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THE POLITICS OF NATIONAL HEALTH

Thelma Hunter

THESIS

Submitted for the Degree of Doctor of Philosophy
in the Department of Political Science, School
of General Studies, Australian National University

January 1969

This statement is to certify that the thesis is based on my own original research.

Robert A. Hunter

This statement is to certify that the thesis is based on my own original research.

Robert A. Hunter

This work is a study of what has come to be known as the Australian National Health Scheme -- the provision of financial benefits in connection with medical care, sometimes more loosely termed the National Health Service. It is written from the point of view of a political scientist interested primarily in the political history and public controversey surrounding a single important area of policy, the current organisation of the Scheme and its administrative structure. It is not an account of national health as might be interpreted by the social worker, the economist or the medical practitioner.

Necessarily, the study is selective in the choice of materials. A glance at the Department of Health's Annual Report confirms this point. The table of contents lists altogether nineteen areas of national health activity which the Commonwealth Government either helps to finance or finances and operates itself. Leaving aside the National Health Scheme, these include, for example, federal activities in the field of quarantine, in public health covering the whole range of communicable diseases, and the various health laboratories and national research and educational establishments. Most of these activities receive mention as part of a legislative programme but none are fully examined or evaluated in the way in which I have attempted to analyse the National Health Scheme. In terms of expenditure there is thus omitted parts of health policy which together account for twenty-three per cent, approximately, of Commonwealth outlays. Nor do I say anything, except in passing, about the health services provided by State governments in Australia -- for

example on the quality of hospital facilities, the maternal welfare services or the administration of the tuberculosis campaigns. These would be major omissions in a complete study of the health benefits and services available to the people of Australia. But they are not relevant to the main thesis of the work.

Acknowledgements are due to Professor L.F. Crisp who has had the unenviable task of correcting drafts of my chapters and of reading the entire manuscript. I have learned a great deal from his stern and unrelenting criticisms. Professor J. Lawrence gave me much encouragement and advice in the initial stages and also read the complete work. Professor L. Zines and my colleague, Dr. L. Hume, commented on earlier drafts of the chapters on the Constitution and on the administration respectively. Dr. B. Furnass and Dr. B.C. Bromhead, medical practitioners, read the work at very short notice and provided useful insights. Officers of the Commonwealth Department of Health have been of great assistance continuously for a number of years. And my husband, Dr. Alex Hunter, has helped immensely to improve the literary quality as well as sharing sympathetically our domestic responsibilities. A special word of thanks to our departmental secretary Mrs. Barbara Atkinson who has so patiently grappled with my handwriting - and apologies to my colleagues for taking so much of her time. I wish, finally to record my thanks to the Editor of the Medical Journal of Australia for permitting me to use extracts from that Journal.

For the deficiences of the end product, naturally, I accept full responsibility.

Thelma Hunter.

C O N T E N T S

C O N T E N T S

APPENDICES

BIBLIOGRAPHY

ABBREVIATIONS

A.L.P.	Australian Labor Party
A.M.A.	Australian Medical Association*
B.M.J.	British Medical Journal
M.J.A.	Medical Journal of Australia
N.L.	The National Liberary of Australia
n.d.	no date given
$	Australian currency**

* To avoid confusion the title Australian Medical Association (A.M.A.) is used throughout this book although, formally, autonomy was not secured until 1962 when the B.M.A. in Australia then became the A.M.A.

** All money references are expressed in the current dollar symbols.

LIST OF TABLES AND CHARTS

INTRODUCTION

1. Collectivism and Individualism in Health Policy.

'Australian democracy has come to look upon the State as a vast public utility, whose duty it is to provide the greatest happiness of the greatest number'.[1] W.K. Hancock's interpretation of the activities of government since colonial days, stated and restated since 1930, has attained wide acceptance. It lends support to the view, also widely accepted, that each political party, when in office, is mainly occupied in administering a set of so-called 'settled policies' requiring collective action by governments on behalf of their citizens and upon which there is broad agreement - such as the protection of manufacturing industry, compulsory arbitration of industrial disputes, and social services.

Hancock's construction of government activity highlights the common components in the public policies of each party. It also gives emphasis to the political pressures which are liable, in a democratic society, to prevent extremes of policy from persisting. But as a guide to the distinguishing features of each political party's activities when in office, it requires qualification. One party may so order its budgetary programme and its legislative priorities as to display its own distinctive approach to social and economic policy. And this can involve much more than minor modifications in administrative procedures. It can, and does, reflect significant dissimilarities in the nature of policy, in the ideological orientations which determine the selection of policy and in the value judgments from which decisions derive. It is not possible to explain away in blanket fashion the contrasting approaches of political parties to public policy. Each particular area requires investigation in detail.

These observations can be demonstrated with validity in relation to health policy. Here there has been, and continues to be, substantial divergence as between the main party groupings. Yet it would be misleading to designate one set of policies as 'right wing' or 'capitalist' and the other as 'left wing' or socialist'. For the purposes of this study a useful contrast which helps to distinguish the characteristic approaches of political and social groups to health policy, is between 'individualism' and 'collectivism'.[2] These designations have the merit of being reasonably neutral in tone; and they successfully select many of the distinctive economic, social and organisational features which stem from the thinking and value judgments of the parties in health matters. They are also useful in evaluating the motivations and reactions of those interest groups most directly affected by government activities in the area of national health. As we shall see, the organised medical profession in Australia and, to a lesser degree, the Friendly Societies have quite naturally associated themselves with the individualistic position taken by the Liberal Country Parties and their forerunners.

One can say, in relation to social and economic policy that individualism denotes the approach of those political and social groups which have no wish to see government usurping, any more than is avoidable, the decision-making activities of individuals and the family, or for that matter, wage-earners, professional or trade-union groups or business units.[3] The individualist

has an inbuilt preference for the decentralisation of decisions away from government and in favour of individuals (or institutions which crystallise and put into operation the group decisions of individuals). The individualist suspects, with Lord Acton, that 'all power corrupts and absolute power corrupts absolutely,' and therefore wishes to avoid moving too far towards a monolithic state structure, which has what he regards as inherently stubborn resistance to change or adaptability to particular personal circumstances and problems. The individualist is prepared also to assert that individual values as expressed through the family unit, professional groups, consumer groups and business people are more important than those values which tend to elevate government to the status of a paternalistic mentor of society. Such individualist values should therefore be presumed superior, until proved inferior or unworkable, in all situations in which legislative objectives appear to threaten traditional, individualistic patterns of organisation.

By contrast, the basic position of the collectivist, although rarely stated in extreme form, is that individualist values, whether of persons, profession, families or pressure groups, are or should be subordinate to the overall objectives determined by a society. Our collectivist would maintain that individual demands are various and conflicting, that the individual often is technically and politically ignorant and therefore ill-equipped to understand what modern technology or social services can provide for him; and that particular interest groups and businesses are self-interested and only coincidentally could their objectives be consistent with other/sections of the community.[4] Therefore, it is point-

less to attempt to reconcile the conflicting ends of these disparate elements in society by means of markets, the operation of pressure groups on government and administration and other such devices. Rather, once national policy objectives have been formulated and passed by the duly-elected legislature, they should be accepted from above and carried out by the state-operated machinery set up for the special purpose. The modern government apparatus thus becomes the modern prototype of Plato's philosopher king - omniscient and omnipotent.

Such a stark delineation of the individualist and collectivist positions - while it provides a useful polarisation of the spectrum of ideas on health policies - can of course come close to being a travesty of the facts. Such extreme intellectual positions rarely are articulated (although they clearly motivate some of the principal actors). And in the push and pull of politics - the art of the possible - a more pragmatic assessment usually is decisive. Thus, in practice, there is a considerable overlap of the actual policies which individualist and collectivist are prepared to implement. The individualist, while maintaining that private individuals and/or institutions can undertake effectively most of the organisational roles necessary to assist the promotion of social welfare, nevertheless would concede that, in many circumstances, government activity and organisations are valuable, even necessary, in order to encourage individuals to look after their own needs. But he sees no necessary connection between government assistance of this sort and nationalisation of the relevant institutions providing hospital, medical or pharmaceutical services. One need not, in principle, involve the other. On the other hand, the collectivist,

while stressing the desirability of centralised government activity by a powerful administration, as well as financial support, will frequently be content with limited intervention and only partial control by government.

However, the extremist position of each, although merely hypothetical in one sense, does influence the choice of methods adopted in implementing policy. Our individualist finds no difficulty in supporting deficit budgeting and measures to eliminate unemployment, provide sickness and pension benefits and assistance for the needy. The relief of poverty and the removal of economic uncertainty is consistent with the individualist position, in the sense that minimum standards are secured by state action, but there is still left scope for a considerable exercise of individual enterprise, preference and discretion.[5] The collectivist, on the other hand, would take state intervention much further and implement it in a different form. He would wish to have government ownership and control of industry, to redistribute incomes, to have publicly-provided social services without means test or contributory qualification and so on. Partly he is motivated towards the same ends as the individualist - to provide at least a minimum of social welfare. But also, and to him more important, he would like to introduce fundamental changes in the structure and character of society. That is, he has the objective, stemming from his egalitarian value judgments, of providing equality and uniformity of treatment for all - not merely of ensuring minimum standards. And he prefers to see the corresponding social attitudes become the accepted norm on such fundamental cultural and social matters as education, pensions and health care.

Turning to the particular questions of health, these orientations towards the individualist or the collectivist end of the spectrum of possibilities, as one would expect, have a most definite influence on the nature of and the selection of policies by the respective parties. For the individualist substantial financial support for existing private institutions is permissible and sometimes even desirable, and he will not cavil at providing for preventive public medicine, finding capital grants for hospitals or for the establishment of diagnostic services to improve the efforts of the (private) medical practitioner. Voluntary contribution insurance schemes for medical care fall in naturally with his position whereas compulsory contribution schemes towards the same purpose are less desirable although perhaps acceptable in some situations.[6] The collectivist expects to go much further and establish publicly-owned and operated hospitals, free diagnostic services, government-operated and heavily-subsidised compulsory contribution insurance for medical care and perhaps even a salaried medical profession. And, in line with his determination to alter the character of society, the funds for these operations would come, not from consolidated revenue (which contains, normally, regressive elements such as sales tax, import duties, and the like) but from a progressive income tax which, in addition to providing for national health policies would be instrumental in redistributing the income of the community.[7]

These observations help us chart the broad character of Australian arrangements for health in relation to organisation and finance as found in other countries. National provisions for health services and benefits in Western societies fall broadly into three categories.[8]

The government may provide a comprehensive range of services and subsidies universally available and financed wholly or largely by taxation, as in Great Britain and a number of European countries. Alternatively, private individuals and institutions may be the main providers of health services whose range, quality and availability is determined mainly (but not exclusively) by the price which the patient is willing to pay, as in the U.S.A. Between these two extremes there may be a combination of government services and subsidies to individuals and to private institutions, as in Australia. The emphasis of each system largely reflects the ideological orientations of the politically predominant groups on health policy. The British system is broadly collectivist, the American unmistakably individualistic and the Australian an unusual combination of the two.

The way in which this blend of collectivism and individualism is effected in what has become known as the Australian National Health Scheme has attracted some interest from critics both of excessive government participation, in the United Kingdom, and of inadequate government commitment, in the U.S.A. This is not directed simply to the matter of finance, though the Australian allocations towards the cost of its National Health Scheme are a striking illustration of the mixture of public and private provision.[9] Even more interest focuses on the combination of substantial government financial assistance with, at the same time, the retention of decision-making in the hands of the private individuals and institutions involved in the operation of the Health Scheme, such as health insurance funds, Friendly Societies, doctors and patients themselves.

Government assistance with the minimum of control might well be described as the 'cri de coeur' of the

dominant Australian policy-makers over a period of eighteen years. They continue to claim that their system represents a uniquely successful compromise between public provision and the retention of individual initiative. Indeed, the proclaimed intention of the Liberal-Country Party Coalition Government which introduced the present National Health Scheme in 1950 was to establish a 'new conception' of national health which would avoid the pitfalls of British socialised medicine on the one hand, and (by implication), American free enterprise on the other. This was to be done by a willing 'partnership' of all the groups involved which would 'keep alive the spirit of initiative and enterprise that really produced progress'.[10]

In theory, when the Liberal-Country Party Government took office in 1949 after a period of almost nine years in opposition, it had before it a full range of alternative approaches to the provision of a national health scheme. However, such was the development of political thinking on health matters which had taken place in the previous decade, such was the state of debate in and out of Parliament and such was the posture adopted by the most influential professional group, the organised medical profession, that the plan to be adopted by the Government ——→ was almost a foregone conclusion. By 1949 the crucial period of policy formulation was over and crystallisation of the national health policies we have today had begun.

2. The Plan of the Book

This work sets out to study the major political forces which have shaped what has come to be known as the Australian National Health Scheme: how the interaction of party politics, of state participation in health, idiosyncrasies of the Constitution and the

pressures applied by interest groups, in particular the organised medical profession, determined the nature and content of a single area of public policy. The continuing influence of these constraints upon the administration and possible extension of the Scheme is then examined. The merits and deficiencies of the Scheme as operated are seen to be inseparable from the original objectives of policy makers and their interest group supporters. And, while these still important objectives inhibit the prospects of any radical change, it is noted that they do not preclude reforms consistent with the particular combination of collectivism and individualism which characterises the Australian Scheme.

Part I examines the first stirring of ideas on the organisation of health services and on provision for insurance against the costs of medical care. There are, at first, the rather formal exercises of Royal Commissions, committees and experts. The movement of political opinion, within each of the two main party groups - and Parliament's legislative contribution up to 1938 - also is charted. In the background there are the parallel reactions of the organised medical profession. At first the profession exhibited a compound of conservatism and suspicious apprehension concerning the prospective intervention of government into what had hitherto been a private preserve. Later the Australian Medical Association's defensive posture altered; and, as its political attitudes to health policy questions crystallised, it found itself fortunate in possessing many powerful friends, and a major party sympathetic to its views, in the country's legislature.

Part II looks at the nineteen forties. For health policy this was a decade of disputation. But

it was also a period in which the constructive thought of planners, together with defensive and offensive reactions of interested parties, crystallised into specific proposals for health legislation. The planners - the National Health and Medical Research Council and the Parliamentary Joint Committee on Social Security - provided the hard core of ideas. Labor's programme for health in particular received strong support from this area. However, collectivism did not triumph. The Australian Medical Association also had its plans for health. And, with the assistance of the constraints provided (as in so many other facets of Australian life) by the Constitution, successfully operated a policy of non-cooperation and denied Labor the opportunity of implementing its radical, far-reaching policies on health, until such times as a Liberal-Country Party government, more sympathetic to the objectives of the organised medical profession, took office. Sir Earle Page, leader of the Country Party, then made his most significant contribution to health policies by introducing the Scheme which now has operated for eighteen years.

Part III analyses the operation of the National Health Scheme: the range of benefits and services offered to the public; the method of financing; the framework of health administration; and the environment of advisory committees, voluntary insurance organisations, professional bodies and other pressure groups within which the Scheme functions.

Part IV provides a current critique of the National Health Scheme - a look at some of its achievements, and its deficiencies. Finally, the proposals which have been put forward in recent years for reforming or changing the nature and direction of the Scheme are briefly considered.

FOOTNOTES (INTRODUCTION)

1. W.K. Hancock, Australia, p.61.

2. A.T. Peacock, 'The Political Economy of Social Welfare', The Three Banks Review, Dec. 1964, pp.10-20.

3. The employment of 'individualism' and 'collectivism' here cuts across that analytical usage which distinguishes between (i) individualism as the actions of single individuals; (ii) (private) corporate collectivism referring to organised group activities; and (iii) state collectivism or government action. In the context of health policy 'individualism' encompasses not only the first but also those groups in the second category (Friendly Societies, professional associations, voluntary insurance bodies, for example) whose group attitudes and value judgments seek to impose specific limits on action by the state. They are to be contrasted with 'collectivists' - also drawn from the first and second groups - who wish to set few, if any, constraints on state activities.

4. R.M. Titmus, Essays on the Welfare State, pp.44-50,231.

5. A. Peacock, op.cit., p.11.

6. D.S. Lees, 'Private General Practice and the National Health Service' in The Sociological Review, July 1962, pp.36-43.

7. C.A.R. Crosland, The Future of Socialism, pp.76-8.

8. K. Evang, Health Service, Society and Medicine, pp.1-14.

9. In 1961 government contributed 53.2 per cent; private insurance funds 35.6 per cent; patients residual obligation towards fees came to 10.1 per cent;

(Continued, Footnote 9)
while donations were 1.1 per cent. The American equivalent was: Government financed 23.9 per cent, voluntary insurance 24 per cent, payment by patients 47.7 per cent and charitable donations 4.4.per cent. The U.K. equivalents were: 84.8 per cent, voluntary insurance nil, 14.4 per cent and 0.8 per cent. J. Deeble, 'The Cost and Sources of Finance of Australian Health Services', The Economic Record, December 1967, p.534. It should be noted however that in 1961 there were in U.K. 100,000 people covered for hospital expenses by voluntary insurance.

10. Sir Earle Page, A New Conception of a National Health Scheme for Australia, address by the Commonwealth Minister of Health to the British Commonwealth Medical Congress, 23 May, 1950.

PART I

GENESIS 1920-1940

'Ideas are in truth, forces. Infinite too is the power of personality. The union of the two always makes history'.

Henry James, Chs. W. Eliot, n.d.

CHAPTER ONE

THE STIRRING OF IDEAS

1. Health and the Constitution before 1940

Before Federation in 1900 all social and health services were the responsibility of the Colonies. The Commonwealth of Australia Constitution Act did little to change this situation. The Federal Government's power was limited to concurrent power over invalid, old age pensions and quarantine.[1] Intermittent discussions from the eighteen-fifties onwards on the desirability and form of Federal control and administration of quarantine had revealed a measure of agreement among the Colonies.[2] Increased communications, the practice of vessels calling at more than one port and a consequent series of smallpox cases, all underlined the need for uniform procedures to deal with quarantine. The notion of a Federal quarantine service took shape and coincided with the discussions on Federation.[3]

At the important Constitutional Conventions, held between 1897-9, there was some suggestion that the Commonwealth's power over quarantine should be limited to control of infections and contagions introduced from outside the Commonwealth and that the proposed States should continue to deal with those which arose or spread within the States. In the event, this type of demarcation of authority was not insisted upon. The Commonwealth's legislative authority was made concurrent but unqualified.

Despite the restrictions of its formal constitutional authority Federal governments became directly and indirectly involved in health activity of a national character. For example, as early as 1908, to meet the need for more knowledge and research into tropical diseases, the Commonwealth established, with the cooperation of the Queensland Government and the Universities of Sydney and Adelaide, an Institute of Tropical Medicine. During World War I it also initiated a number of Australia-wide investigations into causes of death and

invalidity and subsequently set up several strategically placed diagnostic laboratories. The Commonwealth also, during the war years, made grants available to the States to secure the introduction of improved methods of preventing and healing venereal diseases. Grants were made contingent upon compulsory notification of cases by doctors and Commonwealth right of inspection of the States' activities.

The most important, and, for the future, far-reaching involvement was for the establishment of a Commonwealth Department of Health under a newly created Minister for Health in 1921.[4] During and after the First World War a number of interests pressed for a Federal Department of Health.[5] Post-war health problems, and especially the world-wide influenza epidemic which struck Australia in 1919, underlined the need for, and the difficulty of, securing cooperative action on a national level even during an emergency. There was, in addition, sufficient feeling within the States themselves that there should be some limited rationalisation of health administration: and that such was needed to secure a cohesive national policy of research, education and subsidy. The medical profession in Australia also supported greater participation in preventive health matters by Federal government. These pressures were reinforced by a timely offer from the Rockefeller Foundation towards research which was made contingent upon the establishment of a Department of Health by the Commonwealth Government. The Government accepted the offer and the Department came into being in 1921.

To some extent the establishment of the Department reflected a reorientation of ideas concerning the nature of public health and the extent to which the Federal government should participate in that area of policy. So long as health was held to comprise largely matters of sanitation, hygiene and control of foods the activities of government need be of only a limited kind which could satisfactorily be executed by State governments.

But, as the conception of health broadened to include health education, research, national campaigns against disease and, at a later date, financial assistance to meet the costs of medical care (curative medicine) more positive and more extensive action by the national government became necessary. Nevertheless, before 1940, progress was slow in terms of what Federal Governments were prepared to undertake and the States were prepared to concede. For example, although the establishment of the new Department of Health was endorsed at the time by the States, its functions, apart from the administration of Quarantine, were for the first 26 years of its life essentially advisory and investigatory. 'The picture is one of a research institution making its findings available to executive bodies - the State Health Departments - rather than of a central government department, implementing policy on a nation-wide scale.'[6] Nor, although always willing to accept financial assistance from the Commonwealth, did the States themselves at any time initiate any action to give Federal governments additional constitutional powers over health.

The Constitutional position was raised in 1925 by a Royal Commission set up 'to report upon health as a matter of legislation and administration by the Commonwealth in conjunction with the States where necessary'. The Director General of Health, Dr. J.H.L. Cumpston, gave evidence that, from his experience, 'national policies were restricted by suspicion and distrust by State governments'. But it was unlikely, he went on, that the Commonwealth Government would ask for complete or even partial powers by means of a formal amendment to the Constitution. It was equally unlikely, in the existing state of opinion in State executive circles that all six States would simultaneously agree to transfer any or all of their health powers to the Commonwealth. The Commissioners took broadly the same position. It was clear, they added, that

in a country as large as Australia a Commonwealth Ministry of Health similar to that of Great Britain could not effectively carry out its functions except by devolving its powers on State and local authorities. Such devolution would conflict with existing State and local government legislation. 'We do not recommend', they concluded 'that any action be taken by the Commonwealth to obtain general powers to legislate on health unless approached by the States as provided by the Constitution'.[57]

The constitutional position was again raised two years later by the Royal Commission on the Constitution (1927-9).[8] The Director General, on this occasion, advocated more Federal authority to cope with the broad requirements of national health policy. 'It has become apparent that there is hardly a single aspect of public health which does not, for its proper consideration, require to be studied in its national phase... There would appear to be some ground for the proposal that the Commonwealth might be invested with constitutional powers in respect of health...Section 51 of the Constitution might be amended by the addition of the single word "health", without qualification'. The exercise of this power was to be made dependent upon agreement between the Commonwealth and the States as to relative spheres of legislation and administration. Alternatively, Section 51 could be amended by the addition of the word 'health' with some qualification which would make it clear that the Commonwealth's powers would remain concurrent and not exclusive.

Of the States' representatives, only the Tasmanian agreed that there should be any amendment. The Commissioners were also divided in their approach - though all wished to see some increase in Commonwealth powers. Three Commissioners held that these should be defined by agreement from time to time rather than be specified in the Constitution. 'We think', they concluded, 'that power should be referred by inserting

in Section 51 of the Constitution the following paragraph (ixA)': 'Cooperation with any State in respect of health and giving effect to any agreement made between the Commonwealth and the State in relation thereto'. Three other Commissioners were more ambitious and recommended, quite categorically, 'that the Constitution should be amended to give full power to the Commonwealth...on health, industrial matters, trade and commerce, fisheries and forestry'. It was essential, they insisted, that research into the causes and means of prevention of diseases should be concentrated in a central authority. Expert witnesses and the officers of all States, except Victoria, had agreed that the States were financially unable to provide for the supervision of these measures. To avoid a complete usurption of State powers Commonwealth power should be made concurrent. Nothing came of these proposals.

Nor was health legislation, before 1940, ever important or controversial enough to become a major constitutional issue. Commonwealth action gained implicit support from the expansive interpretation of the Federal government's constitutional authority given by the High Court of Australia from 1920 onwards. Broadly, throughout that period, the High Court took the position that the Commonwealth Parliament itself had the power to decide what legislation was to be for the purposes of the Commonwealth.

Until 1940 all health expenditure was based, or assumed to be based, on three sets of powers given to the Federal Government under the Constitution:[9] the appropriation power (Section 81): the Taxation powers (Section 51): and the power to make conditional grants to the States (Section 96).

Section 81 - the so-called 'appropriation power' - specifies that 'all revenues, or moneys raised or received by the Executive Government of the Commonwealth shall form one Consolidated Revenue Fund to be appropriated for the purposes of the Commonwealth in the manner and subject to the charges and liabilities imposed by this Constitution'. The operative words here, from the point of view of constitutional interpretation, have been 'for the purposes of the Commonwealth'.

Behind Section 81 stood Section 51, giving Parliament clear authority 'to make laws for the peace, order and good government of the Commonwealth with respect to...', and there follows a list of thirty-nine subjects including 'Taxation: but so as not to discriminate between States and parts of States.' (Sub-section ii); 'matters incidental to the execution of any power vested by this Constitution' (Sub-section xxxix); and 'insurance, other than State insurance; also State insurance extending beyond thelimits of the State concerned'. (Sub-section xiv). In enacting the 1938 National Health and Pensions Insurance Act, Parliament relied on all of these powers.

The third device open to the Commonwealth, Section 96 - the so-called grants-in-aid power - provides 'that the Parliament may grant financial assistance to any State on such terms and conditions as the Parliament thinks fit'. The potentialities of this power were (and are) considerable and the Royal Commission on Health in 1925 recommended it as the best method of extending Federal control. From the Commonwealth point of view conditional grants could be an important device for persuading the States to participate in Commonwealth-initiated policies. By controlling expenditure, the Federal Government could reach out into State Governments' operations. From the States' point of view, the combination of Federal finance and State-controlled administration could be an ideal arrangement. It seems surprising therefore that, apart from

grants to the States to assist medical research, relatively little use was made of this power. Indeed, it did not come into its own, legislatively speaking, until after 1940.

There was a fourth expedient open to the Commonwealth before 1940 - again provided by Section 51. Parliament could make laws in areas not coming directly under its authority if the relevant areas were referred to it by the States (Sub-section xxxvii). But, in the event, no Federal Government attempted to exploit this so-called referral power until, in 1942, a Labor Government asked the Australian States to refer to the Commonwealth, for a period of five years, power in no less than fourteen new areas of public policy of which 'national health in cooperation with the States' was one.

It would appear, therefore, that apart from the referral power a number of methods were, at all times, open to Commonwealth governments to take action on health despite the formal constitutional restrictions upon its powers. One must conclude that the will to employ them before 1940 was not strong.

2. The Royal Commission on National Insurance 1923-7

It is fair to say that, before 1940, Australian discussion on national health services, and more particularly on the subject of national health insurance, contributed little to the corpus of ideas on the issues involved.[10] The critical formative period did not arrive until the forties when, stimulated by Labor's reformist enthusiasm, Parliament, the Administration and the medical profession began to debate health problems and were thus led to formulate their respective positions and plans. But there were some exceptions. Pre-1940 was not all stagnation.

The first official statement of the need for a comprehensive and unified national health scheme in Australia came from a Royal Commission on National Insurance set up by

the Bruce-Page Government in September 1923. Its terms of reference were 'to enquire into and report upon National Insurance as a means of making provision for casual sickness, permanent invalidity, old age and unemployment'. The scope of the enquiry was later extended to report upon the operation of the maternity allowance system and to consider the amendment of the Invalid and Old Age Pension Act (1908-1923).[13]

In its first report, submitted on the 3 March 1925, the Commission recommended:

> (i) A compulsory system of national insurance providing for the payment of sickness, invalidity, maternity and superannuation benefits to insured persons [then followed details of the proposed benefits]. (ii) A national health scheme to aim at adequate medical treatment for the people and provide the requisite machinery for the prevention of sickness and accident. (iii) Efficient preventive measures to be put into operation in the interest of the insured members. (iv) A health scheme to be established which would be separate from the National Insurance Fund. And (v) the function and objects of the Health Department to be extended, in such a manner as to enable provisions to be made as early as possible for the effective supervision of adequate medical services especially with regard to maternity benefits.

The Commission did not make any detailed suggestions on how the proposed national health scheme could be implemented, nor on the specific components of the range of medical benefits to be provided. Nevertheless, much of the discussion - the Commissioners interviewed 153 witnesses of whom twenty-three were medical practitioners - brought to light some of the deficiencies of the contemporary socio-medical scene which would require revision. It also indicated that some relatively progressive thinking had taken place on the requirements of a comprehensive national health scheme and of a humanitarian approach to the alleviation of economic distress caused by ill-health.

Consider, for example, the first recommendation that a compulsory system of national insurance should be instituted. Many witnesses, and the Commissioners themselves, unambiguously

rejected voluntary insurance as an adequate method of removing the financial impediments to medical and hospital treatment. Insurance, at that time, was mainly the province of Friendly Societies which began to develop in Australia from the middle of the 19th century.[12] In the early years of their existence they grew rapidly. In 1906 and 1907, for example, membership in the state of New South Wales numbered 116,985 and nearly all sickness insurance in that State was in their hands. The Australian societies were modelled on their British counterparts. These so-called lodges or clubs contracted with individual doctors to provide medical services for their members; payment was made on a capitation-fee basis. By the 1920s some forty per cent of Australian doctors participated in contractual arrangements with the societies for that purpose. In addition to medical benefits, the societies often provided drugs, sick pay, and funeral expenses. In N.S.W., a State government subsidy enabled them also to provide cash benefits to all members for illnesses lasting more than a year and to those of their members over the age of sixty-five. Acceptance of the subsidy was optional, but those societies which accepted had to provide benefits without payment to their subscribers beyond the age of sixty-five.

It could not be denied, the Commissioners agreed, that the Friendly Societies met a felt need in providing medical attention for their members. On the other hand, only those people in the lower income groups could be included in these arrangements if they were earning no more than between $700 and $800 a year.[13] Consequently, the middle income earners did not have access to relatively inexpensive treatment. In addition, the services provided by friendly society doctors were limited to general practitioner services only. Specialist attention had to be paid for privately; a major defect for those who were seriously ill.

Finally, the medical needs of Friendly Society members living in the country areas, where there was a scarcity of doctors, were less satisfactorily met than in the metropolitan areas where medical practitioners tended to concentrate. No voluntary scheme, the Commissioners concluded, could be expected to deal with such an intractable problem as the distribution of medical practitioners throughout the community. The Commissioners themselves did not try to do so. But they were firm in their conclusion that 'a health scheme is not a subject for voluntary insurance'. They said, further, that 'there are no grounds for the assumption that if a voluntary scheme were instituted in Australia, it would not have the inherent defects of all such schemes, which, as has been conclusively proved, fail to provide for those who need most assistance, cannot be effectively and generally applied and only attract the more thrifty'.

Let us examine next the implication of the Commission's second recommendation: that a national scheme should aim at adequate medical treatment for the people and provide the requisite machinery for the prevention of sickness and accident. The services envisaged were to include medical benefits; treatment in hospitals appropriate to the nature of the illness; and a preventive health service to cover maternal hygiene, child welfare, industrial hygiene and medical research. As mentioned, while the Commission did not specify the precise components of medical benefits, it clearly took an expansive view of what was involved. Indeed, it was firm in deploring an approach to the problems of health which stopped short at the provision of cash benefits and took no account of facilities and services. 'The payment of cash benefits alone does not provide the essential and desirable object of any scheme... adequate medical facilities should also be made available and efficient preventive measures must be put into operation...'

Adequate medical treatment, therefore, meant the availability of sufficient services in the right places and for appropriate purposes - a requirement which patently was not fulfilled in the case of hospital services in Australia at that time. It was estimated that there were 3.3 hospital beds per thousand of the population; in absolute terms a reasonably satisfactory proportion. But this statement of the statistics obscured the real problem, namely, that many of these facilities, like the supply of doctors, were badly distributed. Thus, in the metropolitan areas there was serious overcrowding while the reverse was frequently the case in the country areas. In addition, there were shortages of particular types of hospital accommodation especially for maternity cases, children's illnesses and infectious diseases.

These difficulties were not investigated in any detail or depth by this 1923 Royal Commission. But much of the evidence brought to light during the discussion foreshadowed the existence of major problems which a committee set up by a Parliamentary Joint Committee on Social Security, the Medical Services Review Committee, was to quantify some twenty years later.[14]

The Commission's third recommendation, that efficient preventive measures should be instituted in the interests of the insured member, stemmed from the emphasis on the coordination of the preventive and curative aspects of illness as an ingredient of a national health scheme. A number of suggestions were made towards securing this objective: for example, that general practitioners should, wherever necessary, work alongside public health authorities; and that there should be closer association of health and hospital authorities. Though the hospitals were controlled by the States, the Commonwealth could formulate general principles which could be applied locally by the States. Finally, Friendly Societies and employers in industrial establishments should be encouraged

to take an interest in their members' - in the case of employers, their employees' - health. Each could require or arrange for periodic medical examinations which might well prevent the onset of illness and therefore the demand for curative treatment. Taken together, these measures could do much to provide a comprehensive Commonwealth-State service.

Next, the Commission advocated that a national health scheme should be kept separate from other social insurance provisions. 'After reviewing the experience of other countries, we are of the opinion that it is not desirable that these provisions be included in any scheme providing for financial benefits but that they should be dealt with under a separate national health scheme which, although closely related to the objects of the National Insurance Fund, can be more effectively and satisfactorily dealt with if disassociated from the administration of financial benefits. Where medical benefits have been administered under a scheme of providing cash benefits also, they have been invariably limited and have proved inadequate while the increasing costs of the former have had detrimental effect on the provisions of the latter'.

Finally, the Department of Health was seen to be the agency which could most appropriately implement a national health scheme of the kind envisaged by the Commission. Administratively speaking, it was strategically placed to ensure the coordination of the curative and preventive aspects of the scheme. In particular, the Department could integrate the cash benefits to be made available under the insurance scheme with the broader services to be encouraged, developed or provided by a central department.

Many of these ideas must have seemed somewhat utopian to witnesses. It was, perhaps, for this reason

that the recommendations were couched in fairly general terms. However, the conclusion is inescapable that, in the context of its time, these broad indicators of policy, and their ramifications, were both radical and humane.

The national health recommendation of the Royal Commission on National Insurance, 1923, came to nothing. A National Insurance Bill, which did not include medical benefits, was introduced into Parliament on 14 September 1928 but it did not get beyond the First Reading and the Bruce-Page Government fell from office in September 1929.

3. The Royal Commission on Health 1925.[15]

This body sat between January and July 1925. Of its five members, four were medical practitioners including the Chairman and two others who were eminent figures in the Australian Medical Association. Its terms of reference were 'to report upon public health as a matter for legislation and administration by the Commonwealth in conjunction with the States where necessary'. It examined 320 witnesses and its enquiries covered almost every aspect of health activity in Australia. Its findings were, however, much less directly concerned with curative medicine and health insurance. But there was, indirectly, some relevance.

The Commission reported on thirteen areas of health policy and made, in all, a total of fifty-five recommendations along the following lines:-

> (i) Ill-health in the community. (ii) Coordination of the medical services of the Commonwealth. (iii) Co-operation of Commonwealth and State health authorities. (iv) The prevention of the outbreak, development, or spread of disease. (v) The prevention and control of venereal disease. (vi) Uniform legislation with regard to the purity of food and drugs. (vii) Maternity hygiene. (viii) Child welfare. (ix) Industrial hygiene. (x) The encouragement and development of research work. (xi) The relationship which should exist between public health authorities and medical practitioners in regard to the prevention of disease. (xii) The relationship which should exist between public health authorities and other public authorities rendering medical services. (xiii) The publication of information relating to matters concerning public health.

Most of the subjects investigated dealt with matters legislated on and administered exclusively by State governments. The major emphasis of its recommendations were therefore for indirect action by the Commonwealth and the encouragement of voluntary cooperation on the part of the States.

The Commission's recommendations were made upon the assumption that the existing constitutional division of powers would be maintained. Consequently, as a basis for Commonwealth-State cooperation, they recommended that:

> (i) Legislation should be passed to provide subsidies to measures approved by the Commonwealth Department of Health which State or local authorities are unable to finance alone - with appropriate conditions attached in order to secure efficiency....(ii) The Commonwealth Department of Health should formulate a model outline of general principles of health administration along the lines...suggested, and that the Commonwealth should subsidise States for expenditure on health, provided that their health administration sufficiently conforms to such a model. (iii) A Health Council should be established.

Obviously, the importance of the first two of these recommendations lay in the possibilities to which they pointed for securing extended and uniform health policies throughout Australia. No national government, determined to act imaginatively in this area need be impeded by the fact that the States had the major powers over public health. Although the Commission clearly had in mind preventive health measures, curative services, such as the supply of hospitals, could also be encouraged in this way.

The proposals for a Health Council (established almost immediately and later to become the National Health and Medical Research Council (N.H.M.R.C.)) underlined the Commission's realistic recognition of the need for a permanent statutory instrument to review, report on and make suggestions in the area of Federal-State cooperation. Dr. J.H.L. Cumpston, Director General of Health from 1921 to 1945 has attributed to this body substantial credit for creating and maintaining the widespread recognition of

the national importance of public health in a Federal system. Although the Commissioners, again, clearly thought almost exclusively in terms of preventive medicine, the Federal Health Council had, by implication, important potentialities in the wider and cognate area of curative medicine. Its successor, the National Health and Medical Research Council (N.H.M.R.C.), demonstrated the point most effectively in the forties when it produced its radical plans for a national salaried medical service in Australia. Before that date, however, the Council's activities, though useful, were restricted to matters connected with preventive medicine.

In addition to the establishment of a Health Council the Health Department was to be extended and reorganised on a divisional basis. To assist it in performing its new functions, medical practitioners were to be obliged by law to provide all necessary information.[16]

Evidently these recommendations were the product of some constructive thinking in the area of public health. And they scarcely received the attention or examination they warranted. Nevertheless, there was remarkably little discussion on associated curative health services. While, on health insurance, the Commissioners' recommendations were restricted to an amendment to the Invalid Pension's Act to allow payment of pensions to the dependants of patients suffering from tuberculosis while they were undergoing treatment in sanitoria or hospitals.[17] There was also a recommendation for a minor amendment to the Maternity Allowance Act. Apart from these, problems concerned with the alleviation of the economic distress caused by ill health were largely ignored.

Therefore, the report contributed only in a minor fashion to the requirements and components of a comprehensive national health service compared with that of the Royal Commission on National Insurance.

4. The Kinnear Report 1937[18]

The years between 1929 and 1934 were relatively barren of thought and action on the health front - as indeed they were in the whole area of social policy. Though a Labor Government was in power for two of the years, it found itself seriously handicapped by the financial crisis then gathering momentum, as well as the activities of a vigilant and hostile Senate. The issue of health insurance was revived in 1934 and 1935. In the winter of 1935-36 Sir Frederick Stewart, subsequently a Minister for Social Services, visited Europe to investigate problems of social insurance. As a consequence, Sir Walter Kinnear, formerly Controller of Health Insurance in Great Britain, was invited to investigate the possibility of introducing a scheme of national health insurance in Australia along the lines of the British National Insurance Act of 1911. Kinnear visited Australia and his report was published on 15 June, 1937.

Broadly, this report recommended a scheme of health and pensions insurance for wage earners who received less than $370 a year.[19] Finance for the scheme, it was intended, would be arranged through compulsory contributions, on a tripartite basis, by employees, employers and government. The administration was to be carried out by a newly-established Insurance Department although the more detailed matters were to be operated by approved Friendly Societies.

In support of his scheme, Kinnear pointed to its widespread international acceptance and to the fact that it had been successfully tried and tested in Great Britain.[20] 'It is now', Kinnear wrote, 'almost universally agreed that a National Insurance Scheme should be on a contributory and compulsory basis'. These principles, he went on, had been endorsed and adopted in 1927 (two years after the First Report of the Australian Royal Commission on National Insurance) by the International Labor

Office and ratified by eighteen countries including Great Britain. The British scheme had been introduced in 1911 and was generally conceded, after 25 years, to be working satisfactorily. A representative Royal Commission in 1929 appointed to inquire into the British scheme had concluded that: 'We are satisfied that the scheme of National Health Insurance has fully justified itself, and has, on the whole, been successful in operation'...and 'we are convinced that National Health Insurance has now become a permanent feature of the social system of this country and should be continued on its present compulsory and contribution basis'. Even the British Medical Association itself had, in 1922, applauded the success of the system in giving large numbers medical attention which they had not previously been able to afford, in improving the amount and character of medical attention, in bringing illness under skilled treatment earlier and in calling to the attention of the profession a greater recognition of its collective responsibility to the Community.

There were, in addition, Kinnear wrote, 'basic similarities' in the Australian and U.K. situation which made the introduction of the British scheme possible and appropriate. Both countries had an established Friendly Society system which, along with other voluntary institutions, could be used and expanded to administer the scheme. In Australia, as in Great Britain, voluntary arrangements alone had proved inadequate to deal with the problem of the so-called medically indigent (those impoverished by the high cost of illness). On the subject of voluntary insurance he saw the same disadvantages as the 1923 Commission. 'The class of persons who most need social protection is frequently unable to afford it without some assistance from other sources and, even if they can afford it, often lack the initiative and foresight to become and remain insured'. Although State governments did

meet the needs of the more serious categories, through free hospital provision, these arrangements had an aura of charity which was repugnant to recipients. Certain modifications might have to be made, to take account of specifically Australian factors, such as the generally higher level of incomes and the facilities already available, through voluntary institutions, for supplementing sickness insurance. But apart from these amendments, which were in any case thought to be minor, the scheme suggested for Australia was substantially similar to the U.K. scheme. The main difference between Kinnear's report and that of the 1923 Royal Commission on National Insurance was that the former included medical benefits in kind as well as cash benefits during sickness, disablement, old age and for widows and pensions.

On medical benefits (which were to cause conflict with the Australian Medical Association) Kinnear recommended the following: (i) Medical benefits to be made available to all insured persons over fourteen years. (ii) Benefits to consist of general practitioner treatment, more extensive than that provided by existing Friendly Societies under contract arrangements with doctors, but excluding specialist treatment and medical attention during confinement already covered by alternative arrangements. (iii) A pharmaceutical service and provision of surgical appliances. (iv) Doctors to be paid on a per capita arrangement, that is, a specific annual payment for each person on his list or panel, plus a mileage allowance. (v) No compulsion to join, and free choice of both patient and doctor. (vi) Chemists to be reimbursed by the National Insurance Commission, the remuneration to cover the cost of the drug plus a dispensing fee. (vii) Gradual extension of the service to the whole of Australian country districts and outback. (viii) A National Insurance Commission to handle arrangements with doctors and chemists. (ix) Machinery for

dealing with complaints to be set up, with doctors and chemists taking part in its work. (x) A Medical Benefits Council to be set up to represent doctors, chemists and contributors, in order to ensure cooperative action and resolve problems. (xi) Medical Benefits Committees to be established in each State, representing doctors and chemists, in order to deal with complaints. (xii) Cooperation with other State health agencies.

Certainly a national health scheme providing such an extensive range of benefits, both in cash and in kind, had no precedent in Australia. Further, in combination with the pensions arrangements, it was, in the context of its time, a recognition of felt needs. If implemented, it would have done much to bring national insurance in Australia in line with that in European countries.

Viewed more specifically as a set of proposals to institute a comprehensive national health scheme attacking the economic disabilities in wide sections of the population, and attempting to integrate preventative and curative aspects of national health, the Kinnear Report was less than satisfactory. Thus, insurance rights were to apply only to a limited section of the population - wage earners earning less than $14 a week. The non-manual workers, the self-employed, married women, and all the dependents of the insured person were excluded. As for the middle income groups, they were to continue with whatever voluntary arrangements they already had. Contributions were to be on a flat-rate basis. Consequently, even within the $730 a year limit, the poorer paid workers would have had to pay the same as those earning the maximum permissible.

In addition, the range of services to be provided was scarcely comprehensive. While Kinnear specified that medical services 'shall not be restricted to the mere issue

of medical certificates', and that they must be 'preventative as well as curative', there was little detailed application of these points in his scheme. The so-called 'all proper and necessary medical services' turned out to be only those of a general practitioner nature. There was no provision for specialist treatment. And any additional services provided were subject to the availability of surplus funds from the approved societies. In effect, therefore, the Report recommended a set of cash benefits for particular services rather than an integrated national health scheme. Significantly, the Kinnear Report displayed little of the concern of the 1923 Commission with the advantages of keeping a national health scheme separate from the other national insurance arrangements. Nor, apparently, did it see any particular value in integrating arrangements with the work of the Health Department. Kinnear was more impressed with the merits, as he saw them, of integrating health insurance with pensions. 'It is highly desirable that the Health and Pension Schemes presented in this report should be treated as one organic whole...it is of real importance that the insured person should regard them as parts of a single whole...each benefit is an integral part of the structure of social insurance embodied in this report'.

This approach had its commendable aspects. Yet it did not adequately recognise, as the 1923 Commission had done, that there were substantial advantages in using the Department of Health to administer health insurance. In the long run the prospects for the administration of an integrated health policy lay with employment of the department already committed to other facets of health policy.

A National Health and Pensions Insurance Act, in the main based on the Kinnear Report, became law on 5th July, 1938 after a stormy passage inside and outside of the House of Representatives. But, for reasons to be discussed in the following chapter, it was never implemented.

FOOTNOTES (Chapter One)

1. Commonwealth of Australia Constitution Act, Section 51(ix) and (xxiiiA).

2. There was less reluctance on the part of the Colonies to share legislative authority over quarantine than over pensions. For a discussion on the merits and demerits of giving the Federal Government power over invalid pensions see T.H. Kewley, Social Security in Australia, pp.64-6

3. The Federal Council Act of 1885, which established a limited and largely ineffective forerunner of union in the shape of a Federal Council, gave the latter legislative authority over a numbers of areas of which quarantine was one, provided that at least two of the Colonies agreed to refer such authority to the Council. A Federal Quarantine Bill, prepared in Queensland, was actually introduced into the Federal Council in 1899, went as far as the Committee stage, but was subsequently abandoned. J.H.L. Cumpston, The Health of the People, pp.28-39

4. In the parallel field of social services the Commonwealth Government also displayed few constitutional inhibitions in taking action. Legislation passed to provide invalid and old age pensions in 1908 was followed by maternity allowances in 1912. In addition, two abortive attempts were made to introduce comprehensive national insurance schemes - one in 1928 and the other in 1938. None of these measures were thought by the Government to raise questions of a serious constitutional nature. Some sections of the Opposition, however, did attempt to discredit the Legislation in terms of the Constitution. T.H. Kewley, op.cit., pp.107-9, 147

5. J.H.L. Cumpston, The Health of the People, pp.53-72, 94-107

6. P.D. Abbot and L.O. Goldsmith, 'History and Functions of the Commonwealth Health Department', Public Administration, Vol. XI, No.3, Sept. 1952, p.120

7. Cumpston, op.cit., p.135

8. Ibid., pp.160-65

9. A.H. Birch, Federation, Finance and Social Legislation, pp.153-55

10. I am referring exclusively to national investigations on this subject.

11. Commonwealth of Australia, Royal Commission on National Insurance 1923-7. The First Report, 'Casual Sickness, Permanent Invalidity, Maternity and Old-Age', 3 March 1925, pp.8, 22-9, 33-4, 37-8.

12. B.J. Kelleher, 'Friendly Societies in the Australian Economy', The Australian Quarterly, Vol.XXXIV, No.3, Sept. 1962, pp.53-61

13. The basic wage on 1 August 1929 was $9.10, Official Year-Book of the Commonwealth of Australia, No.22, p.543

14. See chap.IV, pp.10-11; 13-14.

15. Commonwealth of Australia, Royal Commission on Health, 14 Jan. 1926.

16. An interesting pointer to the distinction so frequently made by the organised medical profession in Australia between the activities of the Department of Health in preventive health matters - which it welcomed - and in curative health matters - which it resisted. See Chapter III.

17. The exclusion of these sensitive areas of national health policy was an important reason why the Commissioners and the A.M.A. subsequently endorsed the Commission's proposals without controversy.

18. Sir Walter Kinnear, Report on Health and Pensions Insurance, Canberra 1937, pp.8, 14, 15, 28.

19. The basic wage, at the end of December 1939, was $8.07, Official Year-Book of the Commonwealth of Australia, No.52, p.351

20. Quite apart from the many other objections to the scheme, its close similarity to the British scheme was severely criticised. See C. Clark, 'Bacon and Eggs for Breakfast', Australian Quarterly, Vol.9, No.4, 1937, pp.24-31.

CHAPTER TWO

THE PARTIES

1. Platforms and Policies 1923-1937

Between 1923 and 1937 Labor was in office in the Commonwealth Parliament only once, from October 1929 to December 1931. For the remainder of the period, other parties, single party or coalition governments, held office. In the area of social legislation, neither party, for different reasons, succeeded in fulfilling a number of its declared objectives. Labor, frustrated by financial difficulty created by the depression, the combined opposition of the Senate, a conservative Central Bank and the Arbitration Court, was obliged to drop its major proposals. The Bruce-Page Government's National Insurance Bill (1928) and the Lyons-Page National Health and Pensions Insurance Act (1938), never proclaimed, were each abortive. By 1936, therefore, it could with justification be said that[1]

> 'Measured against the scope and content of social services in older countries such as Sweden and Great Britain, ours in Australia are rudimentary. Once famed as pioneer workers in the social laboratory, we have fallen behind.'

Health policy, as such, received little attention from political parties and governments before the nineteen forties. As a political issue, it failed to stir the imagination of Australia's abler politicians, although policies on preventive medicine, measures to minimise public health hazards, such as the control of infectious disease, fared somewhat better than curative medical care and national health insurance. Party political platforms on health were vague and nebulous. Even the Labor Party plank for the nationalisation of public health (which had been approved as early as 1919) seems, to judge by the absence of discussion at election times, to have been an article of faith rather than a fully-considered, practical policy. Non-Labor

parties, considering they were in office for most of the time, scarcely did better. Election speakers quite frequently made no mention at all of curative health matters and often gave only passing reference to public health. One has the impression, looking through the pamphlet literature of the time, that health, especially health insurance, found its way into Australian legislation by accident rather than by design.

Soon after its foundation in 1919, the Federal Country Party began to demonstrate an interest in preventive health services and in the possibility of extending Federal control in this area of policy. Its original platform included Federal-State coordination of preventive health measures; an amendment to the Constitution to provide for Federal control over the registration of doctors and nurses and for food and drug standards; and a contributory scheme of national insurance against old age, sickness, invalidity, maternity and accident. No mention was made of medical or hospital insurance or services.[2]

The Bruce-Page Government took office in February 1923. The leader of the Country Party and Federal Treasurer, Earle Page, a 'truant surgeon' to use his own phrase, had a natural interest in health matters. He was respected within the medical profession and was ever-conscious of and sympathetic to its point of view - a situation which was, as we shall see, not always conducive to speedy action in an area of policy allegedly 'close to his heart'. A man of fertile, if not always consistent ideas, to him must be attributed in large measure the credit for keeping discussions on health alive and for promoting a number of important preventive health measures. Page held the health portfolio once only between 1923-38. But as leader of the Country Party throughout the period he was in a strong position to influence both the Coalition and the choice of Coalition health ministers receptive to his ideas.[3] Some, including Sir Neville Howse,

were personal friends. The latter, in particular, was well chosen to promote Page's objectives. He was Minister for Health twice, from January 1925 to April 1927 and again from February 1928 to October 1929. He had been Director-General of Medical Services for the Australian Imperial Force during the First World War, a man 'who believed that the lessons learned in the army under war conditions could be applied to a considerable extent in civil life...Being by nature impatient of official routine, he believed that if a reform was necessary it should be made'.[4] Page's policy speech in 1922, which stated the basic principles upon which the Bruce-Page Government was to operate for the next seven years, included national insurance against sickness, unemployment, poverty, and age.

