The Price of Health

Australian Governments and Medical Politics 1910-1960

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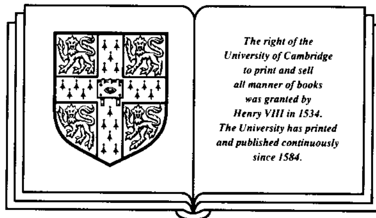

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CHAPTER 1

'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 over-supplied 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

societies to the economics of medical practice was even greater than these numbers suggest. The Royal Commission found that during the earlier stages of their careers most metropolitan doctors were dependent on lodge work. A national survey revealed that in 1943 one-third of the prescriptions dispensed by private chemists were on lodge prescriptions and this did not include those supplied through friendly society dispensaries.[14]

The financial strength of the friendly societies cushioned medical practitioners from the worst effects of the depression and assisted the societies to recover some of their lost ground. Expenditure on medical services by the friendly societies increased in real terms throughout the interwar years, even when membership was falling, as the societies drew on reserve funds to subsidize the contributions of unemployed members (Tables 1.3 and 1.4).

This was recognized by the BMA lodge doctors in Western Australia who agreed to donate 10 per cent of their capitation fees to keep all unemployed lodge members who were married or with dependants on the medical lists. In 1928 the Victorian branch had reopened its efforts to obtain a revision of the Wasley Award. With

Table 1.3 Expenditure of Friendly Societies, 1920–1949: Medical Attendance and Medicine (£'000)

	1920	*1925*	*1930*	*1935*	*1938*	*1945*	*1949*
New South Wales	317	307	331	278	306	419[a]	456
Victoria	186	210	230	247	293	381	549
Queensland	73	87[b]	106	96	105	105[c]	131
South Australia	39	80	101	91	100	109	170
Western Australia	20	25	34	32	41	48	82
Tasmania	22	23	30	28	31	36[d]	46
Commonwealth	658	736	831	772	876	n.a.	1433

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

Source: *Commonwealth Yearbooks*.

Table 1.4 Expenditure of Friendly Societies, 1920–1949: Medical Attendance and Medicine at 1925–7 Prices (£'000)

	1920	*1925*	*1930*	*1935*	*1938*	*1945*	*1949*
New South Wales	264	308	339	325	338	340[a]	267
Victoria	155	211	235	289	323	333	322
Queensland	61	88[b]	109	112	116	92[c]	76
South Australia	33	80	104	106	110	95	100
Western Australia	17	25	35	37	45	42	48
Tasmania	18	27	31	33	34	31[d]	27
Commonwealth	549	738	852	902	966	n.a.	838

[a] 1947 [b] 1924 [c] 1944 [d] 1946
Source: *Commonwealth Yearbooks*.

the onset of depression this campaign was all but abandoned; in late 1932 the branch president noted: 'In the profession there is a great divergence of opinion, but I know that at present there are many medical men who, if it were not for their lodge payments, would be in a very invidious position, and they feel that they would be unwilling to have any misunderstandings with lodges'.[15] It was not until 1940 that another attempt was made to raise Victorian capitation rates to the levels enjoyed by lodge doctors in other states.

Even more significantly, the hitherto successful campaign to restrict specialist services under lodge contracts was increasingly flouted. During the 1930s several friendly societies were able to establish specialist panels, despite BMA warnings to its members that concessional specialist services were only to be available on a fee-for-service basis and open to all recognized members of a specialty, not through an exclusive contract with a lodge. Specialists who participated were assigned panels of up to 10,000 patients, each paying an annual fee of one shilling. A (possibly exaggerated) estimate in 1941 was that most lodge specialists would see, on average, one per cent of these patients in a year, drawing in return a handsome supplement of around £500 a year to their earnings from fee-for-service practice.[16]

