a conditioned response. As Duncan explains, unlike Europe, the Church in Australia, at least prior to the 1940s, ‘confirmed the legitimacy of Catholic support for Labor reformism,
recognised the independence of the laity in politics and granted an acceptable use of the term socialism’ (1991: 176). Yet despite the different circumstances, the attitude of the Australian Church to welfare was not too dissimilar to that in Europe. Is it not possible then to argue that local conditions do not mediate the impact of Catholic social principles? This would perhaps go too far. The identification of a fourth world of welfare capitalism – the radical regime characterised by a means-tested, residual type of welfare state – suggests that there are influences other than Catholicism that produce a conservative welfare state. This holds true even though its origins lie in radical egalitarianism, a description applicable to Australia. Unable to achieve the necessary political power, Australia, and like countries, opt for welfare policies specifically targeted at maintaining workers (Castles & Mitchell, 1993). Generally speaking, this is consistent with Catholic social teaching. It is reasonable, then to argue that Australian Catholic social policy is a consequence of unrequited radical egalitarianism as well as Catholic social principles, a view supported by the closeness of the labour movement to Catholicism.

This thesis extends the work of Esping-Andersen, Castles, van Kersbergen, and Smyth through its examination of Catholic health policy, an under researched topic, in two periods in Australian history, the 1940s and the 1970s. Whilst the conclusions drawn are open to challenge, not the least because of the paucity of supporting primary documentation, it is argued that this thesis has made a contribution to the body of literature surrounding the development of the welfare state. In particular it has enhanced the understanding of the importance of religion in the development of social policy. More specifically this thesis has interesting and important things to say to the theologian, the historian, and welfare state theorists.

In the case of the theologian the thesis develops the importance of the ‘resistance’ and ‘initiative’ distinction, which helps to explain the different ‘readings’ of Catholic social teaching, and their importance for the development of social policy. Adoption of either strategy is very much influenced by location and time. So the attitude of resistance adopted by the Church, both in Europe and Australia, was influenced by liberalism and socialism that resulted in the Church adopting what has been termed a ‘preconciliar’ attitude that was not substantially changed until well after Vatican II.
In relation to the historian this thesis has addressed the paucity of information available on the role the Australian Church in the development of health policy, which whilst largely ‘spoiling’ in nature, was nevertheless important. Thus it extends and deepens understanding of the development of the Australian welfare state. In particular it brings health out of the shadow of education, the main focus of Catholic concern throughout the Church’s history in Australia.

In the case of welfare state theory this thesis has extended the examination of the role of religion in the development of the welfare state that most recently has been carried by Esping-Andersen, Castles, and van Kersbergen, and even more recently by Smyth. It has detailed the role of Catholic social teaching and the Catholic Church upon Australian health policy in an effort to understand how a Church proclaiming its mission to the poor and needy could resist proposals that ostensibly would address that mission. Consequently it has concluded that the response was certainly conservative, but the conservatism was not attributable to Catholic social teaching per se, but was moulded by social and political circumstances that produced a preconciliar ‘reading’ of Catholic social teaching. It inclined the Church to resist the expansion of the state, a view subsequently modified by Vatican II. This is not to argue that Catholic social teaching has changed. Rather the emphasis resulting from Vatican II has acknowledged the importance of the principle of subsidiarity, but has also resurrected the concept of the common good. Certainly the Church has not abandoned the principle of subsidiarity.

Recently there has been a renewed emphasis on the principle of subsidiarity that has seen governments, including the Australian Government, move towards locating services at what has been labelled the ‘better’ level, namely the local level. This strategy, however, is also the means for lessening the role of the state by pushing services back onto individuals and the community, a move that has the capacity to diminish access to services, and burden providers (De Vita 1999: 213). This raises questions about equity and fairness. At the same time there is increasing concern among Catholic providers, a concern that was also evident in the debates of the 1940s and the 1970s, about how much funding and regulation can be tolerated before it begins to interfere in the Church’s mission, especially to the marginalised and poor. Debate over the appropriate role of the state, and relations between Church and state,
then, remain important. This does not suggest that recourse to the principle of subsidiarity is necessarily antithetical to the interests of either the wider community or the interests of the individual. Rather it suggests that one must be mindful of the context within which it is being proposed, and the motivation. The principle of subsidiarity, properly invoked, must inform decisions in areas such as health in order to ensure that the needs of the individual are met and their wishes are accorded due recognition. Strong local associations mediate between the standardising and bureaucratising tendencies of government, and the needs of the family and the local community. This is not to argue for the removal of the state and a return to an emphasis on family and community responsibility for health and welfare provision, as exemplified in current support for private health insurance arrangements in Australia, and a reconceptualisation of Medicare as a ‘safety net’. That reflects an aversion to too great a role for government in matters considered primarily private concerns. As Salamon puts it: ‘According to this argument, the growth of government weakens private, nonprofit institutions, displacing nonprofit functions and “crowding out” private charitable contributions’ (1999: 331). The complexity and cost of health and social welfare services, however, requires government intervention. It is conceivable that some of these services may be administered and managed by non-government providers, of which the Catholic Church is one. It is not without problems, however, especially if government motivation is shaped by economic concerns. Moreover, such a return may produce those characteristics that it is designed to avert, namely the bureaucratisation of those very providers deemed more suited to the provision of health and welfare services. Ironically

large and strong, state subsidies can also make them overly bureaucratic and unresponsive. What is more, this arrangement can leave government with insufficient in-house capability to monitor the resulting ties and can weaken citizen attachment to even the most democratic regime (Salamon, 1999: 361).