From 1923 onwards, the policy speeches of the Country and Nationalist parties usually stressed common objectives. How far Page and the Country Party were responsible for initiating and encouraging Nationalist, and later United Australia Party, interest in health is uncertain. But it is not unlikely that, on a relatively non-controversial matter such as preventive health policy, the Nationalists would be willing to accommodate the enthusiasms of the leader of the Country Party. Also, one should bear in mind that the Nationalist Party throughout the period contained members who, before 1916, were Labor men and who were likely therefore to be favourably disposed towards social legislation.[5] Bruce himself, by implication at any rate, admitted Page's influence on Country Party policy. 'I'm not prepared to say how many ideas he cocked up at me and I'm not frightfully concerned which of the things we did originated with him and with me...because in the long run it was my responsibility...Page could have the most brilliant ideas on earth but he couldn't put it over...still it was more or less a happy combination'.[6]

Two of Page's first actions on health were the appointment of the Royal Commissions on National Insurance, in 1923, and Health. 1925. The suggestion for the latter was put at a Premiers' Conference held in Melbourne in May 1923. The States did not endorse the proposal but suggested that the matter be considered by a special conference of Commonwealth and State Health Ministers. Invitations were subsequently sent to the States but some declined to attend. Undeterred, Sir Neville House proceeded, without formal approval of the States, to set up the Commission. His unilateral action appeared justified when, at the first meeting of Commonwealth and State Health Ministers in July, 1926, the States warmly welcomed the proposal to set up a Federal Health Council and endorsed in principle practically all the recommendations of the Royal Commission.[7]

The Federal Health Council was quickly established. Indeed, once again, Page did not wait until the July meeting of State Premiers. He secured the private endorsement of the States beforehand by telegram; and the Federal Health Council, which was subsequently to become the National Health and Medical Research Council, held its first meeting in Melbourne between 25-28 January 1927. A separate health portfolio had been established in 1921. Within the Department of Health a division of Tuberculosis and Venereal Disease was established under the control of a director, although, on the tuberculosis side, this appears to have been little more than a gesture: no great advances in Federal action in this area came until 1945 and even later. Many other recommendations of the Royal Commission were not (and never have been) followed up. The use of grants-in-aid, for the purpose of securing uniformity in health legislation, was never as fully exploited as it might have been. Some of its proposals, for example the establishment of health districts comprising

adjacent local authorities and the gradual development of health centres in each district, seem never to have been considered seriously at all.

Probably these measures were poorly timed in relation to the more urgent issues of the twenties and thirties such as industrial arbitration, tariff policy, and the onset of the depression. Moreover, after 1928, the attitude of the States tended more and more to oppose the extension of Commonwealth activity in the area of health policy. Bearing in mind these difficulties, the achievements of the Bruce-Page government were not inconsiderable during this period. In addition to following up some of the recommendations of the Royal Commission on Health it made a start on international coordination against epidemics, and quarantine control of infected vessels and established a radium bank.

Nevertheless, the claim, made by Bruce during the 1928 election campaign, that this activity, most of it on a fairly small scale, established a sense of appreciation on health matters between 1923–8 was only partly borne out by the facts.[8] Perhaps, as the Prime Minister said, a national health policy had been made possible by the creation of a Federal Health Council. But if this was so the Government made little of its advice and recommendations. On national health insurance, it did nothing at all to follow up the suggestions of the 1923 Commission. The policy speeches of both Bruce and Page during the 1928 election nevertheless foreshadowed action on both health and social insurance. Bruce undertook to hold a conference with the States to coordinate Federal and State administration in transport, national insurance and unemployment insurance; to extend Federal activity in the control of tuberculosis and in the improvement of obstetric hygiene.

There was no mention of health insurance as such and the National Insurance Bill, introduced into Parliament on the

4 September 1928, contained no provisions for a general national health scheme. Its main provisions were for benefits for the disabled, for widows, the sick, orphans, and maternity allowances. These were to be financed by a tripartite system of compulsory insurance and to apply to all earning less than £838 per annum. The exclusion of medical benefits was consistent with the caveat entered by the Commissioners that medical benefits should not be associated with other social insurance arrangements. It was also consistent, as we shall see in the following chapter, with the immediate and decisive adverse reaction from the organised medical profession. The Government may have intended to introduce a separate measure at a later date. In the event, the Bruce-Page Government did not run its full course and fell from office in 1929. How Page would have dealt with incipient resistance of his professional colleagues therefore must remain an academic speculation.

It seems likely, for a number of reasons unrelated to the omission of medical benefits provisions, that the 1928 National Insurance Bill would have been abortive anyway. However, despite the absence of such provisions, certain features in the opposition case were much the same in 1928, when the Bill did not include a medical benefits scheme, as in 1938, when it did. For example, the Friendly Societies, attending to their economic interests, were strongly opposed to the proposal that competitive agencies, insurance organisations and trades unions, would be employed, just as they were opposed ten years later. And Labor, pursuing its collectivist line, consistently spoke on both occasions against the omission of unemployment insurance and the inequitable burden imposed on the lower income groups by flat-rate contributions rather than finance raised on a progressive income-tax. Scullin led the Labor opposition on these points in the twenties and Curtin reiterated the same views in the thirties.

In the event, Page's enthusiasm was not widely shared either within his own party or by the members of Nationalist Party - at least not sufficiently to permit them to proceed with any rapidity in the matter when financial obstacles began to loom large in the Treasury eye. And the States were divided and sensitive to the degree of financial commitment which might be involved for them.[9] It is hardly surprising, therefore, that there were few, if any, voices of protest when Page announced, in his budget speech of 22 August 1929, that his Government intended to postpone the measure. His reason was, allegedly, to await the results of a questionnaire to the States, designed to elicit information to assist the Government to proceed as economically as possible with the proposed legislation. But the fact was, he could scarcely ignore the tepid response to his scheme from all quarters.

To revert, for a moment, to the distinction between collectivist and individualist approaches to health policy raised in the introduction, the approach of Page and his Government at this particular time is instructive. In some respects there were more collectivist strands in their thinking in the twenties than at a later date and certainly more than in the nineteen-forties. For instance, a national health scheme to be placed under Federal control, even if it related exclusively to the area of public health, was at that particular time a fairly ambitious idea. So, too, was compulsory insurance, at least in Australia. Indeed, Page's denunciation of voluntary insurance in 1928 and his assertion that the State could and should take action in the field, would have warmed the heart of many a collectivist. 'Voluntary insurance', he said, 'covers practically only the thrifty or the better-off section of the community who have some surplus earning'. The great disadvantage of Friendly Societies (those institutions which he was to

defend so eloquently, along with voluntary health insurance, when he initiated the present National Health Scheme) was that they 'covered only part of the field.'[10] Moreover, by making insurance compulsory, the cost of promotion and seeking out business could be abolished. The government could insist that elements of society other than the needy or the medically-unfortunate groups should carry a certain part of the burden of cost.

In health, as in other areas of policy, Page was hardly consistent in his advocacy of Federal control. It was at times difficult to know where he stood on the matter. He was, for example, an advocate of decentralisation and new States at the same time as he was prepared to be tough minded with the States in other respects. As mentioned, he had not waited for their approval to set up the 1925 Commission; and there was no formal discussion before the Federal Health Council met in 1927. Nevertheless, consistent or not, had Page's National Insurance proposals succeeded either in 1928, or ten years later in 1938, they would have represented an advance which many collectivists would have welcomed.

During the Scullin Labor Government's brief tenure of office between 1929 and 1931, political and economic circumstances could scarcely have been less conducive to the advancement of health policy. The Labor platform had, since 1919, contained the plank 'the nationalisation of public health'; and its manifesto at the general election in the same year was quite specific. For example, Labor undertook to 'organise a national medical service charged with the prevention as well as the cure of disease...free medical and dental attendances for persons in necessitous circumstances and sanatoriums for the treatment of sufferers from phthisis and other diseases'.[11] But Scullin's policy speech in 1929 promised only national insurance, including unemployment

insurance which, as we have seen, had been omitted from the 1926 Act. It made no mention of health.

In the event, nothing at all was done. Worse, under the influence of a pre-Keynesian deflationary approach to the problem of large-scale unemployment, Labor was forced, against the intuitive conviction of some of its members, to curtail rather than increase social expenditures. Critical examination of all areas of expenditure brought the Department of Health under special scrutiny; there was even some talk of abolition. In fact, the Department's programme was slowed down. It retired completely from maternal and infant hygiene, tuberculosis and venereal disease control, and research generally.[12]

In the 1931 election campaign, Scullin promised to restore social service cuts imposed by the Premiers' Plan. Page's platform made no mention of health or social services. The main issues, clearly, were still tariff reform and the depression. The United Australia Party and the Country Party took office in 1934, and from the mid-thirties onwards interest and activity on health and social security began to gather momentum. Pressure from the States, where Labor was beginning to gain ground, was one factor. Another was the composition of the United Australia Party itself which, like its predecessor, contained many Labor men, who, although to the right of the Party, were sympathetic even if not deeply committed to social welfare policies. In the Country Party Page was still at the helm.

Substantial advances were made between 1935 and 1940 but, again, many of these related to public health rather than health insurance. Though in themselves important, they can be given only brief mention here. They included: the setting up of an Advisory Council on Nutrition; the reconstitution and extension of the activities of the Federal Health Council which in 1936 became the

National Health and Medical Research Council;[13] and the decision in 1936 to establish the Lady Gowrie pre-school centres to study the physical and mental development of the pre-school child.

There was also some revival of interest in national insurance. Following the Kinnear report the policy speeches of both Lyons and Page in 1937 forecast the enactment of a National Health and Pensions Insurance Act, to be introduced in the first Parliamentary session of 1938. 'Experience in Great Britain and other countries has proved that much can be done towards solving the problems which confront the worker as a result of ill-health, unemployment, and old age, by the institution of National Insurance...A definite attempt must be made, in conjunction with the States, to provide relief for the hardships of unemployment and the government proposes to do all in its power to this end'. Kinnear visited Australia again in 1938 and was actively associated with the Treasurer, R.G. Casey, in the preparation of this measure along with a senior officer of the British Ministry of Health and three National Insurance Commissioners. The ensuing legislation followed closely Sir Walter's report which has been described in the preceding chapter.

2. The Demise of the National Health and Pensions Insurance Act 1938.[14]

The National Health and Pensions Insurance Bill was introduced into Parliament by the Treasurer on 4 May 1938, passed both Houses by June, and became law on 5 July. It was one of the longest and most detailed measures ever brought before the House. Its second reading debate occupied seven days during which every member spoke. The Bill was carried by thirty-six votes to twenty-six - the Labor Party vigorously contesting it. Nevertheless, the Act was ill-fated. The two Government parties split on many of the provisions; and the Country Party itself was divided inter-

ally on some issues. There were repeated meetings of Cabinet ministers, conferences between the parties and their powerful supporters in the country; and in the midst of these developments a Royal Commission on National Insurance was set up to investigate payment to the medical profession. All failed to produce a satisfactory or, at the least, an acceptable Act. As a result, the proclamation, formally set for 1 January 1939, and the implementation of the medical provisions of the Act, scheduled for May of the same year, were both permitted to lapse. Postponement of the Act was announced in February 1939 and on 14 March Cabinet reluctantly decided to make 'drastic modifications' to the unproclaimed Act, some of these in line with the claims of the medical profession. On the same day, R.G. Menzies, then Deputy Leader of the United Australia Party, resigned - allegedly because of his Government's retreat from its election pledges on national insurance. He returned in April as leader of the United Australia Party. But despite his earlier commitment, and his resignation allegedly on principle, his Minister for Health and Social Services in June 1939 referred the Act to a select committee, whence, as a practical measure, it never reappeared.

The factors which combined to ensure the shelving of the 1938 National Health and Pensions Insurance Act were numerous and interlocked in a complex fashion. But certain strands can be discerned.

First, in Parliament, the Labor Party under the leadership of J. Curtin opposed the legislation and especially the health insurance provisions. Brought down to essentials, Labor saw the Act as too narrow in the scope of its services, too limited in the range of persons to be insured and financially regressive in its incidence on the low income earners of the community. For example, the medical services

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contemplated did not include ante-natal, post-natal or infant health benefits. It excluded wives and children. On this point Curtin was emphatic that 'this narrowness really means in practice an absolute failure to provide the thing which is the heart of the sickness problem of Australia, namely a national health service'. Labor also objected most strongly to the regressive character of the proposed compulsory contributory system on a flat rate basis. It did not differentiate between the income and commitments of insured persons and therefore would be a greater financial burden on the lower income groups. It was Labor's conviction that any national insurance scheme should be financed by a progressive income tax; that is, graduated according to ability to pay. Labor also disliked the Government's intention to introduce 'approved' societies and sought to protect the trade unions and the Friendly Societies by insisting that only they should qualify as administrative agencies.

All of these objections, it should be noted, were consistent with the Party's more comprehensive collectivist approach to social security and to national health in particular. (They also indicated the rationale behind Labor's vigorous attack on the Government's failure to include provision for unemployment insurance along the lines drawn up by Mr Godfrey Ince of the British Ministry of Labor in 1937). To publicise its views Labor published in detail its objections to the legislation and its own suggested amendments, in a pamphlet designed to expose the 'hollow predictions' of the Lyons government. The conclusions set out in this pamphlet are worth summarising.[15] The National Health and Pensions Insurance Act, it stated, is unacceptable because:

> (i) It is not national; numerous groups are not included in its scope - shopkeepers, farmers and self-employed workers. (ii) It does not include unemployment insurance. (iii) It contains no ante-natal, post-natal or infant health benefits;

ner are there health provisions for wives and families. The first fundamental feature of any health scheme should commence with motherhood and babyhood. (iv) The Act contains no definite provisions for optical treatment, dental treatment or hospital cases. (v) Casual workers are omitted from its provisions. (vi) It discriminates between males and females. (vii) It is retrogressive as a social measure because it ignores a cardinal principle of taxation - that those in the best position to pay should bear the cost. It imposes charges on the lower-paid workers through their contributions - charges which cannot be passed on as in the case of employer contributions. (viii) It is designed to relieve the Government of the necessity to increase taxation on higher incomes and property in order to maintain existing or to provide wider social services.

A second major obstacle helping to defeat the Act was that the Country Party itself was in an ambiguous and severely divided state on national insurance. In its opposition to certain clauses some of its members were closer to the Labor Party than to the United Australia Party. On a number of occasions they actually found themselves voting alongside Labor. Earle Page himself was in a difficult position. As we have already seen, he had tried in 1928 to introduce a similar act without health benefits and was in principle very much in favour of this scheme. In his autobiography, Truant Surgeon, where he gave an explanation of the trend of events he stated that, like the 1928 Act, the scheme attempted too much, and that he had warned R. G. Casey and Sir Walter Kinnear that this was so before leaving for London (where he remained during the parliamentary debates on the Act). It was his belief, he said, following as he frequently did the medical metaphor, that 'if the new measures attempted to cover all that Kinnear proposes the Government would be burdened with a child of such size that only a caesarean section would permit its parliamentary delivery and both the offspring and the mother would be killed in the process'.[16] Page, nevertheless, wanted to get as much of the scheme under way as possible.

On his return from overseas he busied himself in discussions with the medical profession and in trying to devise modifications of the medical benefit provisions.

As a result, in February 1939, Casey arranged for the National Insurance Commission to meet representatives of the approved Societies and the A.M.A. Page himself accompanied Casey to the conference and they subsequently submitted joint recommendations to the cabinet. On the basis of these recommendations, the Government decided to substitute a revised version of the Act including modified medical benefits arrangements.

But meanwhile, a third factor was hindering Page in his efforts to secure separate arrangements with the profession. This was the sensitivity of members of his Party to the hostility of small farmers to the scheme. The Party held, and the Composite Ministry was agreed, that the cost of excluding small farmers, graziers and dairymen would be too high, in terms of lost employers' contributions, and would present a difficult matter to administer. An assurance that the particular problems of farmers would be given sympathetic consideration in another measure did not satisfy the dissidents. Thus, Page, whatever his own preferences, was eventually forced to give way to these pressures within his own Party.

In any event, the opposition of the Australian Medical Association (A.M.A.) itself was a fourth and vital element determining the fate of the Act. The details of their position and their activities will be dealt with in the next chapter. Suffice it to stress here that the dissatisfaction of the A.M.A. succeeded in holding up the implementation of the medical provisions of the Act until external events overtook the measure.

Fifth, the Friendly Societies were strongly opposed to the Act and ranged themselves naturally alongside the A.M.A.'s strongly stated individualistic position.[17] These societies were to share the administration of the Act not only with the relevant government departments but also with newly-created 'approved' societies. As indicated

earlier, the societies had long experience of contract service in which they acted as the principal financial and administrative intermediaries between the patient and doctors and pharmacists in order to obtain for their voluntary membership medical and pharmaceutical benefits on a per capita basis. The Societies saw their financial position, not to mention their prestige and goodwill, undermined by the legislation. For example, they argued that the existence of the Act would be bound to eat into the existing voluntary membership of Friendly Societies. The rate of sickness benefits under the legislation was relatively high. This feature, the Societies insisted, would encourage contributors to remain for longer periods on sickness benefits especially if the member were both a compulsory and voluntary contributor. The strain on a Society's funds could therefore be considerable. There might be difficulty in absorbing this extra cost especially if, in addition to these financial burdens, they also had to compete with the newly-established 'approved' Societies. Further, because the larger Friendly Societies were organised on a State-wide basis, unlike some regional Societies or others geared to serve the needs of a particular occupational group, the smaller Societies felt themselves to be excessively vulnerable. It was claimed, since the Act contained no provision for their representation on the central body which would administer national insurance, that they would not be in a position to make their views known in order to anticipate problems and difficulties of this kind.

Finally, the Act became the arena in which personal antagonisms and disagreements within the Government parties were played out helping to bring about the downfall of legislation in their train.[18] According to one historian of the period, these conflicts 'aggravated the landslide which, beginning as a fall of rock in the government's back yard, held for a moment when the Bill was passed, became a shower of

colliding boulders and ended in an avalanche'.[19] This conflict centred, finally, on the struggle for leadership of the United Australia Party prior to and following the death of Lyons.

R.G. Menzies, as Deputy Leader of the United Australia Party, seemed the most likely contender. Page, as Deputy Prime Minister, was another. It is not clear whether Page himself wished to become Prime Minister but it seems certain that he wished to prevent the succession of Menzies to the position. In February 1939, Page indicated that a majority of the Cabinet wished to postpone the Act formally on the grounds that defence preparations and the possibility of war must now be given priority. At a Cabinet meeting early in March, the Prime Minister, Lyons and Casey also proposed the postponement of the Act to meet the need for revisions. This action, however, was opposed by Menzies and two other Cabinet Ministers. The Country Party subsequently submitted detailed proposals indicating the kind of revisions it thought necessary for a workable scheme and Casey undertook to examine them. As a result, on 14 May, Cabinet decided to make 'drastic modifications' to the Act, including provision for a modified medical benefits arrangement. 'After prolonged consideration the government has decided to substitute a revised and modified system of national health insurance for the provisions now embodied in the Act. It has been faced with this necessity because of increased liabilities on account of defence and prospective additional costs of liberalising the national insurance plan as laid down in the Act, together with decreased ability on the part of the government and the people of Australia to meet the cost'.[20] Without anticipating too much the developments described in the next chapter, the implications of this deviation from the Government's original intention are worth mentioning here in order to

illustrate the extent to which, on national health insurance, the Coalition Government would have been willing to retreat from its original more collectivist intentions under pressure from the more individualistically oriented objections of some sections of the United Australia Party and the A.M.A.

The most significant element of the modified scheme consisted of a retreat from the original arrangement for a per capita method of payment for medical practitioners. It thus gave a major concession to the A.M.A.'s desire to retain a fee-for-service system. In addition, there were no statutory provisions concerning the fee to be charged to insured patients. Instead of free treatment available to all contributors there was substituted a subsidy to assist contributors to the Friendly Societies.[21]

> 'The Government has every sympathy with the medical view that payment for medical services should be on a family basis and it believes that subvention <u>in aid</u> of a service is preferable to a system of free treatment to insured persons and a separate system of assistance to women and children'.

In addition, the Government conceded that there should be as little disturbance as possible with the existing voluntary insurance system. The friendly societies were to continue as the administrative agents, rather than, as the 1938 Act had envisaged, a Medical Benefits Council under the Department of Health.

On the same day that these modifications were announced, R.G. Menzies resigned, claiming that national insurance was the last straw in a series of controversial issues on which he found himself in disagreement with the Government. Whether Menzies resigned over the national insurance issue or whether he did so as a tactical measure to ensure that he would be elected a successor to Lyons remains unclear. Menzies himself certainly claimed to be committed to national insurance in most convincing terms.[22] Consider his statement:

'The Cabinet has decided to repeal provisions relating to old age, widows' and orphans' pensions and to substitute for the remainder of the Act a new medical scheme, the details of which have yet to be worked out, and which, of ccurse, may or may not be approved, altered, extended or rejected by Parliament.

'I frankly do not think we can expect to be taken seriously if we start off again with conferences and drafting committees at a time when we have already so notoriously failed to go [amend] with an act which represents two years of labour, a vast amount of organisation, and a considerable expenditure of public and private funds. In effect the decision means the end of the important contributory pensions side of insurance and a precarious existence for the balance. I have therefore been forced to the conclusion that Cabinet's decision virtually either cripples or destroys national insurance for years to come...

'On this matter, unlike some others on which I have differed with my colleagues, I had commitments of a positive kind to my electors, from which I could not honourably escape...On January 24... with a view to answering what I regarded ill-informed criticism, I circularised some thousands of my electors on the subject of the National Insurance Act, explaining and defending the scheme.

'In the course of my letter I said: "Personally I am so utterly convinced of the essential quality of national insurance that I am quite prepared to incur any temporary unpopularity to see it made effective. I am not unaware of the manner in which certain interests which would seek to defeat me or to take my place in the representation of Kooyong are using national insurance against me. Let me say quite categorically that I stand by National Insurance and that a defeat in defending it would, in my opinion, be an honourable one".'

On March 14, Menzies resigned from the Lyons government.

Page, on the other hand, claimed that Menzies' action was highly irresponsible and that he [Menzies] had in fact shown little interest in national insurance. Despite Page's attempts to secure the election of an alternative Prime Minister, and a vindictive personal attack made on Menzies which many of Page's supporters felt impelled to repudiate, Menzies was elected Leader of the United Australia Party by a narrow majority over W.M. Hughes. On April 26, Menzies formed a government drawn wholly from the United Australia Party, though still depending in the House on the continuous support of the Country Party. In June 1939 Page's judgment

of Menzies appeared vindicated. In what Page described as 'the greatest volte-face made by any man in Commonwealth political history', Menzies, through his Minister for Health and Social Services, put forward a formal resolution that the Act should be sent to yet another select committee. This meant that it would not operate on the scheduled date, September 4. Curtin moved an amendment to repeal the Act which was defeated by 34 to 30. Page made his final bid to save the medical benefits provisions and voted against the Curtin amendment. All to no avail. The Government successfully introduced and passed a Bill to annul the proclamation made under the Act, thus postponing the date on which it was to come into operation. With this the National Health and Pensions Insurance Act passed from the Parliamentary scene. As a practical measure, it was never revived.

The confusion of issues surrounding the demise of the National Health and Pensions Insurance Act illustrate some important facets of party attitudes to a national insurance scheme and to a health scheme in particular. First and foremost, it brought about the retreat of the Coalition Government and especially of the Country Party under Page from the idea of a compulsory contribution insurance scheme including health benefits. Driven by pressure from the A.M.A. and the Friendly Societies it was unable or unwilling to hold fast to the concept of a compulsory national scheme, albeit restricted to particular income groups, to be financed by governments, employers and contributors.

It follows also that the pre-eminence of voluntary insurance and private medical practice, which was to become the essence of the Liberal-Country Party Government's National Health Scheme in the nineteen-fifties, had its origin in the unwillingness of the A.M.A. to countenance infringement of the fee-for-service system, or intervention in private medical practice; and the reluctance of the Australian Friendly

Societies to share their hold on health insurance with government or any other agencies.

Finally, as already emphasised, the Labor Party's opposition was rooted in its collectivist convictions. Only by direct progressive taxation could the scheme be equitably financed. And only by widening its provisions and making them universally available could the scheme come closer to the conception that a health scheme was a social service, available to all as a right, and not simply a financial grant to those whose need was demonstrable.

FOOTNOTES (Chapter Two)

1. W.G.K. Duncan (ed.), Social Services in Australia, p.161.

2. The Australian Country Party Association, Platform, Sydney, 1927.

3. W. Ellis to the author, letter 10.1.66.

4. J.H.L. Cumpston, The Health of the People, p.118.

5. G. Sawer, Australian Federal Politics and Law, (1901-1929) pp.187-223.

6. C. Edwards, Bruce of Melbourne, p.82.

7. Conference of Commonwealth and State Ministers of Health held at Melbourne, 22 July 1926.

8. Policy Speech by S.M. Bruce, 8 October 1928.

9. T.H. Kewley, Social Security in Australia, pp.143-49.

10. C.P.D., Vol.119 (1928), p.6746.

11. Manifesto - the A.L.P. Message to the People of Australia, 13 December 1919.

12. P.D. Abbot and L.O. Goldsmith, 'History and Functions of the Commonwealth Health Department', Public Administration, Vol.XI, No.3, September 1962, pp.122-3.

13. Ibid. Other activity of the Lyons/Page Government on health included a Medical Research Endowment Act 1937, and a Therapeutic Subsidy Act 1937. Maternal Welfare also occupied much discussion in the National Health and Medical Research Council.

14. C.P.D., Vol.155, pp.787, 1327, 1764, 156, 2086, 2307, Vol.159, pp.534, 160, 1515, 1857.

15. The Labor Party opposed in policies the following clauses

of the Act: 17, 18, 20, 21, 23, 25, 36. Federal Parliamentary Labor Party: Why Labour Opposed the Lyons Government's National Insurance Scheme, and How It Could be Improved. Pamphlet, Perth, N.D.

16. E. Page, Truant Surgeon, p.267

17. Consultative Committee of the Friendly Societies of Australia, National Health Insurance and the Friendly Societies of Australia, (Melbourne, 1938)

18. According to Sir Raphael Cilento (interview December 1965) there was resistance within the Department of Health to the administrative aspects and this constituted yet another element in delaying implementation of the Act.

19. U. Ellis, A History of the Australian Country Party, p.235

20. Ellis, op.cit., p.237.

21. M.J.A., Vol.1,8April1939, p. 559.

22. Page, op.cit., p.267.

CHAPTER THREE

THE ORGANISED MEDICAL PROFESSION AND NATIONAL HEALTH INSURANCE[1]

Ever since national health insurance first emerged as a public issue, the organised medical profession has devoted itself to the task of protecting the interests of doctors as it appeared they might be affected by actual or proposed policies. The Australian Medical Association (A.M.A.) consistently has made a distinction between government action to initiate and implement nation-wide measures designed to <u>prevent</u> illness, such as campaigns for the eradication of various diseases, and projects intended to secure throughout the country the benefits of <u>curative</u> medicine. While it frequently welcomed and co-operated in the former, it has regarded government intervention in the latter with suspicion and reserve. Nor has it hesitated to resist particular policies either in the process of formulation or once implemented.

The specific bases of A.M.A. opposition have varied in detail over the years, but certain general principles have recurred with regularity: the superior value of the fee-for-service method of payment over any other financial arrangements; the desirability of complete privacy in the doctor-patient relationship; the importance of complete and untrammelled professional freedom; and control by medical men over areas of policy which they regard as purely medical. In addition, there have been other more subtle and less tangible reasons for the A.M.A.'s strong reservations concerning national health insurance: lack of experience in working with governments; a genuine fear of and distaste for any kind of control irrespective of the controlling body; professional individualism - a characteristic common to many highly specialised vocational

groups; and/ in some cases a latent fear that doctors might lose their high prestige in the Australian community.

The A.M.A. regards itself as a non-political organisation. 'The British Medical Association', wrote its president in October 1949, (before it had become an autonomous body) 'is an entirely non-political body and includes among its members individuals of all shades of political opinions. The association has not, nor can it have, any political affiliation. It is, however, a democratic organisation and it is opposed to the nationalisation of medicine and the regimentation of doctors in any State-controlled scheme.'[2] Therefore, in order to protect its interests and professional values, the A.M.A.'s main representative organ, Federal Council (and before it, the Federal Committee), has been prepared to take political action, usually with the support of State Branches. It has not hesitated to employ the methods open to all interest groups. For example, Council has worked through the political party most likely to promote its interests - always non-Labor parties. It has made group representations to individual parliamentarians, maintained direct communication with Ministers and continuous consultation with administrative agencies of government. And it has employed the press, as well as its own professional journals, to publicise its viewpoint. Finally, and most importantly, Federal Council has successfully challenged legislation on two occasions in the High Court of Australia.

The success of the A.M.A. in protecting the interests of its members derives substantially from the existence of an efficient and dedicated organisation, Federal Council. It is helpful therefore to digress somewhat in order to examine briefly how this body emerged and what functions were assigned to it by the profession.

1. From State Branches to Federal Council

Colonial branches of The British Medical Association in Australia (the A.M.A. eventually) existed from

1879 onwards, Before that date, attempts to organise the medical profession in Australian Colonies were both spasmodic and frequently abortive.[3] Personal rivalries, genuine disagreement about function and financial difficulties, especially those of sustaining a medical journal, all were important. Between 1846 and the turn of the century no fewer than ten local medical societies were formed and operated. Some of them were reasonably successful, and survived. Some did not survive. Only in Victoria did medical men show considerable interest and, relative to other States, more ability in attempting to preserve medical associations, once established.

The first Colonial Branch of the British Medical Association was set up in South Australia in 1879. The New South Wales Branch came next in July 1880 and the Victorian almost simultaneously, in August of the same year. The Queensland Branch was formed in 1894 and in 1900 amalgamated with the Queensland Medical Society founded in 1871. The Western Australia Branch was set up in 1899 and the Tasmanian in 1911. The N.S.W. Branch got off to a good start with a very active secretary and later a Journal, the Australian Medical Gazette, which it published in 1895 and thereafter amalgamated with the Medical Journal of Victoria to become, eventually, the Medical Journal of Australia, in 1914.

At least a decade before the Federation of the Australian Colonies in 1901, the move towards intercolonial unity in the medical profession found practical expression in a series of International Medical Congresses in Adelaide (1887), Melbourne (1889), and Sydney (1892). Governmental federation created an obvious need for a national medical body, but despite this stimulus, it was not until 1912 that (on the initiative of the South Australian Branch) a Federal Committee was formed. The

main function of the new Committee was to act 'as an advisory body to the (Australian) Branches in medical or political matters of a national character'.[4]

Another major step towards a central focus for professional opinion was taken when the Committee decided at its first meeting on 28 May, 1912, to found an Australian Medical Publishing Company for the purpose of publishing a weekly paper. The first issue of the Medical Journal of Australia appeared on 4 July, 1914. Finance to float the company was provided by the Branches and each nominated three members of the company.

At the same meeting, the Federal Committee passed a resolution to seek amendment of the constitution [illegible]

to provide autonomy for Australian Branches from the parent English body. But autonomy did not, in the event, come quickly. Discussion went on intermittently between the Australian and the parent body over the next decade. Only in 1923 did it become a reality and it took another decade - until 1933 - for the Federal Committee finally to become the Federal Council. Thus the Federal Committee operated as the main national body of the professions organised / Branches in Australia for twenty-one years.

In 1933, the Federal Committee became the Federal Council, complete with a constitution which was the product of four years' discussion with the State Branches. On 15 May, 1933, the national body was incorporated under the Companies Act of N.S.W. and its first meeting was held in Sydney on 28 August, 1933. The first president was Sir Henry Newland, and the first vice-president, Dr J. Newman Morris, both of whom were later to become important figures in the debates and conflicts between the professions organised / and governments seeking to implement national health insurance schemes.

Between 1933 and 1962, Council comprised fifteen Branch representatives, four from N.S.W., three from Victoria, and two from each of the other States. It met twice a year to deal with matters referred to it by State Branches, Commonwealth Departments and other national organisations. It also organised triennial congresses attended by specialists as well as by general practitioners.

State Branches remained largely autonomous bodies. Their independent status on State matters was not affected by the existence of Federal Council. In Federal matters, however, by mutual consent, Council's decisions were regarded as binding by the Branches. In general, topics were discussed at Branch level and subsequently by Federal Council. According to a past General Secretary of the A.M.A., writing in The Medical Journal of Australia on 19 May, 1962, 'in very few instances over the years were Federal Council's decisions seriously questioned by a Branch'.

Before 1959, close links were maintained between the A.M.A. in Australia and the English parent body. There was some intermittent discussion on the possibility of forming a separate national organisation but little came of this until late in the nineteen-fifties. Australia was, indeed, the last of the Commonwealth countries to establish a separate association. On 26 September, 1959, Federal Council decided to put the proposal for separation to the Branches. These and other medical organisations were all strongly in support of a distinct and independent Australian Medical Association, and a committee was set up in February 1960 to draw up a new constitution. A major effort was made to involve as much of the organised medical profession as possible. The Royal Colleges, (though, in the event, they did not affiliate with the A.M.A.), the State Branches and a total of some thirty medical societies were consulted about the form of the Constitution. A

National Committee met in Sydney on 26 November 1960 to discuss and draw up the draft document. The Australian Medical Association was registered in Canberra, A.C.T., on 25 October, 1961, and came into operation on 1 January, 1962. The former State B.M.A. Branches became Branches of the Australian Medical Association.

2. The Medico-Political Activities of the A.M.A.[5]

From an early date the organised medical profession in Australia has taken its medico-political activities seriously. However, differences of opinion, sometimes strongly held, have always existed within the profession about allocation of time and resources to these issues, particularly when they conflicted with discussion of purely professional or scientific matters. In 1869, for example, the Medical Society of Victoria decided to support the city coroner in his attempts to establish the post of a government pathologist, a move of which many of its members disapproved. Their censure precipitated the foundation of another society, the Medical Association of Victoria.

The organised profession in Queensland also was frequently divided on a similar question. One group reported that during its fourteen meetings, political rather than scientific matters formed the subjects for discussion. Two other societies ceased to function, allegedly in part for this reason. In 1886, a new society took active measures to prevent a recurrence of this conflict. 'It was decided for the first few years of the present society that discussion should be purely scientific and that questions of ethics, legislation, etc., should not, for the present, be discussed at general meetings unless they had previously been discussed and formulated in the shape of a definite resolution by a committee duly appointed for the purpose'. Queensland went a step further in delineating the activities of medical organisations when, in 1890, the Queensland Medico-Ethical Association was set up specifically to discuss ethical and political matters.

The Western Australian Branch had, by contrast, 'flourished' on the basis of active participation in the political as well as the medical life of the Colony, while the Tasmania Branch had, in its early days, 'many bitter struggles with the Press and the Government in attempts to improve conditions of medical practice, contract practice and hospital service'.[6]

The then Federal Committee was more specific than the early Branches about the importance of medico-political activities and the necessity for both the Committee and the Branches to have adequate powers to pursue these matters. At its first session, in 1912, the Committee proposed the autonomy of B.M.A. Branches in Australia from Britain, largely on the grounds that government legislation to introduce national health insurance and nationalisation of hospitals was imminent. Until 1933, it continued to concern itself with any projected legislation which affected the profession. Indeed, it was during these twenty-one years that the Federal Committee established the pattern which the Federal Council followed and developed from 1933 onwards.

Some of Federal Council's objectives, laid down in its Constitution, clearly give authority (i) to promote in Australia the medical and allied sciences; (ii) to maintain the honour of the medical profession; (iii) to advance and protect the general and social interests of the medical profession; (iv) to consider, originate and promote improvements or alterations in the law relating to the medical profession...and also to oppose or support for the purposes aforesaid, to petition the Parliament of the Commonwealth of Australia or any of the States, to take such other steps and proceedings as may be desired expedient for carrying out this object; (v) to consider and advise on any question of medical policy referred to and for consideration by any Branches of the Association or any body affiliated with the Association.[7]

Federal Council, then, operates as the profession's main negotiating body in all matters where Commonwealth activity affects it. To this end, it maintains close liaison with the government departments concerned, the Commonwealth Department of Health, the Department of Social Services and the Repatriation Department. Council also has representatives on the National Health and Medical Research Council, the Australian Postgraduate Federation in Medicine, and the Australian Council of Social Services.

Within the context of the National Health Scheme, as we shall see, it has formal representation on most of the statutory agencies engaged in administering The Scheme. In addition, it maintains regular, informal contact with senior administrators in the Health Department. To some degree, Council also acts as an intermediary body between government and the specialist medical organisations, some of which, as already mentioned, did not affiliate with the newly formed A.M.A. in 1961.

When the A.M.A. became an autonomous Australian body it was emphatic that it needed a free hand to deal with governments. It believed that the importance of medico-political negotiations in the future would increase. 'A purely Australian Association with the full representation of the Australian medical profession will have an even stronger and greater part to play'.[8]

Without anticipating too much the remainder of this chapter, it is worth emphasising that leading officers themselves have evaluated the role of the Federal Council at various times in terms of the skill with which it has managed its political and legal affairs. In particular, many take pride in its success in resisting attempts by successive governments to encroach upon what the A.M.A. regards as the exclusive professional domain of doctors as a group.[9]

Consider, for example, one review in the Medical Journal of Australia in 1962, entitled 'The Nationalisation of Medicine' which ended: '...By constant and untiring efforts the Federal Council has served the profession well. Over the years it has been counsellor, mediator and champion of the medical cause in all dealings with governmental bodies. It has become the medico-political mouthpiece of the profession...'.[10]

3. Evolution of Attitudes to National Health Insurance

When the Bruce-Page Government took office in February, 1923, it did so on a party platform which included proposals for a scheme of national insurance.

As soon as the Royal Commission on National Insurance was appointed, the Federal Committee of the A.M.A. took positive measures to formulate the attitude it would adopt to any plans on national insurance, and on health insurance in particular. The Branches were asked to indicate their points of view on the subject. Dr Newman Morris was asked to investigate the Commission's arguments for the necessity of National Insurance. In a well-informed and important article published in the Medical Journal of Australia, Morris presented the background to the English and European Schemes and raised the whole question of the appropriateness of such a Scheme in Australia. He also stressed the need for the profession to clarify its position and above all to take a definite stand: 'Whatever our attitude', he said, 'it must be united'. It is a prophetic commentary on the ensuing pattern of relations between Federal governments and the A.M.A. that this otherwise well-informed and reasonable article ended with the following quotation from an article 'The Doctor and the People', written by a medical practitioner: 'It is plain that politicians are in our hands. They can pass medical bills, but without our assistance

all such legislation is useless. If only a great and universal impulse passed through our ranks bidding us act as one man, a battle between the doctors and the politicians would be the shortest ever fought...A strike is unthinkable but a determination to refuse to work with a government is not unthinkable'.[11]

At a meeting of the Federal Committee on 26 February, 1924, three resolutions were passed, clearly indicating that Council wished to look more closely into the matter.[12] It was resolved:

(i) To ask the Commission to postpone its report until the Committee had time to collect information and to determine the attitude of its Branches.

(ii) To remind the Prime Minister, S.M. Bruce, of an undertaking made by a former Prime Minister, Joseph Cook, in 1913 that he would not enter into any legislation, dealing in matters affecting the medical profession's relations with the public until the Federal Committee has had time to consider proposals and to make recommendations about them.

(iii) That the Branches send out a questionnaire to establish the attitude of members.

Individual practitioners and representatives of the Federal Committee gave evidence in the various States before the Royal Commission on National Insurance. It became apparent, from their submissions, that many had serious reservations about the Government's Scheme. Some claimed that it was unnecessary, that medical treatment was, in practice, available to all either by paying fees, or by insuring themselves with a Friendly Society, or by accepting hospital facilities in out-patients' departments. Others insisted that the administrative costs of such a scheme in a country of Australia's size would be prohibitive.

The most frequent objection raised was one on which the Federal body then and later took a consistent line. The Government would do better to concentrate on measures of a preventive nature to which the profession would

(and did) give its complete support, than to tamper with the practice of medicine which raised fundamental issues concerned with payment and control by outside authorities and might, in the vivid words of one writer, 'upheave the world to meet a comparatively small problem'.

On 29 May, 1924, the Federal Committee outlined its official position on the possibility of introducing national insurance in Australia along the lines of the British 1911 Act.[13] It was resolved that:

> (i) Having given grave consideration to the difficult problems involved, the Committee finds that the medical profession is generally opposed to medical benefits being included in compulsory national insurance.
> (ii) The Committee does not see its way at present to submitting a constructive scheme for compulsory national health insurance. The Committee is, nevertheless, continuing its investigations of the possibility of formulating proposals for this purpose.
> (iii) The Committee is of the opinion that national measures should be instituted which would include the provision of adequate midwifery ante-natal and post-natal clinics, laboratories throughout the country for investigation and pathological work, treatment of T.B. and V.D. and of malignant diseases, on a contributory basis for those who could not go into private hospitals. And (iv) that medical practitioners should be associated with the administrative departments in relation to preventive [illegible] medicine.

The scheme which subsequently emerged as official A.M.A. policy emphasised the need to retain the method of paying doctors by fees; free choice of doctor; and control by a Commission on which doctors would have majority representation rather than by the Department of Health. The latter, however, could continue to control preventive medical matters. 'The treatment of disease and injury', the Committee insisted, distinguishing, as it frequently did, between preventive and curative medicine, 'is the province of the medical profession itself and no departmental supervision would be tolerated...The medical profession in England has learned a lesson...In Australia the mistake of accepting lay control of purely professional matters will not be made'.[14]

The National Insurance Bill, which was introduced into Parliament on 14 September, 1928, did not include

measures for health insurance. There appears to have been little exchange between the Government and Federal Committee on this omission. In July, 1927, the Chairman of the Advisory Council on National Insurance had simply informed the profession that the Government's proposed scheme did not include health insurance, and that the medical profession was to be involved only for purposes of issuing certificates for people claiming sickness or accident benefit. Even so, the organised profession had strong reservations. It opposed the use of Friendly Societies as approved societies under the Government's scheme. It claimed that they would compete with the profession by making contract arrangements with medical practitioners who might charge cheaper rates in handling matters of certification. Though Page took pains to subdue the fears of the profession on this point, the Federal Committee determined to watch the bill closely.

In the event, the 1928 Bill was never enacted and the Bruce-Page Government fell from office in October 1929.

4. Reactions to the National Health and Pensions Insurance Act 1938.

The National Health and Pensions Insurance Bill was introduced into Parliament by the Treasurer, R.G. Casey, on 14 May, 1938, passed both Houses on 30 June and became law on 5 July. The Act was never implemented.

The apparently unexpected opposition of the medical profession was the central obstacle to implementation of the medical benefits provisions of the Act. The Lyons-Page Government appeared to be unaware of the extent and, more important, of the quality of the A.M.A.'s opposition. On the contrary, Casey was specific that he had the full support of the medical profession. 'We are satisfied', he said, 'from assurances we have received from representatives of the medical profession that we

can look forward to the ungrudging cooperation of the great majority of doctors in Australia'.

Observations from other sources gave a more accurate indication of doctors' feelings in the matter. One M.H.R. claimed to have received no fewer than thirty telegrams from members of the profession in his electorate protesting that the allegedly agreed capitation fee was grossly inadequate. Within a week the Government was put in the embarrassing position of having to admit that the Federal Council had changed its mind. 'We entered', said the Prime Minister, Mr. Lyons, 'into what we thought was an agreement with the Council of the B.M.A. regarding the contract services to be rendered, but now Council feels that it cannot carry out the undertaking we thought had been given'. He then admitted that, 'a hitch had occurred in regard to the agreement which it was understood had been reached'.[15]

The Executive Committee of Council met in Sydney on 21 May, 1938, set out the objections of the organised profession and suggested amendments. The following points and sequence of events were clarified for the benefit of its own members, as well as the Government:-[16]

> (i) At its meeting with the Government on 10 March 1938, agreements had been reached on the non-financial aspects of the conditions of employment, but there had been from the start an 'impasse' on the financial aspects. The Government had refusedtto go beyond the capitation fee of $1.10 and the Executive Committee had proposed a fee of $1.40. (ii) That on 27 March, the Conference was resumed. But, 'due to certain imponderable factors of great importance which could not actually be assessed in money' Executive Committee had agreed to the Government's terms. The Committee had, however, 'distinctly stated' even at this time that members could not be bound by it. (iii) However, Federal Executive Committee had given an undertaking that the terms of the arrangement with the Government would not be disclosed until the Bill was actually introduced. (iv) Since then the profession at large had had time to consider the terms of the agreement and it had emerged that they were opposed to certain aspects of the Bill.

As a result of this May meeting Council informed the Government that the revised capitation fee acceptable

to the profession was $1.40 in the metropolitan areas, with an additional twenty five per cent for country areas; that the mileage allowance suggested was inadequate; that there must be at least a nominal fee-for-service at night time to discourage the abuse of after-hour services; and that the Bill should be amended in a number of further, relatively minor, respects.

This apparently clear-cut statement of the position concealed a number of anomalies in Federal Council's position which were never satisfactorily resolved. These hinged partly upon internal divisions between the then predominantly specialist majority, and the general practitioners within Council. There was also a breach between Federal Council and the general ranks of the profession. The latter claimed that specialists were committing them, unfairly, to what was to them an unsatisfactory scheme; and that, in any case, Council had no plenary power to bind the Branches. On both of these points Council was obliged to give way.

If the Government knew of these internal difficulties within the profession it became aware only after the Second Reading of the Bill, not before. It could, therefore, quite legitimately, have been excused for coming to the altogether reasonable conclusion that the executive Committee of Federal Council spoke for the profession. Further, the 'imponderable factors of great importance' which assisted agreement but 'which could not actually be assessed in terms of money' were never revealed. In any case, why these suddenly should have ceased to operate between 10 March and 21 May - little more than two months - also was never made clear. It is difficult to escape the impression that, despite any success the Executive Committee of Council may have had in explaining the matter away, it did repudiate an agreement freely arrived at.

The National Health and Pensions Insurance Act was passed by both Houses. It did not include provision for any of the amendments suggested by Federal Council. Nevertheless, the Government did feel compelled to take account of the opposition of the profession; and therefore set up a Royal Commission to enquire into all the financial aspects of the terms of service under the Act, including mileage, capitation fees, and the payments to be made to doctors by Friendly Societies. Its proceedings commenced on 8th August, 1938.

Federal Council did not dally meanwhile. A Federal National Health Insurance Committee was set up on 30 June 1938 (when the Act had passed through both Houses) to deal with all matters relating to national health insurance. At its first meeting, the Committee passed a number of important resolutions: (i) that Federal Council should take no action on national health insurance matters without first consulting the Committee; (ii) that the constitutional aspects of medical benefits be examined; (iii) that the Federal Government should be asked to include within the terms of reference of the Royal Commission the question of a general medical service for the nation; and (iv) that the relationship between the capitation fee and the income of the insured person be investigated. It was also resolved (v) that since the Royal Commission had been set up by the Government as a court of inquiry and not as a tribunal agreed upon by all the parties concerned: 'The members of the B.M.A. in Australia, while willing to present evidence, will accept the findings provided only that the findings will ensure an efficient medical service to the public and satisfactory conditions to themselves'.[17]

The new Committee also decided to send out a questionnaire to all of its members to assist the prepara-

tion of the profession's case for submission to the Royal Commission. At the same time, individual State Branches were to 'train' members to act as witnesses before the Commission. Legal representatives were nominated and an emergency fund set up to meet the expenses involved in the whole proceedings. The parent body, the B.M.A. in England, gave $2,000 towards the cost of presenting the case.

Many members of the medical profession, some on Federal Council, appeared to be concerned mainly with the financial provisions of the Act. Federal Council, in particular, claimed to have been satisfied with most other conditions of service. Yet there were other members within the profession who insisted that it was principle rather than finance which was at issue. Dr R.O. Williams, a New South Wales practitioner, in an address to the New South Wales Branch entitled '<u>The National Health Insurance Act from another Angle</u>, predicted that the 'important dangers in the establishment of national insurance in Australia were not financial but political'. The Government had deliberately set out to steal some of the Labor Party's most valuable political assets and the Bill left a great deal to regulation. This would accentuate the deplorable bureaucratic tendency of modern Government which the Lord Chief Justice of England, Lord Hewart, had criticised so strongly in relation to the British National Health Insurance Act.

This 'new angle', if indeed it was a new one, was to prove of prime importance in the conflict between the organised profession and the Labor Government in the next decade.[18]

The proceedings of the Royal Commission were abruptly interrupted in October 1938, when Counsel advising the Commission and two solicitors instructing Counsel were killed in an airline crash. Meanwhile, there was some impatience within the body of the profession and

growing criticisms of the alleged secrecy shrouding the activities of Federal Council. Dr H.R.R. Grieve, a member of the National Health Insurance Committee, sought to reassure practitioners on both counts. 'Let the profession take note that in the past six months the full measure of its own strength throughout Australia had been gradually revealed. If in the past its policy has been drawn on a defeatist basis it has but to realise its own strength, disclosed in this crisis, to ensure the continuation, through its leaders, of a more virile, fearless policy in favour of what it profoundly and honestly believes to be right in the interests of the standard of efficiency and high traditions of medicine in Australia...Have faith in our own strength and unity and the outcome will be assured.'[19]

Federal Council appeared vindicated in its stand when a special session of the National Health Insurance Committee announced that the Government had now proposed a modification of the Medical Benefits Scheme. On 20 March, 1939, Sir Henry Newland wrote to the Commonwealth Treasurer asking him to put the altered version into writing and urged him to ask the Royal Commission to complete its findings. On 23 March, the Government sent a written statement of its new proposals to Federal Council. At its next meeting, Council announced that it hoped to make an announcement 'very soon' about its attitude to the changes. On 17 May the Contract Practice Committee of Federal Council met the Commonwealth Minister for Health and Social Services, Sir Frederick Stewart, and members of the National Insurance Commission. The Medical Journal of Australia reported that 'a friendly discussion had taken place' and that it approved the modified scheme.

Nothing further came of these discussions. In the event, other considerations had finally determined the

fate of the Act. On 6 January 1940, the M.J.A. reported briefly that the Commonwealth Government had postponed the introduction of National Health Insurance and that the issue was therefore in abeyance.

Though the A.M.A. can scarcely be said to have come out of these deliberations badly, it clearly was not well prepared. The 1938 Act had the effect of placing it on its mettle. Clearly, it could never again be caught off guard on health, especially health insurance issues. Positive action was needed immediately, as some of the Branches insisted, to anticipate any contingency on the legislative front. The West Australian Branch, for example, at its annual general meeting on 17 March, 1940, urged that 'it [National Health Insurance] will be brought in at the first opportunity and we must be fully prepared to launch a constructive scheme at a moment's notice'. On 27 June, 1940, the South Australian Branch announced that the Minister had conferred with a committee of Federal Council and that Council was 'now waiting on the next move by the Government as a result of the Conference'.

In the meantime, a sub-committee of Federal Council was at work developing proposals for a contributory insurance scheme which were later to form the basis of A.M.A. plans for a National Health Scheme in the nineteen forties.

FOOTNOTES (Chapter Three)

1. This Chapter as well as Chapter 7 has been based almost entirely upon material appearing in The Medical Journal of Australia, mainly, but not exclusively, between 1923-49. Footnotes are selective. I have not used them where it is clear from the text where they may be found.

N.B. The term A.M.A. is used to denote 'the organised medical profession in Australia', whether originally B.M.A. or subsequent to 1962, A.M.A.

2. B.M.A., A National Health Service, p.6.

3. A. Tovell and B. Gandevia, 'Early Australian Medical Associations', in M.J.A., Vol.1, 19 May 1962, pp.756-59.

4. Ibid., Ross-Smith, The Evolution of a National Medical Association in Australia, pp.746-52.

5. My major emphasis has been on the Federal Council, not the Branches.

6. Tovell and Gandevia, op.cit., pp.758-59.

7. A.M.A., 'Memorandum and Articles of Association of the Australian Medical Association' (1967), pp.5-7. Only five of the nineteen objects of the Association are paraphrased here.

8. Ross-Smith, op.cit., p.752.

9. This point was freely admitted by several leading officers of the A.M.A. and some past members of Federal Council in conversation with the author in February, 1968.

10. Margery Scott-Young, 'The Nationalisation of Medicine', M.J.A., Vol.2, 18 August 1962, (Supplement), pp.21-25.

11. M.J.A., Vol.1, 8 March 1924, pp.227-34.

12. M.J.A., Vol.1, 15 March 1924, pp.272-3.

13. M.J.A., Vol.2, 2 August 1924, p.124.

14. M.J.A., Vol.1, 2 May 1925, p.458. The medical profession's reactions to the recommendations of the Royal Commission on Health, which were as already noted almost exclusively concerned with preventive medicine, were

predictably warmer than the 1923 Commission's plans for curative medical care. At a special meeting of the Federal Committee on 15 June 1926, the Royal Commission's report was considered and a resolution carried unanimously 'that the broad principles of the report be adopted'.

15. C.P.D., Vol.2, 1938, pp.804, 257, 885.

16. M.J.A., Vol.1, 28 May 1938, p.943.

17. M.J.A., Vol.2, 9 July 1938, p.67.

18. M.J.A., Vol.2, 13 August 1938, pp.257-9.

19. Ibid., Vol.2, 19 November 1938, p.884. Sir Ronald Grieve, at that time an office-holder in the N.S.W. Branch of the A.M.A., was one of the important leaders of general practitioner opposition to Federal Council. According to Sir Ronald, he himself approached the Prime Minister, Mr Lyons, who assured him, even before the setting up of the Royal Commission, that the 1938 Act would never be implemented. He, Lyons, also alleged that he had not known anything about the medical benefits provisions of the Act until the Second Reading Debate. (Conversation with Sir Ronald Grieve, 28 February 1968).