Neither the BMA nor the lodges accepted that the political issue of control of conditions of lodge medical practice had been settled once and for all. While the friendly societies in New South Wales, Queensland, South Australia and Western Australia soon re-established more or less amicable relations, conflict continued in Victoria and Tasmania. Facing the strongest and most aggressive of the societies, in particular the Australian Natives Association, the Victorian branch of the BMA saw many of its achievements under-

mined. Capitation fees remained lower than in any other state and the fight for the more stringent enforcement of income restrictions was unsuccessful. After a seven-year struggle to achieve a Federal Common Form of Agreement with the friendly societies, which would have brought capitation fees and conditions in all states up to the New South Wales standard, by 1947 the BMA had to admit its lack of success, accepting state by state agreements which left Victorian and Tasmanian lodge doctors considerably worse off than their interstate colleagues.[17]

Capacity to pay remained the main barrier to alternatives to pre-paid panel practice in working class communities. In areas where the BMA had succeeded in eliminating friendly society medical services lodge practice was replaced by a remarkably similar substitute, although decisively under medical control. In Newcastle, where a dispute with the lodges led to the resignation of all BMA members from lodge practice, successful 'doctors' clubs' were established by the former lodge doctors on the same basis as the friendly societies, contracting to provide a limited range of services for a fixed annual charge. Again, as with lodge practice, a fee was charged for each additional service. The clubs operated on a small scale, doctors' wives carried out the administrative work, and weekly contributions were deducted from wages by agreement with the trade unions and employers. Similar contract personal health services were provided for occupational groups such as timber workers in Victoria and miners on the West Australian goldfields through their trade unions. These doctors' clubs showed the attraction of contract service to general practitioners in working class areas, as they involved minimal bookkeeping and a reduction in bad debts while providing a service to all family members. Moves by state and federal governments to establish limited contract services for particular social groups proved equally acceptable to organized medicine. The Commonwealth Repatriation Department provided medical services for war widows and their children by subsidizing friendly society contributions. In 1937 the New South Wales government established a medical service for the unemployed on a similar basis with no dissent from the medical profession.[18]

As a result, the line between capitation-based contract practice and fee-for-service was often hazy. While most specialist services and general practitioners in middle class and rural areas, where the friendly societies were weak or non-existent, were exclusively fee-for-service, those with working class practices usually depended on a mixture of fee-for-service and lodge practice. The contract practice

committees of each state branch of the BMA worked assiduously to extend the range of services excluded from the lodge contract. The societies fought equally hard, but with decreasing success, to develop a complete capitation-based service.

There is little hard evidence on the size of the market for private medicine. Thame has suggested that one-half the population depended on fee-paying medical care, a figure which appears to have been reached by elimination – identifying the proportion of the population ineligible for concessional or charitable services. However, exclusion from free or concessional services did not always mean ability to pay for private practice: the cost of a visit to a general practitioner's surgery – between 10 shillings and 2 guineas – meant that for much of the 'middle classes' medical services were an emergency resort. In less serious cases many relied on the unpaid advice of pharmacists or on fringe practitioners such as the Chinese herbalists still prominent in most country towns.[19]

Given the complicated mixture of pre-paid and fee-for-service practice, fee structures varied considerably. In New South Wales local or regional associations of practitioners issued confidential recommended fee schedules to their members, with little central co-ordination or interference and no binding power. In Victoria the BMA's state council played a more active role. A British investigator found that, unlike the English practice of income-related sliding fees, Australian doctors tended to charge a flat minimum fee for each service, restricting the scope for cross-subsidy between wealthy and poorer patients. The evidence on this point is contradictory. A manual of advice for general practitioners noted that the use of sliding scales was one of the more difficult skills of private practice. Years of experience were required to instantly assess a patient's true income. Its author concluded, however, that, despite this challenge, most general practitioners ended up using some form of sliding scale.[20]

