PART I

Medicine and the State: 1900 to 1939

CHAPTER 1

'A Game of Animal Grab': Medical Practice, 1920 – 1939

By the 1920s the Australian medical profession had achieved a nearly unchallenged dominance over the supply of personal health services. Its rivals in homoeopathy and other irregular medical traditions had been driven out or marginalized and in each state medical boards, dominated by the profession, ensured that this dominance would remain unchallenged. The costs of medical education were enough to restrict new entrants to the profession. Practitioners, the public and governments agreed that shortages of practitioners rather than excessive competition was the major problem. Paradoxically, these professional advances were accompanied by growing economic insecurity. Private medical practice on a fee-for-service basis faced the insuperable obstacle of a lack of capacity to pay from all but an affluent minority of the population. The politics of organized medicine increasingly centred on finding a means to guarantee medical incomes, and extend services to wider sections of the population without compromising professional autonomy.

At the same time the plight of the 'middle classes' entered the language of medical politics. Conflict over the future of medical practice revolved around growing demands to widen access to the public hospital system to sections of the population previously excluded from charitable institutions. The growing sophistication and expense of hospital-based technologies made the small private hospital and home-based care increasingly inferior for all but simple ailments and operations. In all states organized medicine, represented by the state branches of the British Medical Association (BMA),

fought a losing battle to exclude potential paying patients from the public system. By the early 1930s the profession realized the futility of obstructing these encroachments on private general practice, and investigated ways to widen the market for medical services to embrace those presently excluded. These class boundaries remained hazy, ranging from those 'just above the basic wage' to 'just barely comfortable in life people' who pay their way, and who make so large a proportion of a doctor's paying patients, comprising those Macintyre has recently described as the 'anxious class', earning somewhere between £200 and £500 a year and struggling to maintain their status above the mass of the manual working class.[1]

Far from asserting their independence of the state, by the end of the decade each of the Australian branches of the BMA was calling for greater government or other collective intervention in the provision of medical services, and influential sections of the medical profession were entertaining plans for radical changes in the remuneration of medical practitioners. At the same time, the financial pressures on the public hospital system forced state, and then Commonwealth governments to move health services from the margins of politics.

General practitioners and the medical market

Medical practice during the interwar years was a small-scale cottage industry dominated by general practitioners in sole practice. In 1921 over two-thirds of those describing themselves as 'medical practitioners' were in sole practice (Table 1.1). Only a very small proportion listed any employees. In keeping with this small business ethos most medical graduates starting in practice could expect a long battle before they achieved any economic security and overcame their heavy burden of debt. The pressing issues were not questions of therapeutics but the day-to-day struggle to build up or keep a viable practice. The competitive suspicion that often raged between rival general practitioners was portrayed by Herbert Moran, a Sydney surgeon, as 'like a game of animal grab, but you've got to grab according to the rules, otherwise they'll be reporting you to the Ethics Committee of the BMA' – rather than the idyllic image of professional co-operation presented in medical school.[2]

Unlike medical practitioners in the more free market atmosphere of the United States, where the struggle between regular 'allopathic' medicine and its rivals, homoeopathy, chiropractic and osteopathy, raged bitterly up to the First World War, the Australian doctor had less difficulty in maintaining professional prestige. Despite regular

complaints about competition from 'quacks' and a widespread preference for patent medicines over the expensive and uncertain results of medical advice, the prestige of the imperial connection – the 'British' in the title of the BMA was not dropped until 1962 – and state registration controlled by BMA-dominated medical boards helped to assure the status of regular medicine in Australia. In all states but Queensland the medical acts required that all board members be qualified medical practitioners. Intense conflicts could occur over the subordination of 'ancillary' professions, such as midwifery and optometry, but by the 1920s this rarely took the form of open conflict. The slow strangulation of homoeopathic medicine in Victoria – limited to one new registration a year – was more typical. Starved of new doctors, Melbourne's Homoeopathic Hospital gradually opened its doors to more orthodox members of the BMA. These exclusionary tactics were also used successfully against refugees from Nazi anti-semitism in the 1930s. After intense pressure from the BMA from 1937 to 1939 the medical acts in Victoria, New South Wales, Tasmania and Queensland were amended to refuse recognition of medical qualifications, unless from a country already agreeing to reciprocal recognition. In effect this barred German and Austrian doctors from practice if they were not prepared (or able) to undergo lengthy and expensive retraining.[3]