PART II

THE YEARS OF CONTROVERSY 1941-49

'One of Federal Council's most outstanding feats was its succesful stand against the Labor Government in the late nineteen-forties when the Government endeavoured to nationalise medicine in Australia'.

General Secretary
of the Australian Medical Association, 1962

CHAPTER FOUR

PLANNING HEALTH POLICY

Commenting on the emergence of a comprehensive and collectivist National Health Service in Britain, H. Eckstein stresses three important characteristics of the socio-medical scene. First, British policy-makers could draw upon a wide range of practical suggestions. Over the years, a substantial number of reports (official and unofficial in origin) had been published on a range of health problems and various schemes of insurance had received extensive discussion and public debate. The end result was therefore the product of lengthy and sustained thinking on the minutiae of health and insurance - the quantity, quality and distribution of health services and the availability to individuals of the means for securing medical care. Second, there was the existence, at a crucial period in the evolution of health policies, of a climate of opinion which favoured widespread change in the availability and means of providing health services. Third, the medical profession in Britain contained a radical, left-wing body of opinion which allied itself, long before the decade of change in the forties, to Labor Party thinking. This reformist sentiment, within the most influential professional group concerned, helped make disagreements between the British Medical Association and the Labor Party 'peripheral to the desire for change' and therefore relatively easy to resolve.[1]

The emergence of the Australian National Health Scheme was characterised by a different and contrasting set of circumstances. Reports, investigations and discussions were relatively few and referred mainly to government-inspired inquiries. Forty years of Federation produced only three national reports of consequence and

of these one was, in essence, an application of British ideas and experience to the Australian situation. Consistent with this dearth of inquiry the climate of opinion was not such as to suggest a public avid for change. True, in the coming decade, especially between 1941 and 1949 when a Labor Government held office, very much more constructive and detailed thinking on health services occurred than ever before. But the main political parties in Australia were more seriously divided in their approach to national health policy than was the case in England - as subsequent legislation of the respective (Australian) parties was to prove. Most important of all were the views of the organised medical profession in Australia. These were those of an essentially conservative group concerned to protect its own professional interests. Doctors ranged themselves naturally with Liberal-Country Party politics and in opposition to what they tended to think of as Labor's utopian (and dangerous) ideas.

Therefore the solutions that were to be proposed between 1941 and 1949, despite apparent similarities in objectives and certain aspects of policy were to reveal some major and irreconcilable divergencies of opinion. No single group involved denied the need to plan and provide, with considerable financial assistance from government, more and improved health services equitably distributed throughout Australia and financially available to all in need. But Liberal-Country Party ideas, like those of the organised medical profession, were based on an individualistic approach to the socio-medical problem. Their plans were dominated by the requirements of private rather than social medicine. And it was to be expected that their proposals would involve the minimum of interference with existing institutional arrangements, more particularly with private medical practice. By contrast,

the radical proposals which came from the Labor Party, supported by the recommendations and suggestions of the National Health and Medical Research Council and the Parliamentary Joint Committee on Social Security, were more collectivist in temper and emphasis. They recommended, in effect, considerable intervention by government, even nationalisation of health services in some of its aspects, if it appeared this was required.

These alternative approaches, especially as they related to insurance arrangements, formed the basis of political divisions at a critical juncture in the emergence of national health policy. During the course of this argument, both in and out of Parliament, we shall see how the conception of national health as a comprehensive, publicly-provided social service was replaced by a more pragmatic, ad hoc approach to medical care, which, through subsidies, benefits and special financial devices, has set up the main characteristics of the present health arrangements.

To understand the present National Health Scheme it is necessary to examine the ideas which preceded it, those on which it was based and the alternatives against which it was proposed (but which also influenced it).

1. The Planners.

Between 1941 and 1949 three major groups devised and recommended definite plans for a reorganised and unified national health service combined with a comprehensive system of national insurance and a general medical service. These were: an all-party Commonwealth Parliamentary Joint Committee on Social Security (The Joint Committee); a government instrumentality, the National Health and Medical Research Council (N.H.M.R.C.); and the Federal Council of the Australian Medical Association (the A.M.A.).

In July, 1941, the Menzies Government set up a Parliamentary Joint Committee 'to enquire into and from time to time report upon ways and means of improving social and living conditions in Australia and of rectifying conditions in existing legislation'. Its terms of reference included widows and orphans pensions, unemployment insurance, contributory invalid old-age pensions, a national housing scheme and a comprehensive health scheme encompassing child welfare, maternal welfare, nutrition, community medical services and hospitalisation. Of its nine reports, four dealt with national health.[2]

The early wartime Government had urgent reasons for initiating and encouraging investigations on social services. Pressures for social reform, particularly from the Labor Party, were strong to this end. The Joint Committee was widely regarded as a concession to Labor. In addition, an unfavourable balance of parties in Federal Parliament in the face of mounting wartime difficulties called for measures designed to maintain unity. The joint participation of members of Parliament in committee activity was intended to be one such device.[3] In the event, the Joint Committee produced only one report before the Government fell from office in October 1941.

The Joint Committee took evidence from the N.H.M.R.C., members of the medical profession, the A.M.A. and other informed and interested organisations. In addition, it set up its own Medical Planning Committee whose report, submitted in 1944, was the basis of the Joint Committee recommendations on a general medical service.[4]

The second planning body, the N.H.M.R.C. was the successor to the Federal Health Council which, in 1936, was enlarged and given more powers in the area of Federal State policy. Its main function is to advise

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the Commonwealth and State governments in all matters of public health legislation and administration and generally to promote Federal State cooperation and unity in this area. Since its inception it has made important recommendations concerning, among other things, public health, child welfare, national fitness, immunization, the treatment of tuberculosis and cancer; and it has set up a number of semi-permanent sub-committees to deal with particular aspects of the problem of medical care in Australia.

The N.H.M.R.C., at that time, was composed of the Directors of the Federal and State Departments of Health, two additional members representing the Commonwealth, one representative each of the A.M.A., the Royal Colleges of Surgeons and Physicians and those (combined) Australian Universities which have medical schools, plus two lay representatives. Its authority to speak on health matters was therefore of a high order. Over the years many of its recommendations had become law.[5]

Between 1939 and 1945 the N.H.M.R.C. activities focussed on the requirements and conditions directly associated with the war and on forward planning for re-organisation and reform after the war. The Department of Defence had established a Medical Coordination Committee to plan all aspects of medical personnel and equipment. And the Health Department and the N.H.M.R.C. worked together in cooperation with the Committee actively from the beginning and continued to do so throughout the war. The compulsory enlistment of all registered medical practitioners, with only minor frictions, was secured because of the harmonious coordination of these three authorities. 'Indeed', to quote J.H.L. Cumpston, 'the range of activity undertaken during the war years removed any lingering doubts about the national responsibility of the Commonwealth in public health...'.

At the Council's Tenth Session in 1941, Sir Frederick Stewart, Minister for Health and Social Services, confirmed the Commonwealth's growing interest in national health and emphasised the need for the N.H.M.R.C. to prepare itself for likely post-war developments in the field. In particular, he asked for an investigation into the reorganisation of health services; and that the N.H.M.R.C. direct its attention to the matter of the possible revival of the National Health and Pensions Insurance Act although 'not necessarily in its present form'. The Minister promised 'serious and sympathetic consideration' to any recommendation the Council might make. At the same meeting, a Committee of the N.H.M.R.C. was appointed 'to prepare a report on the most effective organisation for the preservation and protection of the health of the people of Australia'. At its Eleventh Meeting, in July 1941, the N.H.M.R.C. adopted this Committee's report entitled: 'Recommendations on the Reorganisation of Medical Service in Australia' (The Recommendations).

The Labor Government took office in October and E.J. Holloway, Labor's Minister for Health and Social Services, addressed the Council at its meeting in November 1941. His remarks foreshadowed Labor's ambitious objectives on the health front. 'Your consideration of a programme on public health progress after the war opens up a matter which will test the courage and determination of the greatest minds of the medical profession. Public health will be a most important part of our reconstruction after the war and this will mean something more than the normal medical peacetime requirements...I hope that attention will be given to the need for a national salaried medical profession to better serve our nation and build up

our national fitness'. The Council's second and much more controversial report 'An Outline of a Possible Scheme for a Salaried Medical Service' (The Outline) appeared on 26 November 1941.[6]

In the meantime, a third planning body emerged. Between the appearance of 'The Recommendations' in July and 'The Outline' in November of the same year, the A.M.A. had produced its set of plans for national health and national health insurance. The Federal Council of the A.M.A., as early as the nineteen twenties, had been moving toward the formation of a policy of national health insurance which would be acceptable to the profession. This process was accelerated during the debates on the 1938 National Health and Pensions Insurance Act which had followed the Kinnear Report. Federal Council's reactions to the medical provisions of the legislation are dealt with in some detail in Chapter III. Briefly, it objected in the first instance to the size of the per capita fee to be paid to general practitioners under the scheme. But it quickly became apparent that the principle of participating in a government scheme was opposed by general practitioners. In particular, they feared the possible loss of their professional freedom and resented the alleged intrusion of any third party in the doctor-patient relationship.

To counteract an unpalatable national scheme it therefore became necessary to formulate their own. The matter became one of urgency for the Federal Council with the onset of investigations conducted by the Joint Committee and the appearance of the N.H.M.R.C's 'Outline'. By the time the N.H.M.R.C. met on 26 November 1941, it had before it the A.M.A.'s alternative plan entitled: 'A General Medical Service for Australia' (The Plan, September 1941). Some eighteen months later,

it was revised and published under the title 'The Principles which should guide a General Medical Service of Australia' (The Principles, March 1943).[7]

To summarise the chronology of the proposals: The first independent set of proposals came with the N.H.M.R.C.'s 'Recommendations' in July 1941. The A.M.A. produced its first 'Plan' in September. 'The Outline' prepared by the N.H.M.R.C. appeared in November. There was a gap of some eighteen months followed by the amended A.M.A. 'Principles'. The Joint Committee Reports on Health appeared over a period of three years from 1943 to 1946. Finally in October 1949 the A.M.A. published another pamphlet entitled: 'A National Health Service'.[8]

2. The Plans: Consensus and Conflict.

The political disputes on health policy in the forties, and in particular those on national health insurance, often obscured the very real measure of agreement which existed concerning the problems of national health and the deficiencies of existing legislative and organisational arrangements in meeting them. The issue was twofold: one aspect concerned the nature, organisation and distribution of existing health services, while the other concerned the need for a national health scheme to bring improved, enlarged and integrated services within financial reach of the entire population.

There was considerable accord on objectives, on the deficiencies of existing arrangements and on the main features desirable in a national health service. There was also agreement on certain aspects of policy. The core of disagreement centred on the proposals for a general medical service and on the financial and administrative aspects of national health insurance.

Take first the objectives of policy. Broadly, all three groups were geared to a common and ambitious ideal: the prevention, cure and control of illness, through a series of extended services which would be universally available and coordinated in a unified national health policy. Every individual was to have access to the services of a general practitioner as well as to all consultant and auxiliary services. Each individual must be able to provide himself, or to be provided by society, with easy access to good medical and hospital services. Consider, as an example, the statement of principles by the A.M.A. (although its plans turned out, in the event, to be the least comprehensive of all three). It stated:

> That (i) the system of medical service should be directed to the achievement of positive health and the prevention of disease no less than to the relief of sickness, (ii) That there should be provided for every individual the services of a general practitioner or a family doctor of his own choice. (iii) That consultants and specialists, laboratory services and all necessary auxiliary services together with institutional provision when required should be available for the individual patient normally through the agency of the family doctor. And (iv) that the several parts of the complete service should be closely coordinated and developed by the application of a planned national health policy. 9

An admirable statement of principles with which none of the three planning bodies could disagree.

Taken together the recommendations of all three planning bodies were extremely comprehensive, covering the entire field of preventative and curative medicine. Some indication of the range may be gauged by reference to Table I (pp. 30-1). All displayed a lively awareness of health problems although the N.H.M.R.C. and the Joint Committee ranged more widely than the A.M.A. The latter, especially in its 1949 document, demonstrated equal willingness and ability to see the problem of health as a whole.

It is neither possible nor necessary in the context of this study to examine the detailed recommendations made on every area of health policy. Table I (p.107) sets out in tabular form the main recommendations made by each group. For our purposes the more controversial areas are selected for discussion: that is, the plans for a hospital service, medical service, health insurance and the administration of a national insurance scheme. Moreover, this choice of topics illustrates a point of major political significance: that the bases of disagreement hinged, not on the need or the nature of the reforms as such, but upon the method of implementation and, in particular, on the way in which the medical profession was to be integrated into a national plan.

The Reorganisation of Hospital Services: In this area there was general agreement that the existing system of hospital services was inadequate and that considerable re-organisation of administrative and regional arrangements was required. But little was known on the general hospital situation until the Medical and Hospital Survey committee of the Joint Committee made its report, in 1943, containing useful factual information on the distributive and quantitative aspects of hospital resources.[10]

This review committee uncovered and quantified many long-standing defects. It estimated, for example, that in 1943 there was a total of some 57,660 hospital beds representing 8 beds per 1000 persons distributed between 1,737 hospitals. Of these hospital beds, 73 per cent were government-owned or government-subsidised; and 27 per cent were private. The daily average occupancy of beds was 5.5 per 1000. This number, though some 10 per cent short of ideal requirements, was estimated as sufficient to meet Australia's needs. However, discrepancies between locality and need were widespread. For example, in some

country districts in Western Australia, there were more hospital beds than potential patients; while in the capital cities and their suburbs the reverse was the case. In addition, as in the twenties, there was still a shortage of 8,717 beds for specific categories of patients, the sub-acute, chronic and convalescent cases. For infectious diseases, on the other hand, there was a surplus of 762 beds.

It was clear that geographical factors often created and certainly accentuated the problem of distribution of hospital (and medical) services. By the early 1940s, some 50 per cent of the population inhabited the Eastern seaboard and was heavily concentrated in the main capital cities. A few of the larger provincial cities had links with rural towns and centres: but beyond these there were the outback settlements which often constituted no more than a solitary group of houses. Such outposts could not support economically a resident doctor, while the Flying Doctor Service only partially met their requirements. Hospital facilities in the intervening country areas varied from the one-bed to the small cottage hospital which might accommodate as many as twenty to forty in-patients per day. But here too, more often than not, there was only one doctor. A few hospitals might go as high as four or five. But only the larger towns, such as Newcastle, Geelong and Townsville, normally could support this number. Transport facilities were still far from adequate.

A national hospital system, therefore, all were agreed, was a fundamental requirement of a national health service. All stressed the urgency of the need to secure requisite numbers and types of hospital facilities where they were most needed. An elaborate plan of regionalisation, similar to that which health planners had adopted in England, was approved for Australia. The

N.H.M.R.C. made the most specific proposals on this topic. With some variations they were commended by the A.M.A. and the Joint Committee.[11]

The whole populated area of the Commonwealth was to be divided into health districts, which should also, as far as possible, be hospital districts. A District Officer, an officer of the Central Health Department, was to be appointed to each health district. He would be responsible for the supervision of all health legislation and preventive measures in his district, the coordination of hospital services, natal clinics, school medical services, industrial hygiene, physical education and national fitness. Hospital services throughout the populated area of the Commonwealth were to be arranged on a district hospital system, with base and subsidiary hospital centres. Local centres were to be staffed by local medical men and central hospitals were to be kept for specialist cases. Metropolitan areas and a few of the larger cities would have, in addition to the hospitals, a ring of suburban consultative centres to be used for consultations and casualty treatments. There would also be a ring of small hospitals for cases requiring minor types of treatment. And country district hospitals were to have facilities for diagnosis and advice on health matters. Existing State agencies, including hospitals, were to be incorporated into the national scheme. But private hospitals would not be forced to join. The hospital system was, finally, to be staffed by full-time and part-time salaried medical officers.

These new developments, it was estimated, would do much to relieve the pressures stressed by the Medical Survey Sub-Committee of the Joint Committee. Patients would, for the first time, be assured of full hospital and medical facilities. Doctors would have more time for the preventive care of

their patients. Intervention between doctor and patient would be minimal and, wherever necessary, under supervision of doctors themselves. The Joint Committee endorsed these recommendations. Indeed it went further and advocated, in its Seventh Report, that an expert advisory body be set up to deal with overall planning and that the Commonwealth must itself take the responsibility for making up shortages in the hospital system.[12]

The A.M.A. also favoured reorganisation of the hospital system. But, though it advocated the abolition of the honorary system (under which doctors gave their services free in the public hospitals), it insisted that hospitals should, as a general rule, be staffed on a part-time basis by private practitioners. The A.M.A. also emphasised the desirability, so far as possible, of general practitioners continuing to treat their patients after they have been hospitalised.

The Provision of a General Medical Service: All the planning bodies agreed that medical services, as then distributed, did not meet the nation's requirements. In 1943 the Medical Survey Committee estimated that there were some 6143 practising medical graduates (including specialists) in Australia and 1700 students could be expected to graduate between 1943 and 1948. Numerically, these numbers, evenly distributed, were estimated to be more than sufficient to provide a complete practitioner service. In practice, as with hospital services, there was widespread discrepancy in the availability of medical services between city, country and outback areas. There were also shortages in certain categories of medical practitioner.

Two factors in particular frequently caused and aggravated this maldistribution. First, the

accepted methods of professional advancement for doctors produced a concentration of medical practitioners in the capital cities. The young medical practitioner, in the normal course of events, proceeded after graduation to a compulsory residency in a large public hospital. The better qualified or talented among them aimed to specialise and, eventually, to secure a higher hospital appointment. These remained in the cities. The majority of medical graduates, after residency, bought a practice or a place in a partnership. A few might opt for public health work but then, as now, these tended to be exceptional cases. Private practice, for most doctors, carried more remuneration and more prestige. Second, doctors, like other professional groups, were most likely to establish their practices where their incomes would be highest. Thus, not surprisingly, the capital cities and especially the high-income residential and industrial suburbs were over-supplied with doctors. The doctor-patient ratio in these areas was often as high as one per 1,000 population as against one per 3,000 or over 4,000 in country areas. While, in the outback, the Commonwealth Government had to subsidise doctors to ensure any medical services at all.

These shortages, created by the maldistribution of doctors, could scarcely be disputed. But there was only one small area of agreement on the corrective measures to be taken and how to put them into operation. This centred on the need to encourage <u>group practice</u>. Group practice, it was agreed by all three bodies, had a number of advantages over individual practice. First, from the patient's point of view, a greater range of accurate diagnoses could be made available without excessive cost, and without the inconvenience of using the overcrowded out-patients' departments of general hospitals. For the medical practitioner, group practice could offer

special advantages. It could help to minimise the overlap of professional skills by pooling them. The overheads involved in operating a practice could also be reduced. It could provide better and more complete records of disease. It could allow the medical practitioner to coordinate the preventative and curative care of his patient. Group practice could ensure adequate remuneration, reasonable opportunities for the maintenance and improvement of his knowledge, satisfy his desire for some degree of specialisation and absolve him from his obligation to be accessible twenty-four hours a day.

The idea of group practice, as such, drew no adverse comment from the A.M.A. But it had reservations concerning the context in which the arrangement might be expected to operate. For example, the organised profession would not have welcomed group practice in the form of health centres staffed by full-time, salaried practitioners. Thus, as might be expected, the A.M.A. plan stressed the need for patients to retain free choice of doctors and the doctors free choice of their associates. It was of primary importance that 'the organisation of the health service of the nation should be based upon the family as a normal unit and on the family doctor as the normal medical attendant and guardian. Personal service and not institutional service was the first requirement of proper and efficient treatment.'[13] Only the general practitioner could keep track of the resources of the health services, on the one hand, and the peculiarities and needs of the individual consumers of health services on the other. The free choice of doctor was the right of every citizen and a pre-condition of the confidence which was essential for a satisfactory service. The family doctor was also in a unique position to integrate, for the benefit of his patients, the preventative

special advantages. It could help to minimise the overlap of professional skills by pooling them. The overheads involved in operating a practice could also be reduced. It could provide better and more complete records of disease. It could allow the medical practitioner to coordinate the preventative and curative care of his patient. Group practice could ensure adequate remuneration, reasonable opportunities for the maintenance and improvement of his knowledge, satisfy his desire for some degree of specialisation and absolve him from his obligation to be accessible twenty-four hours a day.

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and curative aspects of medicine. The specialist should be regarded as complementary to the family doctor and not as a substitute, although the best selection of an appropriate specialist could only be through the family doctor.

The N.H.M.R.C. was much less disposed to be firm on the issue of free choice of doctors and associates. This was desirable as far as possible. But it might not always be so. If the major problem of providing a medical service was to correct excessive concentration of services in certain areas to the deprivation of others, then logically some doctors might have to go, at least for a time, to less desirable centres. And similarly, some patients would have to take whatever doctors were available. Moreover, if group practice was to be based on health centres, as both the N.H.M.R.C. and the Joint Committee envisaged, then institutional treatment was bound to expand and domiciliary treatment would contract.

Thus, even in the small area of agreement provided by ideas on group practice the recommendations of the different bodies could not be reconciled because of divergent opinions on how medical practitioners should be employed and paid. Indeed, so far as medical services were concerned, the dominant issue, conditioning decisions on all others, was this question of how to employ and pay the doctor.

A number of alternatives were possible:
(i) Payment of doctors could continue on a fee-for-service basis (as under ordinary private practice) for each individual service provided. The doctor would receive a specified fee which he could either lower or increase at his discretion or, more likely, adjust to an agreed professional minimum or maximum. (ii) Payment of doctors could be on a per capita panel system similar to that which operated in England. This arrangement would involve the

allocation of patients among doctors, presumably on a population basis. Each doctor would have a specified number of patients, for each of whom he would be paid a specified inclusive fee. The number of services actually provided would not, therefore, increase the doctor's remuneration. Only by increasing the list of his patients could this be accomplished. (iii) Doctors could be paid a salary for part-time employment but could also retain the right of private practice. Under this system the doctor, as well as running his own practice, would undertake to provide a specified number of sessions per week on the government's service in return for an agreed annual salary. (iv) A full-time salaried service could be operated which, in effect, would make doctors public servants. Conditions of service, superannuation rights, leave, all would be subject to specific arrangements with the appropriate authorities. And (v) Various combinations of these systems could be employed.[14]

The N.H.M.R.C., for its part, discarded the continuance of the fee-for-service system on the grounds that it perpetuated the economic difficulties of patients which all had agreed should be reduced. The Council was also against the per capita system which it thought would act so as to inhibit thorough treatment of the patient. The shorter the time the doctor spent on his patient the more patients he could have on his panel. As an incentive, therefore, this was both inadequate and undesirable. In addition, a scheme based on either the panel or the fee-for-service system would require assessment of individual annual payments as well as a complicated system of records and book-keeping.

'The Outline' of the N.H.M.R.C. was based specifically on the assumption that a salaried service

was 'practicable and should receive serious consideration. Payment of doctors by salaries operated in varying degrees in Tasmania, Western Australia, Papua and New Guinea with notable success'. The N.H.M.R.C. was emphatic that its recommendations, as such, were not inconsistent with (some) private medical practice and private hospitals. It was 'inevitable that the fundamental human impulse towards individual freedom would urge many people to continue to consult private medical practitioners and pay the usual fees instead of using the facilities offered by the National Scheme'. The Joint Committee was also clear and specific upon the advantages of a salaried service. 'We believe that the ultimate solution will probably be found in a full-time salaried service with standardised, uniform hospital-provision in which complete hospital and public health services would be available to all and will be financed by tax on incomes for that purpose'. It would offer security to the doctor, an assured salary and reasonable working hours, superannuation rights and regular facilities for post-graduate studies. As a first step, however and to test its practicability, they suggested a voluntary full salaried service for the remote areas under a limited-term appointment. In other areas, it proposed a voluntary part-time salaried medical service. Doctors were to keep their private practices and to decide for themselves how much time they could give to this part-time salaried service. Experimental health centres based on group practice could test various forms of payment.

The A.M.A., predictably, rejected outright the idea of a salaried medical service, except for remote areas. Payment of fees was referred to specifically in 'The Plan' only in the case of honorary service in hospitals which, it held, should be abolished. If patients were covered in

any way by insurance, doctors should be paid for attending them. Free medical services should be provided only in cases where this did not apply. Hospitals were to be staffed on a part-time basis by visiting medical staff who were also engaged in private practice. Although neither 'the Plan' nor 'the Principles' dealt explicitly with the method of payment, the A.M.A. position on this matter was clear and unequivocable. Its representative had refused to sign the N.H.M.R.C. 'Outline'.[15] And the Joint Committee, in its Sixth Report, confirmed the fact of what it described as 'the chief features of the 1941 plan' of the A.M.A. namely: 'opposition to a national salaried service with consequent abolition of private practice and opposition to payment by capitation fee on the panel system. The weight of evidence is in favour of the fee-for-service system genuinely influenced by the desire to retain medical practice in its present form'.

National Insurance: Among the three bodies there was general agreement on the deficiencies of earlier abortive legislation to meet financial hardship created by the high cost of illness. And it was conceded by all that the controversial National Health and Pensions Insurance Act of 1938 was too restricted in both its objectives and provisions to be worth resuscitating.

But, once again, there were differences of a major order in the solutions offered. The N.H.R.M.C. and the Joint Committee were unequivocal in the conviction that a free and comprehensive set of health and medical services financed by taxation according to capacity to pay, should be made available to every member of the community as a social right, irrespective of their financial means. Indeed a complete health service made a logical enough corollary to most of the recommendations already made: regionalisation based on health districts coterminous with hospital districts; health centres based on group

practice; doctors employed by government; and the co-ordination within the health centres of both curative and preventative medical treatment. Further, since the ultimate objective of these ambitious reforms was to secure 'the highest degree of physical and mental health', it followed that the system of health insurance should cover all who needed these services.

The Joint Committee, with its wide terms of reference, ranged extensively over the entire field of public health and curative medicine. It concluded that the insured person was to be covered not only for all forms of medical treatment but also for all dental and opthalmic services. The latter service was to begin with the younger age groups and be extended as more trained professional staff became available.

The problem of coverage for the cost of treatment in hospitals was fairly intractable. The Commonwealth could not, without a major constitutional revision of powers, hope to own hospitals. Administratively, and to a large extent financially, they were a State responsibility. Moreover, some fifty per cent of Australia's hospitals were private hospitals. On the other hand, the public hospital system, at that time, was in severe financial difficulties. Thus the solution offered by the Joint Committee was one designed to secure a foothold for the Commonwealth in the field of hospital policy and, at the same time, to relieve financial burdens on the poor and the middle income groups.

Flat rate subsidies were to be given to the States for hospital maintenance. They would be conditional upon the provision of free treatment without a means test to the occupants of public wards of public hospitals; and upon the reduction of charges, by an amount equal to the rate of the subsidy, to patients occupying intermediate and private wards. Private hospitals were to be included in

the arrangement provided they conformed to certain approved standards. Differential rates of subsidy were to be paid for patients with mental and chronic diseases, tuberculosis, infectious diseases, and to sub-acute and convalescent patients. The amount of benefit for out-patients would naturally differ from that for in-patients and would need to be related in some way to the number of attendances. But, if the idea of group clinics and health centres was carried out, out-patients would be provided for automatically at one or other of these institutions. The only difference here would be that they would be treated mainly by general practitioners rather than by specialists. The idea of a subsidy was seen to have certain specific advantages. It would substantially encourage the development of public hospitals along community hospital lines, an improvement which had been strongly recommended in evidence given to the Joint Committee. And it would assist in introducing considerable uniformity into a diversified and uncoordinated hospital system; for example, by requiring all hospitals to be of approved standard in order to qualify for subsidy. Any savings which accrued to the States were to be paid into a trust fund to be used for the extension of facilities.

This, then, was the basis of the Hospital Benefits Scheme recommended by the Joint Committee in its Seventh Report, a scheme which, it wrote, would 'while recognising the rights of the States to impose varying conditions on the people, enable the Commonwealth to confer an equal benefit on all without discrimination against any State or individual'.[16]

Pending the introduction of a comprehensive health scheme, the Joint Committee recommended the setting up of an advisory body to deal with general planning problems such as the setting up of hospitals, the

securing of uniform standards and the regionalisation of hospitals in cooperation with State hospital authorities.

The A.M.A. plans, as they related to national health insurance, were in all respects narrower in concept and more restricted in their scope than those of the other two planning authorities. Despite the ambitious objectives, already quoted, the solution eventually offered, the extension of voluntary insurance to cover certain restricted medical benefits, turned out to be in some respects more limited even than those envisaged by the National Health and Pensions Insurance Act.

Consider first the pronouncement on insurance made in the A.M.A.'s first document 'The Plan'. 'Insurance', the A.M.A. wrote, 'was the traditional method used by society to protect itself against hazards.' The Friendly Societies remained, as in the twenties, the main providers of medical insurance for the poorer sections of the community. These gave 'a fairly complete general practitioner service' for about one quarter of the population, which, within its limitations, was 'of a high order'. But, 'The Plan' went on, 'a great weakness ... of all voluntary schemes of insurance is its incompleteness and inadequacy': and then, italicising to give emphasis to the point, '<u>no insurance scheme can be regarded as satisfactory which does not provide a complete medical service and which excludes from its provisions the unemployed and the unemployable</u>'. Further, 'unless a plan is compulsory it defeats the insurance principle of spreading the risk over the entire group'. The A.M.A. 'Plan' then proceeded to outline broadly a scheme for compulsory insurance to include all persons with or without dependants with an income less than $732 a year.[17]

The A.M.A. did not specify either in 1941 or 1943 the actual content of the services to be included

as benefits. These were to be 'clearly defined' but would, in general, include 'all proper and necessary medical services' and specialist services available only on the recommendation of a general practitioner.

Consider next the A.M.A.'s 'Principles' enunciated in 1943. The disadvantages of voluntary insurance were reiterated in precisely the same terms as in 1941. The document, however, made no mention at all of compulsory insurance and gave no explanation why it had been omitted.

By 1949, however, the A.M.A. was altogether much more specific about what it regarded as the requirements of national health insurance. For the middle income groups it advocated 'the use of voluntary prepayments similar to that of the Medical Benefits Fund of New South Wales'. For the lower income groups, the existing system of lodge medical benefits was to be extended to provide a more complete service. For pensioners and unemployed persons over prolonged periods, there should be a general practitioner service paid for through existing State agencies and a free supply of life-saving and disease-preventing drugs. 'Should Government decide on a larger measure of financial assistance to all members of the community', it concluded, 'subsidies should be paid direct to the patients according to a scale of benefits and should apply to the full range of medical services'. Severe illness should receive a higher rate of benefits and there should be a greatly increased subsidy towards the cost of hospital care.[18]

In effect, therefore, the A.M.A. had changed its views between 1941 and 1949. Where, apparently, it had initially been in favour of a compulsory scheme, albeit limited to specific income groups, the A.M.A. came to reject even this degree of compulsion in favour of the retention of the Friendly Society system and subsidies to maintain and develop a system of voluntary insurance.

Administration: It was generally agreed that the Commonwealth Government had insufficient power to deal adequately with matters of national health; that there was a lack of uniformity in too many areas of health legislation; that there were too many differences in the organisation of health and hospital services among the six States; and, above all, that many of these defects resulted from a failure to recognise the essential unity of preventive and curative medicine. All three groups were clearly aware of the need to be tentative in their suggestions as to the precise allocations of responsibility between Commonwealth and State. At that time, it should be remembered, the Labor Government was attempting to secure additional powers over national health, either by referrals from the States or by referendum; and the outcome was not clearly defined until three years after the reports were completed.

Within this context three issues arose. First, whether the services should be administered by the Department of Health or by a commission; second, how much should be controlled by the Commonwealth Government; and third, whether health service administration should be separate from or integrated with a reconstructed ministry of social services. In the first two cases differences of principle were important in determining the nature of the respective recommendations. The A.M.A., not unexpectedly, was the most specific of all in defining the basic requirements of the administrative structure (see Table I). It started from the position that the existence of any third party between doctor and patient should be as limited as possible; that there should be medical control of the purely professional side of the services, including the quality of practitioners and any disciplinary activity; and there should be consultation

with the organised medical profession on all medical matters by those responsible for the administration and financial control of the services.

The 1941 'Plan' therefore suggested that responsibility for administration be placed in a statutory body having a board of management composed of representatives of various interested groups. It should be established under a Commonwealth Act and be within the administrative responsibilities of the Department of Health. Medical practitioners should be included in all committees and sub-committees of this body which had functions relating to health - an indication that the profession might insist upon predominately medical control.[19] These proposals were however absent from the 1943 and 1949 documents.

Next, both the 'Plan' and the 'Principles' advocated that consultative advisory machinery should be established to ensure liaison between State authorities and the practising profession in each State. Subsequent developments in the national health service could, by this method, be based upon a systematic and coordinated plan. In 1949, the mechanism envisaged to secure this coordination was specified. A medical advisory committee composed of doctors was to be set up with the function of advising statutory health authorities on questions submitted and of initiating reports on desirable health policies. The committee was to be appointed by the Minister for Health in each State from a panel of names submitted by the A.M.A. and, where one existed, the Faculty of Medicine.[20]

On the question of the degree of Commonwealth control, most of the A.M.A.'s pronouncements and recommendations quite clearly implied that this should be kept to a minimum. From their point of view, the greater the

degree of decentralisation the easier it would be for the profession to resist undue encroachments by the controlling body. Thus the 1949 document specified, again the words were italicised, that 'greater efficiency will result if Governments realise that Federal financial aid should be expended through State agencies and only in conformity with the above principles [the retention of complete professional freedom]'.

On the question of integrating financial benefits with health and other social services, the A.M.A. had little to contribute. It merely restressed the need to keep medical benefits separate from other social security payments, basing its position on that adopted by the Royal Commission on National Insurance in 1923. It was not made clear, and the A.M.A. did not try to do so, how curative and preventive health services were to be satisfactorily integrated, given its objections to the Health Department as the administrative agency.

The N.H.M.R.C. advocated administration by a reconstituted Department of Health. Although the N.H.M.R.C. conceded that the recommendations for regionalisation could clearly be implemented without any change in the administrative structure, through a system of grants-in-aid, the 'Outline' was based on the 'basic assumption' that the whole system would be under control of a single government with the Department of Health as the main administrative agency. The Department could then be reorganised to include many more doctor-administrators with direct practical knowledge of curative health services. The N.H.R.M.C. saw 'no insuperable difficulty to complete control by the Commonwealth even including the transfer of State Health Departments and, in fact, recommended as an ultimate objective, such control or transfer for all aspects of preventive and curative medicine, including hospitals'. The 'Outline'

insisted that this need not imply more than minor intervention in the doctor-patient relationship and that the method of administrative control of medical matters should be 'carefully considered in consultation with the medical profession before any decision was made'. Within the departmental framework it was entirely possible, the N.H.R...C. concluded, that control would be by medical men exclusively.[21]

The Joint Committee envisaged two administrative possibilities, depending upon the extent of the Commonwealth's future constitutional power in the health field. The Federal government could lay down the broad principles of a health service, including general hospital standards, and finance the States by grants made contingent upon the acceptance of these standards. Alternatively, the Commonwealth itself could provide and administer the scheme, decentralising authority to State and local institutions. If the latter method were adopted, control and coordination could be vested in a Commonwealth Health Commission with a chairman and at least one other member nominated by the medical profession.

A new Department of Social Security should be established to be responsible for social services, medical and health services, welfare services and social planning. All social legislation including health was to be consolidated in a single Act of Parliament.[22]

3. Conclusions.

Looking back over the activities of these three bodies in respect of hospitals, medical services, health-insurance and administration, one is forced to conclude that, despite agreement on the deficiencies of the community's health services, on making them available through a satisfactory system of national health insurance and despite apparent similarity of objectives, there were

a number of intractable differences in the plans which we have been examining. These centred primarily on the proposals for a general medical service and on their financial and administrative ramifications.

The A.M.A.'s recommendations were basically individualistic in emphasis. Hence, whatever changes were made there should be, in its view, minimum interference with the nature of existing private medical practice. Hence, too, the stress on the role of the family doctor and of the importance of personal as against institutional service. Government participation, either as a provider or as a supervisor must therefore be as limited as possible; and voluntary action (by insurance) was in all respects preferable to compulsion either through contributory insurance or via the taxation system.

Both the N.H.R.M.C. and the Joint Committee came much closer in their thinking, and consequently in their suggestions, to the collectivist ideal. Thus they advocated fundamental changes in the existing socio-medico structure which would involve, over time, considerable extension of government activity. For them, salaried not private practice was the ultimate objective; though a certain amount of experimentation was not ruled out. Moreover, institutional treatment (in health centres and group clinics) might well, in certain circumstances, be preferable despite some limitation on freedom of choice of doctor. Finally, voluntary action had been tried, tested and found wanting. It followed that compulsory contributions, preferably through the system of taxation, should be the mechanism for ensuring the availability of a free health service as a social right to every member of the community.

In the event, as we shall see, it proved impossible to reconcile the recommendations of the A.M.A. with

those of the more radical authorities. The bitter debate between the Labor Government and the Federal Council of the A.M.A. ended only when Labor fell from office in December 1949. When the Liberal-Country Party replaced Labor it had before it, in theory, a number of alternatives in national health policy. The selection of those put forward by the A.M.A. was, however, a foregone conclusion; and this set health policy in Australia, and health insurance in particular, on the narrow path from which it has scarcely deviated for nearly twenty years.

TABLE I

MAIN RECOMMENDATIONS ON NATIONAL HEALTH 1941-9

	All groups	N.H.M.R.C.	J.C.	A.M.A.
I. HOSPITAL SERVICES				
1. Regionalisation based on health districts coterminous with hospital dist:	x			
2. Expansion of all hospital facilities	x			
3. Contraction of use of out-patient departments	x			
4. Retention of private hospitals	x			
5. Hospitals staffed on part-time basis by private practitioners. Continuity of GP services as far as possible into hospitals. Abolition of honorary system				x
6. Medical Services based on salaried medical officers: some full-time, some part-time		x	x	
7. Expert advisory body to deal with overall planning uniform standards, etc.			x	
II. MEDICAL SERVICES				
1. Group practice based on family doctor and free choice of medical associates	x			
2. Voluntary and full-time salaried services in outback	x			
3. A voluntary national salaried medical service		x	x	
4. Retention of private practice	x			
5. Registration of specialists	x			
6. Private practice based on fee-for-service method				x
7. Health centres to experiment with various forms of payment			x	x
III. NATIONAL INSURANCE				
1. Compulsory insurance based on income limit				x(1941)
2. Voluntary insurance				x(1943)
3. Voluntary insurance plus extension of lodge system for lower income groups				x(1949)

	All groups	N.H.M.R.C.	J.C.	A.M.A.
4. G.P. services free to pensioners & unemployed				x
5. Free medicine to pensioners & unemployed only				x(1949)
6. Benefits for T.B. sufferers	x			
7. Complete G.P. and specialist services universally available	x	x	x	
8. Dental and optical services			x	
9. Hospital Benefits Scheme - free public ward treatment. No means test			x	
10. Finance by taxation based on capacity to pay	x			
IV. PUBLIC HEALTH AND PREVENTATIVE MEDICINE				
1. National maternity plan			x	x
2. Housing				x
3. Milk for school children				x
4. School medical service				x
5. Industrial hygiene				x
6. Control of tropical disease				x
7. Rehabilitation centres				x
8. Medical research				x
9. Mental health			x	
10. Tuberculosis campaigns			x	x
11. National fitness and Child welfare			x	
12. Flying doctor and air ambulance service			x	
13. Immunization campaigns				x
V. ADMINISTRATION				
1. Independent statutory body - board of management with representatives of various interested groups to co-ordinate preventative and curative medicine within the framework of national insurance 1941				x(1941)
2. Reconstitutioned Department of Health		x	x	
3. Commonwealth Health Commission and Department of Social Services			x	
4. State Medical Advisory Committees				x(1949)

FOOTNOTES (CHAPTER FOUR)

1. H. Eckstein, The English Health Service, pp.101-32.

2. Commonwealth Joint Committee on Social Security, Reports No. 6-9:

6th: A Comprehensive Health Service, 1 July 1943

7th: Hospital Benefits; Hospitalization; Consolidation of Social Legislation, 15 Feb. 1944.

8th: A Comprehensive Health Service, 27 June 1945.

9th: National Fitness, 29 July 1946.

Members of the Joint Committee 1941-3: The Hon. J. Perkins (Chairman), Senate: W.J. Cooper, R.V. Keane (Deputy Chairman); House of Representatives: H.C. Barnard, M. Blackburn, R.S. Ryan. The Committee reconstituted by the Labor Government in Nov. 1941, consisted of: H.C. Barnard (Chairman), Senate: J.J. Arnold, W.J. Cooper, R.V. Keane; House of Representatives: M. Blackburn, J.A. Perkins, R.S. Ryan. The only change was, therefore, the addition of one member, Senator J.J. Arnold, the discharge of another, Senator R.V. Keane, and the reshuffling of the Chairmanship - H.C. Barnard replacing J.A. Perkins, who remained on the Committee. The reconstituted Committee on 14 October 1943 consisted of: H.C. Barnard (Chairman), Senate: W.J. Cooper*, D. Tangney; House of Representatives: F.A. Daly, L.C. Haylen, R.S. Ryan*, and Sir F.H. Stewart*.

* Resigned before 7th Report was presented (15 Feb.1944) 'on technical matters'.

3. P. Hasluck, The Government and the People, pp.366-9.

4. Members of the Conference held on 8-9 December 1943 were: 7 representatives of the A.M.A., 1 member of the N.H.M.R.C., 4 members of the Joint Committee's Medical Survey Committee, Directors of Defence and Medical Services. This conference appointed a sub-committee/consisting of 3 the Medical Planning Committe members of the Medical Survey Committee, 1 representative of

the Commonwealth Director of Health, 3 members of the Joint Committee, 3 members of the A.M.A. (The Committee's report was unanimous).

5. J.H.L. Cumpston, The Health of the People, pp.143-60,165-83.

6. Report of the National Health and Medical Research Council Eleventh Session, July 1941, and Twelfth Session, November 1941. Sir Raphael Cilento in conversation with the author, in Canberra, towards the end of 1965, took substantial responsibility for the radical emphasis of the scheme for a national salaried medical service. This could explain why Cumpston later attributed the plan to more radical elements in the N.H.M.R.C. In departmental circles, however, it was referred to as the 'Cumpston Plan'.
During the period under discussion the members of the N.H.M.R.C. were as follows: Representing the Commonwealth - Dr J.H.L. Cumpston, Dr. F. McCallum and Prof. H. Sutton (who was replaced by M.J. Holmes at the 12th Session); Representing the States: Dr E.S. Morris (N.S.W.), Dr H.N. Featonby (Victoria) Sir P. Cilento (Queensland), Dr A. Johnson (S.Australia) - replaced by Dr A.P. Smallwood at the 11th Session, Dr A.C. Atkinson (W.Australia), and Dr The Hon. J.F. Go (Tasmania); Dr H. Ritchie (Royal Australian College of Physicians); Prof. H.R. Dew (Royal Australian College of Surgeons); Prof. A.L. Mitchell (Australian University Medical Schools); Dr G. Newman-Morris (Federal Council of the A.M.A.) - replaced by Dr W.W. Simmons in 1943; R. Victor Wilson (Layman appointed by the Commonwealth), and Mrs I.H. Moss (Layman appointed by the Government).

7. Sixth Report of the Joint Committee on Social Security, Appendix C and D. pp. 39-48.

8. A.M.A., A National Health Service, October 1949.
Several sources of conflict and dissension surrounding the

various investigations should be noted. First, Dr Newman-Morris, the A.M.A. representative on the N.H.M.R.C., refused, on instruction from its General Secretary, to sign the 'Outline'. Second, the N.H.M.R.C. was criticised by the A.M.A. for exceeding its functions as an advising body. Third, the N.H.M.R.C. Chairman, Dr. Cumpston, refuted this criticism and insisted, in any case, that the 'Outline' was 'Tentative and readily susceptible of informed criticism and amendment'. Fourth, the N.H.M.R.C. was not officially involved in the deliberation of the Medical Planning Committee set up by the Joint Committee. Finally, the Joint Committee Chairman, H.C. Barnard, regarded the recommendation of a national medical service as incomplete.

9. Sixth Report, op.cit., Appendix C, p.44.

10. Sir Raphael Cilento, Blueprint for the Health of a Nation, pp.21-58.

11. Report of N.H.M.R.C., 24 July 1941, pp.5-8.

12. Seventh Report, op.cit., p.3.

13. Sixth Report, op.cit., p.45.

14. T. Hunter, 'Planning Health Policy in Australia', Public Administration, Autumn 1966, pp.323-5.

15. J.G. Hunter, General Secretary of the A.M.A. =to Dr G. Newman-Morris, 21 Nov. 1941. N.H.M.R.C. Nov. 1941.

16. Seventh Report, op.cit., p.4.

17. Sixth Report, op.cit., Appendix C, p.40, para 24.

18. B.M.A., A National Health Service, op.cit., p.12.

19. Sixth Report, Appendix C, op.cit., pp.43-44, para.32 & 57.

20. B.M.A., A National Health Service, op.cit., p.13.

21. Report of N.H.M.R.C., Nov.1941, Minutes, pp.1-17.

22. Sixth Report, op.cit., pp.17-18.

CHAPTER FIVE

LABOR'S AGENDA FOR A COMPREHENSIVE NATIONAL HEALTH SERVICE

1. Objectives

The Australian Labor Party was in office from October 1941 until December 1949, first under the leadership of John Curtin, and subsequently J.B. Chifley.

The direction which the Government would take was indicated by the Party platform and the decisions of Federal Conference. It will be remembered that national insurance had been a plank of Labor's platform since 1915; and the nationalisation of public health since 1919. Both these had been left intact throughout the thirties but the national insurance provisions had been expanded since 1936 to include the provisions for sickness, accidents, life and unemployment insurance. There was an attempt at the 1939 Conference to secure the repeal of this later addition on the grounds that Labor would do better to insist on the withdrawal of the unpopular 1938 Act rather than try to repair it. The motion was unsuccessful. Instead Conference decided to retain the plank on national insurance and to add the following words, 'to include benefits to dependents of the person insured'.[1]

Until 1945, the Government's main efforts were directed towards the successful completion of the war. But, from the beginning, close attention was given also to problems of social security and national health. On 8 October, a day after the Government was sworn in, the Minister for Social Services and Health, E.J. Holloway, indicated that the anomalies in the social system which the Joint Committee's investigations had underlined would 'receive almost immediate consideration'. A month later,

in answer to a parliamentary question concerning the Government's intentions on health, he revealed that Labor was actively considering the N.H.M.R.C. report and that, currently, it was before the Joint Committee.[2]

There was little parliamentary discussion on health in 1942 but the Government clearly had not been wasting any time. Chifley, who was then Treasurer, had by September of that year applied himself to the study of all the four Joint Committee reports which had appeared by that date. The Commonwealth sought from the States a reference of shared power in the field of National Health. And the Prime Minister announced, during his speech on the estimates on 22 September, that the Government 'was drawing together the threads of various inquiries'.[3] On 17 October, Chifley wrote to the Joint Committee asking for its advice concerning health measures which it might be possible to introduce during the period of war. As a result of this request the Joint Committee, between 1943 and 1945, produced its 6th, 7th and 8th reports on health.[4] On 11 February 1943, Chifley, now Minister for Post War Reconstruction as well as Treasurer, put forth his proposal for a National Welfare Fund to include 'health, sickness and other associated services'... 'The several health schemes', he said, 'will need much detailed preparation. It may be impracticable to introduce a complete new health service during the war'.

In the meantime, a special Conference of the Party was held in Melbourne in November 1942 and January 1943; and two decisions were taken directing the Government to undertake planning for post-war reconstruction and to 'bring in social insurance and health laws covering all forms of sickness, free ante-natal and post-natal treatment in maternity cases'. At the same time, the Conference endorsed the Party's platform dealing with

national insurance and the nationalisation of public health. In December 1943, at the Party's general Federal Conference, Senator Fraser, who had succeeded Holloway as Minister for Social Services and Health, moved and carried a motion to submit to Government the necessity to start immediately on a scheme 'whereby each individual will be given social and economic security' and the Federal Government be requested 'to introduce a comprehensive social security act providing for adequate old age and invalid pensions, unemployment benefits, medical and dental services, ~~unemployment benefits~~, motherhood benefits, etc.'

The 1943 Conference also called for a referendum to give Federal Government undisputed power, as tentatively approved at the Constitutional Convention in November 1942, over fourteen areas of policy under State jurisdiction including'national health in cooperation with the States.' The 1945 Conference called for a continuity of Labor Party policy on social security and urged Government to bring in measures not already passed. In view of the charges frequently made outside and inside Parliament that Labor intended to nationalise health services, it is of interest to note that Senator Fraser's motion in 1943 asking for immediate implementation of the Party's plank on nationalisation, was defeated. Both Curtin and Calwell spoke against the Minister's motion. The former on the grounds that the Government did not have the constitutional authority to control hospitals; the latter because it would jeopardise the attempt being made by Government at that time to secure the referral of powers from the States. It is also significant that, after 1943, although the plank on nationalisation remained intact there was no discussion of nationalisation of health at Party conferences.[5]
The 1948 Conference did pass a motion that Government should

take the necessary steps to ensure a comprehensive Commonwealth hospitalisation scheme, free and available to all, but there was no suggestion that existing State hospitals should be nationalised.

To revert for a moment to earlier Party decisions. In 1942 the Government had initiated two related and important moves which presaged extensive action on health. The first need only be mentioned here since it is dealt with in more detail in the following chapter. Doctor H.V. Evatt, Attorney-General and Minister for External Affairs, began in October and November 1942 to press his Government's case for a wide extension of Commonwealth powers either by a referendum or by referral from the States. Among the additional powers sought was 'national health in cooperation with the States'. The second measure was the establishment, in December 1942, of a new Department of Post-war Reconstruction with Chifley holding the portfolio in conjunction with that of Treasurer until 1945. The Department's main objectives were the planning of policies to attain full employment, a comprehensive national social security scheme, and the integration of domestic policies with Australia's wider international obligations. The successful implementation of these plans hinged upon the Government having extended constitutional powers. Hence the request for an amendment or a referral. In a financial statement in Parliament on 11 February 1943, Chifley proposed the foundation of a national welfare scheme to be developed in progressive stages which would be fulfilled after the war. The scheme was to include health, sickness, unemployment and other associated services. The several health service schemes, he said, would need much detailed preparation, and it might be impracticable to introduce a complete health service during the war. During the Parliamentary

discussions on the National Welfare Fund Curtin confirmed his Party's objectives - to lay the foundations of a better social order, to do away with disparity between rich and poor, and to produce a healthy, virile and contented nation.

By 1943, therefore, the Government had before it a series of directives from the Federal Conference, the reports of the Joint Committee, the N.H.M.R.C. outline and plans for reorganisation, and the A.M.A.'s 'Plan'. In addition, a great deal of thought and policy formulation was going on in the Departments of Post-War Reconstruction, Social Services and the Treasury. Indeed, the detailed working of much of Labor's social security programme, including some of the national health legislation, took place within a section of the Treasury under H.C. Goodes.[7]

In the election campaign of August-September 1943, Curtin's policy speech promised a comprehensive programme of post-war reconstruction including an expansion of social services and active pursuit of full employment as the main aim of economic policy. In 1946, Chifley's policy speech promised that if the social services referendum was carried a comprehensive national health service would be established.