Far from achieving dominance, fee-for-service co-existed in uneasy association with capitation systems of remuneration through the interwar years and few lodge doctors or leaders of the medical profession seriously visualized a system based on different principles. The most that could be hoped was that the middle classes would continue to be excluded from lodge practice and that the range of services outside the lodge contract would continue to grow. Charles Byrne, a medical critic of the lodge system, noted that, despite his colleagues' hostility, the friendly societies remained 'the crux of present medical practice. The lodge patient was welcomed by the

doctor with open arms when he came as a private patient [to receive services outside the restricted lodge list] but the same could not be said of the lodge patient as such'.[21]

General practitioners, specialists and the 'closed' hospital

The Australian medical system was a complicated hierarchy based on a limitation of access by suppliers of services and by patients. Panel doctors and outpatients' clinics catered for those who were unable to afford entry to the market for private medical services. This professional pyramid has been conventionally depicted as the result of technological imperatives. The advance of scientific knowledge led to a fragmentation of medical practice and a proliferation of specialties. Rising costs and other restrictions to access to medical services were a consequence of the failure of administrative and financial institutions to adapt to the pace of scientific and technological change. In this view, the problem of access to modern medical care, and the political conflicts around attempts to widen this access, were not the result of the restrictive practices or outright greed of the medical profession but of a cultural lag in institutional adaptation.

In recent years this technological determinism has come under increasing attack from sociologists (largely from the left) as well as economists supporting an extension of the free market to health care. Although they draw quite different political conclusions, both groups of critics have argued that, far from being the mere reflux of technological change, the advance of specialization has resulted from struggles by professional groups to establish restrictive monopolies on market entry. In Australia specialists have usually relied on the power of the state to exclude their rivals, a social closure grounded in politics. Advocates of the free market have castigated this state intervention to establish monopoly power, but have provided little explanation outside abstract models of the rent-seeking propensities of economic man. Leftist critics have suggested a natural affinity between the dominant ideology of the capitalist state and the individualism of curative medicine. However, neither of these approaches has been particularly fruitful. The bases of medical autonomy have been confused between the professional dominance established over the immediate execution of work – medical control of hierarchies in the division of labour within the health system – and the institutional regulation of relationships between clients and experts. In the

latter the power of the profession has been far more contingent on wider political considerations.[22]

In contrast, this account stresses the politics of access and control of medical services. General practitioners and specialists, hospital administrators and the lay boards to whom they were responsible, state governments, trade unions and political parties, and the patients all were allegedly serving had different interests and (often intermittently) expressed distinctive views of desirable forms of access and control of the health system. The power of the medical profession was not simply a question of a privileged access to the state (which was frequently absent), nor of a homologous relationship between curative medicine and capitalist ideology, nor merely of the strength of the British Medical Association.

The crucial question of medical politics has always been in the manner in which the 'interests' of patient and doctor are formulated. Health economists have long argued that the unique characteristic of medical services is the extent to which monopoly of knowledge enables the service provider to construct the demand for his or her services. Put simply, patients depend on their doctor to define their malady and propose the alternative treatments available. This monopoly of therapeutic knowledge has been the key to the political strength of the medical profession. The distinctiveness of the medical discourse has been the basis, not the result, of the political power of the medical profession.[23]

In interwar Australia the public hospital was the main site of this conflict. As hospital practice was the main route to professional advancement, through the acquisition of specialist knowledge and qualifications, the exclusion of general practitioners from access to public hospital patients underpinned the hierarchy of highly paid honorary consultants and marginalized general practitioners. Specialization represented the application of scientific advances and the creation of barriers to exclude less favoured colleagues from lucrative areas of work. This interaction of market and political pressures, therapeutic and technical change provided the major theme in the consolidation of specialties, and the successive attempts by general practitioners to reverse their exclusion from significant sections of the market for medical care.[24]

The interwar crisis in medical services centred on the finance, organization and access to the public hospital system by both patients and doctors. Here the effects of social class and income on access to health services were most starkly posed. If much of the urban working class depended on friendly society contract medical cover, the poor