Catholic authorities in Australia now recognise the importance of a national and universal health system in the building of a just society, but this does not obviate the need to be mindful that the rights of the individual are not assumed into the state, a need that still holds a place for the principle of subsidiarity. Nevertheless, the complexity and cost of health care means that the burden is too great for individuals and associations to bear alone. Achievement of the common good then requires state involvement. Moreover, it may assist Catholic providers to fulfil their mission to the
poor and needy, a position that, despite good intentions, to some extent was abrogated in the 1940s and 1970s.

This thesis, through an examination of the influence of Catholic social teaching upon health policy, then, reinforces the need to be mindful of the ‘social origins’ of the welfare state. To understand the somewhat paradoxical resistance of the Australian Catholic authorities to the introduction of national health insurance in both the 1940s and the 1970s it is important, then, to understand the social and political context that framed the actions of the Church in Australia. Australian Catholic social thought, at least in the 1970s, was resistant to a change from a ‘welfare society’ to a ‘welfare state’. In part this was due to the fact that the Australian Church had yet to be influenced by the change in orientation ushered in by Vatican II. Fear of communism, which dominated the thinking of the Church throughout the period of this study, pragmatism, and fear of loss of control over its institutions, underpinned the resistance of the Australian Church to an expansion of the role of the state as proposed by Labor’s two schemes. A conservative reading of Catholic social teaching supported this stance.

Unlike Esping-Andersen, Castles, and van Kersbergen this thesis contends that the resistance of the Australian Catholic authorities to the introduction of national health insurance was not a consequence of Catholic social teaching \textit{per se}. Rather, it was a consequence of a preconciliar interpretation of Catholic social teaching that was greatly influenced by the Australian social and political context. Whilst the Australian Church reached a measure of accommodation with liberalism, and socialism, it nevertheless built a segregated society. This kept the flock faithful, but at the expense of a narrow outlook that was staid, reactionary, and inflexible, a position not helped by the growing threat of communism that emerged during the period of this study. Thus the Australian Catholic Church assumed an attitude of resistance to those policies it deemed socialist, a position not helped by the wider unreflective and pragmatic Australian society that was more concerned with practicalities than theory. Concern about the introduction of national health schemes, then, focussed on the survival of Catholic hospitals as independent institutions rather than looking to and addressing the needs of those Australians denied access to health care because of inability or limited ability to pay, a cause certainly in accord with
Catholic social principles. Justification for this response rested upon a preconciliar interpretation of Catholic social teaching which, shaped by social and political conditions, emphasised the importance of the principle of subsidiarity, and the subordination of consideration of an equally important Catholic social principle, namely the common good. Consequently the Church opted for resistance to the expansion of the role of the state in favour of individual effort and mutual aid.

The tension within Catholic social teaching – containing as it does aspects that may lead to resistance or initiative – helps to explain the paradox identified in Chapter One. The distinction makes it possible to argue that the Church’s attitude to policies that expand the role of the state are not foreordained but conditioned by time and circumstances. Nevertheless, the Church in Australia resisted the implementation of national health schemes that would especially benefit the neediest in society, not once but twice. However disappointing this outcome, it is nonetheless explicable. Whether it is justified is open to debate. As has been demonstrated, the Church’s resistance to welfare policy was influenced by Church concern about liberalism, nationalism, secularism and socialism, especially in relation to their impact in Europe. Thus it tightened central control, embraced authoritarianism, and adopted conservative social and political positions in the process. In other words the Church adopted a defensive stance that ultimately earned it the labels reactionary and authoritarian (Steinfels in Douglass & Hollenbach, 1994: 21-22). As Smyth puts it, the Australian Church favoured a ‘welfare society’ over a ‘welfare state’ (2003).

Finally it is argued that this thesis has fulfilled the threefold purpose outlined in Chapter One. First, it has made a contribution to the debate over the role of religion – in this case Catholicism – in the formation of social policy. Following the lead of Smyth, it has extended the insights of Esping-Andersen, Castles, and van Kersbergen in relation to the influence of Catholicism on the development of welfare policy through its examination of the Australian Church’s resistance to Labor proposals to introduce national health schemes in the 1940s and the 1970s. Secondly, it has explained the paradox identified in Chapter One. That is, it has demonstrated that Catholic resistance was shaped by a preconciliar interpretation of Catholic social teaching that itself was influenced by Australian and European social and political conditions. Consequently the concept of the common good was subordinated to the
principle of subsidiarity. Thirdly, it has, it is hoped, extended our understanding of these two periods of Australian social welfare history through an examination of a neglected area of study, namely Catholic health policy.