2. Health, Social Security and Economic Policy

It will be apparent from the preceding resumé of Labor's platform and the Government's pronouncements and actions, that the establishment of a national health service was merely one aspect - albeit, important - of the Government's social security programme. This in turn was regarded as complementary and integral to its economic policy and both were designed as essential components of a collectivist, egalitarian social order. Chifley was the driving force behind the implementation of these three objectives. As Treasurer, Minister for Post-War Reconstruction and, finally as Prime Minister, he pressed his policies

and identified his views closely with that of the Party. Consider his statements on the inter-relation of economic and social policy as they appeared in three articles published in December, 1943. 'Full employment', he began, 'and social security must go hand in hand. Increased social security would maintain purchasing power and therefore employment. Full employment, in its turn, would keep the cost of social security to a minimum. The reports of the Joint Committee have acknowledged the community's responsibilities on health and social security. Agreement must [now] be followed by action. The gaps in the system must be filled and the whole welded into a comprehensive scheme'. He went on, 'In the past the need for coherence had been obscured by the division of social security and health functions between Commonwealth and the States. Developments in this field of policy have therefore been uneven and spasmodic. Only the national government can secure national standards and equity'. In a word, his Government's approach was national and comprehensive, where that of the previous governments had been sectional and piecemeal.[8]

Chifley regarded his economic and social policies as a means to the establishment of an egalitarian society. This was evident in his fiscal approach. In particular, he rejected contributory insurance as a method of financing social legislation on the grounds that the incidence of costs fell most heavily upon the poorer income groups, whereas employers could pass on some of the cost of their contributions in the form of higher prices. The most equitable method was (and it will be remembered his views were confirmed in the reports of the Joint Committee and the N.H.&.R.C.) a graduated tax on every income-earner, determined according to his capacity to pay. This was indeed, as Chifley explained, the rationale of his

Government's National Welfare Fund which had been enacted earlier in the year. The fund consisted of a specified annual grant from consolidated revenue of $60,000,000 or a sum equal to a quarter of the total income tax collected, whichever was the lesser. The ultimate objective was to finance all social and health services, as they were introduced, from this National Welfare Fund. Later, in 1945, as earlier foreshadowed by Chifley, the Government was able to go a step further in this direction. In an amendment to the National Welfare Fund Act, income tax was divided into two contributions. One of these was earmarked exclusively for social and health services; the other, for general appropriation purposes. In the year 1945-6, the amount thus directed to health and social security was $70 million. For 1946-7, $102 million was assessed as the sum likely to come from income tax. Thus health and social services acquired a financial basis derived, formally and specifically, from personal and corporate income tax. It was expected that, at first,the fund would build up credits to be used later when the full range of health and social services were introduced.

It is to be noted that the National Welfare Fund was consistent with, as well as an instrument of, Labor's collectivist objectives. In effect, each person contributed according to his means. At the same time, all had the assurance that their tax contributions entitled them to full access to the Government's comprehensive social security programme. As such, it differed from the individualistic orientations of all previous (non-Labor) legislation in recognising that fiscal policy could and should be harnessed to the pursuit of egalitarian social objectives.[9]

There were other contributions. In 1945 the proceeds of pay-roll tax, levied on employers, were also

directed towards the same purposes. This yielded a further $22 million in 1945-6. Then, as the demands of health and social services ran down the accumulated credits of the war years, it was contemplated that the fund and pay-roll tax should be further supplemented by grants, as required, from consolidated revenue. This reliance on three sources of revenue, resembling the tripartite scheme of the 1938 Act, led to the superficial observation by commentators that Labor's health and social services were being financed on a contributory basis. But such comment was both misleading and inaccurate. The beneficiaries of the legislation made no direct contribution other than in taxation; and, on the other hand, no benefit paid out was linked in any way with a contribution qualification. Indeed, Labor throughout its period in office frequently resisted pressure from the Opposition to finance its proposals by means of the orthodox contributory method. It held firmly to its collectivist point of view: that health and social services should be financed by taxes levied, so far as possible, according to ability to pay, thus providing an income redistribution effect.[10]

Chifley's pragmatic Fabian outlook may be seen in his approach to health policy, in his dealing with the A.M.A. and in the nature of the health legislation enacted by his Government. The second of these components will be examined in some detail in another chapter. But it is worth stating the conclusion at this point: the repeated attempts to secure even the minimum cooperation of the A.M.A. can scarcely be described as the action of a man intent on the abolition of private medical practice, despite frequent allegations from the Opposition as well as the A.M.A. that this was his intention. As to his views on private medical practice - and Chifley was unrepentantly outspoken here - he considered that the private

practice of medicine suffered, patently, from the same deficiencies as the free-enterprise economic system. It had shown itself unable to prevent, despite many advantages for the entrepreneurs (in this case doctors), social distress and economic hardship. Demonstrably, and the reports of the Joint Committee confirmed this, it was unable always to provide medical services in the right places and at the right times and at a cost which all members of society could afford.[11] The same sort of argument applied to other aspects of the private provision of health services. The manufacturers of pharmaceutical products and chemists could not, in a free market, provide medicines at a price which the public could afford. The situation was rather different, although still unsatisfactory, in hospital services. They were largely publicly owned, but arranged and financed in such a diverse and patchwork fashion as to preclude the certainty that facilities were properly distributed or integrated. There was mounting evidence of the anomalies to which this lack of organisation gave rise.

The solution, as Chifley saw it, was not complete government control of health services, but the provision by government of those services which could not be provided in the free medical market. This could be accomplished gradually. Chifley would have been the last to deny that some sacrifice of individual freedom would be necessary to secure greater medical welfare for all. But freedom in health matters, as in other fields, meant little if it led to hardship for many. Nor need the sacrifices be great. Professional groups could choose, for the most part, to pursue their vocations as before. But they would be asked to give a measure of cooperation in a government service. Those who wished to stay outside the service were quite free to do so. There was no reason why a private medical practice and private hospitals could not continue along-

side a government medical and hospital service.[12] Chifley probably hoped that, in the long run, an ambitious and successful government programme would encourage more and more medical practitioners and hospital authorities to join the government service. He was prepared to provide incentives to induce them to do so. But he was a sufficiently realistic politician to appreciate that such joint private enterprise and government action, no matter how desirable, was by no means certain.

The facts of political life would have forced a pragmatic approach on Chifley even had he not been so disposed. Social security was an integral part of his plans for post-war reconstruction. But the successful progress of many elements of these plans depended on the adequate and efficient release of manpower and resources from wartime employment. Chifley was well aware of these difficulties and the constraints they imposed. The first referendum (1944) asking for powers over 'national health in cooperation with the States' was, as we see later, unsuccessful. While the second referendum (1946) which did give substantial powers, was politically restrictive and gave authority to legislate for particular benefits and services - quite a different proposition from the power to legislate comprehensively for 'national health'. In his adaptation to the new circumstances, Chifley showed he recognised the constraints of the Constitution. Finally, there was the challenge offered by the medical profession which was demonstrated in the A.M.A.'s successive appeals to the Constitution in the High Court, its delaying tactics over the introduction of health insurance and pharmaceutical benefits and the outright refusal to operate the latter. It would have been folly, indeed, to persist with a plan fully to nationalise health in the face of these intransigent political forces. Chifley was no idealistic fool and made many concessions to expediency, as we shall see.

It is not very surprising to discover on examining Labor's record during 1941 to 1949, a period when it made great strides in the field of economic policy and other areas of social security, that health legislation emerges as piecemeal and ad hoc in character and does not match the Party's ambitious objectives. But, in view of the intransigent opposition, Labor could not go further. Two Acts - the Pharmaceutical Benefits legislation and the far-reaching National Health Service Act - never became operative. On reading the debates on the details of these legislative measures it constantly surprises that the Opposition could, consistent with intellectual honesty, reject them on the grounds that they were moves to establish socialised medicine. But emotion and political instinct ruled in this area rather than reason. It was a basic premise of the Opposition that the Labor Party policy was to nationalise, or 'socialise', everything.

Opposition fears were not entirely unjustified. In support of its position on health, members could point to the unchanged platform of Labor on the nationalisation of public health, the stated objective of some of Labor's members to the left of the party and the direction and quality of the legislative programme for public ownership enacted during Labor's term of office.[13] It must have seemed a safe assumption that, despite constitutional obstacles, Labor would go as far as it could in the direction of nationalising medicine. In answer to more pragmatic, realistic claims that the majority of Labor's measures were designed mainly to rationalise the very confused area of health legislation in Australia, the Opposition could state, with some reason, that it was by no means clear where rationalisation ended and nationalisation began. Thus, because nationalisation was assumed to be the ultimate objective, certain of Labor's proposals could not be, and

were not, assessed independently of the direction in which they were allegedly aligned. The Pharmaceutical Benefits proposals are a good example of sound legislation dropped (but later to be taken up by a Liberal-Country Party government) for ideological reasons.

3. Legislative and Administrative Action on Health[14]

The Maternity Allowance Act of 1943 was a non-controversial measure based largely on the recommendations of the Joint Committee and designed as complementary to the Menzies Government's Child Endowment Act of 1941 which gave universal allowances for each child after the first until it reached the age of sixteen. The Maternity Allowance Act provided a lump sum payment of $2.50 a week to all mothers, free of means test, over a period of eight weeks, four weeks before and four weeks after the birth of a child. Amending legislation, in 1944, extended the allowance to 'suitable aboriginal women' who did not come under State legislation. In 1944, a further amendment increased allowances in the case of multiple births. The 1947 Social Services Consolidation Act later made it possible for a single payment to be claimed and paid on the birth of a child extending eligibility to mothers temporarily absent from Australia and to aliens satisfying the conditions of twelve months residency. The Invalid and Old Age Pensions (Funeral Benefits) Act 1943 provided a grant towards funeral expenses of deceased aged and invalid pensioners of up to a total of £20. The Social Services Consolidation Act liberalised conditions precluding payment to agencies administering contributory funeral funds other than friendly societies. If the fund did not cover the cost of the funeral the balance, but not exceeding $20, could be paid.

The Unemployment Benefit and Sickness Act 1944 provided for payment of benefits after seven days for as

long as the period of sickness or unemployment lasted. The Act applied to males from 16 up to 65 years of age and to females from 16 up to 60 years of age, resident in Australia for at least twelve months, to Aboriginal workers and to other Aborigines who satisfied certain conditions as to their personal qualifications, and to those who 'by reason of age, physical or mental disability or domestic circumstances or any other reason...is unable to earn a sufficient livelihood for himself and his dependents'. The benefits were subject to proof of loss of income that the claimant was actively seeking suitable employment and that he was prepared to undergo necessary medical treatment to secure his return to work. The benefits were also subject to a means test based exclusively upon income, and subject to reduction if the person was receiving sick pay from other sources (except friendly societies). The Act excluded those receiving old-age and invalid or widow pensions, and married women who had been employed (unless they could show that their husbands could not support them). The Social Services Consolidation Act provided additional benefit where the wife was at least partially dependent on her husband; or for a housekeeper also dependent upon the man (but not employed by him), looking after at least one child under the age of 16. It also extended the period in which a claim must be lodged to obtain arrears, and excluded Commonwealth benefits under the Hospital Benefits Act and the Tuberculosis Act. Amending legislation in 1948, however, exempted reimbursements from medical, dental and other expenses. The Invalid and Old Age Pension (reciprocity with New Zealand Act) 1943 carried out an agreement with New Zealand for reciprocal recognition of qualifications for pension rights in the case of persons spending some parts of their life in Australia, and parts of it in New Zealand.

The Pharmaceutical Benefits Acts 1944-45-47-49 were designed to supplement sickness benefits and made available free medicines on receipt of a doctor's

certificate. The various amendments were made in an attempt to secure the cooperation of the A.M.A. in the scheme. The details of the legislation, and the High Court cases, are dealt with in the succeeding two chapters. The Hospital Benefits Act 1945-47-48 provided for a system of subsidies to public hospitals through grants to the States, contingent upon the latter giving free treatment in public wards of public hospitals without a means test. This was based on the scheme put forward by the Joint Committee.[15] The 1947 amendment made benefits available to Australian residents who are temporarily absent from Australia, and the 1948 amendment increased the subsidy from 60¢ to 80¢ a day but eliminated the arrangement under the original act whereby the Commonwealth undertook to reimburse to the States the amount lost to them in charitable donations as a result of participating in the scheme.

The Tuberculosis Act 1945-46-48 was based on the recommendations of the Joint Committee in 1943 and, in the same year, of the N.H.M.R.C. The main objective of the legislation was to supplement the free hospital scheme in relation to the problem of tuberculosis. Under the original act the Commonwealth undertook to pay up to a specified maximum of 50 per cent of State expenditure on diagnostic facilities, and a similar grant on after-care facilities. In order to encourage patients to stay away from their families in the second stage of illness, the 1946 amendment undertook to pay a special allowance in addition to normal invalid or sickness benefits to patients or to families of tubercular patients. The 1948 amendment was based on the report of H.W. Wunderley, Director of the Tuberculosis Division of the Commonwealth Department of Health and a medical authority on the illness, indicating the need for a more vigorous action to irradicate the disease. In return for State cooperation in an all

out campaign, the Commonwealth agreed to provide all funds for approved capital expenditure and all maintenance expenditure which exceeded a specified amount. The means test provisions were liberalised; and generous and flexible allowances were given to any person suffering from the disease and not simply those who were undergoing treatment in approved institutions. A National Tuberculosis Advisory Council was to be set up to coordinate activities consisting of Commonwealth and State Departments of Health and medical specialists in the disease. The Commonwealth Department of Health was made responsible for the overall administration and its State Directors for the medical aspects, the control of sanatoriums, chest clinics, x-ray centres, etc., and the Commonwealth Department of Social Services for eligibility under the means test, and the assessment of actual allowances. The Act was warmly supported by the States and, by the time the Labor Government went out of office in 1949, uniform agreements with each State were virtually completed.

The Mental Institutions Benefits Act 1948 also was designed to supplement the Hospital Benefits Act through agreement with the States that the Commonwealth was to provide free treatment to all patients in approved public institutions, free of means test. Mental patients in private hospitals were to be provided for under the Hospital Benefits Act.

In addition to the legislative measures just described, the Labor Government, during its term of office, initiated a number of activities through the Department of Health and other institutions.[16] For example, there was the establishment of the Commonwealth Acoustics Laboratory in 1942 to carry out scientific investigation, test pre-school and school children for deafness, fit and maintain hearing aids, test ex-servicemen referred by the

Repatriation Department and supply equipment for them, and assist the Armed Forces with investigations into noise problems. There was also, in 1944, the setting up of a Nutrition Committee of the National Health and Medical Research Council, on whose report the free milk scheme of 1950 was based. The School of Public Health and Tropical Medicine was extended in 1945. A Division of Child Health in the Department of Health was established in 1947; also an Institute of Child Health in association with the School of Public Health and Tropical Medicine in 1948. The Commonwealth Bureau of Dental Standards was established in 1947 in order to undertake research, to carry out surveys and to provide consultative services and testing facilities. A unit of Industrial Hygiene was set up in the Department of Health in 1948. The Commonwealth X-Ray and Radium Laboratories were expanded in 1946. The Commonwealth Health Laboratories were set up in Canberra and in a number of country towns between 1946-48.

4. A Charter of National Health - The National Health Service Act 1948(17)

The National Health Service Bill was introduced into the Senate on 14 November 1948. It passed its third reading in that chamber on 2 December, and on the same day it was introduced into the House of Representatives where, on 8 December the principle of the Bill was accepted by 35 votes to 17 (there were nine pairs). An amending Bill was passed in the following year on 27 October 1949 by a majority of twelve. The Labor Government fell from office in December 1949, but the Act remained on the Statute Book and was not repealed until 1953 when it was replaced by the Liberal-Country Party National Health Act upon which the present scheme is based. The Act provided that the Director-General 'may arrange' for a comprehensive set of health services, in all covering some nine general

categories: (i) a general practitioner and dental practitioner service; (ii) consultant and specialist services; (iii) opthalmic services; (iv) maternal and child health services; (v) aerial medical and dental services; (vi) diagnostic and therapeutic services; (vii) convalescent and after-care services; (viii) nursing services; and (ix) a medical service and a dental service in universities, schools and colleges.

To ensure the necessary supply of doctors, dentists and other specialists to operate the scheme, the government could itself erect and maintain its own hospitals, laboratories, health centres and clinics (section 4(a)). To ensure equipment it could enter the manufacturing side of various services if quality and quantity were not forthcoming at reasonable prices (section 14). It could also take over, by agreement, hospital and other medical and dental services provided by the States. It could make special grants to the States conditional upon their providing the services or facilities for the national health service (section 9(i)). And, it could make payments to universities to provide and assist investigation into research and provide courses in training in medical and dental science.

Doctors and dentists were to be encouraged to establish group practices (section 4(e)), but should they suffer loss in the value of their private practice through the establishment of government health centres, compensation would be paid, provided that the practitioner decided to serve under the national health service. A medical benefits scheme was to be established under the regulations to assist patients to meet the cost of these services, (section 22(a)(ii)). Government would pay direct to the doctor one half of his patients' medical fees. These fees were to be based on an agreed schedule and would also be

extended to specialists. Full-time salaries were to be paid only to outback medical practitioners and full-time specialists in hospitals, such as pathologists, medical superintendents and radiologists. Full-time specialists would be paid full-time salaries, others on a sessional basis.

There was to be national registration of dental and medical specialists, and in compiling the register government 'might' take account of similar lists drawn by other statutory and professional authorities. Extensive regulatory powers were given under the Act to define and implement the detailed provisions, including duties and functions of those involved in the operation of the service, terms and conditions of payment of doctors participating in the Medical Benefits Scheme, and for compensation to doctors and dentists whose practices were affected adversely by the establishment of the government centres.

The general administration of the 1948 Act was to be the responsibility of the Director-General of Health who must be a legally qualified practitioner of not less than ten years standing. It was intended to sub-divide the Department into a number of directorates to coincide with the development of the services. To link the profession with the administration, advisory committees were to be established in association with each directorate, and safeguards were to be provided against the abuse of the power to make regulations.

'This Bill', said Senator McKenna, 'marks the beginning of a period in which the resources of the Commonwealth can and will be directed to the prevention of disease, the promotion of positive health, and the treatment and cure of disease and disability. It is, in effect, the source of a charter of national health in the future'. The Government, he said, saw health as an integral part

of its social and economic policy. Hence the Bill had been preceded by a series of more general social security measures and, on the economic front, by a policy of full employment. Inspiration and assistance in the formulation of the plan had been derived from overseas schemes particularly those in the United Kingdom and New Zealand. This was especially so in the case of the proposed dental service. For example, to overcome extreme shortages of dentists, the government intended to train nurses who would be used exclusively for certain limited purposes, such as the supervision of child dental care. Nearer home, the investigations and reports of the Joint Committee had provided invaluable focus and direction to Government policy.

McKenna emphasised the implications of the fact that the proposed Act was an enabling Act, and as such it would set the broad outline of the proposed service, leaving the details of administration to be implemented by regulations. This would permit the government to continue negotiations with the dental profession, hospital authorities, Friendly Societies, any group of medical practitioners and the A.M.A. It was central to the Bill that these proposals could not be implemented in the absence of agreement with the bodies concerned. The Medical Benefits Scheme, which, despite previous, and later, controversy surrounding it, the government regarded as peripheral to the overall plan, was to be implemented when 'issues not yet resolved' had been 'fully discussed and agreed to'. Similarly, in the matter of acquisition of services or organisations from the States or other agencies in the health field, a likely development would be for the Commonwealth to make approaches to hospitals which were conducted by private bodies. And the Commonwealth, at its own expense, would provide and maintain diagnostic facilities where they had not been, up to that date, developed.

Since many years would be required to implement such a far-reaching scheme, some order of priorities had to be established. The first step was to be the development of medical facilities in the outback areas, in particular the flying doctor service and the mobile dental service. Next, to meet the need for increased numbers of qualified personnel in all areas of medical, dental and other activities concerned with health, there was to be a development of all types of training facilities at undergraduate and post-graduate levels. The medical benefits scheme would then be implemented as soon as possible. On the vexed question of nationalisation, McKenna was firm that the Government 'does not contemplate, nor in fact does the constitutional amendment recently sought and obtained permit, any nationalisation of doctors, dentists or members of allied professions or occupations... /the/ establishment of a complete national health service must be achieved by a process of gradual development.' Thus, despite the potential for extensive government participation in the production and distribution of health services, the co-operation of existing groups and institutions would be entirely voluntary. There would be, he concluded, 'no compulsion in taking over anything from the States or from denominations or other bodies in the health field'. Other government speakers on the Bill upheld and explained it in similar terms. Senator Arnold and H.B. Barnard, both of whom had served on the Joint Committee, were able to provide detailed insight into the conditions of the nation's health service which had prompted the Government's Bill. 'If I were asked to describe the /proposed/ act in one sentence', Arnold said, 'I would say that it is a recognition of vast needs and an acceptance of a great responsibility'.

Chifley's speech dealt, characteristically, with the human implications for the poorer sections of the community as well as for some in the middle income groups, of the high cost of medical care in the absence of a health service freely available to all. 'Is the Government to stand by idly and allow this burden to continue to be placed upon the people?' he asked. He had, over the preceding six months, taken the trouble to find out how medical practice operated in four States. Much of his speech was, therefore, taken up with concrete examples of individual cases of hardship and the anomalies he had observed in the then current practice of medicine. 'All the evidence', he said, 'points to the need which the Government's bill was designed to meet. He singled out medical specialists for special criticism. A government register was essential to overcome the widespread practice in all States except Queensland (where statutory provision is required for registration of specialists) of general practitioners setting themselves up as specialists without adequate training and qualifications. This was not to deny - and Chifley did not do so - the devotion to duty which the profession of medical practice demanded. 'But', he ended, referring to the organised medical profession, 'it will be a disgrace to the British Medical Association if that organisation refuses to cooperate with the government in the interest of humanity to put this scheme into effect'.

Opposition speakers, predictably, pointed to the spectre of socialisation allegedly presented by the Bill. Particular criticism fastened upon the 'inevitable inroads' which the medical benefits scheme would make into the privacy of doctor-patient relationships. Page was particularly critical on the extensive regulatory powers of the Minister. The absence of any indication as to how cooperation with the various groups was to be arrived

at also gave rise to some doubts. One member claimed, for example, that by making compensations to medical practitioners contingent upon their participation in the scheme, the Government was effectively exercising economic pressure upon them to force them to join. 'This', he said, 'was regimentation not so much by law but by economic pressure'.

The Opposition's most outspoken opponent of the Bill, not unexpectedly, was Earle Page. The scheme, he began, fell very short of the Prime Minister's promise 'that his Government would provide a medical and dental service that was completely free and of the highest technical efficiency'. 'Instead', he went on, 'we have a scheme which is half free, hopelessly inadequate and technically inefficient'. Having made this sweeping observation Page made no attempt to elaborate upon it. Instead he merely asserted that the Government could have had a service completely free and technically efficient had it taken the advice of the A.M.A. That organisation had emphasised a number of requirements which (by implication) Labor's policy did not meet: that the national health scheme should start with the prevention of disease; that government should employ existing State medical and hospital agencies; and that it should subsidise the latter rather than enter the field itself. The scheme also failed to provide, Page asserted, incentives to research, the maintenance of the doctor-patient relationship as it had grown up 'over the ages', and encouragement to voluntary organisations. In effect, Page was now advocating that primary consideration should be given to certain principles which were to form the basis of his own scheme, cooperative federalism, voluntary partnerships and incentives to individual effort.[18]

The main change made by the 1949 Amending Act was the replacement of the medical benefits clause (c) by

another designed to be more flexible. Doctors were to be permitted to charge a variety of fees, up to a specified maximum; and the Government undertook to give six months' notice of any predicted changes in the scale of fees and add mileage payment to existing fees. McKenna also gave specific assurances that the Government did not wish to and would not pry into the clinical conditions of patients. These concessions met with no additional enthusiasm. Senator O'Sullivan of Queensland moved the withdrawal of the Bill and a complete redrafting based on further negotiations. The motion was defeated and the Act was placed on the statute book.

In the general elections held a few weeks later, the Labor Party was defeated and the Liberal/Country Party returned to office. However, faced with a hostile Senate, Earle Page, who became Minister of Health, was unable to take the risk of introducing a new Act. This did not deter him from using the very extensive powers of regulation given under the Labor act - which he had so severely condemned. He was able within nine months of coming to office to establish and put into operation the first instalment of his own health scheme: the Pharmaceutical Benefits scheme came first in 1950, Hospital Benefits and Pensioner Medical Service in 1951, and in 1953 the Medical Benefits Scheme. In 1953 these schemes were consolidated into a single act of Parliament - the National Health Act. The basic principles and political justifications, as we shall see in Part 3, embodied the Liberal-Country Party's individualistic approach to health policy based on plans acceptable to the A.M.A.

CHAPTER FIVE (FOOTNOTES)

1. Report of Federal Conference of A.L.P. 1939, pp.69-73.

2. C.P.D. Vol.168, 1941, 8 Oct. p.773; 9 Nov.p.227.

3. C.P.D., Vol.172, 1942, 10, 22, Sept., pp.180-3; 647.

4. Appendix 'A', Joint Committee on Social Security, Sixth Report, 1 July, 1943, p.19.

5. Report of Federal Conference of A.L.P., 1942 and 1943. pp.16, 38, 40.

6. Ibid., 1948, p.30.

7. L.F. Crisp, Ben Chifley, p.189.

8. J.B. Chifley, 'Planning for Peace, 1943, pp.1-11.

9. The fund had the additional fiscal advantage that higher taxation rates helped to drain off excess purchasing power in an inflationary war-time economy.

10. T.H. Kewley, Social Security in Australia, pp.234-245.

11. C.P.D., Vol. 200, pp. 4155-61; Vol.201, p.1649.

12. See Chap.7.

13. G. Sawer, Australian Federal Politics and Law, 1929-49, pp.131-5; 159-66; 186-96.

14. T.H. Kewley, Social Security in Australia, pp.255-61; 63-4; 65-74; 87-92; 370-5.

15. See Chap. IV, pp. . .

16. Dept. of Health, Office Manual, 1954, pp.15-46.

17. C.P.D., Vol.200, 1948, pp.3372-3378; 3703-3726; 3832-74; 3929-35; 4133-4213; Vol.205, 1949, pp.1962-1974; 2062-3; 2227-2243.

18. See Chapter 8.

CHAPTER SIX

THE CONSTITUTIONAL ISSUE

The Australian Labor Party had always pressed for increased Commonwealth Constitutional powers. Soon after it took office in October, 1941, it initiated moves for a constitutional referendum. In addition to its own policy objectives on the domestic front, Labor had, on the international front, pledged Australia to implement the so-called 'four freedoms' Declaration of the Atlantic Charter, including the attainment of economic security and social justice in the post-war world, and for the purposes of post-war reconstruction. To secure these ends, Dr H.V. Evatt, Attorney General, introduced in October, 1942, a proposal to alter the constitution to give the Commonwealth necessary additional powers.[1]

1. Commonwealth Attempts to Secure Necessary Constitutional Powers 1941-45.

The States reacted with alarm at the wide range of powers involved (there were 14 in all) and especially at the possibility of a referendum being held during the war. To meet this latter difficulty, a compromise was devised. From 24 November to 2 December, 1942, a Constitutional Convention was held, consisting of members of both Government and Opposition in the Commonwealth Parliament and in the State Parliaments. At the Convention the Government gave up its plan to proceed with the referendum in return for an undertaking that the States would refer to the Commonwealth, under Section 51(xxxvii), the powers it wanted. They would be referred for a period of five years after the war ended.[2]

The case which Evatt prepared for extended social service and health powers was far from exhaustive; but one must remember that most of the reports of the Joint

Committee had not yet appeared. His main argument therefore was that the unevenness, as between States, of expenditure in both of these areas emphasised the need for a national plan.[3] Social services, he wrote, had been developed by the six State Governments and these had 'displayed varying degrees of enthusiasm. This variation in expenditures, as well as their different capacities to meet costs, meant that the provision of social services in practice differed widely. For example, Victoria, which had the largest taxable capacity, was spending less per head than any other State. This did not necessarily mean that the quality of its services was lower. But these wide discrepancies could not be ignored. Nor could the Commonwealth continue to rely exclusively on the Grants Commission to assist the weaker States. The solution was, rather, a national plan on social services to be carried out with the active cooperation of the States.

On health, the Grants Commission report of 1942 had demonstrated a wide variation in the per capita expenditure of all States which could not be wholly accounted for by differences in the methods of financing hospitals. In addition, the States differed in their assessment of the requirements of a progressive health policy. Nor could certain facilities such as fitness centres, child welfare and health centres, and measures designed to improve the standard of nutrition be provided by private enterprise. On health, as in other social services, the need for a national plan was demonstrable.

At the Convention, discussion on health was brief and non-controversial. Evatt elaborated the meaning which he attached to the phrase 'national health in co-operation with the States'. He was particularly concerned to reassure the States that there would be no usurping or duplication of State powers in this area; and to show that

federal agencies, such as the Department of Health, had already operated successfully on a national basis without interfering with the States. At the same time, he insisted that quarantine powers alone were insufficient to serve the objectives of the Commonwealth. 'There are, however', he said, 'many matters such as medical research and special medical services which may satisfactorily be dealt with from a national point of view in cooperation with a State or States.... That the proposed national health power will be exercised in cooperation with the States is ensured by the terms in which the power is proposed to be referred. The direct powers of the Commonwealth with regard to health, as the Constitution now stands, are limited by Section 51 (ix) to operate with some support from the commercial, industrial, defence and appropriation powers'.[4]

There seemed to be some reasonable indication that the States would not resist the efforts of the Commonwealth to extend its powers over health. At a meeting in November, 1941, the N.H.M.R.C., a Federal State body, had approved proposals for re-organisation of medical services and a tentative plan for a national salaried medical service. The report of this important N.H.M.R.C. session also contained extracts from press cuttings indicating the approval with which several State Premiers and Health Ministers regarded the possibility of the Commonwealth extending its health powers. 'The State Government', Tasmanian Premier, R. Cosgrove, had said, in September 1941, 'is prepared to introduce legislation to overcome any Constitutional difficulties if the Commonwealth took over all health services including hospitals'. C.A. Kelly, N.S.W., echoed this wish 'even though I may lose my job and the State Health Department its identity, I believe that the time has come when the health of the community must be a national concern and taken over by the Federal

government'. A.H. Panton, Western Australia, went furthest of all, 'I wholeheartedly agree', he said, 'that medical services should be nationalised'.[5]

The expectation that the States would agree to refer the requested powers was reinforced during the debates on the referral proposals held in the State Assemblies in 1942 and 1943. There was broad agreement on the need for extended Commonwealth powers over health. Little controversy arose on the subject. It was quite clearly regarded as being of secondary, even minor, importance compared to the other powers requested, the implications of which were so heatedly and extensively debated.[6] In the event, judgment on the other powers determined the issue, for it was a 'package' proposal covering all fourteen powers.

The vagueness of the term, 'in cooperation with the States', did, however, create some difficulties on health matters, especially for the convinced advocates of States' rights. South Australia's Bill contained the qualification, 'but so that no law made under this paragraph shall come into force until approved by the Governor-in-Council'. One member, alarmed by the alleged Socialist implications of the powers, claimed that they would suppress in all forms 'the private service of doctors'. One irate Tasmanian M.L.A. insisted, speaking on the same theme, that 'Comrades Evatt and Dedman had beautifully put it over the lambs at the Convention'. A New South Wales member predicted ominously that 'in cooperation with the States' would give the Commonwealth a 'blank cheque' to do as it pleased. And in Queensland concern was expressed on the point that there were no adequate guarantees that existing administrative agencies would not be duplicated; also, it was not clear whether, in the future, a State would have to consult the Commonwealth before it passed health legislation.

At a conference of Commonwealth and State ministers of Health towards the end of 1943, the States appeared rather more tentative. The proposed Hospital Benefits Scheme, at that time only in preliminary and informal stages of discussion, caused most concern. The need for financial contributions by the Commonwealth was strongly felt; but the desire of the States to retain as much control as possible equally so. Discussion therefore tended to centre, not on the general principles of a Commonwealth scheme, but on how to secure a suitable set of administrative arrangements which would not infringe State control. The Minister of Health for Queensland, which had its own free hospital system, was particularly adamant 'that it would not subscribe to two authorities'. The New South Wales Minister expressed scepticism about the idea of a free public hospital service and claimed that the abolition of the means test would exaggerate rather than improve the problem of hospital finance.

The 1943 Conference also discussed the N.H.M.R.C.'s 'outline'. Significantly, disagreement centred not on the scheme as such, but once again on the form of control. The Victorian and New South Wales ministers were intent on receiving assurances - and these were given - that they would not lose control of hospitals.

Despite this retreat from their apparent enthusiasm two years earlier, the States were nevertheless prepared to agree 'that the Commonwealth should lay down the broad principles of a health service and general hospital standards and, subject to their acceptance of these principles and standards, should finance the States under a system of grants in aid in order that uniformity of health service and hospital standards may be established generally throughout the whole of the Commonwealth'.[7]

The States, then, had some reservations about giving the Commonwealth increased powers in health matters. But it is extremely doubtful, had health been the only additional area in which the Commonwealth wished to legislate, that there would have been any fundamental opposition to it. The refusal of the States, by the end of 1943, to refer the powers tentatively agreed upon at the 1942 Convention was due, not to any overwhelming objections on health, but to the far wider implications of the other powers. In the event, only New South Wales and Queensland passed the legislation in the desired form. Victoria passed it conditionally - the Victorian reference became operative only if the other States would approve it in a similar form. South Australia and Western Australia passed it with substantial amendments. And Tasmania's Upper House blocked it completely.

In the light of this setback, the Labor Government decided to submit the issues to a general constitutional referendum. In February, 1944, Evatt brought down a Bill to alter the Constitution by adding the fourteen additional powers endorsed by the 1942 Convention, including 'national health in cooperation with the States or any one of them'.[8]

Evidently, between the draft Bill as agreed to at the Convention and the Constitutional Alteration Act put in the 1944 referendum, the original wording 'national health in cooperation with the States' had been changed. There was no discussion of this alteration during the Parliamentary debates but it seems likely that the Government, in the light of the State Parliaments' reaction to the referral powers, wanted to take the precaution of ensuring that it could, if the referendum passed, go ahead with the Commonwealth national health service with the cooperation of some if not all of the States. In the course of the debate Evatt was able to provide more cogent and

well-informed reasons for the need for extended powers than he had done in 1942. The Joint Committee had by 1943 produced its Sixth Report. The A.M.A. had provided its alternative proposals. The Government had been active at a departmental level, both in the Treasury and the Department of Post-war Reconstruction. Altogether, by 1944, ideas on national health had crystallized into plans. Watt was able to insist with conviction 'that if the plans.. ..of this Parliament are to be put into practice, it is essential that the Commonwealth should have the powers of leadership in the field of national health'. L.C. Haylen, the member for Parkes, put the case more lightheartedly though nonetheless effectively. As a member of the Joint Committee he had found, he said, that the health powers of the Commonwealth were limited 'to a little black box and a quarantine flag'. Additional powers were needed, he said, to enable the Commonwealth 'to play Santa Claus to the States - the only question is, whether Santa Claus will sleep with his whiskers over or under the sheet'.

During the Commonwealth debates on the 1944 Referendum Bill the health powers were once again asubject of minor importance. The main issues concerned the alleged socialistic implication of the other powers requested. Significantly, there were no voices raised during the brief discussion on health on behalf of States' rights. Moreover, R.G. Menzies, who was subsequently to be an eloquent and effective defender of the idea of cooperative federalism, was at that time so convinced that the powers over health should be national, that he was in favour of giving them without the additional qualification, 'in cooperation with the States'. 'If health was a fit subject for national treatment', said Menzies, 'it ought to be within the power of the Commonwealth without this qualification that is attached to it relating to the States'. Page also supported the latter proposal and explained

that the whole idea 'was to secure cooperative action by Federal and State authorities'.

Despite almost universal opposition to the Bill as a whole from non-Labor parties (who had supported the referral proposals in 1942) the Bill was carried in the House of Representatives by 44 to 18 votes. The Senate passed it with a bare majority of 2. At the referendum held on 19 August, 1944, an overwhelming majority voted against it and, of the States, only South Australia and Western Australia voted for it.[9]

2. The First Pharmaceutical Benefits Case 1945.

In the meantime, in April, 1944, the Labor Government passed a Pharmaceutical Benefits Act as the first instalment of its plans for a comprehensive and free national health service in Australia. The Act provided for free medicines to be made available on the production of a doctor's prescription. This apparently innocuous piece of health legislation was immediately opposed by the A.M.A. which alleged that the vocational freedom of its members was severely restricted by the measure. It refused to implement the Act and sought legal advice which supported the view that the Commonwealth Government did not in fact have direct power to legislate in the area of social and health services. The Medical Society of Victoria then asked the Victorian Attorney-General to become the nominal plaintiff in a High Court action, with the Medical Society as relater, on the grounds that the Act was ultra vires the Commonwealth Parliament. The case came before the High Court on 19 November, 1945.[10]

The first issue to which the case gave rise was whether the Attorney-General of any State could invoke the Constitution to challenge Commonwealth legislation which affected the citizens of his State (in this case the [illegible]) as distinct from the State Government. The

Government contended that the Act involved mainly administrative action and the expenditure of money, that there was very little coercive power and that it did not interfere with any public rights of citizens nor infringe upon the legislative province of the State of Victoria. Quite apart from this the Government pointed out that the Parliament of Victoria had not yet legislated in the field which was alleged to have been invaded by the Pharmaceutical Benefits Act. The Court, however, took the view that if the legislation was ultra vires of the Commonwealth it must be an invasion of the public rights of the citizens of the State.[11]

On the second issue, whether the Pharmaceutical Benefits Act was authorised under the powers granted, the Commonwealth invoked both Section 81 and Section 51(xxxix) of the Constitution to uphold its right to legislate. Section 81, it claimed, gave it power 'to appropriate... for the purposes of the Commonwealth' and pointed out, accurately enough, that all previous social legislation other than invalid and old age pensions, had been covered by this Section. Section 51 (xxxix) gave the Commonwealth additional power to impose regulations on 'matters incidental to the execution of any power vested by this constitution in the Parliament'.

Section 81 raised the important question 'What were the purposes of the Commonwealth?' and what authority could determine these purposes? The natural answer to the latter question, said Chief Justice Latham, was the Commonwealth Parliament, which had, he held, a general and not a limited power. 'It was general in the sense that it was for parliament to determine whether or not a particular purpose should be adopted'. This conclusion, however, related only to laws providing for the expen-

diture of money. No matter how wide the power itself might be, it did not enable the Commonwealth to extend its powers beyond those defined by the Constitution. Thus the appropriation of money to reimburse pharmacists for medicine they had dispensed would be a valid exercise of power.

Nevertheless, the Act went beyond the mere appropriation of money. It imposed duties upon medical practitioners and chemists, subject to penalty. These provisions could not be regarded as incidental to the expenditure of money. They were, rather, incidental to the purpose for which the money was to be expended, that is, pharmaceutical benefits. 'The Commonwealth has no general power to make laws for that purpose and therefore has no power to make laws incidental to that purpose'. Section 51(xxxix), therefore, could apply only if there were already power to make laws of such incidental purposes. The Commonwealth did not have that power and therefore the Act was unconstitutional. The Chief Justice summed up the views of the Court thus: 'The Act is far more than an appropriation Act. It is just the kind of Statute which might well be passed by a Parliament which had full powers to make such laws as it thought proper with respect to public health - doctors, chemists, hospitals, drugs, medicines, medical and surgical appliances. The Commonwealth Parliament has no such power'. Justice Dixon was even more specific, 'though the expenditure of money was indispensable to the Act, it contained a general legislative plan covering much more than the spending of money and involving, moreover, control and regulation by law, operating directly upon the individual'.

The Pharmaceutical Benefits Act was now unconstitutional. But there were more serious repercussions for the Government from this decision. Chief Justice

Latham and Justice McTiernan had taken a more extensive view of the scope of the power to spend than other members of the Court. Justices Starke and Williams, by contrast, maintained that 'the purposes of the Commonwealth' in Section 81 were limited to those granted elsewhere in the Constitution, in Section 51 for example. Justice Williams was firm that 'these purposes must be found within the four corners of the Constitution'. Justices Dixon and Rich did not commit themselves quite so firmly. But their arguments suggested that, if the case had hinged on this important point, they would have come down on the side of Williams and Starke. It was this divergence among members of the High Court which threw into doubt the validity in law of the Government's other social legislation, that is, other than its stated plans on national health. If the Chief Justice's rather liberal interpretation had been shared by other members of the Court, doubt about any other legislation probably would not have arisen. But, after the pharmaceutical benefits decision, there was a strong likelihood that, if questioned, services such as widows' pensions, unemployment and sickness benefits could come to be regarded as unconstitutional.

3. The 1946 Referendum.

The danger may have seemed much greater then, but it now appears unlikely that anyone would have had a sufficiently strong motive to question the validity of the existing social services legislation - as strong, for example, as the A.M.A.'s motive in challenging the free medicine scheme. Besides, social service payments, the legality of which came into doubt, were already being paid. The Labor Government, nevertheless, made the most of the situation provided by the decision on pharmaceutical benefits and, backed by legal advice,[12] pressed for another attempt to secure an amendment to the Constitution to establish

once and for all its unassailable authority to legislate for the provision of social services. In 1946 it introduced three further and separate Constitutional amendment bills - one on organised marketing, another on industrial employment, and the third on social and health services. (The Constitutional Alteration, Social Services, Bill). 'This decision', Evatt said in Parliament, [referring to the Pharmaceutical Benefits Case], 'makes the social services amendment the only one which is urgently necessary since it throws serious doubt on the validity of a number of acts on the Commonwealth Statute Book'.[13]

In the referendum proposals of 1944, Labor had asked for blanket approval of a list of fourteen powers. In 1946, the range was altogether more modest and the three proposals were listed separately, so that the fate of one did not depend on that of the others, as had been the case two years earlier. On health, the powers asked for, and subsequently given, were much more specific. The words 'national health in cooperation with the States or any of them' had been replaced by...'pharmaceutical, sickness and hospital benefits, medical services (but so as not to authorise any form of civil conscription), benefits to students and family allowances'. It might be said that the concept as well as the words was, by implication, also more limited.[14] But one must remember that by 1946, it was becoming apparent to Labor that comprehensive health objectives might not be attained, at least in the short run. Certainly, there was enough opposition from the A.M.A. by that time to underline the difficulties. Caution, induced by this situation, may have been the reason that the phrase 'national health in cooperation with the States' was replaced by a statement of specific services.

If the Opposition was aware of this modification in objectives it chose to ignore them. Strong objections were raised in Parliament to the 'lumping together of health services for which the Government had not yet legislated with other social services which were already operating'.[15] John McEwen claimed that 'Parliamentary practice made it improper to tack one thing on to the other'. Further, he said, the Government was forcing the voter to choose between losing his present social service benefits and giving the Commonwealth additional powers over health benefits, about which there was in certain sectors, more controversy. Besides, he went on, it was extremely unlikely that social services would be challenged, however doubtful their legality. Meanwhile, nothing should be allowed to jeopardise the chances that the social service powers would be granted by the 'stupid cunning political tactics of a Labor government in its endeavour to invoke the opportunity presented by this so-called doubt to trick the people into voting for additional powers which would enable it to take under its control the whole of the administration of sickness and hospital benefits, and medical and dental services'. McEwen subsequently moved an unsuccessful amendment that the bill 'be withdrawn and redrafted as two bills: the first dealing with the provision of the maternity allowances, widow's pensions, child endowments, unemployment, benefits to students and family allowances; and the second dealing with sickness and hospital benefits and medical and dental services'. This amendment was defeated by 43 to 15 votes.

Earle Page moved, also unsuccessfully, that health services be kept out of the referendum proposals. With apparent disregard for his contrary statements in 1944 (that the words 'in cooperation with the States' were strictly unnecessary) he now insisted that the proposed

amendment would override State legislation. It would be better, he claimed, to have a special referendum on public health.

But it was Menzies, not Page, who came to the rescue of the organised medical profession on this occasion. He insisted that the health powers, once passed, would give the Labor Government power to nationalise medicine and dentistry. Arguing by analogy with a recent High Court decision on airlines, that the trade and commerce power gave Government the power to set up its own airline, he said, 'apply this to the power to provide medical and dental services...and very little doubt exists that not only the words of the proposed amendment but also the decision of the High Court will mean that...the medical and dental profession could be nationalised by making all doctors and dentists members of the government service which had a monopoly of medical and dental treatment. In that sense this power includes a power to nationalise medicine and dentistry'. Rather than take this risk, he argued, it would be preferable to expand or clarify the Commonwealth Government's insurance powers under Section 51(xiv) of the Constitution, which gave powers over 'insurance, other than State insurance; also State insurance extending beyond the limits of the State concerned'.

This particular possibility does not appear seriously to have been contemplated. Another, more powerful, alternative was adopted. On Wednesday 10 August, 1945, Menzies moved the important 'anti-civil conscription' qualification to the referendum proposals. 'I move that in the proposed new paragraph after the words "services" the following words and brackets be inserted: "but not so as to authorise any form of civil conscription"'. A similar form of words had, he said, been used in the Constitutional Alteration (Industrial Employment) Bill

which asked for powers over 'terms and conditions of employment and industry but not so as to authorise any form of industrial conscription'. Menzies did not conceal that his main objective was to ensure against any possibility that the medical and dental profession would be nationalised. 'So long as there is a doubt, and I entertain grave doubts on the matter, as to whether that power does not authorise the nationalisation of the two professions, their members are entitled to be protected against conscription just as are industrial workers under the Bill I have mentioned'.

Dr Evatt accepted the amendment in good temper and without question. 'I have given consideration to the amendment of Mr Menzies which was circulated some time ago. It is perfectly true, as the Rt. Hon. Gentleman said, that he has borrowed certain words from the Bill dealing with industrial matters, but the Government had previously borrowed the same set of words from the National Security Bill introduced by the Rt. Hon. Gentleman when he was Attorney-General. I believe that one good turn deserves another and if industrial workers are entitled to be protected against conscription, members of the medical and dental profession are entitled to similar protection. I therefore have pleasure in accepting this amendment'.

In the light of subsequent events - the A.M.A.'s successful resort to the Constitution on this very issue only two years later - Dr Evatt's acceptance of this change, apparently without questioning the Opposition's motives, is surprising and difficult to explain. There are various possibilities. Evatt's own explanation, which he gave in Court during the Second Pharmaceutical Benefits Case, was that it proved beyond doubt that the Government did not envisage any form of compulsion insofar as the profession was concerned. Doctors could elect, if they so wished, not to use the Government's scheme.

It may also have been that Evatt felt that the anti-civil conscription proviso was the necessary concession to the rising tide of opposition to Labor's other socialistic policies. Some argued that these would involve continued direction of labor after the war. On the national health scheme, a national medical service designed to man adequately improved facilities throughout Australia might similarly require the Government to direct medical practitioners to country and outback areas where shortages were greatest. Or finally, the Government may simply have judged the proviso a concession essential to ensure the passage of the 1946 referendum.

Whatever the motive, the effect on Labor's national health objectives, in general, and on pharmaceutical benefits legislation, in particular, was fatal. Evatt, by accepting the proviso, provided the opportunity for an important qualification, possessing only dubious and temporary justification, to be enshrined in a Constitution which traditionally has been almost impossible to amend. Quite apart from its immediate objectives the proviso remains, therefore, an institutionalised and major obstacle to national legislation on social and health services.

The Referendum proposals, to give government power over industrial employment, organised marketing, and certain social services, were put to the people on the same day as the Federal election on 28 September 1946. Only the social services powers were granted. These secured a majority in all States and a popular vote of 2,297,934 to 1,927,148. The Australian Constitution had been amended for the fourth time since 1901 and the Commonwealth Government now had power 'subject to this Constitution... ...to make laws for the peace, order and good government... with respect to the provision of maternity allowances, widows' pensions, child endowment, unemployment, pharma-

ceutical, sickness and hospital benefits, medical and dental services (so as not to authorise any form of civil conscription) benefits to students, and family endowment.[16] At the same time, the Labor Party won a decisive electoral victory. It therefore had the assurance that its social security measures, and particularly those passed between 1941 and 1946, would not be invalidated. It had also the authority to go ahead, subject to the anti-civil conscription proviso, with its pharmaceutical, dental and medical services. Or so it seemed.

The Second Pharmaceutical Benefits Case 1949

But the constitutional repercussions generated by the Government's health legislation were not at an end. Relations between the A.M.A. and the Labor Government continued to deteriorate.[17] In July 1949, the Government passed its fourth Pharmaceutical Benefits Act. But Federal Council of the A.M.A., now armed with the anti-civil conscription proviso, was ready for yet another legal fray. For the second time within five years it challenged Labor's legislation. On 7th October 1949, almost one month before Labor fell from office, the High Court of Australia declared that clause 7(a) of the 1949 Pharmaceutical Benefits Act contravened the anti-civil conscription proviso of the 1946 amendment to the Australian Constitution and was therefore invalid. The Court's decision creates a legal precedent. The A.M.A. or any other professional group, or the States themselves, could, in the future, advance a claim that similar types of social legislation constitute civil conscription. The issues involved in the case therefore are worth clarification.[18] The A.M.A.'s case against the Government was based on three main arguments.

First, and most important, was that Section 7(a) of the Act, by requiring medical practitioners to write out prescriptions on a prescribed form, therefore making this procedure compulsory, became contrary to the 'anti-civil conscription' proviso of the 1946 amendment. Second, the Act tried to control matters which were exclusively within the sphere of State legislation, such as the standard of drugs, sale of poisons and control of hospitals. More specifically, the Act purported to acquire property on behalf of the Commonwealth without providing for 'just terms' within the meaning of Section 51 (xxxi) of the Constitution. Third, such provisions of the Act as related to suspension or revocation of the approval of chemists and medical practitioners purported to confer non-judicial power in State Courts, whereas Section 77 (iii) permits only the investment of judicial power. Besides, there were a number of sections of the Act, and of the regulations, which were not within the incidental power conferred by Section 51 (xxxix) of the Constitution.

The main question concerned the scope and effect of the proviso 'but not so as to authorise any form of civil conscription'. Punctuation provided an initial and apparently extreme source of disagreement. The absence of a comma immediately before the proviso was taken by a majority to mean that the proviso phrase applied only to medical and dental services and not to all the other services and allowances. C.J. Latham maintained that it did not and that it must be taken to refer to all the services, allowances and benefits over which the Commonwealth since 1946 had power to legislate. It was not reasonable, he argued, to base the scope of a Constitutional power on the presence or absence of a comma. The others disagreed and took a strict grammatical interpretation despite the disclaimer by Justice Rich that

'any suggestion that the spasmodic sprinkling of commas by draftsmen, printers and proof readers should dominate interpretation'.

Once this preliminary question was settled, the Court had to establish the meaning of the term 'civil conscription' and whether this applied to the Act. The novelty of the phrase in itself created some difficulties of interpretation.[19] It was taken by a majority to mean 'the compulsion of law which requires that men should engage in a particular occupation, perform particular work, or perform work in a particular way'. The obligation imposed on a doctor to write his prescription in a specified manner - on a special form - compelled him to work in a particular way and was, therefore, contrary to the anti-civil conscription proviso. Latham emphasised this point by referring to laws which would <u>not</u> amount to civil conscription. For example, a law forbidding a person to make up a prescription or sell specified articles unless duly qualified was simply a law forbidding a person from practising as a medical practitioner unless qualified.

It is worth noting that two judges disagreed with the analysis of the meaning and application of the proviso. Justice Dixon, for example, held that Section 7(a) was part of the incidental machinery of the plan to provide pharmaceutical benefits; while Justice McTiernan agreed that it was no more logical to label the filling in of a form as 'conscription' as, say, filling in an income tax form, which was also subject to penalty. He also held, but he was the only member of the Court to do so, that the power to make laws with respect to the provision of Pharmaceutical Benefits was completely unfettered by the restriction on civil conscription. These, he argued, applied only to laws providing for medical and dental services. Neither of the laws in question

would **compel** a person to work as a pharmaceutical chemist or to practice as a doctor.

On the other hand, as Latham pointed out, 'conscription (compulsory service) may be partial or complete. It may control a man in relation to all his services in a particular occupation to which he is assigned or it may control only some of the services rendered or the work done by him in that occupation. In my opinion the limitation imposed by the words "but not so as to authorise any form of civil conscription" were intended to prevent not only civil conscription in its complete form of enrolment of masses of men for compulsory full-time civilian service, but also to prevent any form whatever of compulsion to render any particular service to the community. The words "any form" are important. They show that Parliament intended that any service to which the limitations applied should be completely voluntary and not procured by compulsion of law'.

Apart from this one clause, however, the Court upheld the validity of the Act in all other respects.[20] In particular, the Court confirmed the Commonwealth's power, given by the 1946 referendum, to make laws for the provision of pharmaceutical benefits, to provide these benefits out of public money and even to impose certain conditions. However, there was no power under the Constitution to make laws which allowed 'any form whatever of compulsion to render any particular service to the community'. The Pharmaceutical Benefits Act, if it took effect, could only do so on a voluntary basis.

From the preceding description of the course of events, on the Constitutional front, it is apparent that the Australian States as such were not the initiators of formal protest against the Commonwealth Government's

attempt to extend its health powers. Indeed, during the crucial years between 1941 and 1946, they were broadly in agreement with the principle of extended central government powers and action. And discussions between States and Federal Ministers of Health reinforced this conclusion.[21] The prime movers in the Constitutional debates were the A.M.A. whose refusal to countenance, to them, Labor's objectionable legislation, set in motion a chain of events with consequent Constitutional repercussions which could scarcely have been anticipated. It is to a detailed examination of the conflict on the political front between the A.M.A. and the Labor Government that we must now turn.

