# THE PRICE OF HEALTH

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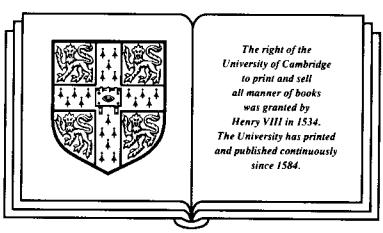
# THE PRICE OF HEALTH

*Australian Governments and Medical Politics 1910-1960*

**JAMES A. GILLESPIE**
School of History, Philosophy and Politics
Macquarie University

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# Preface

Of all the areas of public policy commonly lumped under the rubric of 'the welfare state' none has been as hotly contested as health policy. The extent, and very legitimacy, of state intervention in the provision and subsidization of medical and other health services has fuelled clashes involving most of the major interest groups and political parties, and the institutions of the state themselves, as each level of government has vied for control of the direction of the system. Along the way, Australia has been the only liberal democracy to legislate to establish a popular national health insurance system, only to see it promptly dismantled.

The bitterness of this political history calls for some perspective to be placed upon contemporary events. In tracing the course of these battles my aim has been to explain some of the structural causes which have made a lasting settlement so intractable. This understanding can only be achieved by moving away from a view of conflict as a simple clash between medical professional independence on one side and state intervention on the other. The hostility of organized medicine towards state intervention was neither automatic nor consistent. Similarly, this history was by no means unique to Australia. Some of the ingredients of Australian medical politics have been common to the medical profession – or to the sociology of the professions – in general. In carving out and defending a privileged labour market the Australian medical profession was acting much as their colleagues elsewhere in the world. Similarly, government intervention, to affect both the pattern of services and access to

medical care and its cost, has hardly been unique to Australia. What does demand exploration is the specific direction events took in this country. The forms taken by government policy and the interests and political coalitions which determined their outcome cannot be reduced to mere local variations of a standard international pattern.

This account stresses the importance of politics in forming our present health system. It identifies the structural interests at play. As advocates of the free market have long lamented, the market for medical care has ever been one of the most restricted and regulated areas of the economy. Whatever defences may be made for restrictive practices, it remains that the balance of strength between doctors, patients and the state has been set by these restrictive market conditions.[1]

Most accounts of the rise of the organized medical profession attribute its strength, 'the most powerful trade union in the British Empire', to this market position. Controlling the major institutions as well as access to the health system, able to use professional licensure and a privileged relationship with the state to regulate or exclude competitors, the medical profession in most industrialized capitalist societies has provided the model of professional autonomy. The political and social power of the medical profession has been seen as a function of independence from lay control and especially from state regulation of the relationships, both therapeutic and financial, between doctors and patients.

In the Australian context critics and apologists alike have seen two influences as central to this autonomy. The first of these was the dominance of registered medical practitioners over rivals within the market for health services. Medical dominance in Australia has been seen as predicated upon the successful subordination of potential competitors (such as midwives and optometrists) with the reduction of their status to 'ancillary' services under medical direction and the marginalization or outright persecution of more direct rivals such as chiropractic and homoeopathy.

The intervention of the state is central to this analysis. By handing over control of registration to the medical profession and giving it a privileged position in advice of policy questions it provided doctors with a means of isolating and destroying their rivals at a time when standard medical practices were not demonstrably superior to those of their rivals.[2]

At the same time, forms of remuneration have taken on great significance in medical politics as the embodiment of particular relationships between practitioners, their clients, and third parties.

The dominance of an expanding and increasingly homogeneous market for medical services underpinned the shift from relative poverty and low public esteem in the late nineteenth century to the improved economic and exalted social status of medical practitioners by the 1930s, a progress underpinned by the establishment of fee-for-service as the major form of remuneration for personal medical services. Fee-for-service embodied the central features of medical autonomy – the freedom from contractual arrangements to outside bodies, the ability of the individual doctor to vary charges according to the means of the patient, and the assumption of individual responsibility for the costs of illness. Consequently, the dominance of fee-for-service has been seen by both its critics and advocates as a prior condition for the autonomy and political power of the medical profession.[3]

An adequate account of the relationship of the state to the provision of health care must start from premises other than the stark opposition of 'intervention' and 'autonomy'. The British sociologist Terence Johnson's concept of 'professionalization' as a 'process towards partial autonomy, being limited to specific areas of independent action which are defined by an occupation's relationship to the state; areas of autonomy which arise from time to time and place to place', provides the basis for an analysis which can explore the contradictory record of the political practice of the medical profession in the face of state involvement in the provision and regulation of medical services. 'Medicalization', the transformation of western notions of the body, health and illness through the dominance of scientific medicine, should not be reduced to a question of social control, of the dominance annexed by one social/professional group, but should recognize the important differences in which knowledges are taken up, the contradictions within the profession and the strength of lay knowledges.[4]

The argument presented here is that a particular model of the relationship between public health and private practice underlay Australian medical politics from 1920 to 1950. The advocates of a national health policy attempted to subordinate the general practitioner and 'curative' medicine within a broader framework of preventive public health, with national co-ordination, or even direct control by the Commonwealth Department of Health. The turning point in Australian health policy during the 1940s was not the defeat of schemes of 'socialized' medicine, but the defeat of this wider vision of public health and its replacement by policies which concentrated on access to the existing pattern of private health services. While the

approach to the incidence of costs and the provision of benefits differed sharply – as it does today – between the main political parties, this was within a wider consensus. From the end of the Second World War, both the major forces in Australian politics agreed that the central problem was the subsidization of existing services. Within this consensus, conservative and Labor governments differed on how health care should be financed and the extent to which benefits should be the target. Federal and state Labor administrations were hostile to the demeaning conditions of the means-tested public wards and did not share the social assumptions of the conservative parties – the fear that older traditions of charitable giving would crumble in the face of massive state subsidies. But these conflicts were fought within a common set of assumptions. Government had a duty to provide access to medical care for those citizens unable to afford the fees of private practice. The extended boundaries of public intervention were not to challenge the profession's control over how those services were supplied.[5]