Table 1.1 Employment Status of Australian Medical Practitioners, 1921

	No.	%
Employer	483	14.7
On Own Account	2,247	68.5
Employee	549	16.7

Source: *1921 census*.

These firm barriers to entry meant that overcrowding of the medical profession was not a major problem for most of this period. The ratio of doctors to population, admittedly a very rough means of estimating the supply of services but the only one available, remained relatively high. In 1920 the average population served by each doctor in the United States was 746 and in Canada 1,008. In contrast, Australia had a marked shortage of medical practitioners throughout the interwar years. In 1920 each Australian medical practitioner served an average population of 1,351. Although this number fell slowly over the following two decades – by 1940 the Australian population per doctor was 1,061 – it remained high by international standards.

These aggregate statistics must be qualified in the light of regional differences in the market for medical services (see Appendix Table 1.7). In 1920 Queensland – lacking its own medical school and with a relatively poor and scattered population – had one doctor for each 1,826 people. This contrasted sharply with Victoria's more favourable – but still high – ratio of one doctor for just over 1,000 inhabitants.

If legal and regulatory restrictions were not enough to impede entry, these barriers to competition were augmented by financial obstacles. The costs of entering medical practice were heavy. Burdened with the debts of education and the establishment or purchase of a practice, newly registered general practitioners were faced with a professional life of long hours and hard work in return for relatively low remuneration for at least the first decades of their careers.

The first of these costs was the acquisition of a medical degree. Medical education was a long and expensive process. An American visitor noted in 1924 that medical fees at the University of Melbourne amounted to £25 per annum and that only 20 (out of 619) medical students received free places at a time when the basic wage stood at well under £4 a week. The lengthening of the medical course, first to five years (in 1922) and then to six (1934), extended the clinical components of the degree, but at the cost of even more prohibitive financial barriers. In 1930 the full cost of a medical degree at the University of Sydney, excluding living expenses, was £350 and a decade later the potential general practitioner required £400 alone in fees for six years of university and hospital training. These costs were sufficient to exclude most students without substantial financial means from medical courses. During the intercensal years 1921 to 1933 there was an absolute decline in the numbers of women doctors in private practice; their proportion of the profession fell from just under 10 per cent to 5.7 per cent.[5]

The newly registered doctor was then faced with the costs of establishing a practice. Those with sufficient private means or family support could buy an established practice; for their less wealthy colleagues the choice was either working as an ill-paid assistant or 'squatting' – setting up in a likely neighbourhood and surviving the enmity of local doctors until a practice was built up. Neither offered a secure or lucrative living in the early years and eliminated the chances of all but a wealthy few to pursue post-graduate studies abroad, still the principal route to specialization. Purchase of a practice, usually with finance provided by a medical agency, saddled the future general practitioner with a debt amounting to one year's gross takings, averaged out from the receipts of the previous three years. To

this encumbrance was added the price of the house and surgery which went with the practice. The value of the practice to the new incumbent depended almost entirely upon its transferable goodwill, its 'appointments' – the size of the previous doctor's friendly society panel of patients, appointment as a part-time medical officer of health to the local council, access to hospital paybeds and the chances of appointment as a local medical officer for the Repatriation Department (effectively restricted to doctors with a service record themselves). Financial survival during the first years of practice depended on these guaranteed sources of income and the new doctor's ability to attract fee-paying patients, 'cultivated sedulously around the lodge, the local church and a chemist shop'.[6]