TABLE II TO CHAPTER SIX

LEGAL OPINION ON THE CONSTITUTIONALITY OF COMMONWEALTH SOCIAL SERVICE LEGISLATION 1946*

Act	Sir Robert Garran, K.C.	Mr Maughan, K.C.	Mr Barwick, K.C.	Mr Ham, K.C.	Dr Coppel, K.C.
Maternity Allowance Act 1912-1944	Validity insecure	Validity doubtful	Validity doubtful	Invalid	Probably invalid
Child Endowment Act 1941-1945	Validity insecure	Validity doubtful	Validity doubtful	Invalid	Probably invalid
Widows' Pensions Act 1924-1943	Validity insecure	Validity doubtful	Validity doubtful	Invalid	Probably invalid
Unemployment & Sickness Benefits Act 1944	Validity doubtful	Validity doubtful	Validity doubtful	Invalid	Probably invalid
National Welfare Fund Act 1943	Valid	Valid	Valid	Valid	Fund can only be applied in accordance with valid Acts
Invalid and Old-age Pensions Act 1908-43 (Parts IVA and VA)	Valid	Validity doubtful	Valid	Valid	Valid
Science and Industry Research Act 1920-1939	Valid	Valid	Valid	Invalid	Invalid

(continued overleaf)

* Source: C.R.D. Vol.186, p.486

Act	Sir Robert Garran, K.C.	Mr Maughan, K.C.	Mr Barwick, K.C.	Mr Ham, K.C.	Dr Coppel, K.C.
Education Act 1945	Probably valid	Valid except sections 5 to 7, 14(b),(c)	Valid except section 14(b),(c)	Invalid	Invalid except as to educational training of discharged members of the Forces and education in the Territories.
Hospital Benefits Act 1945, Sections 4 & 7 (in relation to private hospitals)	Validity insecure	Validity doubtful	Invalid	Invalid	Valid except section 4.
Re-establishment and Employment act 1945 (in relation to expenditure for the benefit of persons other thandischarged members of the Forces (see Part II, Division 5, & Parts III and IV)	Part II: Division 5 - Valid. Part III: Validity insecure. Part IV: Validity insecure but section 61 invalid also section 27 invalid.	Valid insofar as the they apply to members of the Forces or persons in similar position.	Valid insofar as they apply to members of the Forces and civilians who have been engaged in war work.	Valid except Part II, Div: 5, Part III, (except as to persons who were members of the Defence Forces), Part IV, VIII and XI, but invalid Parts severable.	Valid except Part II, Division 5, Parts III and IV to the extent to which they deal with persons who are not discharged members of Forces or civilians who have been engaged in war work.
Medical Research Endowment act 1937	Valid	Valid	Valid	Invalid	Valid
National Fitness act 1941	Valid	Validity doubtful	Validity doubtful	Invalid	Valid

TABLE III TO CHAPTER SIX

DIVISION OF COMMONWEALTH AND STATE HEALTH FUNCTIONS

COMMONWEALTH	STATE
National Health Benefits	Environmental Sanitation
Tuberculosis	Control of food, drugs, poisons
Public Health, e.g.:	Control of infectious diseases (compulsory notification of disease)
(1) Compilation of a C'Wealth poisons register.	Maintenance and control of hospitals
(2) Reports and agenda for N.H. & M.R.C.	Maintenance and control of mental health institutions and administration of legislation on medical health
(3) Immigration medical service.	Responsibility for the special measures with regard to the health and welfare of mothers and babies, including baby health clinics, ante- and post-natal clinics, and other measures
Quarantine	Responsibility for the operation of bodies regulating the professional groups in medicine, doctors, nurses, pharmacists, opticians
Therapeutic Subsidies	Administration of national campaigns for the eradication of disease
Territory Health	Health of School Children
National Fitness	
Nursing	
Commonwealth Health Laboratories	
School of Public Health and Tropical Medicine	
Institute of Child Health	
National Biological Standards Laboratory	
Commonwealth Acoustics Laboratory	
Commonwealth X-ray and Radium Laboratory	
Commonwealth Bureau of Dental Standards	
Institute of Anatomy	
National Health and Medical Research Council	
World Health Organization	
Commonwealth Grants	

Sources: (1) Annual Report, Commonwealth Director-General of Health, 1966-7.
(2) R.N. Spann (ed.), Public Administration in Australia, p.142.

FOOTNOTES (CHAPTER SIX)

1. W.S. Livingston, Federalism and Constitutional Change, pp. pp.124-27.

2. Section 51(xxxvii) reads:- 'The Parliament shall, subject to this Constitution, have power to make laws for the peace, order, and good government of the Commonwealth with respect to matters referred to the Parliament of the Commonwealth by the Parliament or Parliaments of any State or States, but so that the law shall extend only to States by whose Parliament the matter is referred, or which afterwards adopt the law.'

3. H.V. Evatt, Post-War Reconstruction - a Case for Greater Commonwealth Powers, 1942. pp.70-74.

4. Commonwealth of Australia, Convention of the Representatives of the Commonwealth and State Parliaments on Proposed Alteration of the Commonwealth Constitution - Report of Proceedings, Canberra, 1942, p.154.

5. Report of the National Health and Medical Research Council, 12th Session, 1941. Minutes, pp.18-19. It should be noted that all the Premiers mentioned were Labor.

6. There are few / references to National Health in the Legislative Assemblies - my account is based on references which may be found (though it is not a profitable exercise) in (a) N.S.W. P.D. Vol.169, 1942, pp.1345, 1364. (b) Victoria P.D. Vol.214, 1942, pp.2389-90, 3011-18. (c) Queensland P.D. Vol.180, 1942-3, p.1510, Vol.179, 1942-3, p.834. (d) Tasmania Mercury, 16 December 1942, 21 January, February 13/14, March 14, 1943. (e) S.A. P.D. Vol.2, 1942-3, pp.1714-97, p.1829.

7. Conference of Ministers of Health of the Commonwealth and States of Australia, Canberra 1943, Resolution No.2.

8. C.P.D., Vol.177, 1944, pp.151, 464-6; 1078; 1101.

9. No 2,305,418; Yes, 1,963,400.

10. Attorney-General v. Commonwealth. Australian Law Journal, Vol.19, 21 December 1945, pp.279-284.

11. In the U.S.A., unlike Australia, an Attorney-General may only challenge federal legislation on behalf of his own State government. A.H. Birch, Federalism, Finance and Social Legislation, p.155.

12. See Table II, p.157.

13. C.P.D.Vol.186 (1946), pp.486, 896, 900, 990, 994, 1044-45, 1051, 1193, 1194, 1213-15.

14. This point has been made by at least two authorities, and has some interesting legal implications. The National Health Service Act passed in 1948 gave the Director-General power to provide for 'a national health service' as well as for a medical benefits scheme and to make arrangements with the States to provide the service. (See Chap.5.) The Liberal-Country Party Act of 1953 has eliminated the word Service but some of the wording contains verbal ambiguities which might be brought into question in certain circumstances. J.H.L. Cumpston in his Health of the People pp.244-54 claims that the Labor Act and to a lessr extent the Liberal-Country Act have gone beyond the powers given in the 1946 referendum. P.D. Phillips, K.C., has also raised a doubt about the extent to which an amendment providing for certain benefits might provide limitations of the Commonwealth's Constitutional Powers. See P.D. Phillips Federation and the Provision of Social Services, in A.H. Hancock, The National Income and Social Welfare, pp.39-60.

15. C.P.D., Vol.186, 1946, pp.1044-1215.

16. Sec.51 xxiii(a). See also Table III, p.159.

17. See Chapter 7.

18. Australian Law Journal, Vol.23, 1949, pp.389-91 and Commonwealth Law Reports, 79, 1949.

19. The National Security Act 1939, Section 5(7) (a) had introduced the phrase 'industrial conscription' but no judicial pronouncement on the meaning of the phrase was ever given. The Court, therefore, had no precedent on which it could draw.

20. The A.M.A. tried to prove the Act invalid on no less than seven clauses and twelve of the regulations! P.D. Phillips, K.C. who acted as Counsel for Victoria in the 1945 case has aptly commented 'The factual basis upon which the debate was passed was so narrow as to seem almost subject for derision', and that 'the judgements do not reveal that very able tribunal at its best'. P.D. Phillips, Federation and the Provision of Social Services' in Hancock(ed) The National Income and Social Welfare, pp.39-60.

21. Commonwealth of Australia, Conference of the Ministers for Health of the Commonwealth and States of Australia, 1944, 1946. One cannot of course be certain that the States would not in the event have taken objection to the 1948 National Health Service Act.

CHAPTER SEVEN

THE A.M.A. AND THE POLITICS OF NON-COOPERATION

The National Health and Medical Research Council proposals for a salaried medical service appeared in November, 1941, and were printed and widely publicised in the Medical Journal of Australia. From the profession's point of view they were as radical as they appear to have been unexpected.

Dr Grieve drew together the criticisms of his colleagues and, in a revealing letter in the Medical Journal of Australia in November, 1941, set the tone and flavour of the medical practitioners' position. 'There is much loose thinking on the future of medicine in Australia and much looser talking and writing...There are two main themes, whether the author be a Minister of State nurtured in nationalisation, a government medical officer who has never practised medicine, or even an occasional correspondent in the Medical Journal of Australia. The one is that the present organisation must be superseded by a 'Nationalised Health Service', the other that the extravagant statement of policy by various governmental authorities...should be accepted as accomplishments of policy, that nationalisation being inevitable, men in medicine should, in a variety of ways and degrees, emulate the men of Vichy'. There followed a highly eulogistic statement of the ideals of medicine and a Burkean defence of the status quo....'Why do they [the Government] seek to destroy an organisation full of enterprise and high purpose, built up over a century by splendid, useful, evolution and ever ready to help in further advances... On the whole question, then, there can be no surrender nor any betrayal of an efficiency built up patiently over the years. There can be no Vichy'.[1]

In January 1942, the Labor Government, in response to representations from Federal Council, gave a written promise to the profession (later to be seen as ill-advised) that it would not introduce a scheme for a whole-time salaried service while the war was in progress. The letter is worth reproducing in full, since it was referred to again and again by the A.M.A.[2]

Commonwealth of Australia,
Minister for Health,
Commonwealth Offices,
Melbourne, C.2.

19 January, 1942.

Dear Sir Henry,

Your letter of the 15th January is to hand in which you discuss the plan for a National Salaried Whole-Time Medical Service which has been submitted to me by the National Health and Medical Research Council, and the desirability of deferring its introduction until after the war, and also that the views of your Association should be canvassed before any final decisions are arrived at.

In reply, I wish now to reiterate my promise that you will be consulted; also you can be assured that the scheme will not be introduced until after the war.

Best wishes,

Yours sincerely,

(Signed) E.J. Holloway
Minister for Health

The Government did not disclaim this letter but insisted that the assurance given referred explicitly and only to a whole time salaried service. Nor did any of Labor's health legislation provide for such a service. Whatever the Government may have had in mind originally it did, in the event, make substantial concessions to the A.M.A. The Medical Benefits Scheme envisaged under the National Health Service Act (1948) was based on the retention of the fee-for-service method of paying doctors.

It seems surprising, therefore, that this letter should have been so frequently cited as justification for the organised profession's refusal to cooperate in

the implementation of Labor's health legislation.

1. Hospital Benefits - An Uncontested Issue

One piece of Labor legislation on health caused no great controversy. The Hospital Benefits Act, passed in 1945, provided, by agreement with the States, a subsidy towards the daily maintenance costs of hospitals on condition that the States abandoned the means test (where this applied) and made available free public ward treatment to patients in public hospitals. The cost of treatment in non-public wards was also to be reduced to qualify for the subsidy.

The new arrangements hardly affected private general practitioners. Unlike **the** proposals for free medicines and a general medical service, this scheme caused little friction with the organised medical profession. Federal Council might have liked to take a firm stand to forestall attempts by some State Governments to abolish the honorary system, but it had no encouragement to do so. Indeed, the Branch members differed markedly in their attitude to this latter question. N.S.W. and Victoria came out vigorously in favour of the retention of the honorary system, the other four States almost as strongly against. These differences were rooted in the diverse experience of doctors in each State. Thus in Queensland and Tasmania, where they had had for a long time a free public hospital system, visiting doctors were accustomed to being paid by governments, while in Victoria and New South Wales they were not.

Federal Council was quick to perceive that a united stand on this issue was neither feasible nor possible. Its reaction to the Commonwealth Government's legislation, therefore, merely took the form of token gestures by comparison with their forthright indictments in other areas of health policy. In the event, Council

was satisfied to register only a strong protest to the Minister, for failing to communicate with the profession before introducing the Act, and against the abolition of the means test. The one firm resolution passed on the matter was to the effect that 'No member of the medical profession should attend in an honorary capacity in public wards of public hospitals, patients who can afford to pay for private treatment'. Thus, in form at least, Council refused to continue the system of free medical attendance, which some of its members so zealously guarded, to all public ward patients. In practice, doctors carried on as before.[3]

By December, 1948, however, there was some suggestion that majority opinion within Council might be veering away from the honorary system. Some members from New South Wales conceded that payment of visiting medical staff in public hospitals might become inevitable; and Federal Council took the precaution of passing a resolution to ensure that 'unless impracticable', all methods of payment should be on a fee-for-service basis. More surprisingly, Council conceded that where public hospitals were free to all members of the community and the 'whole financial responsibility for their upkeep had been accepted by the Government, no reason existed for the continuation of the honorary system.'[4]

It seems, therefore, that Federal Council might, in time, have taken the opportunity provided by the Hospital Benefits Act to end the honorary system which many of its members clearly opposed.

2. The Conflict over Free Medicine.

Where Federal Council's attitude to Hospital Benefits voiced only negative disapproval, and disclosed a measure of internal discord, reactions to the free medicine scheme, by contrast, brought out positive,

direct condemnation. It became evident too that almost all the profession was united behind Council on the matter.

In November, 1943, the Minister for Health and Social Services, Senator J.M. Fraser, wrote to Sir Henry Newland inviting him to a discussion upon 'such aspects of the pharmacy benefits scheme as would affect the medical profession'. The invitation was accompanied by a memorandum setting out the details of the proposed scheme and the considerations which were to affect its structure. Any practicable scheme, Fraser pointed out, must take account of war-time shortages, the need for economy in drugs, without the loss of therapeutic efficiency, and conservation of manpower in all services - medical, pharmaceutical and administrative. Certain restrictions in the service would, therefore, be necessary.

Prescriptions were to be based upon a formulary to avoid the necessity of pricing each prescription and reduce administrative costs. But the extension of the formulary was to have no 'limits other than those dictated by therapeutic efficiency, economy and public welfare'. All prescriptions based on the formulary would be available for pharmaceutical benefits. In individual cases, doctors could reduce or omit the dosage of certain ingredients. They could not, however, increase the dosage. Prescriptions were to be written on forms provided by the Commonwealth since they would be, in effect, documents of entitlement to the receipt of money and their use would minimise forgery and illegal practices. For this reason, Fraser refused to sanction the use of private prescription forms.

Federal Council's initial reactions to this memorandum were hostile. It protested, first, that the Government should have consulted the profession before drawing up the scheme. Instead it [Federal Council] had been presented with a 'fait accompli' and not legislation based upon consultation.

Council distinguished four major objections to the prcposed Act. (i) It was discriminatory in character. Prescribing on the basis of a formulary would mean that some patients who required medicines not included in the formulary would be precluded from the benefits of the Act. 'It is this principle which involves an interference with the doctors' freedom of judgement in prescribing for his patient'. (ii) The Act contained 'drastic' penalty clauses for procedures which varies from those laid down by the Government. (iii) It introduced the principle of control by a government department rather than a corporate body. And (iv) it created the opportunity for the introduction of a nationalised medical service by means of an Act not drawn up for that purpose.

The Government rejected the assertion that the Act was discriminatory. The formulary covered at least 80 per cent of all prescriptions and, it was intended, would continuously be expanded. Further, the formulary was thought to be comprehensive enough to make prescriptions outside of its range unnecessary, though doctors, of course, were free to do so if they wished.

On the second objection, the Government argued that the penalty clauses were designed solely to prevent indiscriminate prescribing. And, for this purpose, it was prepared to accept the profession's own definition of abuse of the Act.

On Council's third objection, the Government claimed it had every constitutional right to determine the form of control for its legislation. This, of course, was undeniable. But possibly the Government was unnecessarily rigid on this point. There was, after all, some merit in the proposal to control by means of a commission instead of a government department - as indeed Labor conceded some years

later. However, at this stage it was not prepared to compromise on its selection of the Department of Health as the main administrative agency.[5]

Finally, on Council's fourth objection, the Government's position was that there was a great difference between a scheme for free medicine and a nationalised medical service. As Federal Council itself hinted at one stage, the Government could operate its scheme simply through arrangements with pharmacists. Doctors were not necessarily involved.

On this last point Council was indeed on weak ground. But one must remember that the debates on Pharmaceutical Benefits legislation paralleled those on the entire subject of a general medical service to Australia. Consequently, the fears more legitimately appropriate to one set of proposals were transferred, regardless of logic or relevance, to the other, lesser issue.

The first Pharmaceutical Benefits Act became law on 5 April 1944. Fraser then wrote to Federal Council asking it to nominate six members of the medical profession willing and qualified to serve on a Formulary Committee to decide the precise nature of the formulary. At a meeting in June 1944, Council resolved not to do so and announced that it 'would not be a party to the Act, that is, the Pharmaceutical Benefits Act, which it considers to be almost entirely without merit'.[6] Two conferences with Fraser, one in June 1944, another in October 1945, resulted in an impasse. Council then decided to advise doctors to return forms and the Commonwealth Pharmaceutical Formulary to the secretary of their Branch and to continue to prescribe for patients as in the past.

The initiative for the next and vital stage of the conflict came from Victoria. The Medical Society of Victoria sought legal advice which supported the view that the Commonwealth Government did not in fact have the power to pass legislation on pharmaceutical benefits. The Society then asked the Victorian Attorney-General to 'lend his name' and become the nominal plaintiff in a High Court action with the Medical Society as relator, and at a meeting of the committee of the Society on 27 June, 1945, it was decided to proceed with the action. The case came before the High Court on 19 November, 1945. The Pharmaceutical Benefits Act, 1944, was declared unconstitutional on the grounds that it was against Sections 81 and 51 of the Australian Constitution.[7]

This decision threw into doubt, not only the Pharmaceutical Benefits Legislation, but all of the Labor Government's social legislation. The resulting uncertainty helped to precipitate the Government referendum in 1946, the second in two years, asking for Commonwealth powers to legislate on marketing, employment and certain social services including pharmaceutical, sickness and hospital benefits, medical and dental services '(but not so as to authorise any form of civil conscription)'

While the first stage in the campaign quite clearly had been won by the profession, the next stage, it seemed, might be won by Government. Council had apparently not anticipated that its move to counter the constitutional ambiguities of the Act might lead, through a referendum, to much more comprehensive powers for Government. Page once again attempted, on this occasion unsuccessfully, to assist the A.M.A. by having the health clause omitted from the Constitutional Referendum Bill. Eventually, it was Menzies who emerged as saviour. It was he who secured 'at the instigation of Sir Henry Newland' the inclusion of the anti-civil conscription proviso which was to pro-

vide the sheet-anchor of free enterprise medical practice in Australia.[8]

In the Federal election held in September, 1946, the Labor Government, now under the leadership of Chifley, won a decisive victory. In the referendum, held at the same time, only the powers on social services were given. Chifley now felt he had assurance that the legislation on social security which he had already passed could not be invalidated. He also felt he had the authority to go ahead, subject to the civil conscription proviso, with his plans for hospital, pharmaceutical, medical and other health services.

The next stage in the debate on Pharmaceutical Benefits involved another series of fruitless exchanges between the Government and Federal Council, the tenor of these becoming more and more heated. There was a temporary but passing glimmer of hope when at a conference held on 21 April, 1947, Federal Council suggested to Senator N. McKenna (who had succeeded Fraser as Minister for Health and Social Service in 1946) that it would be willing to accept a formulary if its contents were restricted to a narrower range of expensive, so-called life-saving and disease-preventing drugs, such as penicillin, the sulphonamides and insulin; and provided the doctor could prescribe on his own prescription form. McKenna, in turn, agreed to reconsider a revision of the clause imposing penalties for irregularities, and another which had provided for a formulary committee of seven appointed by the Government to determine precisely which drugs were to be available as benefits. Of those on the committee, only two were practising doctors - a source of dissatisfaction to the profession. Meanwhile, Council undertook to amplify its proposals on the question of the content of the formulary and how it (Council) would define indiscriminate prescribing.

Subsequently, in June, 1947, the Second Pharmaceutical Benefits Act was passed containing the specific revisions which McKenna had promised to consider.[9] The question of the content of the formulary was left open pending agreement with Federal Council. The Government suggested that the matter should be referred to a committee of experts consisting of three members appointed by Council, preferably including a pharmacologist, and three government officers, including the Director-General of Health.

Predictably, agreement was not forthcoming. In a strongly worded letter to McKenna, Hunter insisted that the new Act merely made concessions on minor details and that the objectionable principles of the 1944-5 Act had not been eradicated. In the circumstances, Federal Council could not advise its members to use Government prescription forms and formulary. In an equally direct reply, McKenna maintained that there was 'no substance' in at least three of Council's 'principles' and that, on the other (that relating to penalty clauses), Council objections had been met.

Council thereupon sent the following documents to its members to be circulated among patients.[10]

Pharmaceutical Benefits Act 1947

The Federal Council of the British Medical Association in Australia desires each member of the Association to know the actual steps to be taken in the event of the Pharmaceutical Benefits Act 1947, coming into operation. Each member should:
(i) return to the Association Branch Office prescription forms and formulary sent by the controlling authority under the Act; (ii) continue to prescribe as heretofore on private forms or lodge prescription books; and (iii) ensure that all patients receive a copy of the printed statement sent [see below] by his own branch of the British Medical Association.

The British Medical Association wishes to repeat to the people that if the Government were genuine in its desire to give them these medicines free, it could easily do so by paying for them on presentation of a doctor's prescription.

'Why I, Your Doctor, Will Not Take Part in the "Free Medicine" Plan'

1. The Act limits "Free Medicine" to those preparations contained in a list [the Commonwealth Pharmaceutical Formulary] drawn up by the Government, and no set list can meet the prescribing needs in my practice. In other words, I must be at liberty to prescribe the mixture I think best for your particular complaint and not the mixture the Government thinks adequate.

2. The Government refuses to accept the doctor's prescription written on his own prescription form as entitling a patient to free medicine, but insists that all prescriptions be written in duplicate on a government form. I refuse to carry out this procedure for these reasons:

(a) It is entirely unnecessary.
(b) It would require me to spend a considerable part of my valuable time performing clerical work which could be done by others.
(c) It would immediately bring me under government control, and I am not prepared to run the risk of being fined $100 or sent to gaol for three months for some so-called 'offence' against the Act or the Regulations under it.

I HAVE NO OBJECTION TO THE GOVERNMENT PAYING THE CHEMIST FOR DISPENSING ANY PRESCRIPTION I MIGHT GIVE YOU - THAT IS, SUPPLYING YOU WITH "FREE MEDICINE".

Following this action, Dr J.G. Hunter, General Secretary of the A.M.A., sought legal advice concerning the implications of the 1947 Act and the limit of the Government's Constitutional powers granted under the referendum.

The response of the profession to Council's policy of non-cooperation was almost unanimous. Less than two per cent of doctors fell in with the Government scheme. Of these, a few solitary voices raised the question of medical ethics involved in the policy of non-cooperation. Was the doctor, as a doctor, morally justified in refusing to write prescriptions on any form which would automatically give a free benefit to his patient? This speculation went unheeded by the vast majority. A few doctors were outspoken enough to criticise Federal Council. But on the whole,

vocal opposition to Council's policy was slight. The Branches appear to have been behind Council in a very substantial way.

At a Conference in Melbourne in July, 1948, the Government made a final attempt to secure cooperation. It agreed to a revision of the formulary and the use of prescription forms which could be overprinted by individual doctor's personal data. To no avail.

In March, 1949, McKenna introduced an amending Act into the Senate containing the substantive and contentious provision which made it an offence for doctors who were using the Government formulary, to prescribe on forms other than those provided by Government. 'The Government is determined', said McKenna, 'that the present unsatisfactory position shall be resolved.' The Act was proclaimed on 25 July, 1949, and on the same day a writ was served against the Act in the High Court of Australia. In a strongly worded press statement Federal Council made its position clear:[11]

> Pharmaceutical Benefits Act
>
> The Government has now declared its intention. It will readily and vindictively prosecute doctors who stand for their freedom and the freedom of their patients. It will exercise its legal powers to make such prosecutions possible.
>
> The Government has repeatedly stated that it could not and would not compel doctors to prescribe medicines from the Government list - it now reverses that policy. It now proposes to force doctors to sign prescriptions which happen to be within the Government list on Government forms. This is plainly an attempt at coercion.
>
> The British Medical Association has received certain legal advice on the Government's powers of compulsion under the Pharmaceutical Benefits Act. Its members will not yield to coercion, nor indeed to any limitation of their own or their patients' freedom. It will take all necessary steps, including legal action, to preserve its freedom.

On 7 October, 1949, the Act was declared invalid on the grounds that it compelled doctors to practice their profession in a particular way and therefore contravened the 'civil conscription' qualification in the 1946 amendment to the Constitution.

3. The Protracted Debate on a General Medical Service

While the debate on Pharmaceutical Benefits approached its first legal crisis, the conflict over the Government's attempt to legislate for a general medical service was building up. The provisions of the National Health Service Act have already been discussed in the preceding chapter. It must be emphasised that, in the context of the debate with the A.M.A., the Government did make a number of important compromises to Council's avowed objections.

Thus the Act substituted a subsidised scheme of medical benefits based on a fee-for-service system of payment, for a free medical service. Payment was to be by salary only for doctors in outback medical practice, full-time specialists in hospitals and salaried medical officers in some experimental health centres. The vast majority of medical practitioners would continue as before, except that the Government would pay half of an agreed fee; patients would be required to pay the other half themselves. Secondly, the voluntary nature of the arrangements were written into the legislation and the regulations. Hence the Act provided that 'nothing in this Act shall be construed as civil conscription' and the regulatory powers of the Minister were 'subject to securing agreement' with the States and any other institution involved. Thirdly, specific assurances were also written in that, 'wherever possible and necessary,' separate Acts of Parliament would be used when major changes were being introduced, to avoid abuse of the wide regulatory powers. Finally, on the vexed question of control, the Department of Health was to be the main administrative agency but a Commission was not 'ruled out' when the scheme was well under way. In any case, the Director-General of Health must be a medical practitioner of ten years standing - a provision designed to ensure

harmonious cooperation between the administration and the profession.

That the profession would not accept the Act was almost a foregone conclusion, and it is therefore difficult to understand why the Labor Government thought it might be otherwise. Perhaps only its conviction of the need for a National Health Scheme and its determination not to be thwarted by the A.M.A. carried it through the continuous and frustrating attempts to come to some sort of agreement in the years leading up to the Act.

Since the step-by-step development of the debate on a general medical service is somewhat complex and intermingled with the pharmaceutical benefits issue, it is useful to set out here in summary form the sequence and nature of the main interchanges between Government and Federal Council on this matter between 1941 and 1949:[12]

November 1941: The National Health and Medical Research Council report on 'Outline of a Possible Scheme for a Salaried Medical Service' was published. A.M.A. 'Plans' for 'A General Medical Service for Australia' appeared in the M.J.A.

January 1942: Holloway's letter to Sir Henry Newland giving assurances that N.H.R.M.C. scheme would 'not be introduced until after the war'.

November 1942: A telegram from the N.H.R.M.C. to the A.M.A. inviting the A.M.A. to a meeting to consider, at the request of the Parliamentary Joint Committee on Social Security whether 'the whole or any portion of the Council's "Outline" should be introduced during the war'. Invitation refused.

March 1943: A resolution of Federal Council expressing opposition to any drastic alterations in the form of medical service during the war and for one year afterwards.

April 1943: A.M.A. 'Principles' which should govern a Medical Service for Australia appeared in Medical Journal of Australia.

July 1943: Parliamentary Joint Committee, 'Sixth Interim Report on Comprehensive Health Scheme'.

May 1944: Medical Service based on a fee-for-service principle adopted by Federal Council as 'one acceptable substitute for any unacceptable scheme proposed by the Government'.

June 1944: Canberra conference with Federal Council convened by Fraser. Government announces its intention to make 'the most competent medical service freely available to every citizen'.

September 1944: Melbourne conference under chairmanship of Director General of Health: A.M.A. declares it is 'not prepared to accept a salaried medical service', but is prepared to discuss medical service on a fee-for-service basis, 'providing that negotiations shall not proceed beyond stage of discussion until one year after the war'. 'The payment by the patient direct to the doctor of a fixed percentage of the fee is commended by A.M.A. delegates for consideration'. Decision to resume conference early in 1945 did not eventuate.

November 1945: First Pharmaceutical Benefits Act invalidated in High Court of Australia.

May 1946: Canberra conference of State and Federal Ministers of Health: Government (a) puts forward proposals for complete medical service; (b) announces the establishment of a Departmental Committee to consider the practical aspects and to establish a basis upon matters of policy; and (c) proposes a second committee of medical men to provide technical information to assist government. Federal Council asked to nominate a representative in each State.

June 1946: After conferring with the Branches Federal Council declines Fraser's invitation on grounds that 'the practical aspects of the scheme and the basis for matters of policy has not yet been reported on'. A second committee therefore is considered premature.

May 1947: Letter from McKenna, to Newland, inviting Federal Council to discuss matters relating to a national medical service. Another letter suggesting that discussion might be based on resolutions adopted by Departmental Conference held in February 1947 but not yet accepted by Government.

July 1947: Letter from Newland to McKenna 'trusting' that the Minister would invite Federal Council 'to confer with him on the plans he had in view for a national medical service'. Melbourne conference: Federal Council's 'Principles' elaborated and detailed. Departmental resolutions put forward for payment by capitation and salary. McKenna alleged to have stated bluntly that his eventual aim was the abolition of private medical practice.

Second Half of 1947: Minister requests, and is given, memorandum from Newland on fee-for-service method of payment. (N.B. the difference between McKenna's alleged statement and what was actually done).

October 1948: McKenna invites Federal Council to confer and at subsequent Conference announces amendment in Government attitude: 'It is not necessary or possible that the scheme at its inception should be complete or free'. The fee-for-service system accepted. McKenna refers to this as a 'realistic recognition of the inevitability of gradualness'. Federal Council is invited by Minister to nominate representatives to joint committee to work out with Commonwealth authorities the details of Government's proposals including schedule of fees.

November 1948: The National Health Service Bill introduced into Senate.

December 1948: Special meetings of Federal Council held on 11, 12 and 13 December to consider the Bill. A decision made to hold out in negotiations as delaying tactics. Letter from Federal Council to Senator McKenna suggesting an amendment of the form of control, experimental health centres and regulatory power, as 'one essential condition for harmonious cooperation of the medical profession in the proposed National Health Service Act'. Retaliatory letter from McKenna stating Government's intention to proceed within the limits of its constitutional power, to put its plans into operation.

March 1949: A letter is sent from Council to the Prime Minister, Chifley, informing Government that the profession is inflexible in its determination to resist certain facets of the Health Service Act. Chifley replies to Council re-affirming decision to go ahead. Reply from President of Federal Council suggesting 'direct payment to patients in accordance with scale of benefits' and restating priorities according to its 'Plan' and 'principles'.

October 1949: Pharmaceutical Benefits Act, 1947 invalidated by High Court. National Health Service Amendment Act passed.

December 1949: Labor Government is defeated at Federal General Elections.

How should one review the trend of these events? In some respects the debates and issues surrounding the proposals for a general medical service were an extension of, and in no way essentially different from, those concerning the Pharmaceutical Benefits Act. They centred upon Council's insistence upon complete and unrestricted professional freedom, its rejection of anything which implied interference by any third party in the doctor-patient relationship and its resistance to control by the Commonwealth Department of Health. One might also reasonably conclude that the medical profession did not move from the position outlined in its own statements of principle in 1943 and 1941 or even in 1938. But there was a difference: the climate of the post-war period was one in which the reformist and collectivist zeal of the Labor Party was slowly but steadily provoking an individualistic reaction from various influential groupings in Australian society.

The rejection, in August 1944, of a referendum to extend the Commonwealth's powers over a wide area of national activities, including 'national health in cooperation with the States', after two years of Constitutional Convention and redrafting and, later, the failures with referenda for Commonwealth employment and marketing powers (1946), and price and rent control (1948) are only three of the more positive indicators of the conservative reaction of some groups to what appeared to be over-centralisation of government and, possibly, a danger of too much collectivism. Federal Council's vigorously individualistic opposition to the Labor Government's health measures was, therefore, only one force among a number in the community which resisted further moves towards Commonwealth paternalism, no matter how benevolent in intention, where these moves conflicted with what they saw as their own legitimate, private, and, as in this case, professional interests.

It was, of course, possible and desirable to argue the merits of the case on grounds both wider and more technical than mere self-interest. Federal Council, in the event, was able and fully equipped to do this. It was also important to deploy, in all favourable aspects, the full factual basis of these arguments at each point in the interchange of opinion and assertion between the Government and the profession. On these more particular occasions, Federal Council displayed skill and tenacity in debate, organizational competence in their publicity arrangements and an intuitive appreciation of the weakness of the Government's position in the face of changing political circumstances.

The A.M.A. also took strong exception to, and exploited to the full, what it described as the Government's 'stand and deliver' attitude in its negotiations with the Council. The Government, it claimed, pretended that it wished to negotiate, but in practice made

it clear that it intended to go ahead with or without the profession's agreement. 'The Government has set itself a plan', Chifley had said at the 1944 conference...'I say it in the plainest terms: our objective is a free medical service for the people of this country...If it is finally the position that the medical profession is not agreeable to cooperate, the Government has got to look around and find other means'.[13] The Federal Council alleged that, as the debate continued, the Government behaved increasingly as though an agreed basis of policy had been reached. Council was frequently sceptical of the use of the terms negotiation and consultation, for what it regarded as a series of 'faits accomplis'.

It was also predictably quick to echo a criticism of the Government voiced by the chairman of the Joint Committee, Mr H.C. Barnard. He had complained that the Government's action, in by-passing the Committee decisions and initiating direct negotiations with the A.M.A's Federal Council severely jeopardised the chances of coming to some agreement with the profession. Federal Council then maintained that the report of the Medical Planning Committee (set up by the Joint Committee) showed evidence that a modus vivendi quite likely could have been worked out between the Committee and the profession had not the Government begun its own negotiations direct with the Federal Council; the fact that Sir Henry Newland had dissociated the A.M.A. from the report of the Medical Planning Committee apparently was not thought to be relevant to this claim.

Not that Labor was seriously perturbed by these events. The conviction was held strongly that it was the Government's function to 'erect the structure' and for the profession to assist in other ways. In other words, the Government started from the position that it was the right and duty of the Government to formulate policy and

to seek cooperation and assistance in the detailed implementation of its policy from the groups concerned.

On this issue, moreover, it claimed after the 1946 Referendum to have a definite mandate. 'If ever a Government could claim to have been authorised by the electors to execute a specific measure', said McKenna, with feeling, 'the present Government can claim to have been authorised to introduce the scheme'. Having decided the form of policy, the Government had 'as a matter of courtesy and for the purpose of giving advice, placed its viewpoint before Federal Council even before it was submitted to Parliament'. In fact, as Chifley pointed out in Parliament, the A.M.A. had been offered representation on every committee which dealt with national health. And, even after Council's outright rejection of the 1948 Act, Labor continued to offer representation to the A.M.A. up to the point when it fell from office.

Federal Council, for its part, took the view from the beginning that it should have a more direct role in the formulation of policy and that the particular principles which it regarded as essential, should be incorporated in any Government scheme. It insisted that negotiations should continue until these principles were accepted.

It is hardly unexpected, therefore, that the years 1941-9 were marked by a series of fruitless exchanges between Government and Federal Council. Thus, when Fraser wrote to Newland on 13 May, 1946, announcing the Government's intention to set up a Departmental Committee to 'consider the practical aspects of the scheme' and asked Federal Council to set up another to assist in determining the locale and types of various health centres envisaged, Council retorted that such a committee was premature since the first [the Departmental Committee] had not yet 'established a basis upon matters of policy'.

Therefore, although Council frequently accused the Government of rigidity, it could scarcely avoid the charge itself, in the sense that it never at any time deviated from its own particular interpretation of principles and consistently and regularly insisted that since these remained unacceptable to the Government no practical basis of policy could be established. From Council's standpoint, clearly, it was the Government and not Council which broke up negotiations and had 'cut the painter' between itself and the Medical profession when it decided to go ahead with its National Health Service Act

Consequently, it was to be expected that the profession would and did produce a number of specific objections designed to hold up the implementation of the 1948 Act. And it stood sturdily by its position that 'the Medical profession should not be stampeded into the acceptance of a measure with which it had fundamental causes for disagreement'.

In his letter to McKenna of 13 December, 1948, Newland set out Council's objections to the Act. It took exception, with now monotonous consistency, to the form of control and the wide regulatory powers of the Minister. In addition, it disapproved the provisions for health centres, contractual arrangements between Government and doctors, the 'entirely new and untried' form of the fee-for-service method of payment (based on Government payments to doctors rather than refund to patients) and the alleged necessity to make available the clinical records of patients.

Council thereupon asked the Minister to consider amending the Act in order to remove 'those objectionable features', thus ensuring '<u>one</u> essential condition' for harmonious cooperation of the medical profession in the proposed National Health Act.[14]

The final exchanges came from the Government. On 22 December, Council was given the stark information that it was 'the decision of the Government, that within the limits of its constitutional power, it will proceed to put its plans into operation', and that 'Government did not intend to alter its decision on the points at issue'. McKenna vigorously termed as 'presumptious' Council's demand that, in a proposed fee-for-service arrangement, government should deal with each individual patient, rather than with a few thousand doctors.

Moreover, he argued that, even if it met Council's objections, there was still no guarantee that Council would cooperate. The profession's conduct of negotiations clearly had indicated that, if the Government met its demand on this matter, such action would provide only 'one essential condition' for cooperation of the medical profession in the proposed Act. The implication was that there would be other conditions raised - and yet others. The Government, therefore, 'has regretfully come to the conclusion that despite the splendid services rendered by the great number of medical practitioners, your Association is grievously lacking in a sense of social responsibility'.

Council then sent a final letter to the Prime Minister claiming that Government had 'summarily rejected its objections' and reaffirmed its determination 'to resist the proposed National Health Service'.

Chifley's answer to this letter was thoughtful, dignified, and direct.[15] Several points were stressed and reiterated and were clearly designed both to give assurances and to restate the Government's position.

The medical benefits provision of the Act, he wrote, were, as they stood, simple and straightforward. To put the burden of applying for refund on the patient, as Council suggested, would considerably complicate

matters and compel many people to wait for their reimbursements. Such a delay would detract from the basic object of the scheme, which was intended to ease financial difficulties of seeking medical care. To talk of doctors 'cooperating' on these terms was meaningless.

No control by the Government of doctors was involved or envisaged and it was 'absurd' of the profession to suggest this. Doctors could choose to participate in the scheme or not, as they liked, but 'those participating will be obliged merely to observe the essentially simple rules necessary for accounting purposes'. The Government would be prepared to consider whether doctors taking part in the scheme might also retain rights of private practice, though he, Chifley, could not quite see the point of this.

Nor did the scheme interfere in any way with the confidential doctor-patient relationship. Patients would continue to choose their own doctor as before. Council had insisted that urgent priority should be given to the preventive aspects of health policy. Many of these, Chifley went on, were clearly envisaged under the enabling clauses of the Act. Some had already been introduced and the limitations were those of the physical resources involved rather than policy as such. In fact, Council's stress on these priorities appeared as a ploy to delay the implementation of medical benefits and Chifley would have none of this. 'It will be obvious that your Association's views on the importance of the positive measures can in no way justify its refusal to cooperate with the Government in the Medical Benefits Scheme'.

In fact, he went on, the Government had met the essential element of Council's opposition, that is, that there should be no interference with the fee-for-service system. Moreover, the Labor Government had based its scheme on Sir Henry Newland's own proposals. 'It is this fact that makes the more recent attitude of your

Association incomprehensible and I find it difficult to understand the motives underlying your Council's refusal to cooperate'. Chifley ended:-

> 'The Government cannot permit the introduction of the Medical Benefits Scheme to be delayed by interminable discussion. It is the Government that must accept responsibility to the community for whatever scheme is adopted. This, I would suggest very seriously, is a fact your Council does not appear to appreciate fully. Indeed your Council's view seems to be that the British Medical Association and not the Government should decide the conditions under which any National Health Service should operate.'

Throughout the proceedings just described, there were ambiguities and inconsistencies on both sides. But Labor was, in essentials, more flexible than the medical profession. The A.M.A. did not, and in terms of its professional values apparently could not, deviate from its original position. Labor, on the other hand, although it formally upheld the argument that responsibility for formulation of policy could only be in the hands of the duly-elected government, did in practice make concessions. The fee-for-service form of payment was the most substantive component in the A.M.A. policy. It was the element of private practice they were determined not to lose. And, from the Government's point of view, the retreat from its ambitious plan for a <u>completely</u> free medical scheme based on a salaried service, to a medical benefits scheme covering only fifty per cent of the doctors' fees, was a major compromise. Yet it did concede this ground.

The charges frequently made by Federal Council, that some members of the Government would have preferred to abolish private practice, may have been correct as an interpretation of Labor's long-term objectives at one stage. But even if Labor made the mistake of under-rating the determination of its opponent to prevent such an occurrence in the early days, it could scarcely continue to do so. Moreover, it was forced finally, perhaps belatedly, to admit that 'abuses and difficulties....were

possible in a completely free scheme'; that 'the broad objectives of a free scheme would be achieved by a process of evolution and that it was not necessary or possible that a scheme at its inception should be complete or free'. This was/it was argued a realistic recognition of the inevitability of gradualness.

McKenna may have felt that the Government had met Council's major objections, 'I defy anybody', he said after a point by point comparison of the A.M.A. scheme and that introduced in the Act, 'to find any point of essential difference between the schemes propounded by the Government and that enunciated by the A.M.A. as recently as February of this year'. On the question of clinical records he was equally adamant. 'With respect to secrecy, I make it perfectly clear that the Government has not the slightest desire to know what is wrong with any person in Australia. We are as anxious as he [an Opposition speaker] to develop a scheme under which details of complaints will be kept secret and the confidential nature of the patients' ailments will be preserved. Only in some cases where an account is disputed might this be necessary.[16]

In the event, McKenna was quite wrong in assuming 'that the A.M.A. and the Government are in complete accord in the new principles and there can be no real reason why the Government and the medical profession should not co-operate in their efforts.' On the contrary, Members of the A.M.A. were advised not to cooperate in any fee-for-service scheme which did not have the approval of Federal Council; to refrain from replying to any approach to them as individuals by the Government without the approval of their Branch Councils; and to 'spread among all persons of all kinds of political creed the gospel of individual freedom...this fight, for fight it is, is one for every person who wishes to live his own life as he may wish to

live it'. Council, there can be no doubt, was clearly prepared to do everything in its power to resist.

The Government made one final attempt to reassure the profession. In October, 1949, it passed an Amending Act in which it undertook to give three months' notice of any proposed change in fee arrangements with doctors, additional payments for mileage, and specified that the nature of information required by Government concerning the patient would be of a most general nature. To no avail; the A.M.A. remained unmollified and adamant. The profession was in a strong position. It was only necessary to maintain resistance for a short period in order to permit elections to decide whose was the victory.

Less than two months later, on 10 December, the Government fell from office and the Liberal-Country Party came to power with Earle Page, ex-surgeon and spokesman for the profession for over twenty years, as Minister for Health.

The A.M.A. had successfully held out until the general political tide had turned in its favour. Had the tide not done so, there is every indication that the A.M.A. could have succeeded in its boycott and perhaps even in securing judgment that the 1948 Act was unconstitutional in much the same way as it had the Pharmaceutical Benefits Acts of 1944 and 1947.

FOOTNOTES (CHAPTER SEVEN)

1. M.J.A., Vol.II, 15 November, 1941, pp.579-80.

2. Ibid, Vol.1, 2 January, 1943, p.9.

3. Ibid, Vol.2, 8 December, 1945, p.409.

4. Ibid, Vol.2, 16 April, 1949, p.533.

5. Later, as we shall see, the A.M.A. was, under a Liberal-Country Party Government, prepared to accept the Department as the main administrative agency.

6. Ibid, Vol.2, 28 October, 1944, p.466.

7. See Chapter VI.

8. Margery Scott-Young, op.cit., 'The Nationalisation of Medicine', M.J.A., Vol.II, 18 August, 1962, p.23, footnote 2.

9. C.P.D., Vol.192, 4 June, 1947, pp.3301-2, pp.3316-22. Clause 20 provided for a formulary committee enlarged from six to seven members and for an increase in the representation of the medical profession. Clause 22, relating to penalties for indiscriminate prescribing was omitted from the aAct. Clause 23, the regulation making clause, was extended to cover matters concerned with the writing of prescriptions.

10. M.J.A., Vol.1, 1 May, 1948, pp.568-69.

11. Ibid, Vol.1, 16 April, 1949, p.531.

12. Ibid, Vol.2, 11 November, 1941, pp.17-21, Vol.1, 15 February, 1949, pp.157-61, 16 April, pp.523-25.

13. Cilento, Blueprint for the Health of a Nation, p.114.

14. M.J.A., Vol.1, 16 April, 1949, p.532.

15. M.J.A., Vol.1, 15 April, 1949, pp.523-5

16. C.P.D., Vol.1, 2 December, 1948, p.3862.

PART III

THE NATIONAL HEALTH SCHEME

'The Australian Plan, for which I have been mainly responsible, is not a law or even a system of laws...it is an overall concept or set of principles embodied in a lengthy and complicated series of statutes'.

Sir Earle Page, 1960

CHAPTER EIGHT

THE BENEFITS PROVIDED

The major criteria and policy objectives underlying the Australian National Health Scheme were most authoritatively developed by Sir Earle Page, the Minister for Health in the Liberal-Country Party Government, when he introduced his ideas to the British Commonwealth Medical Congress in Brisbane on 23 May 1950:[1] 'I have come to offer for your consideration a new conception of a national health scheme based on a combination of government aid with nation-wide voluntary insurance against sickness and disease. This means a partnership between the government and the individual through the union of governmental aid with voluntary effort. This partnership is a recognition that both the state and the individual have obligations in the National Health Scheme. Both will benefit: the individual will gain better health, longer life and an easier mind about the expenses of sickness; the state will gain by more efficient production, greater national income and social stability. This partnership will make use of all those factors and organisations which have been built up over centuries to assist restoration of health. This new conception aims to keep everything that is good and to reject the obsolete. This conception does not destroy any past advances but makes provision for the use of all future advanced methods by a nation-wide voluntary insurance against sickness. This conception leaves everyone free, the doctor, the patient, the hospital management and staff, the chemist and the voluntary insurance organisation. This conception keeps alive the elements of initiative and competition in service which really produces progress'.

1. **The Objectives**

Four objectives of policy can be distinguished in this 'new conception' of a health scheme: (i) Arrangements which would have the willing cooperation of the major groups involved - doctors, pharmacists, hospital managements and voluntary insurance societies. (ii) The retention of an expanded system of the voluntary insurance organisations in Australia. (iii) The evolution of a scheme which would give the patient responsibility for meeting a portion of his medical and hospital costs. And (iv) the solution to the problem of the 'medically indigent' (those who could not afford the high costs of hospital and medical services) by a method which would avoid the traps into which other governments allegedly had fallen.

These goals were expanded by Sir Earle Page at various times with a feeling and rhetoric which have scarcely been matched since, though they have been elaborated and reiterated by subsequent Ministers of Health, administrators explaining government policy, and Liberal Party protagonists of the present Scheme.

The first objective, to establish a scheme which would secure the willing cooperation of all the groups concerned, could be, said Page, secured by a partnership to consist of government, doctors, voluntary societies and patients in which all would have a particular and specific function. This sense of partnership could be secured by reducing government interference in the activities of Friendly Societies, doctors and patients to a minimum, thus developing 'a sense of security necessary for long-term arrangements'; and by leaving in the hands of the various groups as much of the detailed administration and control of the scheme as possible. The scheme was, as Page put the matter, to be 'thrown

wide open to social cooperation...'. Since the aim of all the groups in the partnership is the same, he maintained, agreements could readily be made and changes introduced to provide for improvements in the working of the plan without affecting its basic principle. 'Long-term changes need not be fought out with political weapons or paid for with political promises'.

A second objective of the Page Scheme was the retention, on an expanded basis, of the system of voluntary health insurance in Australia. 'Why should we turn to an unknown method', he asked, 'why not try out on a national scale well-known, effective, trustworthy methods. Voluntary insurance for this purpose, backed by government aid to cover those bare areas which voluntary insurance may be unable to cover completely, seems the only solution...'.

Third, the scheme must give the patient a sense of personal responsibility for the provision of his own medical needs. This could be done by requiring him to pay a 'small percentage' of the cost. Page saw the attitude of the public in this matter as of vital importance to the success of the scheme. Indeed, it was one of the distinguishing elements, he said, between the socialised and the free system that the public should maintain a sense of responsibility. 'Does he, the patient, count on the state to take full care of him when he is ill or hurt, or does he voluntarily accept some financial responsibility for his own health treatment?' This was not to say that government should or would opt out of its obligations. Indeed, the idea of government commitment was as essential as the idea of self-help. But the essence of the matter, as Page saw it, was that the government's policy was to help those who helped themselves.

Last, but by no means the least, of Page's objectives was to find a solution to the problem of the medically indigent which would differ from that of other countries. The problem for Australia was how to evolve an approach which would avoid the pitfalls of socialised medicine on the one hand, and those of unaided free enterprice and medical care on the other. Or, how to help solve one problem without creating another. In particular, the method followed must avoid a mass attack on a problem which by its nature was individual. 'The existence of this new class, the medically indigent, has created a disposition on the part of government to solve, en masse, what is essentially an individual problem'.

Page had no doubt, then, that he was offering to the Australian people a system which could avoid the abuses of both free enterprise medicine and the allegedly bureaucratic British system of socialised medicine. This, he claimed, constituted the uniqueness of his Scheme. 'What I have to offer is the experience of Australia in finding a working solution for a set of complex problems which is acute and becoming critical in the U.S.A. This is the difficulty of providing and guaranteeing good medical treatment to every citizen regardless of his ability to pay the full price for it without destroying or damaging beyond repair the freedom of the medical profession and the vital relationship between doctor and patient. Putting it more briefly and bluntly, this is to be the story of Australia's answer to socialised medicine...this new conception can prove the pattern that democracy is seeking'.

If one examines these policy statements in a historical framework, Page was, in 1950, merely restating the individualistic arguments evolved by his party, and before it by the United Australia Party, in parliamentary discussions over various proposals for national health

schemes in the 1920s and 1930s. From an early date the Liberal-Country Parties had their own particular conception of how a national health scheme should be constituted and how it should be put into practice.[2] It differed from that of the Australian Labor Party, not only in matters of detail, but in its fundamental approach. In particular, after 1940, the idea that government should be a partner rather than a provider appeared consistently in both the Liberal and Country Parties' arguments as a counterweight to Labor's position that the government must provide and supervise to ensure that the service would, in practice, be available to all.[3]

The objectives of Liberal policy have remained virtually unchanged over the past 17 years and although there have been a number of minor alterations in the nature of the scheme the essential basis has not been affected. After 1950, successive governments' announcements and the official statements and publications of the Australian Liberal-Country Party Government have reinforced the underlying criteria of health policy. In 1955 the Prime Minister, R.G. Menzies, stated the satisfaction of his Government in that it had managed to provide what he called a solution of a fairly individual nature which would secure the cooperation of all the groups involved in the health scheme. 'I'm very proud of the fact that after years of conflicting views and sometimes sharp dispute, my own Government has been able to institute a medical health scheme which, while it brings medical treatment within the reach of everybody, has set out to preserve these precious elements to which I have referred. The whole thing indeed is a splendid example of how, by hard work and cooperation between government and profession, the existence of a high degree of government action can be reconciled with the preservation of the private enthusiasm and independent activities of the citizen'.[4]

Four years later, D.A. Cameron, then Minister for Health, told the House of Representatives that 'there is no doubt whatsoever that a contributory health benefits scheme on a voluntary basis is most appropriate to Australia's needs and conditions; and the future of this is now assured'.