The first section of this study analyses the structure of interwar medical practice and the limits on state intervention. The limits imposed on the market for medical services and the threat to general practice posed by the growing importance of the hospital and medical specialism set the context for conflict. Chapter 2 examines the failure of the project of national hygiene, the attempt to use the state to impose a new conception of public health, making medical reform the centrepoint of a progressive recasting of social relationships. Chapter 3 develops this account of medical institutions, and conflict over their control, moving to the level of the states – where most direct administrative responsibility was exercised – and looking at the very different relationships between the medical profession and governments which emerged. The attempt to introduce national health insurance in 1938–9 was the first serious move towards a national health policy based on subsidization of medical expenses. Chapter 4 takes the analysis of the power relationships in Australian health policy further by examining the failure of this campaign.

The second section examines the attempt at medical reconstruction during the 1940s. The wartime governments of Menzies and Curtin and the postwar Labor government of Chifley all commissioned schemes for a major alteration in medical practice. Although they have been seen as the principal attempt to socialize medicine, or at least introduce a comprehensive national health service on the British model, a closer examination of these projects shows quite

different aims. The plans of the National Health and Medical Research Council and the Joint Parliamentary Committee on Social Security were vehicles for reviving the projects of interwar health administrators, the national hygienists, and for averting the danger of medical planning falling into the hands of politicians. Organized medicine remained seriously divided over the attractions of a fully salaried medical service. The effective, and ultimately successful opposition to these radical schemes came from the Commonwealth Treasury and the planners of postwar reconstruction who successfully subordinated health policy within their social security programme. Any notion of direct service or attempt to restructure medical practice was lost, and the national health scheme was reduced to a series of cash benefit programmes. It was on this narrow scheme that the major conflicts between organized medicine and the Commonwealth were fought.

The final section examines the creation of the Page–Menzies health scheme of the 1950s. Far from an unalloyed victory for organized medicine, Page's initial project continued many of the obsessions with cost-control which had circumscribed Labor's approach. His heavily means-tested scheme was widened in the face of medical resistance, and especially the BMA's successful destruction of the only administrative agencies which could have implemented the Page scheme. Chapter 12 develops the implications of this political history for later attempts at reform of the health system. The institutional structures formed during the conflicts of the 1940s have set the limits of subsequent reform.

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This book would not have been written but for the personal interest taken by Dr Neal Blewett, then Commonwealth Minister for Health. Most of the research and writing was carried out in the Social Justice Project in the Research School of Social Sciences at the Australian National University, funded with a grant from the Commonwealth Department of Community Services and Health. My greatest debt is to Pat Troy, the initiator and co-ordinator of the Project, who provided such a congenial setting and unstinting encouragement. George Morgan and Sue McGrath gave research assistance at the Project with help and ideas which contributed significantly to the final result.

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# Abbreviations

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| AA | Australian Archives |
| ABL | Archives of Business and Labour, Australian National University |
| ACTU | Australian Council of Trade Unions |
| ALP | Australian Labor Party |
| AMA | Australian Medical Association |
| AWU | Australian Workers Union |
| BMA | British Medical Association |
| CMCC | Central Medical Co-ordination Committee |
| CPP | *Commonwealth Parliamentary Papers* |
| DHA | Drug Houses of Australia |
| DSS | Department of Social Services |
| EMS | Emergency Medical Service |
| FPSG | Federated Pharmaceutical Services Guild of Australia |
| FSDPA | Friendly Societies Dispensaries and Pharmacists Association |
| HCF | Hospitals Contribution Fund |
| JPCSS | Joint Parliamentary Committee on Social Security |
| MBF | Medical Benefits Fund |
| MECC | Medical Equipment Co-ordination Committee |
| MHSC | Medical and Hospital Survey Committee |
| MPA | Medical Policy Association |
| NHI | National Health Insurance |
| NIC | National Insurance Commission |
| NHS | National Health Service |

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|---|---|
| NHMRC | National Health and Medical Research Council |
| NHS | National Health Service |
| NLA | National Library of Australia |
| *NSWPP* | *New South Wales Parliamentary Papers* |
| NSWSA | New South Wales State Archives |
| PMS | Pensioners' Medical Service |
| *QPP* | *Queensland Parliamentary Papers* |
| QSA | Queensland State Archives |
| RACP | Royal Australasian College of Physicians |
| RAC | Rockefeller Archives Center |
| RACS | Royal Australasian College of Surgeons |
| RPAH | Royal Prince Alfred Hospital |
| *SAPP* | *South Australian Parliamentary Papers* |
| SCMO | Senior Commonwealth Medical Officer |
| SEC | State Electricity Commission |
| SMCC | State Medical Co-ordination Committee |
| *Tas.PP* | *Tasmanian Parliamentary Journals and Papers* |
| UAP | United Australia Party |
| VPRO | Victorian Public Record Office |
| VTHC | Victorian Trades Hall Council |