Private practice on a fee-for-service basis, while the most lucrative area of work, was difficult to establish as the mainstay of a practice in all but the more affluent middle class suburbs. The attractions of this work meant that these areas of the large cities were relatively oversupplied with services, leading in turn to greater competition between doctors and lower incomes than could be earned in many of the less salubrious lodge practices in industrial suburbs. Consequently 'the doctors in residential suburbs do not earn as much as those in the industrial suburbs...[but] they live more pleasantly. Many of them are men who have come from country practices to the city and have earned enough to keep them in retirement'.[7]

'The crux of present medical practice': the friendly societies

Nowhere were the limits to the free market for medical services more apparent than in the continued strength of the friendly societies. These mutual benefit societies, organized in local lodges, provided their members with general practitioner services in return for a weekly contribution. General practitioners contracted with a society to provide a limited range of services to a panel of lodge members and their dependants. Particularly during the difficult first years of practice, doctors could expect to earn the bulk of their living from the capitation fees of lodge patients, fee-for-service practice remaining only a supplement to this basic income. Remuneration for lodge work remained entirely by capitation fee, a fixed annual payment for each patient on the lodge doctor's panel. No further charges were made to the patient for a limited range of medical services. Although the size of this fee and the range of services remained a point of conflict between the societies and each state branch of the BMA,

there was never any suggestion by the profession that fee-for-service could ever become the basis for medical practice in working class areas. For members of the urban working class with sufficiently regular incomes to keep up with contributions this represented the most effective way to ensure cheap health care for themselves and their families. By the same token, lodge practice provided the principal source of income for doctors in industrial suburbs.

By the third decade of the twentieth century the societies had changed greatly from the mutual benefit social clubs of the late nineteenth century. As ceremonial and self-help activities declined, friendly societies such as the Oddfellows, the Manchester Unity and the sectarian-based Hibernians and Protestant Alliance became more exclusively concerned with financial services to members, providing insurance for sickness, unemployment, old age, funerals and, above all, medical benefits. Constrained by state legislation which enforced relatively stringent regulation of assets and contributions to benefits, membership requirements and the use of surplus funds, friendly societies remained non-profit associations of their contributors. Despite the gradual decline of a vigorous internal life, their constitutions still included government by representatives of the individual members, and policies were established at meetings of the membership, such as the annual 'Courts' of the Manchester Unity.[8]

The lay control of the societies, their financial power and dominance of the funding of health care for the better-off members of the working class, meant that they were always a target of hatred amongst doctors. Responsible for the solvency of contributors' funds, the friendly societies kept a jealous scrutiny of the cost of medical services, leading to persistent complaints of 'sweating' by medical practitioners contracted to the lodges.[9]

It has been a common view that by 1920 the lodges were effectively vanquished. In a series of extended conflicts in all states (and mirroring earlier disputes in Britain), the Australian branches of the BMA weakened the control of the lodges over the conditions of medical practice. By the early 1920s each state branch of the BMA had secured a Common Form of Agreement with its friendly societies, establishing the Association's control over the terms and conditions of access to lodge practice. The strict income limits imposed by the BMA excluded from lodge lists all who could afford private fee-paying treatment. Similarly, restrictions on the range of services offered to lodge members forced patients to pay fees for most minor operations. By 1920, Willis has claimed, 'The medical profession had achieved its aim of the right to control the conditions

of medical practice, and established fee-for-service as the mode of medical treatment henceforth'.[10]

The 'battle of the clubs' before the First World War ended with major setbacks for the friendly societies. BMA members in each state refused to renew lodge contracts until restrictive conditions were imposed on eligibility, and the range and control of medical services. The Common Form of Agreement imposed by the BMA effectively restricted the societies to a working class clientele – although in the late 1930s, when the income limit was set at £365 in New South Wales, only 80,709 Commonwealth income tax-payers were assessed on incomes greater than £300 a year. The most fundamental victory for the BMA was the abolition of the Medical Institutes set up by friendly societies which had directly employed salaried doctors. Henceforth lodges were restricted to a concessional service mainly catering to the needs of working class families. In Victoria, where the dispute had been most bitter, the Wasley Royal Commission accepted the BMA's claim for a capitation fee of twenty shillings (20s.) in urban areas with twenty-five shillings (25s.) in non-metropolitan districts.[11]