There is little difference, in essence, between these and subsequent pronouncements of Australian Health Ministers. R.W.C. Swartz had this to say when introducing amendments to the National Health Scheme on 23 April 1964: 'This public support', (he was referring to the increase in membership to voluntary insurance organisations), 'is a matter of very great satisfaction to the government. It vindicates the view we have always held that a voluntary insurance scheme based on self-help is the most appropriate to Australia's needs and way of life. This is because the scheme provides the assurance of every citizen's freedom to choose his own doctor with effective protection (by government subsidy) against financial hardship when illness occurs. We believe that this freedom and protection are well worth preserving'. As recently as October 1966, this position was re-emphasised by the Minister for Health, A.J. Forbes. 'The principles of this voluntary health scheme were introduced in the early 50's and the experience of the past decade has demonstrated conclusively that they are sound. The Commonwealth Government is convinced that the fundamental principles of health insurance allied to government assistance, along with the freedom of choice of doctors, offer a system of health care which most closely approaches the ideal of health services for everybody according to their needs and is consistent with human dignity'.[5]

The Liberal-Country Party objectives were given statutory form in the National Health Act of 1953. It consolidated into a single Act four parts of the scheme which had been put into operation under separate arrangements between 1950-3. The Scheme, covering some nine-million people, in 1968, is characterised by a combination of: private medical practice; voluntary insurance by private citizens whose 'cover' is increased by subsidies from the Commonwealth Government paid on behalf of each patient to his approved insurance organisation; hospital services similarly subsidised; and subsidised pharmaceutical services. The main body of the somewhat complex arrangements is contained in four major sets of provisions providing for public financial assistance or so-called 'benefits' towards the cost of hospital, medical and pharmaceutical care, supplemented (except for pharmaceutical benefits), by voluntary insurance. In addition, there are separate arrangements for pensioners to give them free hospital, medical and pharmaceutical services.[6]

f. Hospital Benefits

Hospital benefit arrangements are based on indirect assistance to both public and private hospitals. When introduced, the subsidy of 80 cents per day originally given by the Labor Government was maintained. And an additional subsidy of 40 cents, making $1.20 in all, was given provided: (a) that patients were insured with any one of 118 voluntary insurance organisations; and (b) that the States were no longer required to dispense with the means test for patients occupying public wards in public hospitals.

Between 1952 and 1957 the Commonwealth subsidy remained at the $1.20 per day rate. An amendment to the Act, in 1958, increased it to the present level of $2.00 - to be paid to people insured with a registered benefit

TABLE IV

HOSPITAL BENEFITS

Contributions per Week		Benefits per Week		
Single	Family	Fund	Commonwealth	Total
£	£	$	$	$
10	20	16.80	14.00	30.80
15	30	25.20	14.00	39.20
20	40	33.60	14.00	47.60
25	50	42.00	14.00	56.00
40	80	67.20	14.00	81.20

Source: Commonwealth of Australia, Guide to National Health Benefits, 1966.

TABLE V

MEDICAL BENEFITS

Type of Service	Combined C'wealth and Fund Benefits		
	$	to	$
Certain major operations	120.00		150.00
Appendix operation	40.00		45.00
Confinement including ante-natal & post-natal care	30.00		33.75
Tonsils (under 12 years)	14.00		15.75
Simple fracture of wrist	14.00		15.75
General Practitioner Consultation(Sur.)	1.60		2.00
General Practitioner Consultation(Home)	1.60		2.40

Source: Commonwealth of Australia, Guide to National Health Benefits, 1966.

TABLE VI

PENSIONER MEDICAL SERVICE

As at 30 June	No. of pensioners & dependents enrolled at 30 June	Average no. of services per enrolled person	No. of participating doctors at 30 June	Average receipts per annum
	000's			
1952	501	5.0	3,502	620
1953	558	6.2	3,898	928
1954	597	7.2	4,239	1,024
1955	640	7.6	4,567	1,132
1956	668	7.9	4,730	1,236
1957	684	8.0	4,990	1,234
1958	697	8.3	5,243	1,250
1959	720	9.0	5,531	1,376
1960	740	9.4	5,685	1,466
1961	766	9.4	5,861	1,456
1962	810	9.3	6,012	1,476
1963	831	9.0	6,025	1,520
1964	844	8.9	5,899	1,598
1965	849	8.6	5,896	1,578
1966	1,006	8.4	6,034	2,246
1967	1,043	8.0	6,175	2,360

Source: Commonwealth Director-General of Health, Annual Report, 1966-67.

organisation paying a premium from which they could hope to receive a return of at least $1.60 for each day spent in hospital. Patients who were insured for lower rates than this continued to be paid only the original $1.20 subsidy until 1963 when they were paid the full $2. Clearly, this substantially greater Commonwealth contribution, made contingent on payment of premiums at a certain level, was designed as an incentive to encourage insurance at the higher rates. As the Minister for Health said when he was introducing the amendment, whether the contributors chose to avail themselves of this provision 'would be entirely a matter of choice for contributors...I want to remind the House that the principle of the Commonwealth additional subsidy is to help those who help themselves...This was clearly stated when the Scheme was first introduced'.[7]

The $2.00 per day subsidy is paid out to insured patients through the insurance organisations. Where a patient is uninsured the government pays the 80 cents subsidy direct to the hospital. The <u>total</u> amount of benefit which insured persons receive towards the cost of their family's hospital treatment depends on the level of their contributions plus the government subsidy (see Table IV). Thus, a family paying 50 cents per week in insurance is paid a combined Commonwealth and insurance benefit of $47 which is the average weekly charge made in public wards of public hospitals - except in Queensland where there is free public ward hospitalisation.[8] The administrative procedure for the scheme is, in principle, quite simple. The hospitals issue the bills and along with them a 'certificate of hospitalisation'. The patient then fills in the claim form at the foot of the certificate and sends this, along with his hospital account, to the hospital insurance fund of which he is a member. The fund subsequently remits him the total

benefit, which is the Commonwealth's subsidy of $2.00 plus the rebate to which his contribution rate makes him eligible. If patients prefer, they may arrange for the hospital to obtain payment of its account directly from the insurance organisation. The conditions and scale of benefits differ between certain of the organisations but all of them require a waiting period of two months between joining and eligibility for benefit, except in the case of accidents; another exception is benefit for obstetric treatment which, generally, requires a waiting period of 10 months.

The funds have always insisted that the waiting period is essential to the financial viability of voluntary insurance. Without this, they argue, correctly enough, it would be possible for a contributor to cover himself on a temporary basis and this would qualify to receive both the additional Commonwealth subsidy and the fund benefit. This payment he could use to pay the hospital bill, and then, if he were of this mind, could terminate his contribution as soon as he left hospital. It is evident that this practice, if it were undertaken on any scale at all, would defeat the contributory principle of hospital insurance. The same logic was held to apply when a contributor moved to a higher rate of benefits, either when a new 'table' was introduced or when he was transferring from a lower to a higher 'table'. But in practice the funds do not insist on this waiting period on transfer. When the funds decide on a waiting period, or any other form of constraint, the Government usually does likewise. However, there is the important exception that the Commonwealth subsidy to uninsured patients is paid without any qualifying period.

The needs of patients whose illnesses are chronic, long term or predate their membership of the benefit or-

ganisation, raise special problems. This was also true, until 1963, of patients over the age of 65. Full benefits are paid for a maximum period of 84 to 91 days in any year. Reduced benefits are paid thereafter. A 'special accounts' system, established in 1959, now permits registered organisations to solve some, but not all, of these problems. Before that date the hospital benefits organisations made little provision for these groups. They insured their members only against what is termed 'normal risk' - an actuarial concept which can be determined with some degree of accuracy so far as the general membership is concerned. The application of the so-called 'exclusion clauses' against these groups predated the Commonwealth Government's subsidisation. They were operated in order to maintain the financial viability of voluntary health insurance.

The Government's object in introducing the 'special accounts' system, according to the then Minister for Health, D.A. Cameron, was to find 'a mechanism that would enable benefit to be paid (while) preserving the principles of the voluntary scheme'. Where these 'special accounts' are employed the Commonwealth undertakes to cover the insurance funds against specified categories of uncertain risk.[9] In return, the funds establish the special accounts - to consist of the contributions of members who come into these chronic, long-term and old-age categories. Such member-patients thus become entitled to certain minimum hospital benefits from the accounts irrespective of the length or nature of their illness or whether they suffered from it when they originally joined the fund. Once transferred, the Commonwealth, to ensure that its subsidies here are appropriately employed by the funds, stipulate that they shall remain on 'special accounts' for a period of two years.

The funds are not compelled to establish special accounts; but most choose to do so. Within a year of the establishment of the arrangements, over 90 per cent of the funds had taken advantage of its provisions. The alternative for the fund is that, after a period of two years, it may choose to forego its rights to operate exclusion clauses against member patients in these various special categories. Either way, the patient suffering long-term or chronic illnesses is at least partially covered without any change in his method of applying for benefits or in his rate of contribution. But many serious problems remain unsolved for the aged and chronically ill. We shall return to this point later.

3. Medical Benefits

As in Hospital Benefits, the Medical Benefits Scheme provides for subsidies from the Commonwealth towards medical expenses. But here the subsidy is fully contingent on the patient being insured with one of the approved organisations; it is paid only through a medical benefits fund registered under the Act. Primarily, the scheme is designed to assist those who insure through funds which pay benefits on a fee-for-service basis. The contributor, like any private patient, pays the doctor directly for the medical attention received by him and his family; and is then reimbursed by the medical benefits organisation a proportion of the cost. However, there were, when the scheme began, a few Friendly Societies operating on a contract basis whereby they arranged with medical practitioners to provide medical attention to their members and families for an annual, lump-sum payment. Some of them still so operate within the context of the present Scheme.

Organisations cannot be registered under the Act unless they provide benefits which are at least equal in amount to the Commonwealth benefit for each item of

service. And contributors must be insured on a scale, or table, which covers them for items in the first part of the so-called 'schedule of benefits'. As in hospital benefits, contributors are subject to certain exclusion clauses which preclude payment of benefits: (i) for two months after first joining a fund; (ii) when the maximum amount payable under the fund's rules is reached; and (iii) where the illness is chronic or pre-exists the date of joining. (However, under the latter two conditions, the patient would now be transferred to the special account category if he makes the correct approaches). Commonwealth benefits are payable even if a contributor is ineligible for fund benefits because of any of the latter two circumstances. Otherwise the Commonwealth holds to fund practice in that it ceases to pay benefits to persons who are in arrears or are regarded in some other way as being non-financial. Temporary unemployment is treated exceptionally. The Commonwealth will pay medical benefits; but only so long as the person concerned is also receiving social service unemployment benefit and sickness benefit.

In keeping with Earle Page's objective that patients must retain some element of financial responsibility for their illness, benefit organisations actually provide that the total amount of benefit must not exceed 90 per cent of the hospital/medical costs incurred by the member. Medical benefits rarely reach this level, as we shall see later.

Subsidies for general practitioner and specialist medical services given by the government cover more than one thousand possible medical conditions on the 'schedule of benefits'. They range from 80 cents for a visit to the doctor's consulting room, to $60.00 for a major operation. Again, as with hospital insurance, the benefits payable vary with the level of contribution

paid but are at least equal to the Commonwealth benefit paid (see Table III, which gives examples of the range of benefits). Not all medical attention is covered. For example, the Commonwealth will pay benefit only when the patient is treated by a registered medical practitioner; while most organisations, by contrast, also will pay for treatment by physiotherapist, for home-nursing and the supply of spectacles. Both funds and the Commonwealth exclude payments for medical examinations for insurance purposes. The Commonwealth will not pay benefits for an eye examination by an optometrist - but will when the task is performed by an eye specialist, providing the latter does not lead to the prescription of spectacles. Should this happen, there is no benefit either for the examination or the spectacles. Neither pays for medical auxiliary services in a public hospital unless these are pathological, radiological, or electro-encephelogram services. For such services each usually contributes equally. Similarly, both Commonwealth and fund will pay higher benefit for a visit to a specialist, only if the patient has been referred by a general practitioner. If a patient goes to a specialist on his own initiative he may recoup only the amount paid for general practitioner service.

By 1959 it had become apparent that an important factor determining the actual benefit paid to a contributor from the Medical Benefits Scheme was the level of doctors' fees. If these changed without any commensurate change in medical benefits arrangements, then the benefits payable became a smaller proportion of total medical expenses. Also, it became clear by this date that the medical benefits scheme did not provide adequate cover for serious illnesses, especially where major surgery was needed. To meet criticism of this feature of the scheme a further amendment was made in 1959 and Commonwealth benefits for a wide range of professional services were increased. Nevertheless, the general

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rise in medical fees continued to create a widening gap between payments and fees and therefore in the expenditure which an insured person might have to pay out on account of medical treatment. The A.M.A. itself undertook an examination of the schedule of benefits in the light of increases in doctors' fees. After discussion between the Commonwealth and the A.M.A., a new schedule of benefits came into operation in 1964. The Government subsidy was increased, effectively, by 33⅓ per cent; and for certain items by more than this amount. In addition, a number of new services were added to the list. Today (1968) the medical benefits list now covers some 1,100 items.

These changes and additions did not at first require any further contribution from embers of the fund. In many cases one result was that the Commonwealth subsidy was greater than the benefits paid out by the fund. Later, in April 1965, the insurance funds did increase their contribution rates, after consultation with the Government, on the ground that demands on the funds were beginning to threaten their financial security. The average number of contributors' claims for medical service, it was estimated, rose from 6.5 per year per pers n in 1958-59 to 8.3 per year in 1964-65. For those contributors who were able to pay higher premiums the change meant a further narrowing of the gap between doctors' fees and the total amount recovered as benefit. Government statistics showed, at the time, that the share of the cost borne by the contributor on average dropped from 37.3 per cent in 1963-64 to 32.3 per cent in 1966-67. The funds themselves, very recently, have made some minor improvements to the benefits and services which they provide to their contributors.[10]

All of these changes amounted to only marginal adjustments brought about by rises in fees and / insurance premiums rather than by any appreciation of a need for alteration in the

Scheme itself.

4. The Pensioner Medical Service

This service began operation on 21 February 1951. It is available to all who qualify for a social service pension by virtue of old age, invalidity, widowhood and to those who receive a tuberculosis allowance. Dependents of these groups - wives, children under sixteen and student children up to the age of twenty-one - are also covered. Their entitlement is to free general practitioner services, a range of free medicine, more extensive than is available to other groups in the community, and free public ward accommodation in hospitals. The type of medical attention given under this scheme is similar to the family-doctor service provided under friendly society contract-practice arrangements.

The basic qualification for access to this service is eligibility for a social service pension or a service pension under the Repatriation Act. This permits a single person of pensionable age, with property valued at less than $420, to receive some pension so long as his weekly income does not exceed $24 per week.[11] 'Entitlement cards' are issued by the Department of Social Services to each pensioner; and these provide the doctor with his authority to give free treatment to pensioner patients.

Medical practitioners contract with the government to provide these free services in return for concessional fees which are paid direct to them by the Department of Health when they have forwarded vouchers certifying that the free attention has been given. Pensioners may be required to pay a small after-hours fee of 50 cents and a small part of the mileage fee (the rest is paid by the Department of Health) when the doctor has had to travel over three miles in the city or suburb or over two miles in the country. It is estimated that in 1967 some 6,000 medical practitioners participated in this service (see Table [illegible]). Since

the scheme began there has been a steady increase in the number of pensioners and dependents eligible for free services. Primarily, the increase occurred as a result of the extension of the means test. In 1952 there were 501,000 pensioners and in 1967 there were 1,043,000 - amounting by then to 8.9 per cent of Australia's population. Doctors' fees have increased seven times since the service began. In 1967 they stood at $1.70 and $2.15 for surgery consultations and home visits respectively.

Changes in the scheme mainly have been concerned with eligibility. Until 1954 the criteria which were applied were similar to those for a social service pension. But the progressive easing of the means test, as well as increases in the actual amounts of pensions themselves, resulted in pensioners being admitted to the scheme whom the government claimed 'could not be regarded as being in the indigent class'. As a consequence, in November 1955, all prospective newcomers to the scheme were subject to an additional means test which had the effect of freezing eligibility to pensioners whose total weekly incomes, including income from property, were less than $4.00 ($8.00 for a married couple), plus an additional allowance for dependent children. This 'means test within a means test', however, clearly excluded a substantial proportion of pensioners eligible for social service benefits from the free/service pensioner medical.[12] And this situation continued, surprisingly, until October 1966, when the <u>status quo ante</u> (1955) was re-established by another amendment to the Act. Yet another amendment, in April 1967, led to the inclusion of pensioners eligible for a sheltered workshop allowance under the Social Services Act. This change meant that up to 41,000 persons and their dependents would become eligible to enter the Pensioner Medical Service for hospital and pharmaceutical benefits. Eligibility for general practitioner treatment was made contingent upon reaching agreement with the A.M.A.

Here the government encountered problems with the A.M.A. The Association was reluctant to have such large numbers become eligible - at least at the fee which they were then being paid by the Department of Health. In addition, the publicity given to the abuses of the Pensioner Medical Service by some doctors, brought to light by the statutory disciplinary body (the Medical Services Committees of Inquiry), had made doctors sensitive to extending their area of direct contact with government. The A.M.A. denied that its delay on this matter was in an effort to force the government to re-negotiate an arrangement in regard to those pensioners then entitled. It claimed instead that 'the A.M.A. was disturbed at the erosion of private practice which occurred by the creation of new groups of pensioners not previously entitled to a social service pension'. Whatever the reason, not until November 1967 did the A.M.A. agreed to enter into an agreement with the government for the provision of services to this additional number of pensioners. Fortunately, new pensioners did not suffer as much as they might have, since the amending Act also 'broke the nexus' between the medical services provided to the pensioner and pharmaceutical and hospital services. That is to say, under the 1967 amendment, new pensioners could receive free public-ward treatment in public hospitals and free pharmaceutical benefits irrespective of whether an agreement could be made with the A.M.A. for the extension of free, general-practitioner services. The new pensioners were, consequently, given special entitlement cards to enable them to receive their benefits. In the event, agreement was reached in November 1967.[13]

5. <u>The Pharmaceutical Benefits Scheme</u>[14]

Pharmaceutical Benefits came into force in September 1950. Unlike Hospital or Medical Benefits no in-

surance element is required for eligibility. For a charge of 50 cents per prescription, which on average is 25per cent of the full cost of the drugs, it provides a wide range of medicines. All doctors in Australia participate in the scheme; and special provisions are made for persons in isolated areas served by the flying doctor service. Virtually all pharmacists, dispensaries, public and certain other hospitals, are approved for the purposes of the Scheme.

Procedures are simple. After his examination of a patient a medical practitioner may prescribe a medicine on the list and give authority for the receipt of this benefit by employing a special duplicated prescription form. The pharmacist dispenses the prescription to the patient. He then prices it and sends the form to the Pharmaceutical Section in the State office of the Commonwealth Department of Health where the pricing is checked and reimbursement made to the pharmacist. It is estimated that approximately 80 per cent of all prescriptions qualify for benefit; for pensioners almost 100 per cent. To ensure the effectiveness of the scheme in its pharmaceutical aspects the list of drugs is reviewed regularly by the Pharmaceutical Benefits Advisory Committee, by pharmacists and by disciplinary committees of pharmacists in connection with cases of alleged malpractice. In addition, the National Biological Standards Laboratory test and determine the purity and standard of drugs. The Minister has wide powers to ensure that doctors and pharmacists comply with the provisions of the Act.

One important modification of the original scheme was the introduction of the 50 cents charge. Before 1 March, 1960, the scheme was available free to all persons. By the end of 1958 it had become the largest single element in the cost of the whole Australian National Health Scheme - a status which it still retains.

Its cost was the subject of considerable criticism. Accordingly, in August 1959, the Government decided to apply a 50 cents charge as a 'brake to the alarming rise in cost of the scheme'.

But the major alteration in the character of the Scheme concerns the extension of the number of drugs made available. Originally the Liberal-Country Party scheme was confined to drugs of a 'life-saving and disease preventing' nature - a restricted range as at first interpreted. By 1954, only some 299 were on the list. This is a much smaller range than was contemplated by the Labor Government in its 1947 Act which, it was proposed, would be based on the war-time formulary of the British Pharmacopaeia, among which were many drugs not life-saving or disease-preventing. Also, the Labor proposals had no intention of imposing maxima on the number of repeat prescriptions authorised. Under the present scheme, however, the expansion in the range of drugs offered has gone on steadily. Mainly this is the result of gradual extensions recommended by the Pharmaceutical Advisory Committee at its regular reviews. But there was also a substantial addition to numbers when, at the same time as the 50 cents 'braking' charge was introduced, a number of cheaper substitute drugs of the life-saving, disease-preventing character were introduced. It was hoped that their use would help hold down the rising cost of the Pharmaceutical Scheme; but, in the event, the wider range of alternatives made available to patients seems, if anything, to have assisted in raising the demand for drugs as a whole.

By 1968, the range available under the scheme had increased to around 1,100 drugs. Thus, doctors and pharmacists - leaving aside the 50 cents charge on prescriptions - are now operating, effectively, the kind of Pharmaceutical Scheme the Labor Party had in mind in the 1940s and which the medical profession in particular so

strongly and successfully opposed. It is a further interesting comment that the recent application of data-processing techniques to the handling of claims for pharmaceutical benefits has required medical practitioners to use a more standardised type of prescription form than was ever envisaged for the Labor scheme.

[illegible]	[illegible]	[illegible]	Pensioner Medical Service	Pharmaceutical Benefits	Other
[illegible]				Free pharmaceutical benefits: drugs in Commonwealth formulary using Commonwealth form	
[illegible]				Declared ultra vives the Constitution	
[illegible]	Agreements with states [illegible] condition free [illegible] treatment				
[illegible]					Amendment to Constitution
[illegible]	Rate increased to 8/- p.d.				
[illegible]				Attempt to make doctors prescribe free benefits declared invalid	

CHANGE OF GOVERNMENT

[illegible]				Pharmaceutical benefits scheme introduced: restricted to life-saving and disease preventing drugs	
1951 Feb.1			Inauguration of P.M.S. fees: 6/- Surgery, 7/6 Domicilary		
1951 [illegible]			Fees increased to: 8/- and 10/-		
1952 Jan.1	Hospital insurance scheme: [illegible]/- p.d. benefit for insured persons		Fees increased to: 9/- and 11/-		
1952 Aug.	New agreements with states: all states except Queensland introduce public ward charges				
1953 [illegible]		Medical benefits scheme commenced			
[illegible] Nov.1			Fees increased to: 10/- and 12/-		
[illegible] Oct.1			Eligibility for P.M.S. based on the means test in force 31.12.5[illegible]		
[illegible]		Provision made for the Minister to determine an amount (not exceeding £[illegible]) to be payable in respect of a medical service not specified in the schedules			
1957 Aug.	Agreements with states renewed. Same rates				
1958 Jan.1	Introduction of 12/- p.d. additional benefit if insured for at least 16/- p.d. fund benefit	Schedules redrafted - minor variations. Maximum Commonwealth benefit retained at £11.5			
1958 Jul.1			Fees increased to: 11/- and 13/-		
1959 Jan.1	Special accounts introduced: standard rate 16/- p.d. fund benefit	Special Accounts introduced: standard rate equal to Commonwealth benefit			
1960 Jan.1	Payment of special account benefit for hospital cases in nursing homes	Revision of Schedules - benefits increased. Max. Commonwealth benefit £22.10.0. Withdrawal of compulsory transfer of over 65s to Special Account.			
1960 Mar.1				Introduction of 5/- prescription charge: range of benefits widened.	
1961 Mar.1				Professional fees increased: ready prepared 2/9 to 3/- extemporaneous 5/- to 5/6	
1962 Aug.20	Agreements with states expired				
1962 Dec.1			Fees increased to: 12/- and 14/-		

(continued overleaf)

[illegible]

[illegible]	[illegible]	[illegible]	[illegible] Medical Service	Pharmaceutical Benefits	Other
[illegible]				Free pharmaceutical benefits: drugs in Commonwealth formulary using Commonwealth form	
[illegible]				Declared ultra vives the Constitution	
[illegible]	Agreements with States [illegible] p.d. condition free public ward treatment				
[illegible]					Amendment to Constitution
[illegible]	Rate increased to 8/- p.d.				
[illegible]				Attempt to make doctors prescribe free benefits declared invalid	
			CHANGE OF GOVERNMENT		
[illegible]				Pharmaceutical benefits scheme introduced: restricted to life-saving and disease preventing drugs	
1951 Feb.1			Inauguration of P.M.S. fees: 6/- Surgery 7/6 Domicilary		
1951 [illegible]			Fees increased to: 8/- and 10/-		
1952 Jan.1	Hospital insurance scheme: [illegible] p.d. benefit for insured persons		Fees increased to: 9/- and 11/-		
1952 Aug.	New agreements with States: all States except Queensland introduce public ward charges				
1953 Jul.1		Medical benefits scheme commenced			
[illegible] Nov.1			Fees increased to: 10/- and 12/-		
[illegible] Oct.1			Eligibility for P.M.S. based on the means test in force 31.12.55		
[illegible]		Provision made for the Minister to determine an amount (not exceeding [illegible]) to be payable in respect of a medical service not specified in the schedules			
1957 Aug.	Agreements with States renewed. Same rates				
1958 Jan.1	Introduction of 12/- p.d. additional benefit if insured for at least 16/- p.d. fund benefit	Schedules redrafted - minor variations. Maximum Commonwealth benefit retained at £11.5			
1958 Jul.1			Fees increased to: 11/- and 13/-		
1959 Jan.1	Special accounts introduced: standard rate 16/- p.d. fund benefit	Special Accounts introduced: standard rate equal to Commonwealth benefit			
1960 Jan.1	Payment of special account benefit for hospital cases in nursing homes	Revision of Schedules - benefits increased. Max: Commonwealth benefit £22.10.0. Withdrawal of compulsory transfer of over 65s to Special Account.			
1960 Mar.1				Introduction of 5/- prescription charge: range of benefits widened.	
1961 Mar.1				Professional fees increased: ready prepared 2/9 to 3/- extemporaneous 5/- to 5/6	
1962 Aug.20	Agreements with States expired				
1962 Dec.1			Fees increased to: 12/- and 14/-		

(continued overleaf)

Date	[illegible]	[illegible]	[illegible] Service	Pharmaceutical Benefits	Other
[illegible]				Free pharmaceutical benefits: drugs in Commonwealth formulary using Commonwealth form	
				Declared ultra vives the Constitution	
[illegible]	Agreements with States [illegible] condition free [illegible] treatment				
[illegible]					Amendment to Constitution
[illegible]	Rate [illegible] 8/- p.d.				
				attempt to make doctors prescribe free benefits declared invalid	
			CHANGE OF GOVERNMENT		
[illegible]				Pharmaceutical benefits scheme introduced: restricted to life-saving and disease preventing drugs	
[illegible] Feb.			Inauguration of P.M.S. fees: 6/- Surgery 7/6 Domiciliary		
[illegible]			Fees increased to: 8/- and 10/-		
[illegible] Jan.	Hospital insurance scheme: [illegible] p.d. benefit for insured persons		Fees increased to: [illegible] and 11/-		
[illegible] Aug.	New agreements with States: all States except Queensland introduce public ward charges				
[illegible]		Medical benefits scheme commenced			
[illegible] Nov.			Fees increased to: 10/- and 12/-		
[illegible] Oct.			[illegible]ibility for P.M.S. [illegible] in force 31.12.55		
[illegible]		Provision made for the Minister to determine an amount (not exceeding [illegible]) to be payable in respect of a medical service not specified in the schedules			
1957 Aug.	Agreements with States renewed. Same rates				
1958 Jan.1	Introduction of 12/- p.d. additional benefit if insured for at least 16/- p.d. fund benefit	Schedules redrafted - minor variations. Maximum Commonwealth benefit retained at £11.5			
1958 Jul.1			Fees increased to: 11/- and 13/-		
1959 Jan.1	Special accounts introduced: standard rate [illegible] p.d. fund benefit	Special Accounts introduced: standard rate equal to Commonwealth benefit			
1960 Jan.1	Payment of special account benefit for hospital cases in nursing homes	Revision of Schedules - benefits increased. Maxi. Commonwealth benefit £22.10.0. Withdrawal of compulsory transfer of over 65s to Special Account.			
1960 Mar.1				Introduction of 5/- prescription charge: range of benefits widened.	
1961 Mar.1				Professional fees increased: ready prepared 2/9 to 3/- extemporaneous 5/- to 5/6	
1962 Aug.20	Agreements with States expired				
1962 Dec.1			Fees increased to: 12/- and 14/-		

(continued overleaf)

Date	Hospital	Medical	Pensioner Medical Service	Pharmaceutical Benefits	Other
[illegible]	[illegible]				
[illegible]	[illegible]				
[illegible]				Rebate of 5/- prescription charge not allowed for new members of Friendly Society dispensaries	
[illegible]					Provision for establishment of a hearing aid service to persons under 21 yrs. of age. Provision of vaccine for immunizing persons against poliomyelitis
[illegible]		Commonwealth benefits [illegible]			
[illegible]		[illegible]			
[illegible]			[illegible]	[illegible]	
[illegible]		Doctors' fees [illegible] all States except [illegible]			
1966 [illegible]			Means test relaxed to means test applying 1.12. [illegible]. Student children up to 21 yrs. included as dependents		
[illegible]			Amendment of the definition of pensioner - consequent upon the Social Services amendment of maximum rate of pension from 30.9.66		
1967 Jan.1	Standard rate increased from 16/- p.d. to $3 p.d. [illegible] benefit arrangements - 80c [illegible] patients; $ [illegible] public wards; $ [illegible] nursing home patients	Schedule reprinted in decimal currency. Level of Commonwealth benefit unchanged			
1967 Apr.21	For [illegible] benefit [illegible] [illegible]			For pharmaceutical benefit purposes, definition of pensioner altered to include persons receiving a sheltered employment allowance; and means test relaxed to means test applying 21.4.67	
1967 [illegible]			Fees increased to $1.70 and $2.15. Agreement reached with A.M.A. to include in the P.M.S. scheme those persons who became eligible for pensions as a result of amendment to Social Services Act on 21.4.67		
1967 Nov.16		Schedules redrafted with minor variations (to come into operation on a date to be proclaimed)			Provisions for establishment of a hearing aid service for pensioners and dependents (effective from 1.2.68)

[illegible] refer to date of introduction implementation of the charge.
[illegible] compiled for the author by the Research Section, Commonwealth Department of Health, December 1967.

Date	Hospital benefits	Medical benefits	Pensioner medical service	Pharmaceutical benefits	Other
[illegible]	[illegible] ... wards; ... patients and ... nursing home patients				
[illegible]	[illegible] ... Special account ... [illegible] - excess ... from Ordinary a/c.				
[illegible]				Rebate of 5/- prescription charge not allowed for new members of Friendly Society dispensaries	
[illegible]					Provision for establishment of a hearing aid service to persons under 21 yrs. of age. Provision of vaccine for immunizing persons against poliomyelitis
[illegible]		Commonwealth benefits increased [illegible] in the schedule [illegible]			
[illegible]		[illegible]			
[illegible]			[illegible]	[illegible]	
[illegible]		Doctors' fees increased in all States except W.A.			
1966 Jan.1			Means test relaxed to means test applying 1.12. [illegible] Student children up to 21 yrs. included as dependents		
1966 Sep.30			Amendment of the definition of pensioner - consequent upon the Social Services amendment of maximum rate of pension from 30.9.66		
1967 Jan.1	Standard rate increased from 16/- p.d. to $3 p.d. New benefit arrangements - 80c uninsured patients; $[illegible] pensioners in public wards; $2 insured and nursing home patients	Schedule reprinted in decimal currency. Level of Commonwealth benefit unchanged			
1967 Apr.21	For hospital benefit purposes, definition of pensioner altered [illegible] receiving [illegible] allowance; and means test [illegible] 21.4.67			For pharmaceutical benefit purposes, definition of pensioner altered to include persons receiving a sheltered employment allowance; and means test relaxed to means test applying 21.4.67	
1967 May 1			Fees increased to $1.70 and $2.15. Agreement reached with A.M.A. to include in the P.M.S. scheme those persons who became eligible for pensions as a result of amendment to Social Services Act on 21.4.67		
1967 Nov.10		Schedules redrafted with minor variations (to come into operation on a date to be proclaimed)			Provisions for establishment of a hearing aid service for pensioners and dependents (effective from 1.2.68)

[illegible] refer to date of introduction implementation of the charge.

[illegible] compiled for the author by the Research Section, Commonwealth Department of Health, December 1967.

FOOTNOTES (CHAPTER EIGHT)

1. Earle Page, A New Conception of a National Health Service in Australia. Address by the Commonwealth Minister for Health to the British Commonwealth Medical Congress, 23 May, 1950. Mss. from the Commonwealth Department of Health, Canberra.

2. See Chap.II and Chap. X.

3. Note for example that the Country Party's platform of 1946, had shifted in emphasis from 'a national programme on an equitable contributory basis to cover health etc.' and an amendment to the Constitution to provide for Federal Control of, (among other things), health, in 1949 to/an amendment to provide for cooperative development by the States and the Commonwealth of public health, hospital services and social services. The 1949 platform also contained for the first time the provision that there would be no nationalisation or socialisation of medical, nursing and pharmaceutical professions. The Australian Country Party Platform (Federal), Feb. 1946, p.14; Ju.1949 p.12.

4. R.G. Menzies, 'Medicine, Politics and the Law', M.J.A., 30 July 1955, p.152.

5. Commonwealth Department of Health, Guide to National Health Benefits, 1966.

6. The National Health Act is divided into nine parts. Part I is preliminary and introductory. Part 2 repeals the National Health Services Act, 1948-49; defines existing health services, ensures their continuity and arranges health measures. Part 3 deals with medical benefits, repealing regulations previously existent. Part 4 incorporates within the framework of the Act the scheme for pensioners already launched by regulations in 1951. It sets out the details of the agreements between the Govern-

(6. Continued)

ment and the Australian Medical Association, and between the Government and the individual practitioner which forms the basis of the Service. A penal clause covering fraud and misrepresentation was added by an amendment Act (No. 68 of 1955, Section 12.) Part 5 deals with hospital benefits. Part 6 defines the conditions governing the medical and hospital benefits organisations within the framework of the National Health Scheme. Part 7 repeals the Pharmaceutical Benefits Act of 1952 and incorporates the substance of that act within the current legislation, both in relation to pensioners andother members of the community. Part 8 legislates for the establishment of committees of inquiry, both Federal and State, in respect of medical and pharmaceutical services. Part 9 covers various miscellaneous matters. Schedules of benefits constitute appendices.

Amendments to the National Health Act have taken place every year since its inception, and in 1967 there were two amendments to the Act. (For details of each change see chart.)

The Acts and Regulations which have been repealed as a result of the Consolidation were the following: 1. The National Health Service Acts, 1948-49; 2. The National Health Medical Benefits Regulations, made under the National Health Service Acts 1948-49; 3. The National Medical Services to pensioners regulations; 4. The Hospital Benefits Act 1951; 5. The Pharmaceutical Benefits Act, 1947-49, 1949-52; 6. The National Health Medicines for pensioners regulations, made under the National Health Service Act, 1948-49; 7. The National Health Pensioners Medical Services Committee of Inquiry regulations and the National Health medicines for pensioners Committees of Inquiry regulations. My descriptions of the National Health Scheme have been drawn from a variety of sources, of which

the most important were: (1) Interviews with appropriate administrators; (2) Annual Reports of the Commonwealth Director General of Health; (3) Earle Page, What Price Medical Care?, Lippincott Company, N.Y., 1960; (4) Sir Theodore Fox, 'The Antipodes Private Practice Publicly Supported', The Lancet, Vol.1, No.7286, 20 April 1963, p.875, No.7287, 27 April 1963, p.933. Other publications describing the National Health Scheme may be found in the general bibliography.

7. Health - Journal of the Commonwealth Department of Health, No.4, 1958.

8. The daily rates for treatment in the public wards of public hospitals in the individual States as at 1st September 1966 were: New South Wales $8; Victoria $10; Queensland, no charge; South Australia, General $7.50, Maternity $8; Western Australia $7; Tasmania $8. M.J.A. Supplement, Vol.II, No.21, p.19.

9. The mechanism of special accounts is complicated. The patient is on the Special Accounts only for his pre-existing or chronic illness. If he, in addition, fractures his arm he is paid out of the ordinary fund and at the full rate.

10. See Chapter Ten, ■

11. Information from Department of Social Services. See also Commonwealth of Australia Year-Book, 1966, pp.505-6.

12. The precise figure is not known. One estimate has been given for the period 1963-4, namely that 'of the 86,224 people admitted to age, invalid and widows pensions, 27 per cent did not qualify for the service at the time their pensions were granted'. T.H. Kewley, Social Security in Australia, p.369.

13. In June 1968, Federal Council of the A.M.A. decided to put to the Commonwealth Government proposals to improve the P.M.S. by (1) expansion of services, to include minor surgery and diagnostic procedures; (2) the appointment by the Government of district nurses to work with general practitioners in caring for pensioner patients. They also proposed that the concession on fees for pensioner treatment should not exceed 20 per cent of average private fees.
Canberra Times, Wednesday 5 June, 1968.
(In the event, according to the Commonwealth Department of Health, on 12 November 1968, the additional pensioners involved turned out to be two and a half thousand, not forty thousand).

14. Annual Reports 1954-5 to 1966-7, Commonwealth Department of Health; also T. Hunter, 'Some Thoughts on the Pharmaceutical Benefits Scheme', The Australian Journal of Social Issues, Vol.I, No.4 (Spring 1963).

CHAPTER NINE

ADMINISTRATION AND CONSOLIDATION OF POLICY 1949-67 [1]

The administration of the National Health Scheme is accomplished through a complex arrangement of agencies, some statutory, some 'approved' and some non-statutory. In a formal sense there is the Department of Health and its regional (State) offices together with a number of advisory and disciplinary bodies such as the Commonwealth Health Insurance Council, the Pharmaceutical Benefits Advisory Committee and the various medical and pharmaceutical services committees of inquiry which operate in the States in order to exert surveillance over these parts of the scheme. There are also the hospital and medical benefits funds approved under the Act to provide the insurance elements of national health. The main mass of administrative detail of the Scheme - on contributions, membership and payment of benefits - is carried out by these funds. Less formally, doctors and pharmaceutical groups play a varying and often important role. In addition to their functions within the advisory and disciplinary bodies, the executives of their professional organisations consult regularly with senior public service officials. Finally, with no official status in the formal administrative machinery, there are industry and vocational bodies. Hospitals associations, nursing associations, and the representative bodies of manufacturers of ethical pharmaceutical products, exert influence in a not-too-easily-determinate fashion at various points of the administrative apparatus.

1. The Commonwealth Department of Health [2]

The main administrative agency in the National Health Scheme was established on 7 March 1921 by Executive Council Minute under the Commonwealth Public Service Act. Until

1928 the Department was situated in Melbourne, when it moved to Canberra. In 1927 the Director of Quarantine became Director-General and permanent head of the Department; and a new ministerial portfolio for Health was created. In the hierarchy of ministers, Health does not rank highly. The portfolio does not automatically carry its holder into Cabinet. A Health Minister's inclusion in Cabinet would depend rather on personal seniority in his party and ministry. Since 1949 only Earle Page and Senator H.L. Wade among Health Ministers have achieved Cabinet membership.

For the first twenty-six years of its life, the Department of Health operated largely in an advisory and investigating capacity. Its main functions were to investigate disease, to coordinate research activities, to make its findings available to the States and generally to educate the public in health matters. To execute these functions the Department was organised on a divisional basis and this was gradually expanded and added to as the Department's activities increased.[3] The recommendation of the 1926 Royal Commission on Health, for example, resulted in the establishment of a Tuberculosis Division and the National Health and Medical Research Council Division.

By 1930, the Department was organised into six divisions. These were: Industrial Hygiene, Public Health Engineering Laboratories, Tropical Hygiene, Marine Hygiene, Tuberculosis and Venereal Diseases. Between 1930 and 1939 a period of retrenchment set in and a number of the Department's activities were eliminated or curtailed. The situation began to change dramatically with the outbreak of the Second World War. A sudden, substantial expansion of Commonwealth activities took place in many areas of social and economic activity which hitherto had

been the province of State private enterprise institutions. The health-conscious policies of the Labor Government between 1941 and 1949 gave impetus and direction to these enlarged functions (Chapter 5). The divisions of national health and pharmaceutical benefits were set up for the first time and tuberculosis and other divisions expanded. The Administrative division, which included a research and policy section, was enlarged. These new divisions were created on the assumption that a comprehensive centralised health scheme would be established and extended. As we have seen, this did not eventuate.

The replacement of the Labor Government by a Liberal-Country Party Government in 1949, as we have seen, initiated a reorientation of health policy designed to encourage private organisations in the provision of health insurance. The main emphasis of the Department's functions was seen, therefore, to be on ensuring cooperation and coordination of the activities of decentralised private agencies.

The divisional structure was retained but the national health division has scarcely been expanded. Nor have its functions been increased beyond those necessary to secure the efficient administration of financial benefits under the Scheme. As it at present operates, these include the registration of the funds in conformity with the requirements of the Act, the registration of price agreements with pharmacists and (in the case of the Pensioner Medical Service) with the A.M.A. and approved hospitals under the Act. A limited degree of control is exerted, which takes the form of approval of, or insistence upon, standards, qualifications, financial viability and conformity to practice for the hospitals and funds. Medical practitioners and pharmacists are expected to discipline themselves through their professional organisations as

well as the committees of inquiry. These controls - if control is the word for a mixture of permissiveness, regulation and requirement - operate within the framework of a Commonwealth statute the main function of which is to provide subsidy and a few guidelines for policy and practice.

Some minor expansions of the Department's activities have taken place since 1964. Partly they are the result of rationalisation measures, some of which have been developing within the Department since the nineteen-fifties; and partly they are the consequence of a general public service overhaul of the second division of the officers of the whole Commonwealth Public Service which took place in 1964. More attention is now given to accounting and financial aspects as evidenced by the expansion of these sections. More interestingly, the 1964 reorganisation brought with it an expansion of the activities of the planning and legislation branch which had, since 1950, operated on a relatively small scale. The branch now spends some 50-60 per cent of its time on matters relating to national health and acts as a form of policy secretariat for the Health Department.[4] As such, it is mainly responsible for ensuring that the Minister is furnished regularly, and on specific occasions, with information on matters of current policy. It provides Cabinet submissions when the Minister requests these. It also arranges material for the Minister each year when he attends the annual conference with the State Ministers of Health. And it prepares memoranda which may be necessary when any conference takes place with the Australian Medical Association or any other group or committee. When amendments to the National Health Scheme are being considered the officers of the planning and legislation branch coordinate the medical, hospital and pharmaceutical aspects. In

other words, the section's principal task is to take an overall integrated approach in order to keep each aspect of the scheme consistent with the others.

There is a small research section of relatively recent origin within the planning and legislation branch. It is concerned with minor research activity and coordinates research material as it becomes available from records of the individual pharmaceutical, hospital and medical branches. The establishment of this section was overdue. Indeed, it is remarkable that the national health scheme operated for almost twenty years without one. Even so, work undertaken by the research section clearly has its difficulties. The establishment is a relatively small one; and there is no suggestion that it is or will be concerned, at least in the immediate future, with financial estimates geared to forward planning. One problem (which also affects many areas of the public service) is that the turnover of staff within the section is high. Competition for qualified staff from other departments, especially for graduate staff, is ever present. And the keen young research worker is just as likely to be devoted to quick promotion which, more often than not, means a transfer to another department, as he is to discovering and wrestling with the more intransigent problems of health administration. This difficulty is hardly likely to be overcome unless the government places stronger emphasis on research.[5]

CHART I

THE ORGANIZATION OF THE AUSTRALIAN NATIONAL HEALTH SCHEME AND THE COMMONWEALTH DEPARTMENT OF HEALTH

MINISTER FOR HEALTH
||
DIRECTOR-GENERAL
||
2 DEPUTY DIRECTORS GENERAL
||
5 ASSISTANT DIRECTORS GENERAL

1 — Management Services & Benefits Division
- Establishment and Finance Branch
- Planning & Legislation Branch
- Medical & Hospital Branch

2 — National Health Division
- Pharmaceutical Services Branch
- Therapeutic Substances Branch
- Public Health Branch

3 — Laboratory Services & Quarantine Division
- International Health
- General Quarantine

4 — National Health & Medical Research Council Division
- Animal Quarantine
- Plant Quarantine

5 — Tuberculosis Division

||
6 STATE OFFICES
||
COMMONWEALTH DIRECTOR OF HEALTH
||
4 ASSISTANT DIRECTORS*
- Administration & Finance
- General Benefits
- Pharmaceutical
- Medical

* Except Hobart which has 2 only

2. Regional Offices of the Department

The detailed administrative work of the Commonwealth Health Department is carried out at the State Branch Offices in the capital cities of the six States. The Commonwealth Director of Health in each State is assisted by four assistant directors responsible, respectively, for the medical, pharmaceutical, hospital, financial and administrative aspects of the scheme. These regional offices conform to a pattern, and each has various sections corresponding to those at head office. As with Departmental headquarters at Canberra, their activities in relation to the National Health Scheme constitute only one part of their role. The New South Wales Branch Office is the largest and handles some forty four per cent of all Commonwealth regional activity.

On the hospitals side, the Divisional officers check private hospital claims for hospital benefits. They administer additional hospital benefits and they inspect records. On behalf of the government they also reimburse to the States Commonwealth hospital benefits deducted from the accounts of patients in public hospitals. In relation to additional hospital benefits for insured contributors, the main tasks of the State Branch Office are: a policing exercise to ensure compliance with the terms and conditions of registration laid down by the Registration Committee; a test-check on the eligibility of patients to receive the additional benefit; a registration check; the payment of the monthly claims of registered organisations; and the preparation of quarterly and annual statistics on the operation of individual registered organisations and reports on the working of the scheme. Inspections are carried out of all approved private hospitals and nursing homes at regular intervals, usually once a year.

The system of medical benefits is administered in much the same way. Again the main duties are the checking and

payment of claims submitted by organisations; regular inspection of financial records; examination and preparation of statements and the submission of reports on them to the Director-General; preparation of quarterly statistical returns and a quarterly report on the general operation of the scheme. In addition, an important function is to keep the funds under regular review to ensure that they comply with the terms and conditions of registration. Supervision of special accounts needs particular care; the funds must submit separate claims covering payments to ordinary and special account contributors. The main points to be checked in this connection are: the amount of Commonwealth benefit; that fund and Commonwealth benefits in fact match; that the fund is paying at the appropriate rate for the special account contributor; and that total benefits paid to any contributor do not exceed 90 per cent of the cost incurred.

The administration of the Pensioner Medical Service follows lines very similar to that of the medical benefits. The divisional office checks and pays claims made by doctors in the Commonwealth for services given at a concessional rate.

On <u>pharmaceutical benefits</u> the principal activity of State Branch Offices is to check and pay claims submitted by approved chemists and to undertake a number of semi-technical duties associated with the determination of prices and the availability of drugs. Approved chemists submit their claims monthly. The checking process involves inspection of prescriptions to ensure that statutory regulations have been observed. The prescribed drugs must of course be listed as benefits and adjustments are made to the prices claimed if these are not correct. The quality and quantity of drugs and medicines is also subject to control.

Medicines are sampled and analysed by the Commonwealth Department of Health. Actual prescriptions written by

doctors are given to a pharmacist by a departmental inspector who does not reveal his identity until after the prescription has been made up. A portion is sent for analysis to the government laboratory. These samples are taken on a random basis and the inspectors are liable to visit most pharmacies in an unpredictable manner. On completion, the Department's reports are sent to the Director-General in Canberra. Wherever a faulty formulation has taken place a pharmacist is asked to appear before the Pharmaceutical Services Committee of Inquiry, a committee which, as earlier mentioned, consists mainly of pharmacists practising in the particular State. A pharmacist may ask an outside analyst to provide an independent analysis of his product if it is under question by the committee. The sanction normally involved is either a 'reprimand' or a 'warning', depending on the nature of the error. The Commonwealth therefore ensures that the quality of medicines provided to the consumer, for which it is the main purchaser, is maintained.

Drugs used for pharmaceutical benefits are also controlled through the Therapeutic Substances Act (1953-9) which forbids importation into Australia of therapeutic substances which do not bear/in the labelling an accepted scientific name and the details of their origin. The National Biological Standards Laboratory in Canberra was established to assist the Commonwealth Government in this type of quality control of pharmaceutical preparations under this Act. The officers of the laboratory/may visit premises where drugs are manufactured and report to the proprietors on their findings. A Commonwealth drug analysis laboratory in the University of Sydney and the Commonwealth Laboratories, controlled by the Department of Customs and Excise, may/also undertake checking of drugs under the scheme. Manufacturers of pharmaceutical and therapeutic substances also have, of course, their own laboratories to maintain quality control.

From the foregoing it is apparent that the State Branch Offices, in practice, deal more in the minutiae of administration than does the central office of the Commonwealth Health Department. It is not surprising, therefore, to find that the Departmental headquarters operates its entire National Health responsibilities with a total staff of 107, while the N.S.W. Branch Office has an establishment of 318 and the Victorian of some 275.[6]

It does not follow that any of the important decision-making powers are decentralised. Nor does the relative infrequency with which the Divisions have to refer to Canberra indicate that they are free to use their discretion, other than in very minor ways. Rather, they seldom seek additional advice because their functions are specifically and narrowly defined.[7] In addition, there is a constant and continuous flow of circulars coming from the centre to ensure uniformity and to provide unambiguous and up-to-date statements of government policy.

On the question of decentralisation, the Commonwealth Department is apt to consider the State Branch Office principally as auditors of fund activities, while the important 'policy' matters are reserved for disposition by the central office. An examination of Chart II (p. 269) confirms this point. The five committees listed are the most important channels of communication between government and the professions participating in the Scheme. The decisions and recommendations which emerge from them are crucial to the successful execution of policy and precede any changes, however small. There has never been any serious suggestion that these matters should be handled at a State level. This fact suggests strongly that, so far as the Department is concerned, the intention was, - and remains, that 'policy' decision should be centralised.

At a less formal level, the primary importance of headquarters may be gauged by the attitudes and behaviour of the vocational groups whose interests are affected by the Scheme. Chart III (p. 270) sets out the informal pattern of contact between the A.M.A., the Federal Pharmaceutical Service Guild and the Australian Pharmaceutical Manufacturers Association, on the one hand, and the Commonwealth Department of Health on the other. It is significant that all three groups prefer to go to Canberra even for informal discussions or criticism, even though a (to them) favourable response or decision may not be forthcoming. The centre may well, in the event, support the State Branch offices in matters of policy interpretation. But only the central office would take the responsibility for any reorientation of statutory requirements. Further, experience has shown, for reasons which will be suggested later in this chapter, that the centre is more subject, and amenable, to political pressures. A consideration which must certainly influence those seeking change or protection and one which reinforces the authority of the Commonwealth Department.

Centralisation has increased rather than decreased in recent years. The growing volume of criticism of the Scheme, demands for change, more control of allegedly irresponsible behaviour by funds, doctors and pharmacists - all require consideration and, if necessary, action which can only be taken by the Commonwealth Department of Health. Even assuming that the States might wish to take a stronger line with the A.M.A., for example in respect of complaints and abuses under the Pensioner Medical Service and possibly on the control of medical fees, it would be unable to do so because of the position taken by the central office. It is government policy that medical practitioners and pharmacists should be induced rather than obliged to discipline themselves.

There are a few areas where the State Branch Office may take the initiative and exercise a modicum of discretionary authority. But these relate mainly to technical matters. One example is the power to interpret, more or less liberally, the range of drugs available as benefits in certain restricted cases under the Pharmaceutical Benefits Scheme. Probably one of the more important decisions made independently by the Division relates to the selection of cases to come before the various committees of enquiries in their State.

While there may be a desire for more decentralisation - and a skilful divisional director may in practice take more initiative than the formal situation allows - there are some indications that the State offices do not feel themselves unduly restricted by interference from Canberra. Moreover, many officers prefer the opportunities for field work and grass-roots administration which some divisional activity provides. Movement to the centre is not universally regarded as a desirable or ultimate objective. Quite apart from the cost of uprooting himself and his family there is a feeling among many State Branch administrators that, in wrestling with the minutiae and personalities of difficult individual cases, they are concerned with the 'real issues', no matter how limited and narrow these may appear by comparison with the more wide ranging and controversial problems dealt with in Canberra.

3. Liaison with Other Departments

In the administration of the National Health Scheme the Department of Health, either at the Commonwealth or divisional level, comes into contact with a number of Commonwealth and State Departments and agencies. The most important of these are the State Health Departments, the various Hospitals Commissions in each State, and the Commonwealth Department of Social Services. It also

has routine contact with the Commonwealth Repatriation Department, the Attorney-General's Department and the Medical Boards of each State.

The main area where some Commonwealth-State coordinative activity is required concerns the allocation of Commonwealth Hospital Benefits to the State Hospitals. Traditionally the administration of hospitals in Australia has been in the hands of hospital commissions or boards set up under State legislation; or they are operated by the States themselves. The Commonwealth has no responsibility for hospitals other than Repatriation Hospitals and the civil hospitals in the Northern Territory and the A.C.T. The finance of State public hospitals has come traditionally from three main sources. The most important is the State's own subsidy which today amounts on average to some 40 per cent of the total. Next comes the contribution of the Commonwealth, made through its Hospital Benefits contribution scheme amounting on average to some 31 per cent of the total. The remainder, 29 per cent, comes from patients' fees. 8

Until 1963, hospital benefits were paid by the Commonwealth, in advance, into the State Government's consolidated revenue and were distributed by the State Hospitals Commission according to their own assessments of the needs of its hospitals. The Divisional officers employed their own inspectors to audit claims made upon Commonwealth funds from the Hospitals Commission. But they had, in addition, to rely on the Commission to supply them with certain types of detailed information. Before 1962, State governments paid their subsidies in advance, as did the Commonwealth, through the Hospitals Commission. In 1962 a number of changes were made in these arrangements. Under an amendment to the National Health Act (section 54) the Commonwealth, from that date, paid its contributions directly to the hospital themselves and not in advance to the Hospitals Commission.

This amendment has caused some conflict between Commonwealth and States. The State Commissions argued that this new procedure led to unnecessary duplication of administration, since the Commonwealth had then to maintain contact with, for instance in N.S.W. between 200 or 300 hospitals per month instead of with a single State agency (in this case the Hospitals Commission). The Commonwealth, on the other hand, claimed that, under the old system, the opportunity existed, and was often used by the State Commission, to reduce subsidies to the hospitals by the amount which the Commonwealth paid directly to them. The Commonwealth also maintained that the State Hospitals Commissions had, and used, the opportunity for withholding the Commonwealth grant from the efficient hospitals, employing it instead to subsidise the less efficient ones.

The conflict between the Commonwealth Government and the State Health Department in N.S.W. became acute when, in January, 1963, the Commonwealth commenced payment of its $3.60 per day (increased from the old $1.20) for hospital care of pensioners direct to the hospital instead of to the State Government. Senator H.W. Wade, who was then Minister of Health, claimed that the State Government had 'almost immediately' taken steps to reduce hospital subsidies by the amount formerly paid by the Commonwealth to the State Treasurer. Wade accused the State Government of nullifying the effects of the increased Federal subsidy to the State hospitals by reducing their own contributions. The Premier immediately wired the Prime Minister, Sir Robert Menzies, seeking a retraction of the statements made by the Minister for Health, But Sir Robert supported Wade, claiming that the N.S.W. Health Minister, W.F. Sheahan, had himself admitted that he would, as a result of the Commonwealth action, have to decrease the subsidy. He had said 'that the increased payments...will necessitate a material downward adjustment of the subsidy

paid by the Hospitals Commission to each hospital'. Sheahan in turn denied this and accused the Prime Minister of 'taking this statement out of its context and twisting its its meaning to suit his own desires'. The controversy was conducted by a series of telegrams which were publicized and aroused considerable public comment.[9] The situation was clearly a complex one and would require more unravelling than is possible in this study. But the point can be made that there has been at least one area of overlap which has resulted in conflict between the Federal and the State administration on the National Health Scheme. It is probable, moreover, that these are more in relation to hospital benefits than any other aspect of the scheme.

Another difficulty which has arisen concerns the different criteria applied by State Health Departments for the classification of hospitals and those which are applied by the divisional officers of the Commonwealth Health Department for the purposes of approving hospitals under the Act. The State Department is concerned with such matters as the capacity of the hospital, its staffing, its physical condition, the equipment which it holds and such like matters. The Commonwealth applies a different set of criteria concerned largely with the intensity of hospital care provided. The Commonwealth tests therefore tend to emphasise the particular illness from which the patient suffers rather than the physical attributes of the hospital itself. Thus the Commonwealth could exclude frequently private hospitals, hospitals/catering for patients with chronic illnesses and pre-existing ailments for the purposes of the National Health Act. The States, more concerned with getting as high a contribution as possible towards the financing of these hospitals, would, ideally, prefer not to classify them in this way.

Such a conflict of criteria clearly can create, and indeed has led to, anomalies. A hospital, from the State's point of view, may meet every requirement for being a hospital except that, so far as the Commonwealth is concerned, it caters for the wrong kind of patient. Yet many of these patients are liable to stay in hospital for a considerable period of time. Some of them may be terminal cases. In a quantitative sense, the chronic, long term and terminal illness problem is by no means small.[10] A high proportion of hospitals in any State, sometimes as many as 50 per cent, are likely to be private hospitals. One is hardly surprised that such a situation has created disagreement between the State Departments of Health and the Commonwealth, particularly as the Commonwealth may now inspect private hospitals without consulting the States. Similar problems have arisen between individual hospital boards and the Commonwealth.

It could be argued that the conflicts create a case for a more rational division of functions, permitting either the State classification of hospitals or the Commonwealth classifications to apply to a hospital. But attempts at such a solution probably would generate constitutional difficulties. The States almost certainly would wish to argue that they are the most obvious groups to administer a decision of this character, partly on historical grounds, partly for reasons connected with the federal structure and perhaps even because State agencies are closer to routine individual hospital situations and needs. On the other hand, the Commonwealth is likely to affirm that a national scheme requires uniformity. And, since almost certainly there will be a greater need for Federal assistance in financing hospitals in the future, the Commonwealth probably would not wish to give up what control and initiative it has at the moment.

On the pharmaceutical benefits side of the scheme, the State Branch Office cooperates, where necessary, with appropriate bodies such as the State Health Departments and the State Pharmacy Board. There is also routine liaison with the Repatriation Department. The pharmaceutical section of the Divisional office checks prescriptions on behalf of the latter Department - a function which the Repatriation Department used to perform for itself in the days before the national health scheme. In this instance, the Health Department does not, of course, pay out funds. This is done by the Repatriation Department.

On pensioner problems, the Health Department also requires the assistance of the Social Services Department to ascertain that pensioners do in fact qualify under the Act - a fairly routine matter executed mainly by correspondence. The frequent changes in the criteria of eligibility of pensioners for the pensioner medical service, however, means that there is likely to be increased liaison between the two Departments in the future.

Questions of legal interpretation may cause the Department to refer to the Attorney-General's Department. To give one example, Section 103 covers offences under the Act. But sub-section (1) of Section 103 of the Act refers to the chemist as 'an approved pharmaceutical chemist' whereas sub-section 2 refers to him as 'a pharmaceutical chemist'. It is therefore not clear to what category of professional person the restriction actually applies and only the Attorney-General's Department can, in a particular instance, advise this. There is, finally, cooperation where necessary with the State Police Departments on matters connected with the illegal use of drugs.

4. The Hospitals and Medical Benefits Organisations

Most of the detailed handling of claims by patients under the National Health Scheme is carried out by the 187 funds approved for that purpose under the Act. The Hospital Contribution Fund (H.C.F.), along with the Medical Benefits Fund (M.B.F.) and other component funds forming the Blue Cross Association (five in all), today handle some 70 per cent of all insurance under the Act. The other 30 per cent are covered by Friendly Societies or industrial funds.

Well-established hospital benefit funds had been operating for nearly twenty years before the establishment of the National Health Scheme. The Hospital Contribution Fund was founded as early as 1931 by a group of Sydney metropolitan public hospitals. In 1951, it was estimated that some 40 per cent of the population of New South Wales was covered by hospital insurance. While hospital insurance was the creation of hospitals, medical insurance was, in Australia, the creation of doctors. It will be remembered that in the nineteen forties a major objective of the ..... was to avoid national provision of free medical services which would involve them in contractual relationships with government. To provide an alternative to such a scheme, and to forestall a possible government move to take over the work of the existing hospital contribution fund, the medical profession in N.S.W. formed a medical benefits fund. Doctors themselves provided the capital for its establishment. Individual members of the medical profession were asked for $20 each towards its foundation - the money to be used as a non-returnable loan towards the formation expenses of the first year of operation. Thousands of members of the medical profession subscribed to the establishment of this company and many have since retained a strong interest in medical benefits insurance.[11]

The Fund soon spread to other States and is today the largest medical benefits organisation in Australia. Its board of management has always been predominantly medical, though there is provision for representation of some contributors. In three of the States in which the Fund operates, senior members, past and present, of the Federal Council of the A.M.A. have been chairmen of the State organisations since its inception. In 1951 these medical benefit funds formed an associated company, the Blue Cross Association of Australia, and the constituent bodies have since called themselves Blue Cross Funds.

The re-introduction of charges in public hospitals in all States, other than Queensland, by State governments in 1951, as well as the stimulus provided by government subsidy, led many more people to turn to hospital insurance. This was only to be expected. As a consequence, hospital insurance has grown rapidly throughout Australia since that date.[12] Progress was slower in medical insurance until, in 1953, the incentive of an additional Commonwealth subsidy was introduced under the medical benefits scheme. (See Chart IV, p 314).

Until November 1963, in N.S.W., Victoria and South Australia the H.C.F. restricted itself to hospital insurance and the M.B.F. to medical insurance (although the M.B.F. had formed its Constitution to enable it also to offer hospital benefits). The two funds, between 1960-62, operated under a joint administrative structure; and a single management company, the Hospital and Medical Benefits Management Pty. Ltd., was founded in 1960. This company came to an end in 1963 after a period of conflict and competition between the two Funds.[13]

When the National Health Scheme was established in the early 1950s, Australian friendly societies were in serious financial difficulties.[14] They had never really recovered from the depression of the 1930s, which

had made severe inroads into their membership. In addition, for more than a decade, they had been competing unsuccessfully with other groups such as trade unions and banking insurance groups who provided benefits to other sections of the community.

Despite these membership and financial difficulties, the societies were at first reluctant to enter the government's arrangements. As noted earlier, they had been opposed to the 1938 National Health and Pensions Insurance Act and had, with other groups, conducted a vigorous campaign against it. The societies were afraid they might lose their autonomy. They wished to retain their special identity as benefit organisations with the emphasis on 'friendly' rather than 'benefits'. And they had no desire to become mere government agencies. Some felt that the government was using them, as well as other organisations, to obtain its National Health Scheme 'on the cheap'. Others, more realistically, saw the financial advantages inherent in the scheme and that, in particular, it would increase membership. Most important, they came to realise that, if they remained outside the scheme, they could not hope to compete effectively with the other benefit organisations.[15]

Therefore, in the event, when the other funds joined in the government scheme, the friendly societies soon followed. As a result, membership increased. By 1962 it was 700,000. But it did not increase as much as was necessary to return them to their traditional position of importance in voluntary insurance. The new members coming into the societies after 1953 were interested only in hospital and medical benefits coverage. They were not concerned to cover themselves for sick pay or funeral benefits for which there was provision in other statutory enactments. Consequently, the numbers of these so-called full-membership contributors, who had been

the financial backbone of the movement, did not rise to anything like the extent of members for hospital and medical services only. The societies, therefore, came to handle, compared to the Blue Cross Funds, a relatively small proportion of hospital and benefit insurance. Nevertheless, like the larger funds, they have retained a strong interest in maintaining a National Health Scheme based on voluntary insurance although it has become increasingly apparent that many of them are both uneconomic and inefficient.[16]

To qualify for registration, medical and hospital benefits funds must make application to a Registration Committee constituted under section 117 of the National Health Act. This committee, unlike all of the others operating the scheme, is exclusively departmental in composition. It consists of a Commonwealth actuary or his representative and two officers of the Department of Health. A fund can only be registered under the National Health Act if its rules provide: (i) that benefits are payable to insured contributors; (ii) that contributions are used for the above purpose or for any expenses incurred in connection with it; and (iii) that management expenses of the funds constitute a fixed proportion of income.

Application for registration must conform with certain requirements mainly concerned with the financial viability of the funds. Special attention is paid to the provisions made for the contributor. When the Registration Committee has considered an application for a prospective medical or hospital benefit organisation it submits its report on the application to the Minister, with or without a recommendation that the particular fund should be accepted. Records and accounts of the funds are also subject to close inquiry by the Department of

Health and detailed particulars must be furnished to the Director-General annually (Sec. 76). Funds which do not conform to the statutory requirements can be suspended or struck off the register, temporarily or completely (Sec.79). They may appeal against these decisions to the Supreme Court of their own State which has Federal Jurisdiction to consider the appeal. Its decision is final. Similarly, there must be no changes in the conditions, rules and contribution rates of organisations unless details of change are given to the Director-General, and are approved by him. The Registration Committee can, for example, decide that proposed changes may adversely affect the rights of contributors. Or it may decide that they in some way adversely affect the financial position of the organisation. They report findings to the Minister and give considered opinions on them.

Once accepted, the name of the organisation is placed on the Register. This Register is not, however, open for general inspection unless with the Minister's explicit authority. These provisions for registration appear strict and organisations are subject to penalty if they are not carried out.

Friction can be generated between the government and the funds on these contribution matters. For example, in December 1963, the N.S.W. Hospital Contributions Fund (H.C.F.) sought approval for a wide range of extended hospital and medical benefits (as part of its competitive drive against the M.B.F.). Approval for increase at that particular time was withheld. The Minister, according to the H.C.F., procrastinated; and finally refused approval on the grounds that 'trends in medical costs are rather disturbing' with the implication that the H.C.F. might not be able to meet the financial commitments involved in the increase. The fund rejected the suggestion that

this was so. Senator Wade does a great disservice to the H.C.F. and its contributors by suggesting any weakness in our financial position...our capacity to pay these benefits has been verified by our actuaries'.[17] But the Department stood firm.

Under the Act the government has no power to direct a new rule or a new table of benefits. Initiative must come from the funds themselves. On the other hand, there is, as the example just described illustrates, no certainty that the suggested changes will, in the event, be introduced. The Government's decision to accept or reject the proposals will almost certainly be influenced by the likely effect of the proposed change in terms of premium to be paid, the level of medical fees and likely demand for an increased Commonwealth subsidy.

It would appear that the funds are neither as free nor uncontrolled as is frequently assumed nor indeed as much as the funds themselves would like to be. There is more control exerted over the funds than over any other group, professional or otherwise, involved in the operation of the National Health Scheme. Even so, there is mounting evidence that such control does not mitigate many of the economic anomalies which result from the multiplicity of funds. We shall return to this point in the final chapter.

5. Advisory Bodies

The Commonwealth Health Insurance Council is the main advisory body set up under Section 136 of the National Health Act, a permissive section which provides 'that the Minister may establish such committees as he thinks fit for the purposes of the Act, their functions, duties, procedure, etc., to be provided for under the regulations'.

Its functions are to advise the Minister on matters relating to medical and hospital benefits, and to re-

commend means by which improvement in methods and standards may be effected. The Council consists of the Director-General of Health, who is Chairman, one member nominated by each of the State Associations of registered organisations, five other members representative of registered organisations, usually appointed by the Minister, and one member nominated by the Federal Council of the Australian Medical Association.

The Commonwealth Health Insurance Council held its inaugural meeting in Canberra in April 1959, and meets as required, usually not more often than twice a year. Important changes in the administration of the scheme are often preceded by and sometimes emanate from the Council's deliberations. For example, at its meeting in July, 1963, Council considered a detailed report by a special sub-committee which had reviewed the operation of the special accounts system in the hospital and medical benefits organisations in the light of changes introduced by an amendment to the National Health Act in 1963. As a result, a number of changes in the special accounts system were suggested. They were accepted by the Minister and subsequently included in another amendment to the Act in June, 1964. At the 1965 meeting, an important topic considered was the increased charges made by the Australian Medical Association after an economic survey of general practice had revealed a considerable rise in the costs of medical practice. On this occasion, Council took the view that registered organisations could not attempt to keep pace with every increase in doctors' fees, especially since they, the funds, had provided higher tables earlier in that same year. Consequently, neither the Commonwealth nor the funds increased their benefits at that time.

It is difficult to evaluate the precise role of the Commonwealth Health Insurance Council. Although the administration relies on the expert knowledge of its members on questions affecting the insurance machinery of the

Scheme, there is no sign that substantial policy changes originate in this body. On the contrary, the initiative is more likely to come from the Commonwealth administration. The Director-General himself is the Chairman; and there is more than a suggestion that the Minister for Health employs the well-known administrative device of using an advisory body and its recommendations as a buffer against possible criticism of any changes the Government may wish to make (or not to make). Rises in contribution rates will arouse less overt hostility if the increases originate, apparently, in the fund organisations. It is more difficult for the public to attack the professional decision of an insurance organisation acting under financial pressure than the politically-motivated policies of a government.

Leaving aside its occasional use to ventilate the views and absorb some of the blame of the administration, the essential role of the Council would appear to be that of a sounding board for the opinions and problems of the voluntary insurance organisations. However, it is most difficult to know either the direction or the weight of its influence. The Council's deliberations and recommendations are potentially of great importance to the general public as well as to the fund organisations. Yet there is little public knowledge of its proceedings - they are not reported. The line of distinction between an advisory body, such as the Council, and an executive body, can be a fine one. The few lines published on the Council's affairs in the Department's annual report do not assist or encourage informed discussion of its precise nature or role in practice.

A second advisory committee, in this case mandatory under Section 101 of the National Health Act, was set up 'to make recommendations to the Minister from time to time as to the drugs, medicines or preparations which it con-

siders should be made available as pharmaceutical benefits under the Act'. The Minister may also ask the Committee to advise him 'on any other matter concerning the operation of the scheme'.

This Pharmaceutical Benefits Advisory Committee consists of nine members: an officer of the Health Department who is a pharmacist, appointed by the Director-General; six doctors appointed by the Minister from ten nominated by the Federal Council of the A.M.A.; a pharmacist appointed from three nominated by the Federated Pharmaceutical Services Guild of Australia, and a pharmacologist. This is an important committee. From the point of view of the consumer what he is able to secure as a pharmaceutical benefit, and how, depends on its recommendations. No drug may be listed or added except on the recommendation of the committee. It may also decide that a drug may be listed but only for a restricted use. For example, in 1961, general concern about the use of the tranquilizer, Largactil, led to its use being restricted to pensioners and certain psychiatric cases. A number of groups, including psychiatrists, immediately protested against the withdrawal of the drug for general use. It was subsequently made more accessible to approved hospitals and to patients from hospitals who had certificates confirming their need for the drug. Again in 1960, on the recommendation of the Pharmaceutical Benefits Advisory Committee, a number of new and important drugs were introduced to be used only in major hospitals where all facilities for investigation and treatment were available.

Since the inception of the scheme in 1950, the Committee has very considerably enlarged the range of drugs listed as pharmaceutical benefits. It originally included some 200 items. By 1967 it had around 634; and, with different strengths and forms taken into account, the total was nearer 1,500. In 1961 the

Committee met three times and recommended fifty-seven new drugs plus a number of new forms and strengths of existing drugs. In the same year it made a number of variations to the categories of diseases and conditions for which a number of drugs could be prescribed as pharmaceutical benefits. The removal of a number of drugs from the list normally is due to supersession by more effective drugs. For instance, during 1966-7, a periodic revision resulted in the deletion of eighty-one preparations from the list. There is usually a gap of some five to six months between the recommendation that a drug be placed on the list and its availability. Each recommendation requires ministerial approval followed by amendments to the regulations in which the lists are included. As with the Commonwealth Health Insurance Council, the Committee's activities are held in private session. There are no published reports of their proceedings.

Different groups apply for the listing of particular products as benefits. But the overwhelming majority, about 95 per cent, come from the manufacturers of pharmaceutical products. Some 4 per cent of applications come from doctors, but their importance is much greater than this figure would suggest. The Committee, as noted, is two-thirds medical practitioners in its composition; and their views tend to command more attention than those of the pharmacists on the Committee concerning which preparations should be listed. Whatever may be the merits of this weighting of medical opinion, the doctors are in a strategic position to appreciate the general demand for drugs and how essential they are in general and specialist practice.

Submissions by the general public to the committee account for about one per cent. Such submissions usually comes through a member of Parliament, nursing societies

or other medical societies. Ministerial submissions are made in the same way as any other.

The Pharmaceutical Benefits Advisory Committee appears to operate with a very considerable degree of independence. The Department of Health has taken the initiative in suggesting withdrawals only in cases where the drug was not up to standard in quality. As mentioned earlier, only one member of the committee is a departmental officer and his representative function is to expound the machinery and the procedure of the committee. The committee meets three times each year and copies of submissions must reach all members not less than one month before its meeting. There is no appeal against the decision of the committee, although it (the committee) may ask for an outside opinion from one of the committees or sub-committees of the National Health and Medical Research Council.

It appears that the committee deals punctiliously with all submissions.[18] Where published information is not available it may ask for evidence of adequate quality and safety of a drug. It often seeks advice from specialists other than those on the committee in various fields of medicine. Local Australian expert knowledge of the drug normally is essential. It is not sufficient - in the Committee's procedures - to rely on overseas experience. Recommendations are made largely on the therapeutic value of the drug although, no doubt, cost is a consideration where adequate alternatives are available. The Committee also makes recommendations on the method of prescribing - on maximum quantities or the numbers of repeat prescriptions which should be employed. The details are implemented by the Department of Health.

The third advisory body is the Joint Committee on Pharmaceutical Benefits Pricing Arrangements set up under Section 136 of the National Health Act. It has met on a six-to-nine-monthly basis since the

inception of the Scheme. There are eight members: four representatives of the Federated Pharmaceutical Service Guild of Australia; one representative of the Commonwealth Department of the Treasury; three from the Department of Health; and, since 1964, an independent chairman.

The Committee's function is to provide advice and make recommendations on matters of principle in regard to the supply and pricing of pharmaceutical benefits. These matters can be referred to the Committee either by the Minister or by the Guild itself. Since the high cost of pharmaceutical benefits has been one of the main sources of criticism of the Act, applications by the Guild for increased remunerations are not granted without careful investigation. For example, in response to a suggestion made in the previous year, the Government in 1965 agreed to a recommendation by the Joint Committee for a survey of earnings, costs and profits of pharmacists. A firm of independent consultants was employed for this purpose. A sample of 200 pharmacies was asked to complete a questionnaire covering details of their earnings, costs and profits. Of these, 100 were selected for on-the-spot observation to ascertain the breakup of labour time over the various categories of dispensing and retail contact. Invoices and prescriptions were examined to enable calculations of costs of goods sold. At the close of 1967 (and at the time of writing) the survey had not yet been completed as a number of chemists who had agreed to participate had not yet returned the questionnaire.

Apart from the formal machinery of the Joint Committee, the Department maintains informal contact with pharmacists in various other ways. Departmental officers attend conferences of hospital pharmacies, the Pharmaceutical Association of Australia and, occasionally, meetings of

the Guild. But these informal contacts are not as regular and frequent as those which characterise the relationships between the Department and the A.M.A.

6. Committees of Inquiry and Control

Committees of Inquiry are provided for under Part VII of the National Health Act both at the Federal and State level: but, in practice, they operate only at the State level.

A Federal Medical Services Committee of Inquiry which consisted of the Director-General and four medical practitioners (appointed from among six medical practitioners nominated by the Federal Council of the A.M.A.) met a few times in the fifties; but it soon lapsed. It was supposed to deal with matters involving questions of principle or matters which were common to more than one State. But it quickly emerged that there was virtually nothing of a Federal nature for the committee to discuss because the main problems arose out of the day-to-day activities of doctors and chemists in the various States. The objectives of the Federal Committee have been, in the main, taken over by the informal but regular meetings between the Department in Canberra and Federal Council of the A.M.A.

The State committees of inquiry follow the abortive federal committee in their composition and have four medical practitioners on each. So far as its own members are concerned the medical profession has insisted, as a condition of cooperation, that it must be allowed to carry out discipline on its own members where abuses are discovered. The profession does so, generally,

without benefit of legal advice or the presence of a judicial person on its disciplinary bodies. Another surprising facet of these committees of inquiry is that they deal, almost exclusively, with the problems of the Pensioner Medical Benefit Scheme. Although similar

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committees are provided for in the Act for the hospital and medical benefits schemes, none have been set up. It would appear that the Commonwealth has chosen, for political reasons, to avoid any attempt to discipline in these sensitive areas.

The functions of the State Medical Services Committee of Inquiry are 'to enquire into and report to the Minister or the Director-General on any matter referred to the Committee by the Minister or Director-General...in connection with either the supply of pharmaceutical benefits or the provision of medical services' (Section III). Reports of the Committees are confidential and unpublished. In 1963-64, forty-one inquiries were instituted into the provision of medical services to pensioners. In thirty-five cases a reduction of doctors' claims amounting to $48,950 in all were made. Seven medical practitioners were reprimanded by the Minister and one agreement (to supply medical services to pensioners) was terminated.

The Commonwealth Government, over the past few years, has provided more information on the activities of the pensioner medical benefits Committee of Inquiry as a result of criticism made in Parliament and, to some extent, in the press. The rising cost of the Scheme and alleged abuses by doctors were the main objects of the critique. In the years 1965 and 1966 there were, possibly as a result of this publicity, a significantly smaller number of cases before the Committee (twenty-nine and thirty respectively).

Many doctors are themselves concerned about the definition of what is called 'over-servicing' under the Scheme. In some cases, a doctor cannot be sure whether he is over-servicing a pensioner whom he drops in to see every day, perhaps in the almost certain knowledge that he, the doctor, is likely to be his or her only visitor. For him the visit may be more in the nature of

a social service than a purely medical one. As a result of general concern on this issue, and to provide guidance for doctors who are uncertain what may constitute a breach of the spirit of the service, a medical counsellor was appointed in 1965 to the Department of Health in N.S.W. to advise and assist doctors in dealing with problems in the Pensioner Medical Service, and in prescribing pharmaceutical benefits. In its first year, the counsellor conducted 186 interviews with medical practitioners - a fairly good indication that he is fulfilling a genuine need.

Since the committees provide the only method of control of the medical profession, and one of the few under the National Health Scheme, it is worth setting out in rather more detail the procedure under which they operate.[19]

In each State, the Commonwealth Department of Health keeps a continuous record of services given to pensioners under the Pensioner Medical Service. These are obtained through the vouchers which doctors themselves send to the Department, in order to secure the appropriate fee under which they have contracted to provide the pensioner service. From these vouchers, the Department establishes the average number of services provided each year by the doctor to e eligible pensioners and their dependents. In 1964, the relevant figure from N.S.W. was 9.6, Victoria 9.0, Queensland 7.3, South Australia 9.0, Western Australia 8.7, Tasmania 6.9, and 4.1 for the Northern Territory. In the same year, 1964, the average number of services per annum per doctor was 1,352 in N.S.W., 1085 in Victoria, 1,335 in Queensland, 1,264 in South Australia, 1,196 in Western Australia, 1,167 in Tasmania, and 289 in the Northern Territory. On the basis of these two sets of averages, the Department establishes what is called a level of 'reasonable utilisation'. When there is evidence that the doctor has exceeded this level the Department compares his claims to the claims which other

doctors operating in similar localities have sent in. When 'an extreme example' is found, the matter is sent to the Medical Services Committee on Inquiry. The doctor's claims, over a period of 12 to 15 months, are analysed and put before the Committee of Inquiry along with the names of the pensioners attended.

The committee may, if it thinks the case is a legitimate one, ask the doctor for further details of the clinical conditions of the patient. If, when these details have been investigated, the Committee decides that there was good reason for an extremely high level of servicing, no further action is taken. If there is a doubt in the matter, an inquiry is held.

Doctors are not bound to attend the inquiry but they are advised to do so. A departmental assistant and two court reporters also attend; and, if the doctor brings a legal advisor, a departmental legal representative also is there.

During the inquiry, members of the committee try to gain an accurate and full image of the clinical condition of each of the doctor's patients whom he attends under the pensioner medical service. All members of the committee may question the data in detail on such matters as: (i) whether the patient consulted the doctor at his surgery; (ii) whether the doctor is called to the patient's house or visited the patient at a regular pre-arranged day; (iii) whether the doctor visited the pensioner in a convalescent or nursing home and in this case what nursing care was available to the patient; (iv) which visits were after-hours visits - this to determine the degree of urgency; (v) the frequency with which certain forms of treatment were repeated - this to determine the improvement or otherwise of the patient's condition; and (vi) why (if this applies) two patients in the same family were visited at the

same time. The doctor may himself call witnesses and ask for any necessary elucidation which he, in turn, may wish to have from the committee.

The whole procedure may occupy a number of three-to-four hour sessions. When it is completed, the committee reports to the Minister for Health indicating whether or not payment which has been suspended pending the inquiry should or should not be made to the doctor for the services in doubt. The committee also indicates whether it thinks the doctor should be reprimanded and, if so, whether privately by letter or publicly in the Commonwealth Gazette. Once it has made its recommendation the Committee's task is complete. Actual implementation is then the responsibility of the Minister for Health. Three alternatives here are possible, depending on the report of the Committee. The first, that part or all of the claims be withheld for the services which have been subject to inquiry; the second, that the doctor is reprimanded with or without publication in the Commonwealth Gazette; the third, that the doctor's contract with the Department is terminated for a period of up to 12 months.

One can draw a number of conclusions from this description of the operation of the medical services committee of inquiry. First, the Department is clearly punctilious in its examination of every aspect of the case. Partly for this reason the proceedings are cumbersome and protracted. It takes some four months between the decision that a case needs inquiry and the time that action in the matter finally is taken. But it is also clear that, since only extreme examples of abuse are investigated, there must at any time be scope for abuse which would not qualify for investigation. It should be noted that the medical practitioner is

not always entirely at fault in the inquiry. Some inquiries have revealed that doctors are frequently subject to pressure from patients. Often it can be the patient who initiates abuse of the system, not the doctor.

The Pharmaceutical Services Committees of Inquiry operate in each State in broadly similar ways. These are sanctioned under Section 113-17 of the Act, which provides that 'the Minister may establish in each State a committee, called the Pharmaceutical Services Committee of Inquiry'. As with the Medical Services Committee, the Act provides that pharmacists will be investigated and if necessary disciplined by their peers. Thus each State Committee consists of the Director, and a pharmacist who is an officer of the Commonwealth Department of Health, and four pharmaceutical chemists appointed by the Minister. There is also provision (Section 114) for a Federal Committee but, like the Federal Medical Service Committee, it is not operative. These committees originally dealt only with abuses in connection with the provision of pharmaceutical benefits to pensioners. In 1954 their activities were extended to include abuses in regard to general pharmaceutical benefits. Sanctions, if applied after investigation, are of three kinds. The pharmacist may be given a warning, he may be reprimanded, or his approval may be suspended, usually for a limited period of time.

The statistical pattern of cases taken from the Department of Health Annual Reports is of interest:

Year	Cases
1954	107
1961-2	68
1963-4	75
1965-6	82

Clearly, abuses of the scheme (there were 5,501 pharmacists approved under the Act in 1966) are not great and there is no suggestion that pharmacists, unlike the medical profession, are unduly worried about the operations of the Committee, although they naturally do not welcome them. The Department has, since the inception of the scheme, sent its own pharmacists regularly to counsel both doctors and pharmacists on the operation of the scheme. Serious cases of reprimand are published in the Gazette and these would tend to appear in the professional journals. Other than this, abuses tend to be publicised only in the annual reports.

7. Professional Groups and the Administration

The medical profession plays an important part in the administration of the National Health Scheme, either directly as public health administrators, or indirectly as A.M.A. members on the various advisory and investigatory committees just described. To some extent, this participation was the price of cooperation. As we have seen in tracing the development of the National Health Scheme, the A.M.A. was strongly opposed to administration by the Department of Health of any National Health Scheme. It wished to have the organised profession to control all aspects of professional affairs, to take responsibility for the quality of medical service and to institute whatever disciplinary measures were necessary among medical men. The A.M.A. always maintained that the Health Department and its officers, even though many of them were medical men, were too far removed from the practical problems of medical and hospital care fully to understand the problems of the profession; that the inevitable antagonisms between the public service doctor and the practising doctor would stultify development; and that administrators were less able

to acquire and appreciate the problems of the profession than the profession to acquire the techniques of administration.

The profession would have preferred the National Health Scheme to be administered by an independent commission. Although the Commonwealth Department of Health instead was retained in this role, the medical profession has had little to fear from it as it currently functions. More particularly, the A.M.A. gained its point on the establishment of voluntary insurance assisted by subsidy thus removing the necessity for a large health bureaucracy. And obviously the opportunities available in the advisory and disciplinary committees within the new administrative structure, to guard professional interests, offered a proposition quite different from that proposed by the original Labor legislation - control by a strong central department. Moreover, despite the alleged disparity of experience and aim between public service medical men and the practising arm of the profession, precautions have been taken under the Act to ensure that as many senior positions as possible are occupied by medical men. Thus the Act makes specific mention (in Part I, Section 5) that a 'person is not eligible to be appointed as Director-General unless he is a legally qualified medical practitioner of not less than 10 years standing'. The effect of this provision has been to ensure that the Director at the State, as well as the Director-General at the Federal level, has always, in practice, been a medical practitioner. And the more senior positions within the Department are held by medical men. A reading of the index of senior officials published in the Department's annual report confirms this point. Thus, the Director-General and his two Deputy Directors-General are medical men; so

also are four out of five Divisional Heads.[20] Many doctors have been recruited into the National Health Division from other sections of the Health Department. But it is hardly likely that public service duties, however remote from general practice, would make them less well equipped to deal with the profession than laymen.

On the other hand, below the senior levels the administration tends to be weak on the professiona-medical side in that many medical officers have had most of their experience in sections of the Department which have few connections with general medical practice - for example quarantine control, public health and serum research. The reason for the shortage of medical administrators with the experience appropriate for running the National Health Scheme is fairly clear. Financially, public service practice is less remunerative than private practice. And socially and professionally, public service practice probably has less prestige - a not unimportant consideration. In addition, the system of medical education in the past has given only very minor importance to public health training and administration. The Department does what it can to encourage medical members of the service to gain qualifications such as the Diploma of Public Health or the Diploma of Public Administration; but apparently with little success.

Apart from holding the senior posts in the Health Department, the medical profession, more particularly as represented by the A.M.A., plays an important part in the committees set up under the Act. The medical inquiry committees are exclusively medical in their composition; and the Pharmaceutical Benefits Advisory Committee is two-thirds medical practitioners. In

the Commonwealth Health Insurance Council also the influence of the profession is probably greater than representation would suggest when we remember that the Boards of management of the Medical Benefits organisations in all States have always had a high proportion of doctors, many of whom are members of the A.M.A. Direct appointments by the Minister have, in practice, usually been influential members of the profession.

In addition to the formal machinery of liaison with the medical profession, the Government and the A.M.A. regularly keep one another informed of their respective views on problems which are raised in the working of the scheme. Once a year Federal Council invites the Minister of Health and some of his departmental officers to attend Council meetings.

Over the past few years, at the suggestion of the Director-General, Sir William Refshauge, additional meetings between the Federal Executive Committee of the A.M.A. and Department of Health officers have been held in committee three or four times each year. Though neither the Department nor the A.M.A. in any way officially regards these exchanges as committing them to a particular line of action it is highly unlikely that they do not influence policy to some extent.

This point was emphasised by a past president of the A.M.A., Dr A.M. Murray. 'We would all regard it (the meeting) as a mere waste of time if we did not think that a frank exchange of views did not at times influence or modify a proposed source of action. We look upon this meeting as a sounding board and a very useful opportunity for letting each other know what the other is thinking, and not infrequently this information has very definitely influenced the approach to a question'.[21] Whatever the extent of this in-

fluence, these informal discussions must, at the least, provide the government with much useful information and give the profession continued assurance that its interests are not neglected.

Despite these many concessions made to doctors within the structure of the National Health Scheme, as a group they remain suspicious of government and of any kind of control even where the arrangements are fundamentally reasonable. It was this emphatic individualism and resistance to collectivist trends which brought them successfully through their conflict with the Labor Government in the 1940s. Any future Government which wishes to change, in a fundamental way, the pattern and principles upon which the present Scheme is based must be prepared to cope with these attitudes.

Compared with the medical profession, the pharmacists play a less significant role in the administration of their part of the National Health Scheme. Departmentally, at head office and in the State Branch Offices, however, the Assistant Director-General and the Assistant Directors of Pharmaceutical Services Branches are pharmacists. Within the Department itself, pharmacists, like doctors, are in short supply. The shortage has been particularly acute in Victoria where the division has not had its full strength for many years. The Department, it seems, is in competition with the more remunerative opportunities offered in industry, in hospital pharmacy and, above all, in retail pharmacy. They also feature prominently in the formal structure of advisory committees but again less so than do doctors. In the Pharmaceutical Benefits Advisory Committee, for example, there are only two pharmacists among its nine members. On the other hand, the Pharmaceutical Services Committees of Inquiry are constituted exclusively of pharmacists.

The main negotiating body between the Commonwealth Government and the pharmacists is the Federal Pharmaceutical Service Guild of Australia. The Guild is a registered body of employers under the Federal and State Arbitration Act, and represents 90 per cent or more of the master pharmacists in Australia. Agreements reached following consultation between the Guild and the Minister apply to all approved chemists, including the friendly societies.

Under Section 99 of the National Health Act 'the Minister may, after consultation with the Federal Pharmaceutical Service Guild of Australia, determine' rates and conditions of payment for benefits. The Guild objects to the implications, in practice, of the word 'may, after consultation with...' It alleges that this requires only that the Guild should be consulted and not necessarily that it should agree to the outcome of consultation. This situation is, it argues, quite different from the arrangements made with the A.M.A., with whose Federal Council, under Section 32, the Minister 'may on behalf of the Commonwealth enter into an agreement'. Thus, with the A.M.A., the government is limited by the terms of agreement with the profession; whereas, with the Guild, the Minister may take unilateral action. The Guild claims that the Department has used the provisions of Section 99 to present to pharmacists what the Guild regards as a de facto decision. Ideally, it would like the word 'agreement' substituted for 'consultation', and an independent arbiter set up to negotiate agreements in much the same way as are industrial agreements. Attempts, by direct approach to members of Parliament, as well as directly to the administration to amend this section have so far been without success and seem likely to continue so.

It is doubtful whether there is real substance in the pharmacists' complaints; and there is no suggestion that they might choose to drop out of the Scheme, which they are entirely free to do. The Guild has reason to be satisfied with the operation of the pharmaceutical benefits scheme, which clearly maintains a high, and increasing, demand for the products which pharmacists retail. It is with this point in mind that one should view the claim, made by some members of the Guild, that chemists in Australia would not object to a nationalised health service. Nor, of course, would the manufacturers - for the same reason.

One other set of interests, the <u>manufacturers associations</u>, concern themselves actively with the operations of the Pharmaceutical Benefits Scheme.[22] The Pharmaceutical Manufacturers Association (A.P.M.A.) is a divisional body of the Australian Chamber of Manufacturers. The organisation is concerned only with pharmaceutical products obtainable on a doctor's prescription, and not with the so-called, 'non-ethical', over-the-counter pharmaceutical products. The establishment and growth of the A.P.M.A. is a post-war development whose history roughly parallels that of the industry in Australia. The enormous advances in pharmaceutical research, the discovery of the so-called life-saving drugs, the sulphonomides, the penicillins, and the wide range of psychiatric drugs, have given a great impetus to the pharmaceutical industry. Australian firms (most of them affiliates or subsidiaries of U.S.A., British and European firms) have grown rapidly.

Industrial growth probably would have led naturally to the establishment of a federal organisation. But when the Australian government passed its National Health legislation it became necessary to have a body

to look after the interests of the industry as a whole, to assemble and publish information concerning the industry's activities, and to air its views on the operation of the National Health Scheme.

The principal criticisms advanced by the A.P.M.A. concern the alleged exclusion of many of its members' products from the 'free list' of pharmaceutical benefits. Most submissions made to the Pharmaceutical Benefits Advisory Council, it will be recalled, come from manufacturers. The A.P.M.A. alleges that selection is made in a 'highly arbitrary manner'. . . Members of the Committee and Departmental officials claim, on the other hand, that decisions are made almost entirely in relation to the therapeutic value of the drugs. Manufacturers insist that they are not; that decisions are often 'political' rather than therapeutic. Since the committee meetings and membership are kept fairly secret, it is difficult to know how they can be so sure. They have pressed consistently, without success, for a representative of the industry on the Committee which would make for more 'democratic' and improved public discussion and knowledge of decisions.

To substantiate its claim that decisions of the Advisory Committee are 'political', the A.P.M.A. claims that medical practitioners, particularly in the lower income areas, are under pressure to prescribe only certain drugs on the free list rather than the 'more appropriate' ones. This would be difficult to establish. It is clear, by contrast, that medical practitioners are subject to considerable persuasive influence emanating from drug manufacturers themselves. The latter employ a well-organised and numerous group of medical detailers to distribute samples to doctors of those products they are attempting to have listed.

Advertising of ethical products is illegal; but this activity, in a practical, technical sense, corresponds to it closely. Detailers have been known to go further than merely represent the merits of their products. On occasion, the Committee has reviewed identical, prepared letters received from a number of medical practitioners on behalf of one particular product. The A.P.M.A. has suggested (and drew up a scheme for government consideration) that patients ought to insure themselves for pharmaceutical benefits as they do for hospital and medical benefits. All pharmaceutical goods could then automatically come freely on to the market at a subsidised price; whereas, at the moment, only those on the 'free list' are available to compete. In effect, such an arrangement would create a government subsidy to favour all manufacturers instead of only those whose products are listed.

8. Administrative Committees and Political Responsibility

It is time to draw together some threads of the preceding discussions on the formal and informal machinery of advice, consultation and control. Evidently, the rather unusual structure of administration employed for the National Health Scheme raises some problems which touch on, not only the administrative process itself, but also the politics of Health considered as a facet of the political system as a whole. These problems are best considered in relation to (i) the function of committees in the context of a specialised service such as Health and the use of specialised ability from outside the administration to assist in the operationof these committees; and (ii) the opportunities which the system affords to particular interest groups, through their representatives, to influence the direction of policy. These are not new problems, of

course. The administration of health services in Britain and elsewhere has brought them into prominence. But their implications have not as yet been examined in relation to Australia.

In the National Health Scheme, the Department of Health's use of consultative and advisory committees utilises the knowledge and experience available in the medical, pharmaceutical and accountancy professions. The active and extensive participation of these groups is a recognition of the limitations of purely administrative ability to deal unaided with the complications - medical, social, and economic - thrown up by health policy. The intelligent use of such professional groups, equipped with the expertise to understand the developments of medical science, pharmacy and pharmacology, is not simply valuable and useful in this sphere. It probably is inevitable. Earle Page's enthronement of the idea of social cooperation and partnership of professional groups and government as a cardinal principle of policy in his National Health Scheme has one solid basis here. It is a realistic assessment of the practical needs of health administration.[23]

The complications of the network of advisory, regulative and disciplinary committees used by the Department of Health (as exhibited in Charts II and III) are justified for other reasons. In addition to providing specialised knowledge, these provide a means of regular personal contact between the administration and representatives of those groups upon whom the efficient operation of the scheme depends. They provide an opportunity for all the major interests to confront each other as well as the Minister or his senior administrators. It is also clearly convenient for

senior public servants to have on hand formal machinery for consultation when the need arises. This reduces the need for ad hoc arrangements, perhaps hastily set up and without the experience and knowledge which goes along with more regularised activities. If new legislation is contemplated, the Minister can draw upon these established resources. At the time of writing this chapter (late-1968) the Prime Minister has provided an apt example. John Gorton announced an independent inquiry into the workings of certain financial aspects of the medical and hospital benefits schemes.[24] Whatever the body appointed it will benefit from the advice and accumulated experience of the committee system already inextricably involved in the policy-making of the National Health Scheme.

Apart from assistance to government and administration, the committee system clearly has advantages for professional and vocational groups - and not all of them are administrative. They, as groups, can feel assured that adequate weight is given to professional interests. They are able to keep open a watchful eye in order to avoid what they would regard as encroachment by laymen on private professional domains. At the same time they are in a position, if the committees are properly used, to anticipate some of the internal difficulties of the professional group. It is not always possible for the official body to speak for the whole profession. This point was forcefully illustrated by a recent conflict between the A.M.A. Federal Executive Committee and its Federal Council on the question of admitting more pensioners to the Pensioner Medical Service. The disagreement between these two bodies, one in consultation with government and the other, Federal Council, more actively concerned with the repercussions of the

new arrangements for the general body of the profession, had the effect of holding up for more than a year changes which the Government had in mind. On this particular issue the Federal Executive Committee appears to have been more willing than the Federal Council to extend the Pensioner Medical Service - hence the impasse.[25]

The status to be accorded advisory, regulative and disciplinary committees in the policy-making processes of National Health is difficult to evaluate. The same comment applies, but obviously more so, to the informal consultations which are a feature of relationships between the A.M.A. and the administration. By status is meant two things: first, how far the professional or vocational groups represented within the committees system have privileged positions which permit their representatives to protect the interests of members; and, second, a closely related matter, how far the position of an interest group in the complex of committee activities surrounding the Health Scheme provides it with opportunities to influence the direction of government policy on health matters.

Partly the difficulty of evaluation arises through multiplicity of function. It is important that professional or vocational groups have a place on advisory or consultative committees for reasons connected with their special expertise. It is important also that in disciplinary committees and regulative committees for funds, doctors and pharmacists be judged by their peers (among others) since only they have insight into the special conditions in which they operate. Further, there is the practical political advantage that the association of their representation with the administration gives professional groups confidence in the National Health Scheme and helpsto ensure their continued co-

operation minimises difficulties as they arise and perhaps curtails possible abuse of the Scheme.

There are, however, other functions. Members are also in committees as citizens - or should be. Consequently, as well as examining the technical aspects and the professional difficulties involved in the problems they discuss on advisory and consultative committees, they should also be considering the point of view of the general public as users and patients. And on disciplinary committees they should be prepared to think of themselves as judges working in the public interest. Undoubtedly committee members are aware of such obligations; but few individuals have the capacity easily to submerge their professional interest, at will, to the public interest where there is a conflict between the two. There is a very strong argument, keeping in mind especially the predominance of professional groups in the operation of the Scheme, for altering the composition of many of these committees by the inclusion of lay and legal members.

Partly the problem of evaluation arises because so much discussion and decision-making takes place in private and rarely comes before the public eye. There are no reports available: the bare statements contained in the Director-General's annual reports are not designed to inform or educate. We therefore do not know how decisions are made, and where; whether they were reached unanimously or after how long a debate. It is impossible to tell whether certain committees operate in quasi legislative and executive role for part of the time as distinct from their formal, advisory or consultative role. To put the matter another way, and bearing in mind again that doctors and pharmacists occupy the most senior positions of the Department of Health and form

the majorities on several very important committees, it is difficult to be sure how far interest groups so placed actually decide policy on health rather than make representations and give advice. The point to be stressed is that the information on which to make judgment is not made available.

Because there is relatively little knowledge of how the administration works, it does not follow that decisions once made in the 'dark recesses of bureaucratic power' are now made by professional bureaucracies. But the absence of information does raise questions which touch upon the nature of ministerial responsibility and the operation of interest groups. In a strict formal sense, only a Minister can be held responsible for the policies and the administration of his department. But this does not preclude the reality that those who are part of an administration, or participate in its consultative machinery, are also policy makers. A question arises here: how far are the ideas of professional groups, enjoying a recognised status within the hierarchy of administration, determinedmore by the motivations and interest of the groups they represent than by the requirements of the social service - in this case health - which they serve?

The point on responsibility can be put another way. In his provocative essay, The Irresponsible Society, Richard Titmuss raises the same question, albeit in a rather different context.[27] He chooses the context of powerful private insurance companies which provide for private sickness benefit, retirement and superannuation, and increasingly become the arbiters of welfare and amenity for large sections of the community. But, he argues, the manager-administrators of these enterprises, although they may be making what are 'in

their own eyes, and in the eyes of many other people, sober, profitable and responsible decisions', are not necessarily making decisions which fit a wider public interest. While technically correct in their judgments, indeed, because they are technically correct in seeking the actuarial solution, they do not make a 'socially effective' use of the resources at their disposal. They could have more regard for the insurers conditions and less regard for the commercial needs of the enterprise they serve. Titmuss argues further that the growth of private power of this character is to be deplored and resisted on democratic grounds. The manager-administrators of private insurance companies cannot, like public servants, be held responsible through the Minister for the consequences of their decisions, however far reaching their effect on social welfare. He extends his argument to oppose what he terms 'the Pressure Group State, generated by more massive concentrations of interlocking economic, managerial and self-regarding professional power...'

There is a parallel here with the interest groups which have been given formal and informal functions and status within the Australian National Health Scheme. There is ample opportunity for the A.M.A., the Pharmaceutical Service Guild and the Funds to be 'self-regarding' and, in committee service, to give greater emphasis to the technical, professional and income-earning aspects of the work than they do to the needs of the 'consumers' of the scheme. Moreover, it is possible to read not only opportunity but intention into the Australian situation. Before agreeing to participate, the A.M.A., as we have seen, insisted on full consultation and control of professional matters and the general application of a fee-for-service system (which can be interpreted as freedom for them in income-

earning matters). Similarly, the Funds argued that voluntary insurance could not handle the problem of 'poor risks' and at the same time remain financially viable. Whether this claim was correct or not - some of the larger funds could have arranged their affairs to carry the poor risks - the Government had to concede the point and carry this social problem by means of the 'Special Accounts' system financed from general revenue.

Titmuss's restatement of the classical theory of political responsibility may, in practice, require qualification. Eckstein's study of the interaction of the British Medical Association and the British Ministry of Health is more instructive.[28] He points out that the government and the administration are just as liable to wish to use the interest groups for political and administrative purposes, as the interest groups to use the government. And officers of the Health Scheme may well be subject to pressures from above, from government, just as much as they are liable to pressure from below, from the professional and vocational interest groups. There is no way of knowing precisely how a particular system operates except by close and detailed examination.

That the pressure groups do not necessarily succeed in their aims because of countervailing pressure from other interests, including the administration itself, can be illustrated in the Australian National Health Scheme. There is evidence that some sections of the administration would, in order to make the Scheme more acceptable financially to contributors and to control certain abuses, be prepared to take a stronger line on medical practitioners' fee levels and tighten up the standards of discipline in pharmaceutical and medical services. In this respect the administration is in opposition, to some degree, to the views of doctors, the funds,

pharmacists, and of course the Liberal-Country Party Government. Under another Government the administration might well be encouraged to adopt a more severe attitude to particular interest groups. But, at present, those sections which are so inclined must restrain themselves and work within the guidelines of received policy from above. Also, the medical and pharmaceutical interests whose attitudes and actions are in question her are, of course, strongly entrenched in the majority of the important advisory and consultative committees and in informal liaison arrangements. They can be expected to resist in detail, and probably also in principle, the application of more rigorous standards of discipline in health services or any attempt to control fees and incomes.

The view of Titmuss that private interest groups tend to usurp the functions of responsible public servants understates some important facets of a situation characterised by complicated sets of political relationships. But it does underline an important point. There <u>are</u> anomalous elements in the types of situation he has in mind. There is also the danger that precisely this kind of encroachment on the responsibilities of government can take place in the Australian National Health Scheme. The entrenchment of particular interest groups - doctors and pharmacists principally - in the specialised committees giving consultation advice and discipline could give a particular direction to this area of policy. The danger becomes all the greater when it is remembered that most of the senior administrators of the Department of Health itself were also trained doctors and pharmacists. It is only too easy to conceive of these groups acting together as an essentially conservative force concerned more with the maintenance of the status quo, particularly in respect of pro-

fessional standing and incomes, than with the development of an adaptable administration in touch with contributor-patients and sensitive to changing concepts of health and social welfare.

There are some fairly obvious devices available to safeguard the position. It is to be expected that both administration and committees will be heavily weighted by representation of the expert medical and pharmaceutical personnel. But not all administrative or advisory issues are exclusively or mainly professional. There is clearly a strong case for diluting the present administration with the introduction of some administrators with other than medical and pharmaceutical backgrounds and adding to committees some contributor-patient representation drawn from appropriate organisations. Moreover, some of the lay representation of the committee system of the National Health Scheme could well come from the ranks of the parliamentary backbenchers. To put legislators in touch with one of the more substantial and difficult areas of administration, and to put the administration in touch with its legislators, is to provide an educational experience for both.