Despite the new constraints on the friendly societies, the lodge system of contract practice and remuneration by capitation fee was grudgingly accepted by the BMA as the only means of integrating the working class patient into paid medical services. As a Queensland doctor told the Royal Commission on National Insurance in 1924, it 'means a regular income, and when attached to other work is good enough'. Nor was any attempt made to exclude the dependants of members from lodge medical services, as the BMA had achieved in England. Income limits were left to the individual lodges for enforcement, and these usually adopted a very generous approach to existing members. In 1938 an official of the New South Wales Friendly Societies' Association agreed that 'in ordinary practice, if a member exceeds [the income limit of] £365 in some degree nothing happens. No inquiry is made by the friendly society'.[12]

The limitation of services, the main area in the control of the lodge doctor, enabled a slow erosion rather than a destruction of lodge services as panel patients were forced to pay for an increasing range of basic services. In New South Wales the Common Form of Agreement excluded all operations, treatment for fractures and dislocations, anaesthetics and, most significantly, midwifery. The main effect of this restriction of services was to reinforce class distinctions in medical provision. Despite denials by the BMA, most observers conceded that lodge patients were often treated in a peremptory and

grudging manner. The high administrative costs of the societies, in 1929 estimated at 19 per cent of the revenue from contributors in Victoria, created further pressures for restrictive services and complaints that 'If any economy has to be effected by lodges it frequently is done first at the expense of medical benefit'. While these limitations did not lead to a displacement of the friendly societies they may have encouraged the stigma attached to lodge practice by many of its recipients as well as the medical profession. [13]

Table 1.2 Membership of Friendly Societies, 1910–1949 (10,000s)

	1910	*1915*	*1920*	*1925*	*1930*	*1935*	*1938*	*1945*	*1949*
NSW	12.2	16.1	17.6	20.9	25.0	20.5	21.2	23.0[a]	18.9
Vic.	13.9	15.9	14.4	15.5	16.5	16.4	18.9	20.6	20.2
Qld	4.1	5.2	5.5	6.2[b]	6.8	6.7	7.2	7.4[c]	6.8
SA	5.1	6.5	6.9	7.4	7.7	7.1	7.5	8.0	7.6
WA	1.6	2.0	1.8	2.1	2.5	2.3	2.7	3.0	2.9
Tas.	2.1	2.3	2.3	2.4	2.7	2.4	2.5	2.4[d]	2.1
C'wlth	39.0	48.0	49.0	54.6	61.1	55.4	60.0	n.a.	58.6

[a] 1947 [b] 1924 [c] 1944 [d] 1946

Note: D. Green and L. Cromwell, *Mutual Aid or Welfare State?: Australia's Friendly Societies*, Sydney 1984, Appendix 4, have suggested that to estimate the total population covered, including dependants, these numbers should be multiplied by a factor of 4.34 up to 1930 and 3.2 from the mid 1930s. Although it gives a better representation of long-term trends their procedure has not been followed here as the sudden decrease in size of the multiplier gives an exaggerated view of the decline of the societies' coverage in the late 1930s.

Source: *Commonwealth Yearbooks*.

'Industrial practice' based on the lodge panels remained the main source of income for medical practitioners in working class areas of the cities. Table 1.2 shows the slow growth of the societies in all states during the 1920s. The depression, rather than medical opposition, provided the greatest check to expansion and after 1935 membership recovered. In 1925 the Royal Commission on National Insurance had found that 40 per cent of medical practitioners had friendly society contracts. Two decades later the societies still occupied a pivotal position; 900 out of the 1,950 members of the Victorian branch of the BMA had lodge practices, in Queensland up to one-third of medical incomes were earned from capitation fees, and nationally over one-quarter of the population was covered by friendly society medical benefits. The importance of the friendly