CHART II

THE ADMINISTRATION OF THE NATIONAL HEALTH SCHEME - MAIN STATUTORY AGENCIES

COMMONWEALTH DEPARTMENT OF HEALTH

(1) PHARMACEUTICAL BENEFITS ADVISORY COMMITTEE (Sec. 101)	(2) COMMONWEALTH HEALTH INSURANCE COUNCIL (Sec. 136)	(3) REGISTRATION COMMITTEE (Sec. 70)	(4) JOINT COMMITTEE ON PHARMACEUTICAL BENEFITS PRICING ARRANGEMENTS (Sec. 136)	(5) FEDERAL MEDICAL, HOSPITAL AND PHARMACEUTICAL BENEFITS COMMITTEE OF INQUIRY (Sec. 113)
Recommends drugs to be made available as pharmaceutical benefits.	Advises Minister on changes in Tables, Contributions, etc.	Considers applications for approval, changes in Tables, Rules, etc.	Advises rates and conditions of payment to chemists.	(Not in operation)

6 STATE OFFICES

MEDICAL SERVICES STATE COMMITTEES OF INQUIRY (Sec. 110)	MEDICAL BENEFITS COMMITTEES OF INQUIRY (Sec. 112)	HOSPITAL BENEFITS COMMITTEES OF INQUIRY (Sec. 112)	PHARMACEUTICAL SERVICES STATE COMMITTEES OF INQUIRY (Sec. 115)

119 Either Medical or Hospital .. .. }
70 Both Medical and Hospital .. .. }

189 MEDICAL AND HOSPITAL BENEFIT ORGANISATIONS

ANNUAL CONFERENCES OF COMMONWEALTH AND STATE MINISTERS FOR HEALTH

CHART III

THE ADMINISTRATION OF THE AUSTRALIAN NATIONAL HEALTH SCHEME - MAIN NON-STATUTORY AGENCIES

COMMONWEALTH DEPARTMENT OF HEALTH

(1) AUSTRALIAN MEDICAL ASSOCIATION

Regular Meeting

(1) Of Executive Committee and Health Department.

(2) Represented on C.H.I.C. P.B.A.C.

(2) FEDERATED PHARMACEUTICAL SERVICE GUILD OF AUSTRALIA

Represented on Joint Committee on Pharmaceutical Benefits Pricing Arrangements, also on P.B.A.C.

(3) AUSTRALIAN PHARMACEUTICAL MANUFACTURERS ASSOCIATION

Irregular contact with Commonwealth Department

STATE ASSOCIATIONS OF HEALTH INSURANCE FUNDS

Represented on C.H.I.C.

FOOTNOTES (CHAPTER NINE)

1. Except where otherwise indicated the factual material in this chapter is based on the Annual Reports of the Director-General of Health, 1954-67; HEALTH - The Journal of the Commonwealth Department of Health, 1954-67, and on a considerable number of interviews with officers of the Commonwealth Department of Health in Canberra and New South Wales.

2. P.D. Abbot and L.O. Goldsmith, 'History and Functions of the Commonwealth Department of Health', Public Administration, Vol.XI, No.3, Sept. 1952, pp.119-29.

3. J.H.L. Cumpston, Director-General of Health from 1921-45, attributed the lack of coordination within the Commonwealth Department of Health to the divisional basis on which it is organised.

4. In addition to its functions in relation to the N.H.S., the branch services the other divisions of the department. The title 'planning and legislation' is misleading. It appears to imply some kind of formal forward planning within the administrative structure. Yet such activity is significantly absent in the administration of the Australian National Health Scheme. At the most, ad hoc committees may work, occasionally, on relatively minor administrative alterations of the Scheme; and in such cases are more likely to be concerned with received policy matters than suggested changes.

5. It would also be necessary to follow up this change of emphasis with appropriate changes in salary structures.

6. Figures provided by the Commonwealth Department of Health, Canberra, in Dec. 1967.

7. Commonwealth Department of Health, N.S.W., Functional Statements, 1960.

8. Figures from the Commonwealth Department of Health, Canberra, 1967.

9. Nation, 6 April 1963, p.10.

10. From the patients' point of view the criteria applied by the States is manifestly, whatever the States' motivation, more equitable. A sick person is hardly likely to be concerned or familiar with the technical complexities concerning the approval of hospitals under the Act. The Commonwealth's attempt to overcome Federal-State conflict and public confusion in 1963, by a redesignation of hospitals, has only partly solved the administrative ambiguities and hardly touched the human problems.

11. M.J.A., Vol.II, 23 Aug. 1947, pp.241-2. The present chairman of the Medical Benefits Fund is Sir Ronald Grieve, one of the A.M.A.'s most outspoken members of the forties.

12. A.E. Lee, 'Voluntary Health Insurance in Australia', M.J.A., Vol.I, No.24, 16 June 1962.

13. See Chap.X.

14. B.J. Kelleher, 'Friendly Societies in the Australian Economy', Australian Quarterly, Sept.1962, pp.53-62.

15. The Friendly Societies suffer from another competitive disadvantage, namely that (unlike other funds) they were subject to financial and other controls exercised by State governments through various Friendly Society acts.

16. See Chap.X.

17. Press Statements, 18 May 1964. Dept. of Health, Canberra.

18. R.H. Thorp, Specifications and Quality Control of Pharmaceutical Preparations in Australia, p.2 (unpublished paper).

19. This account is a summary of a lengthy letter by a member of the Committee describing the Committee's work which appeared in the M.J.A. (Supplement), Vol.I, 13 Feb. 1963, p.14.

20. This count does not of course include medical administrators who are responsible for quarantine, school medical, home nursing and like services in other Branches of the Department's activities.

21. M.J.A., 18 Dec. 1965, pp.1036-7.

22. Based on conversation with Executive Director, A.P.M.A., Dec.1962, and publications of A.P.M.A., Increasing Practical Support of Medical Research in Australia, Oct.1962; Who Gets What at What Cost from the Australian National Health Service, Nov. 1962; A Singular History of Cost Reduction in Australia, Aug. 1961.

23. It should be noted that of the nine committees appearing at Table 2, only the Pharmaceutical Benefits Advisory Committee and the Registratory Committee are formally required by the Act itself; the others are permissive.

24. See Chap.XI.

25. This point gives force to the view that those representing interest groups on advisory committees tend

(Continued 25)

to become the more conservative elements in the association. Political and Economic Planning, 'Advisory Committees in British Government', pp.80-7.

26. K. Wheare goes much further than this: 'If the function of a committee is to undertake an impartial and judicial enquiry, the case for excluding interested parties is almost always overwhelming'. K. Wheare, Government by Committee, p.79.

27. R. Titmuss, 'The Irresponsible Society', in Essays in the Welfare State, pp.234-242.

28. H. Eckstein, 'Pressure Group Politics', The Case of the British Medical Association, pp.151-164.

PART IV

A CONTEMPORARY CRITIQUE

'We have created a health scheme which we believe has no superior in the world'.

R.G. Menzies
Policy Speech, 1954

'We have profoundly forgotten that cash payment is not the sole relationship of human beings. We think that it absolves and liquidates all engagements of man...never was the relationship of man to man long carried on by cash payments alone'.

T. Carlyle, 1843

CHAPTER TEN

ACHIEVEMENTS AND SHORTCOMINGS

1. Some Achievements

In assessing the National Health Scheme one should not underestimate the genuine achievement it represents. Prior to 1950 little existed in the form of sickness insurance apart from the contract-service arrangements between doctors and friendly societies - and these applied only to the poorer sections of the population. The wealthy, by definition, could pay for the best attention available. The middle-income earner often came off worst. He paid more in taxation than the lower income group, yet, on occasion, he could be hit most severely by the cost of medical care. He was not poor enough to qualify for free provisions, nor was he in the social group which encouraged the use of friendly societies. Nor was he sufficiently well off to meet, without hardship, the financial emergencies associated with illness.

By contrast, the present Scheme in some measure covers some 90 per cent of the population.[1] It substantially commits Government, in a financial sense, to a much more extensive coverage for contributors and a more comprehensive range of subsidised services than that provided by any other legislative measure passed in this country, by non-Labor governments.

Also, it should not be forgotten that the present Scheme got under way a national, uniform set of health insurance arrangements. Those who have encountered the curious rigidities of the Australian Constitution and the hyper-sensitiveness of State governments, State-based organisations such as the insurance funds or the State branches of the A.M.A. on any move which suggests a contravention of State rights, must acknowledge this

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accomplishment. When an Australian talks of the National Health Scheme, he is referring just as much to the national characteristics it has generated as to any other facet.

Next, the Scheme must be considered a success in terms of the policy orientations of the government which initiated and maintains it. Its content and administration reflect accurately the individualistic political values of the Liberal-Country Party - and those professional groups on which its operation depends. At the administrative level, it constitutes a partnership which is kept together in a fairly self-conscious way, not always without strain or friction, but a partnership nevertheless, of Commonwealth and State, of doctors and governments, of funds and pharmacists. This successful association of government, administration, professional and vocational groups derives from the very considerable degree of freedom which the Scheme permits to all concerned in its operation to pursue their professional and entrepreneurial activities without undue restriction. At the same time, it ensures that the worst effects of free enterprise are avoided or counteracted. For example, there is the device, so called, of 'community rating' whereby the insurance funds must apply the same criteria of insurance to all persons on the same contribution rate, permitting the good risk to off-set the poor risk, and the lucky in health to compensate the unlucky.[2] They are not permitted to apply individual contribution rates according to differential risk characteristics. In another way the 'special accounts' system partially offsets the financial hardship to the insurance funds thrown up by the problem of chronic illness and old age. And substantial subsidies help to support the Scheme. Thus, the National Health Scheme is neither so harshly individualistic as that of the United States where government participates much less in the provision of curative medical

services; nor is it so generous as the British system which provides substantially everything free. For seventeen years the running of the National Health Scheme has remained remarkably consistent with the original objectives set out by Earle Page, to provide an alternative to the British arrangements while avoiding the worst features of the American.

Some of these characteristics of the Australian Scheme have attracted comment. A distinguished British medical practitioner visited Australia in 1962 and subsequently wrote a series of articles describing both the New Zealand and Australian National Health Schemes. He gave them the apt title, 'The Antipodes: Private Practice, Publicly Supported'.[3]

Many doctors would agree with this assessment. A survey of 213 general medical practices undertaken in Australia by a South Australian general practitioner, C. Jungfer, in 1965, showed that a very high proportion of those included in his report was satisfied with the Australian Scheme precisely because, as they saw it, it was based on three essential freedoms: 'The freedom of private contract between patient and doctor, the right to treat patients in hospitals, and freedom to choose their place of practice'. Of those questioned, 94 per cent declared themselves satisfied with the system of financial benefits because they said it enabled patients to seek treatment early and it reduced the proportion of bad debts.[4] More recently, the A.M.A., in a review of the provisions experienced in the practical operation of the National Health Scheme over the past ten years, agreed that the philosophy underlying the present system of providing medical care kept 'to a minimum the intrusion of the government as a third party; that the fee-for-service preserved the doctor-patient relationship and the type of practice to which the public is accustomed, and that the

pharmaceutical benefit scheme had introduced many difficulties but no actual restriction on the doctor's freedom to prescribe in the best interests of his patient'. Finally, the review stated that the Australian Scheme offered for the main partners involved in this provision, government, the professions and the societies, a preferable alternative to both the American and British provisions for medical care.[5]

It is easy to see why, in contrast with their bitter opposition to the Labor government's national health policies in the forties, the attitude of the A.M.A. to the Liberal-Country Party scheme has been in the main accommodating. Present approval, of course, does not exclude a continued concern to ensure that government does not exceed its proper functions, as the profession sees them. On the other hand, it is clear that the present arrangements satisfy the medical profession. The fee-for-service system of payment and the doctor-patient relationship, which the profession in Australia still regards as of paramount importance, are fully endorsed by the nature of the Scheme; and there is no government or any other contractual form of control on the level of doctor's fees (other than in the Pensioner Medical Service). In short, it appears that the doctor in Australia can enjoy the full economic and social satisfaction of a free enterprise medical practice - with the added security that the government takes care that his bill will nearly always be met. Nor is there evidence that the funds have any serious misgivings about the present scheme although, perhaps of all the participants, they are subject to the greatest degree of control of their activities. The Voluntary Health Insurance Council of Australia, the organ of the voluntary societies, is firm in its praise of the Scheme. It sees its part in the scheme in terms of partnership. One chapter of the Council's publication, The Story of Voluntary Health Insurance in Australia, is entitled 'Partners, Contributors,

Funds, Government'.[6] As they see it, they were able, at the initiation of the scheme, to assist by making available their experience as well as their institutions to the Menzies Government. And they attribute to the architects of the scheme a wisdom which preserves the vital freedom of choice, freedom from regimentation and freedom of independence. Essentially, they support the scheme for the same reasons as the A.M.A.

The Liberal-Country Party Government, for its part, is not seriously dissatisfied. It considers most criticisms as marginal in relation to the overall criteria of policy on which the Scheme is based. 'It would be ridiculous to suggest', said Dr A.J. Forbes, in October 1966, 'that Australia's National Health Scheme has not been the subject of criticism. What is significant is that criticism is invariably in the form of demands for extension in the range of services it provides and not [directed against][7] the principles of the scheme'.

In the past, informed criticism has been severely restricted by the absence of inquiry into the operation of the Scheme. This situation has changed dramatically over the past two years. There is now evidence that the National Health Scheme is deficient in many fundamental respects. It is to a consideration of these that we must now turn.

2. Some General Criticisms

As distinct from deficiencies in particular branches of the Scheme - hospital benefits, medical benefits, pensioner and pharmaceutical benefits - there are problems affecting the efficiency and coverage of the National Health Scheme overall.

Chronic Illness and the Aged: Until 1959, hospital and medical insurance organisations placed serious limitations on the financial benefits which these groups could expect to obtain (Chapter 8). After the

point where benefit payments or time limits expired, such groups were not, in general, eligible for further fund benefits. In instances where claims were reimbursed, this was at a reduced rate and reimbursements were often, in effect, ex gratia payments.

The special accounts system was specifically designed to overcome the reluctance of the funds to insure such poor risks. But it has only partly succeeded in doing so. Some patients do qualify, after a period of two to three years, for full benefits. But others, whose benefits are restricted on grounds that they have gone beyond the maximum period or because of chronic illness, may never receive benefits at full rates. Many pre-existing illnesses bring people into this category. The fund organisations themselves insist that it is not possible for voluntary insurance to deal with these problems, despite the additional assistance given them under the special accounts system. They place the burden of providing for society's poor risks firmly upon the government.[8]

But the funds themselves can scarcely escape their share of the responsibility for the state of affairs. R.B. Scotton shows, in an analysis of the financial structure of the funds, that in practice they use the special accounts arrangements partly to increase their reserves, rather than to increase their payments to patients who need it. There is also evidence that some are prepared to, and can, interpret the definitions of chronic illness more liberally than others. The government has not enforced uniformity on what is to patients, clearly a most important set of administrative decisions.[9]

Even more unsatisfactory is the administratively created situation whereby some aged people, suffering from long-term illnesses, may forfeit their special account benefits simply because they cannot secure admission to hospitals which are approved under the

National Health Act. Some private nursing homes are effectively allowed only a quota of approximately half their beds for chronically-ill patients; while public hospitals will, of course, take in only acutely ill patients. Quantitatively, this can be an important problem. In Victoria, for instance, there are no institutions run by the State Government or benevolent bodies which cater for the chronically-ill under sixty years of age. It has been estimated that 30 per cent of the chronically-ill in that State may be under sixty.[10] There has also been considerable confusion on another point, critical for many patients : which categories of hospitals qualify for special account purposes? This was especially so before 1963 when, in addition to the distinction between public and private hospitals, a further distinction was made between those which were 'recognised' and those which were 'not recognised' for the purpose of special accounts. Not surprisingly, patients themselves found it difficult to be certain where they should go to ensure maximum financial assistance.

Interest and sympathy are usually focussed on the problems of the old in our community but similar restrictions can seriously affect other chronically-ill groups as well. Sub-normal children, for example, cannot gain admission to government institutions until they are two years old. If their parents elect to send them to private convalescent homes, they qualify only for the Commonwealth subsidy of $14 per week. Consequently, in a typical case, parents find that they are required to pay considerable additional amounts towards the cost of their child's upkeep. These charges can be waived in cases of hardship. In addition, Commonwealth Health Department officers may, where special accounts are involved, use discretion in individual cases. For example, a patient who is in a rest home, not qualified for special account purposes, may receive full payment if he

is suffering from a condition for which he would normally be admitted to a general hospital, providing he is receiving treatment of standard substantially equivalent to that which he would receive in a general hospital. The Hospital and Charities Commission of Victoria provides also subsidies for patients who are on the waiting list for chronic beds. But such actions are discretionary; the patients suffering hardship, or the parent, have no rights in the matter. And these, of course, are merely partial solutions to anomalous situations.

Apart from the mentally deficient, those who are mentally ill can be severely hit by the inadequacies of our National Health Scheme, especially if the illness is a recurrent one. If such a patient is fortunate enough to be admitted to the psychiatric ward of a public hospital, he will receive hospital benefits in the ordinary way. But if he stays longer than the prescribed maximum period, eighty-four to ninety-one days, he may not automatically be put on special accounts. Some funds would transfer him so. Others would not. There is no uniform practice in the matter. In any case, if the illness is chronic, in the sense that it is recurrent, the patient will be receiving reduced benefits most of the time. Such uncertainty concerning his ability to meet his hospital costs can scarcely be conducive to speedy recovery, particularly where the illness is of a psychiatric nature.

The situation can also be unsatisfactory if a mentally ill patient is admitted, not to a public hospital but to a mental hospital. These institutions, which contain at least one-third of Australia's hospital beds, are quite outside the scope of the National Health Scheme. The Federal Government does not ignore them. Since 1955, it has made capital grants available on the basis of one dollar for every two dollars capital expenditure by the States.

On the other hand, it does not recognise these mental hospitals as 'approved hospitals' under the National Health Scheme. Patients who enter these institutions do not, therefore, qualify for hospital benefits. In most States these patients are not charged fees. In the State of New South Wales, however, charges are made subject to a means test. Why N.S.W. should differ from other States in this regard is not clear. But the situation is clearly an anomalous one, in which mentally ill patients forfeit their rights to hospital insurance and yet are liable to charges by State Government.

Thus the Australian Scheme has failed to find a satisfactory answer for the problem of the chronically-ill. One obvious solution is to guarantee, in a clear-cut way, medical and hospital services for all those persons who, through prolonged chronic illness and other associated economic misfortune, are therefore unable to meet any but a negligible proportion of the cost of medical care. Investigation of each case by skilled medical social workers could be the basis on which such extended medical and hospital services are given.

Instead, the present arrangements rely upon hospitals and doctors to make their own arrangements for needy cases as they occur. In many cases, bills are not pressed where the person concerned clearly has no capacity to pay or is completely indigent. And thus hospitals and doctors each carry the costs of the needy person from the fees and charges placed on the majority of patients. This appears a rather irresponsible, hit or miss method, in which to treat a serious social problem. Yet it is the practice which, faut de mieux, has grown up for most treatment of the needy, chronically-ill patient. It could be a dangerous practice in particular cases, if the patient is not persevering enough to press for medical treatment. In any event, it is an inefficient and, for some, an in-

effective procedure. While hospitals and doctors may be willing to waive, or fail to press, charges against the needy person when he or she first appears as a patient, and can carry on this practice for quite long periods, there clearly is a limit to their patience and their capacity to carry indigent, chronic cases. Yet some patients will not recover, because of age or the nature of the disease, and yet live on for months or years. What is to become of them? The system has no specific answer.

Despite many individual complaints on behalf of the aged and chronically ill, and fairly continuous criticism from pensioner organisations, the influence of organised groups attempting to secure remedies from government in this area has been, to date, conspicuously ineffective. These unfortunate members of society must, if their illness goes on for long, find their own solution by drawing on the pity and conscience of hospital staff and voluntary organisations and doctors. It is a most unsatisfactory, and at times degrading, way in which to survive. It is difficult to escape the conclusion that, despite periodic and dutiful expressions of sympathy for the plight of these groups, the administration of the National Health Scheme has been less sensitive to the demands of its 'consumers', especially if they are needy, than to those of its 'producers' and 'suppliers'.

The Cost of National Health: The cost of the National Health Scheme has increasingly come under criticism. Much of it is ill-informed. But the investigations made in the Institute of Applied Economic Research, University of Melbourne, have yielded some significant results which policy-makers will find it difficult to ignore.

In terms of expenditure, Australia has the fourth highest per capita expenditure on health services, (after the U.S.A., Canada, and Sweden). In terms of

the proportion of national income spent it comes, with 5.8 per cent, sixth. Israel spends 7.4 per cent, Canada 7.2 per cent, the U.S.A. 7.5 per cent, Chile 6.8 per cent, and Sweden 6.2 per cent. But, as J. Deeble points out, expenditures do not necessarily correspond to the amount of services provided. The total of services available in a particular country can vary, for example, because of the relative remunerations obtained by the medical profession, the price levels of pharmaceutical goods and other medical equipment, and the operational cost of the particular services.[11] Three general cost factors of the Australian system should be remarked on here.

First, the cost of administering the insurance component in the National Health Scheme appears to be higher than is necessary. This is not due to inefficient management so much as to the peculiar structure of the insurance services thrown up during the development of the Scheme. As was said before, there is a very large number of organisations handling the medical and hospital benefits insurance of contributors - 187 funds and Friendly Societies. This statistic alone suggests the existence of a considerable duplication of resources. Price competition is not encouraged. The Department of Health maintains the point of view that a public service operation of this kind, heavily subsidised, should have uniform prices. Consequently, competition is only on peripheral matters such as extra administrative services, benefits and advertisements. Their effect upon cost, as we shall see in the next section, is considerable. Then, of course, any system which fixes a uniform rate of benefits and premiums inevitably will try to arrange matters to protect the financially least efficient of the organisations.

Consequently, one is not surprised when Scotton's researches into the financial statistics of medical and hospital benefits funds show that: (i) Operating expenses

have averaged between 13 and 15 per cent since 1953. The official ceiling imposed by the Commonwealth Department of Health is not, in practice, always enforced. Scotton shows that, in 1965 one-third of the funds were operating at expense ratios above the permissible ceiling. (ii) Retention ratios - the proportion of total income not paid out in benefit but retained for operating expenses, surpluses and transfer to reserves - has been around 22 to 29 per cent. The equivalent Canadian and U.S. retention ratios are 15 per cent. (In the U.S.A. this figure varies between 7 per cent for large Blue Cross organisations, comparable to the large Australian Funds, and 47 per cent for some commercial insurance concerns). (iii) Overall surpluses (profits) of the funds are high - they have never been less than 4.9 per cent since 1959. (iv) Reserves appear to be excessive. Contributions, in effect, may be used to increase reserves rather than benefits. In 1965-66 the reserves of all funds amounted to some 10 per cent of their total income. And (v) common contribution rates are so selected that the more efficient funds protect the inefficient. Thus, in 1965-6, although the funds showed an overall operating surplus, more than one quarter of medical funds and more than one third of hospital funds showed an operating deficit. Evidently some rationalisation - that is, elimination of small costly organisations - could reduce the administrative cost component of voluntary insurance.[12]

A second cost factor affecting the Australian Health Scheme is that certain extra costs are inescapable once a system of subsidised voluntary insurance (as distinct from a single compulsory insurance system based on deductions from salaries) is undertaken. Scotton makes the most revealing observations here. Each fund must keep track of its contributors (some of them making contributions weekly). Periodically, there are transfers of large numbers

of contributors from one table of benefits to another. Commissions must be arranged for and paid to agencies for the collection of contributions. And, the largest burden of all, the funds must process each individual contributor's claims according to 'fund and Commonwealth benefits for each medical service and each hospital admission in the light of each claimant's membership status, table insured and medical record'. As Scotton says, 'mountains of paper work are generated'.[13]

Third, only to mention a question to be dealt with in a later section, there is no doubt whatever that expenditure on pharmaceuticals in Australia is abnormally high. For this part of the Health Scheme, on a per centage of national income, Australia spends twice as much as Britain or Sweden and one third more than the U.S.A. (although the money-price of pharmaceuticals is higher in the U.S.A.).

Competition Between the Funds: In recent years, competitive rivalry between the funds has become much more apparent. The Government's official policy on such matters is to require uniformity of benefit payments and contribution charges, to require funds to operate their insurance activity on the so-called 'community rating' actuarial basis, and to forbid competition generally on price. The rationale of this policy towards subsidy-supported, approved insurance organisations can scarcely be questioned. A public service or a quasi-public service should have uniform conditions available to all who wish to use them. This compulsory uniformity, in combination with the 'competitive' structure of the insurance organisations, has, however, diverted rivalry into certain cost-creating and otherwise undesirable forms of non-price competition.

As Scotton points out, there is aggressive rivalry among the funds based on 'large-scale advertising, high commissions (especially on new members) to agents, the establishment of networks of branch payment centres, schemes for extending bonuses and other benefits to good-risk contributors, proliferation of tables and heavy expenditures on prestige buildings and equipment'. Undoubtedly, much of this activity assists communication; and some of it is inseparable from the operation of voluntary insurance. It may also offer some minor advantages to the consumer. However, these tend to be trivial. And among the funds, the effect is to raise the costs of their administration through attempts to transfer, perhaps with only marginal success, citizens from one fund to another fund which, by regulation, offers the same scale of contributions and payments.

On the whole, therefore, there is no real difference between the funds in the services they offer - certainly not enough to justify costly expenditures which claim substantial differentiation of the health insurance and product. Competition in such circumstances must be largely self-defeating and wasteful.

There is, however, one exception. The funds do differ in the way that they are prepared to apply the rules for paying out benefit as distinct from their formulation of the payment conditions. For an individual, the question of which fund organisation will exclude him from benefit or limit the payment in circumstances particularly liable to affect him is, of course, a vital question. The practice of varying the application of the rules may be described as a form of concealed price-cutting which may or may not assist certain groups and at times assist them very considerably. But, ironically enough, it is precisely on these matters that contributors

are offered the least information. They must be content with hints which suggest that 'possibly' a certain condition or term of sickness will be treated favourably; or 'in certain circumstances the fund will see its way to looking at this circumstance favourably...'. The relative merits of the fund organisations on these matters can be assessed only with great difficulty.

Competition, particularly between the largest funds, the Medical Benefits Fund of Australia and the Hospital Contributions Fund of N.S.W., has, in recent years, also had some aspects inconsistent with the proper conduct of some public organisations. The decision of the H.C.F., in 1963, to sever the joint administrative and management arrangements under which the two funds had operated, led to an acrimonious and public debate which seemed, at that time, to involve not only the funds but the Commonwealth and N.S.W. State governments.

The split appeared to be the result of internal competition between the two funds. The H.C.F. claimed that the joint management administrative arrangements had involved them in financial losses; that the H.C.F. wished to introduce new cost-reducing methods which were being resisted by the M.B.F.; and that the M.B.F. had ambitions to absorb the H.C.F. The M.B.F., for its part, claimed that the H.C.F. was not 'considering the interest of the contributors in its desire to split' and that some of the methods and service concessions which the H.C.F. claimed to be 'initiating' were already in operation though they were not publicised. Justifiably or otherwise, the reputation of the H.C.F. appears to have suffered during further public disputes among the funds. At one stage, the H.C.F. claimed that the reserve position of the M.B.F. was not disclosed in its reports. But the M.B.F. was quick to secure an injunction against the H.C.F. which the Supreme Court of N.S.W. dissolved only after the

H.C.F. agreed to publish in advertisements and in circulars that M.B.F. statements of reserves were in fact available and included indications of the precise amounts.

The break up of these two organisations appears to have initiated a period of relatively intense competition between all the funds of the kind described above. The smaller funds have not been slow to take advantage of a certain confusion and loss of confidence among the public caused by the much-advertised divisions between the M.B.F. and the H.C.F. They claimed at one stage to have substantially increased their membership as a result of these confusions.

However much these disputes may have damaged the public image of some of the funds, one incidental advantage has come out of the episode. Some of the more obvious anomalies of the National Health Scheme have been brought to the notice of the public. In particular, these disputes have helped to expose the duplication of resources which exists where so many funds are involved in providing and administering a service which probably could be more rationally and more cheaply provided by a smaller number of organisations or by a single organisation. There is also the apparent ignorance, among even the larger funds, of knowledge concerning their own contributors. The H.C.F. admitted, during one of these controversies, that it had no idea of the exact number of its contributors. Further, complaints of deliberate misrepresentation, in other cases, of bureaucratic mishandling of the public, have led to some trenchant criticism of the complexity of the funds' administration.

Whether the Government should continue to support such a cumbersome and, in some respects, unnecessarily complicated insurance organisation, is increasingly becoming open to doubt both for economic and social reasons. The Government at the moment claims that it could not

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'interfere' more into the funds' affairs without endangering the sacrosanct principles of 'freedom and partnership' on which this Scheme has traditionally been based. However, it may well be forced in the direction of greater control to preserve the National Health Scheme in its present form; and if it wishes to halt the growing volume of criticism and prevent alternative arrangements from receiving serious support.

3. Deficiencies of Particular Schemes

If each of the services offered under the National Health Scheme are examined, a number of serious defects, and omissions, are revealed which, individually and collectively, lower the effectiveness of the Scheme.

The Pensioner Medical Service: The allegedly free service has important imperfections. In the first place, it by no means provides comprehensive coverage. The Government makes misleading claims in its publicly available document, The National Health Scheme, when it says that 'most, but not all, medical treatment is provided free for eligible pensioners and their dependents'.[14] As one example, the service excludes specialist medical treatment, though many of the illnesses of old age must certainly require this kind of attention. Until recently, it made no provision for the treatment of fractures, a condition not liable to occur frequently among old people but of great seriousness when it does. If a pensioner needs a general anaesthetic his 'home' service does not include this. Most important, free hospital treatment is available only in the public ward of public hospitals when a pensioner develops an acute condition. The most general type of occurence still remain unprovided for. Frequently old people are permanently convalescent in private nursing homes or rest homes, many of which are not approved for fund benefits. On this account, the Commonwealth will pay $14. a week, while the fund will pay nothing at all. Moreover, not all of

Australia's citizens of pensionable age (males, 65 and over, females 60 and over) qualify for this limited general practitioner service. Today, (1968), the population of pensionable age totalled 1,246,000. Of this figure, 718,000 receive an aged or service pension, and therefore automatically come under the Pensioner Medical Service. But this still leaves a balance of 528,000 (47 per cent) persons of pensionable age uncovered by the Scheme.

Up to 1954, the means test giving qualification for the Pensioner Medical Service was that applying to pensions under the Social Services Act - a logical enough way of determining eligibility. In 1955, however, an additional means test for the Pensioner Medical Service was applied. The official reason given was that too high a proportion of qualified pensioners earned extra means from property, owned their own homes and even ran a car. It was argued that they could afford to join an approved society and receive their medical and pharmaceutical attention in the normal way. The application of this test in fact precluded 13 per cent of pensioners - by 1964 - from enjoying pensioner medical rights. Repeated attempts by pensioners' associations to remove the test were not successful until, ten years later, the status quo ante (1955) was resumed. Apart from the general criticism generated by the test, it is not clear why the Government then changed its mind. What does seem to be evident is that the voice of the A.M.A. was influential. And remains so.

The most recent (1967) changes in the eligibility of pensioners involved two decisions: one, the question of raising the concessional fee to doctors for providing the service; and two, that of including a new group of pensioners under the Scheme. The A.M.A. claimed that these two decisions were not, as far as it was concerned,

related. It stated that the length of time taken to come to an agreement with the government - negotiations dragged on for nearly a year - was due to the A.M.A.'s desire to discuss with the Government the best way of redesigning the Pensioner Medical Service. The A.M.A. had itself appointed a committee to give advice on this matter.[16] Whatever the reason, the delay caused some considerable confusion in the public mind, particularly among pensioners. Indeed, the Department of Social Services stated, in November, 1967, that only fifteen people had applied since April of that year when the means test had been liberalised. As the Australian Commonwealth Pensioners Federation pointed out at the time, this lag must certainly have been caused by uncertainty among pensioners themselves as to whether or not they were to be included under the new arrangements.

It is evident the liberalisation of the means test for pensioners depends not simply upon government's willingness to include a wider range of pensioners and on the profession's willingness to service them, but on the willingness of both to do so at current fees. Many doctors, at least in private, are prepared to concede that under the Pensioner Medical Service arrangements many doctors are now being paid, albeit at the concessional rate, what they may have had to provide free of charge before the Pensioner Medical Service was established. (A doctor, in 1967, received $1.70 for a surgery visit, and $2.15 for a home visit). Others complain that fees do not keep pace with the rising cost of living. The Medical Services Review Committee Report, while it revealed almost unanimous acceptance among doctors of the need for a Pensioner Medical Service, also revealed some important dissatisfactions. Among those listed was the need to stem the increasing tide of requests for unnecessary treatment, the Government's refusal to pay medical

fees for the treatment of patients occupying public hospital beds, doctors' difficulties with some committees of inquiry, and the lack of understanding of some doctors of the conditions of the Service.[17]

Abuses by doctors of the Pensioner Medical Service are probably the exception rather than the rule.[18] But the sensitivity of doctors has become heightened by the publicity given to them when they occur, as well as to the activities of the medical services committees of inquiry. The underlying theme of A.M.A. comments concerning the committees' activities has stressed the need to educate general practitioners, rather than simply to regulate their activities. The Medical Services Review Committee suggested that a panel of consultants be made available to doctors to keep them informed about their rights and duties under the Service. It was also suggested that pensioners be informed of their obligations under the Scheme.

The same Committee made recommendations to improve the service. It was suggested, among other things, that pensioners be provided with a domiciliary service by consultants, as distinct from general practitioners; or free transport to a special consultation where this is required. Such arrangements would obviate the inconvenience and general hardship which must frequently occur when old people are compelled to wait their turn in the out-patient departments of hospitals. Other suggestions were to employ more district nurses, in order to economise on calls by the doctor; additional pensioner benefits; and 'appropriate fees' for these additional services. Finally, a more representative composition of the Medical Services Committees of Inquiry was recommended. Clearly, medical opinion is convinced that many improvements are possible. Nevertheless, although the Service is the only part of the National Health Scheme which involves

professional and contractual arrangements with government, many doctors dislike the implications of this quasi-employer-employee relationship.

The Pharmaceutical Benefits Scheme: In the year 1966-67, the National Health Scheme absorbed one quarter of all social security payments from the National Welfare Fund; and pharmaceutical benefits accounted for 40 per cent of these national health expenditures, as against 22 per cent in 1951. These proportions bring out the main problem of pharmaceutical benefits. Since its inception it has constituted the largest single item of expenditure on the Scheme. Its costs have continued to rise at a greater rate than other expenditures, although a number of drugs have been taken off the free list or placed under restricted usage and despite the introduction in 1959 of the 50 cents dispensing charge to act as a 'brake' in the demand for pharmaceuticals. Many reasons have been advanced to explain the rises in the costs of pharmaceutical benefits: the extension of the benefit to cover a wider range of drugs than was originally intended; unexpected increases in overall demand because of the introduction of cheaper substitutes; population increases; increases in the number of old age pensioners qualified to use the scheme; general inflationary rises in prices in the post-war years; pressure from the Pharmaceutical Benefits Guild of Australia for higher dispensing fees; and the activities of medical detailers.[19]

Drug manufacture for a small market - because of the high capital and research intensity of the industry - can result in high prices compared with those in a large economy such as the United Kingdom. There is no direct evidence, however, either for or against high manufacturing prices in Australia. Much of the criticism of the cost of pharmaceuticals has instead fastened more on the activities of the medical detailers (representatives) employed by

Australian drug companies. Their task is to advertise the products of their firms, partly by visits to medical practitioners and partly through an ample supply of free samples and literature explaining the relative merits of the drugs provided. Nevertheless, there were official misgivings as to the prices charged by the, mainly foreign-owned, drug companies. In 1965, the Director-General of Health felt driven, in his annual report, to question the desirability of large numbers of medical representatives. The Minister, Dr J. Forbes, subsequently lent support to the Director-General's comments. In Parliament there was a minor outburst in which Senator D. Turnbull (independent of Tasmania), a medical practitioner, accused the Director-General of abusing his position to further a 'private hate' against the drug companies. The real blame, said the Senator, rested with the Government which had made the political decision to enlarge the range of drugs.

This kind of publicity can produce a useful reaction. A reduction in the prices of drugs occurred soon after this particular episode and on other, similar occasions.[20] But reductions in pharmaceutical prices accomplished through adverse criticism are likely to have only a marginal effect. To acquire more fundamental information on the drug manufacturing industry, its costs, the value of the basic materials which are imported and the process of price formation, the Commonwealth government may be compelled to institute an inquiry.

The Institute of Applied Economic Research in the University of Melbourne, investigating the cost and finances of the health services, attribute the main reason for the high costs of pharmaceutical benefits not to manufacture but to the structure of distribution through chemist shops and the powerful and successful pressures exerted by their trade association, the Pharmaceutical Services Guild.

Retail pharmacists in Australia, through the guidance of the Guild, have managed to maintain a vigorously-observed system of resale price maintenance. Thus encouraged by fixed common prices, and by free entry to the trade, an excessive number of pharmacist businesses have come into being. In 1965, for example, Australia had one chemist shop to every 1.7 doctors in private practice; and more pharmacists, in relation to the population, than any other country in the world. The Pharmaceutical Services Guild also has resisted, successfully it/ seems, potential competition from friendly societies and chain store pharmacies which might have led to a reduction of prices, larger and fewer retail outlets and therefore economies of scale.

On the question of the money price of drugs, Deeble reaches the conclusion that, for the drugs on which comparisons are actually possible, Australian prices appear to be somewhat 'above' those in the United Kingdom, and well below those in North America. Whether this is true of their relation to other commodities, he adds, is not certain. On the other hand, it is clear that Australian chemists' fees and margins absorb 40 per cent of the total payments to them for pharmaceuticals as compared with the United Kingdom where they account for only 25 per cent of the total cost. He also notes that 'fees and retail margins have not altered significantly since the days when chemists compounded many items themselves and the industry operated without substantial government support, and that these seem unduly high when the overall volume of prescriptions is virtually guaranteed by subsidy and 85 per cent of prescriptions involve no more than the merchandising of ready-prepared drugs'.[21]

Thus the pharmacists' share of the retail price of a drug is the second largest item in the total cost of the pharmaceutical benefits scheme coming after the

manufacturers' share - rather less than one half. Partly it is a professional fee for dispensing; and partly it is a reward for stocking the drugs (the mark-up on wholesale price). Both these elements appear to be unduly inflated in relation to the service provided. What is euphemistically termed a dispensing fee normally covers, apart from the pharmacists' professional capacity to translate the doctor's script, the transfer of the medicine from the wholesale packaging to the retail bottle; or, since many medicines come in ready-packed in retail containers, the application of the pharmacist's own label and instruction to the container. Occasionally a pharmacist prepares the drug himself. But if this is done he charges a higher dispensing fee.

Doctors themselves fit their prescribing habits to the drugs available for benefits and tend, not unnaturally, to discount the question of cost. They are mainly concerned, so far as they are able to judge this matter, with the pharmaceutical value of the drug. It is sometimes asserted that doctors no longer can know precisely what they are prescribing and, like the pharmacists, have abdicated an essential part of their professional activity, in particular that of prescribing differential doses of pharmaceuticals, to the large drug manufacturing houses which recommend their own standard dosages. A little reflection on this point, however, would seem to indicate that recommendations of this type, worked out by the manufacturers' pharmacists and pharmacologists who are familiar with the drug, offer a safety factor for both doctor and patient.

The Jungfer Report does show, however, that doctors are, in some degree, confused by manufacturers' techniques. Of those replying, 39 per cent claimed that the literature provided by the companies often gave useful

information; and an equal percentage said that it was quite valueless. But all agreed on the difficulty of separating the good from the bad in respect of both the literature and samples with which they are continuously supplied. Some medical practitioners simply prescribed what was new; others paid attention to the reputation of the firm; others again left it to their secretaries to make the decision; and an individualist12 per cent destroyed all the literature from the drug firms. 'The general tenor of the comments', stated Jungfer, 'showed that pharmaceutical firms are losing the goodwill of practitioners by allowing their perspectives to become clouded by sales propaganda and harrassing the practitioner beyond all reason'. It appears that medical practitioners would like to see advertising restricted and made more uniform and would support any firms which did so.[22]

Another factor in the tendency for doctors to over-prescribe, where this exists, must clearly be pressure from patients themselves. It requires a strong-minded doctor to send a patient away without the magic 'script'.

Whatever the reason, the number of prescriptions is increasing and this in itself is a major obstacle to reduction in the cost of the Scheme.

Against all of these criticisms a balanced assessment of the Pharmaceutical Benefits Scheme must take into account the off-setting advantages conferred by employing pharmaceuticals. These make its true economic cost, or net advantage, considerably less than the apparent financial cost. The consumption of expensive drugs has increased enormously but one one must also remember some very cogent compensations. Modern drugs reduce the number of visits which must be made to doctors. Their effectiveness simplifies his diagnostic problem and economises his time spent on patients. Drugs also

eliminate, or help to eliminate, long periods of illness among members of the working population. By shortening the average length of time spent in hospital beds they relieve pressure on the hospitals and, therefore, on the costs of the Hospital Benefits Scheme. And, by permitting many patients to recover health at home, hospitals are smaller than they need otherwise be. Such advantages are particularly obvious in certain forms of mental illness. The use of anti-depressants, for example, makes it practicable, quite literally, to keep thousands of mentally disturbed patients out of hospital and attending either their own general practitioner or the outpatient departments of hospitals. Further, it is possible for many persons with minor mental upsets which require time for readjustment to lead normal working lives. Even if one estimates the cost of the Pharmaceutical Benefits Scheme against only the considerable capital savings in terms of new hospitals which might otherwise be required, the Scheme obviously can show a substantial benefit. The other more indirect benefits to the national economy in terms of the physical and mental health of the working population could well triple this relatively ascertainable advantage were it measurable.

The Hospital Benefits Scheme

The main deficiencies of this Scheme have been analysed on the economic side by R.B. Scotton in an exhaustive survey, Voluntary Insurance and the Incidence of Hospital Cost.[23] Scotton's most striking criticism, 'that the incidence of hospital cost with respect to income has become increasingly regressive as it applies to the public hospital system', is based on the following findings: inadequate measures in the level of Commonwealth benefits; the failure of government subsidies (in particular, State subsidies) to keep up with the rising

costs of maintaining and replacing hospitals; consequent increases in patient fees; the greater stringency of means tests applied in hospitals; the need for lower income groups to pay a greater proportion of the family budget on health insurance; and the growing phenomenon of under-insurance for hospital benefits. Taken together, these findings constitute clear evidence, not only that the Australian Hospital Benefits Scheme does not meet sufficiently the needs of those who most require help, but also, increasingly, gives to them relatively less than to the better-off-groups.

The Commonwealth Government has increased its additional hospital benefit only once since the inception of the scheme. A period of nine years has passed without any increases in the benefits themselves, though the cost of hospitalisation has, over the same period, increased very considerably.[24]

What has happened since 1950 is that hospitals, faced with the problem of rising costs, have met these through higher charges to patients rather than through increases in State or Commonwealth subsidies - although Commonwealth subsidies, including capital grants, have managed to keep pace to a much greater extent than State Government subsidies. The Commonwealth Government has no power to prevent State Governments from meeting an increase in hospital costs by means of a rise in patients' fees. Nor is the emphasis of the present scheme on freedom for all parties concerned conducive to control of this situation. Only pensioners who receive public-ward treatment free escape the effects of these increased charges. Moreover, for other needy members of the community, the means test requirements have become increasingly stringent and smaller numbers of patients therefore qualify for public ward treatment than in the 1950s. Except in Queensland and, until recently, in Tasmania, which both have a free

public hospital system and consequently no means test, the increase in the level of fees charged to these needy groups has, surprisingly, increased much more than the level of fees charged to patients who are better off and occupy private ward beds. Scotton concludes that, whereas in 1954-5 public ward accommodation was available to the contributor and his family, earning an average wage, it is now restricted to those earning three-quarters of the average wage or less.[25] Thus, not only have public ward charges to lower-income patients risen more rapidly than non-public beds, but in addition many patients in income classes which would once have qualified them for public ward admission are now obliged to enter hospital as private and intermediate patients.

The cost of insurance cover for hospital patients in the lower-income groups has also increased relatively more than the cover for the upper income groups since 1954. Today, those patients who wish to cover themselves for public ward treatment, and who meet the means test requirements, pay about as much in dollar terms as patients who wish to cover themselves for intermediate ward treatment. To take one example, in Victoria, in 1966-67, private ward patients who wished to obtain adequate family insurance cover in private wards paid $67.60 per annum, rather more than twice what was paid in 1954-55. Those who required intermediate wards found $27.37 ÷ about three times the 1954-55 rates. While public ward patients had to find $25.34 - or twelve times the 1954-55 figure, Scotton rightly comments that 'the element of progression which means tests are designed to confer on the pricing system has been completely nullified by changes in the fee-structure and the financing pattern of voluntary insurance'.

Another pointer to the regressiveness of the present system is the difficulty which lower income

groups have in making provision for health insurance. A survey of living conditions in Melbourne in 1966, also conducted by the Institute of Applied Economic Research, showed a direct relationship between income and membership of voluntary insurance societies. Of non-pensioner families, 38.5 per cent who earned less than $39. a week were without insurance. And 13.1 per cent of families with incomes over $80. were uninsured. Also, the survey noted that 41 per cent of all uninsured non-pensioner families were in the lower income groups. Compare those figures with the 80-90 per cent overall proportion of the population allegedly covered by 'voluntary insurance'.

The phenomenon of under-insurance adds to the difficulties of those most affected by the regressiveness of the system. Under-insurance is much more common than is usually thought. When the Hospital Benefits Scheme was first established, the lowest table operated by the funds provided a total benefit which was equal to the public ward fees. By June, 1967, only 49.8 per cent of ordinary account (as distinct from special account) contributors were insured on tables which gave them benefits which would cover public ward charges. That is, many contributors now subscribe to out-dated tables which return to hospital contributors only a fraction of the charges which he must necessarily meet in the event of illness. Scotton estimates that in Melbourne only about 22 per cent of families in the lower income group (who are not pensioners) can expect to recoup full public ward fees or more when hospitalised; 21 per cent will recoup less than the full fee but rarely more than two-thirds; 19 per cent will get less than two-thirds; and 38 per cent will not be eligible for any insurance benefits. Thus there must be many cases of acute hardship.

Some of these regressive financial anomalies can be offset by a more progressive rate of income tax taken together with allowances on taxable income. There has been no full-scale study of the incidence of taxation on families in Australia. But there are some indications that the operation of concessions and allowances, an important feature of Australia's taxation system, effectively counteracts the progressive principle built into income tax. As is well known, all medical, hospital and dental expenses, not covered by insurance, are treated as allowances deductible from taxable income. Such deductions apply to all members of the community. But the wealthier gain very much more since their marginal rates of taxation - at 40 per cent, 50 per cent, or higher - permit them to deduct these proportions from that part of their medical, dental and hospital expenditures not already covered by insurance benefits. The lower income groups, with marginal rates of 4 per cent, 6 per cent and 10 per cent, clearly are in a position to use taxation allowances to a much lesser, even negligible, effect.

The ethics of this situation are most unpalatable. Effectively, those in the higher income groups, who are likely to have, because they can afford it, fairly full insurance cover anyway, are also the persons who gain most financially from taxation allowances. Thus the regressiveness of the system falls most heavily on those who, because badly off, are either uninsured or underinsured; or on the indigent and the special cases. 'The extension of present trends', Scotton concludes, 'can only intensify the ultimate conflict between the principle that the availability of hospital service must be governed by medical need rather than by...the practical necessity which hospitals face of increasing revenue from fees'.

The regressiveness of our voluntary health insurance arrangements has not been recognised, officially at any rate, by public authorities in Australia. Perversely, minor changes which might to some extent counter the situation had been resisted, albeit because of ignorance, both by the public and the government. Consider one feature of the present insurance arrangements which frequently occurs. A patient can pay a contribution to cover his private ward expenses in a hospital but, in the event, he must enter an intermediate ward or, even, a public ward. If this occurs his combined hospital fund and Commonwealth benefits will be greater than the actual ward charges. Of course this so-called profit may help to cover other hidden costs of hospitalisation, such as the need to employ a housekeeper where a mother is hospitalised, theatre expenses which are not covered by fund or medical benefit, and so on. On the other hand, it is clear that those who are able to pay for private wards gain more from this situation than others.

In May, 1963, to meet some of its own financial problems, the Hospital Contribution Fund of N.S.W. tried to abolish this rebate system. In a general revision of its own table to meet increased hospital charges imposed by the N.S.W. Government in 1967, the fund tried to include in its rules a new provision that fund benefits were to be limited to the hospital charges actually measured regardless of the rate of contribution by the subscriber. This decision precipitated a minor public outcry into which were brought the other funds, including the main competitor, the Medical Benefits Fund, the Commonwealth Government and, for once, the general public. In the event the rebate system was retained.

The H.C.F. claimed that its proposed move was quite consistent with the general tenor of government policy which favoured limitation of benefits; and argued

that in any case, the Commonwealth had to approve the tables of all funds before they could actually operate at all. Senator Wade, the then Minister for Health, was quick to reply. 'There has never been', he told a press conference in Canberra, 'an edict on the matter'. Although the Government has favoured limitation of excess benefits where these exceed $8 per day, 'that has never been mandatory'. The Government, it appears, is not prepared to contest public opinion, even for a socially-sound and economical principle.[26]

The Medical Benefits Scheme

The major defects of the Medical Benefits Scheme are (i) its lack of comprehensiveness; (ii) the existence of certain restrictions, or so-called exclusion clauses, in the rules of the funds; (iii) inadequate coverage - the existence of wide discrepancies between fee and benefit; and (iv) the absence of fee limitation either by government control or by agreement by medical practitioners.

Benefits are paid for some 1,200 medical procedures. But there can be no doubt that compared with the inclusiveness of the British scheme, Australian assistance towards the cost of medical attention, as well as the services actually covered, leave much to be desired. A number of major medical services are not included in the scheme. We have only limited ophthalmic services and no dental service;[27] pathological and radiological services are covered only if carried out by a medical practitioner; post-operative medical professional services generally do not qualify for separate benefits; examinations for life insurance purposes and expenditures incurred in the case of third-party insurance may be, and most often are, only partly covered by the Commonwealth. Limited benefits are paid by some funds for eye examinations, but not for spectacles.

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Next, certain conditions imposed by the funds frequently cause hardship. Take one instance. The required waiting period of two months between membership and payment of benefits means that certain groups, such as migrants unfamiliar with Australian institutions, may not be able to or cannot afford to arrange insurance sufficiently in advance of illness. Then there is the provision of a prescribed maximum benefit in any one year. The maximum may fall very far short of a patient's requirements if one year happens to be a particularly unfortunate twelve months medically (and financially) speaking. Nor do the funds, at the moment, make any provision for continuing cover when a patient falls into arrears with contributions, although a number of funds have now undertaken to send their members a reminder when this happens. Nevertheless, the clause must hit severely at the unemployed and those members of society unable continuously to meet their own liabilities.[28]

The question of pre-existing ailments provides an especially aggravating and irritating difficulty for patient-contributors. Under fund rules, medical benefits are not paid for conditions which can be shown to have existed prior to the time when the patient became a contributor, sought treatment for them and made a claim on the fund. On this type of claim, payment can be delayed many months while the funds make demands for further certificates and information from the medical practitioners concerned. Some dissatisfied patients claim that funds frequently make arbitrary decisions on this question. For instance, a condition apparent, say, in January, may not require surgery for 12 months until other treatment has, in the meantime, proven unsuccessful. During this period, a patient may have wisely transferred to a higher scale of contributions and have fulfilled the waiting period requirements. He may even have been on a higher table from the beginning and before the original diagnosis.

A third deficiency of the Medical Benefits Scheme is that of coverage, that is, the extent to which medical bills are covered by the combined Commonwealth and fund benefits. There are, so far, no reliable estimates such as those which have been provided by the Institute of Applied Economic Research on the regressiveness of the Hospital Benefits Scheme. Official figures are misleading. In 1966, the Commonwealth Department of Health estimated that, on an 'average medical bill', the fund paid 35.5 per cent, the Commonwealth 32.2 per cent and the contributor 32.3 per cent. Averages, however, conceal many variations and, in practice, many cases of individual hardship occur. But it seems clear from a study of benefit rates for particular conditions that, even for those who insure at the highest premium, medical benefits normally provide much less coverage than hospital benefits. Some patients may have to meet as much as two-thirds of medical bills; and, if they have not contributed to a fund, they must, of course, pay the total bill. The 1964 general revision made a substantial increase to the Commonwealth subsidy of one-third. But it still remains true that, for certain serious medical conditions, a contributor, even on the higher scale tables, can expect to pay as much as half the medical bill. This applies particularly where major surgery is needed.

Coverage depends, then, on the combined fund and Commonwealth subsidy. It also depends upon the level of medical fees for particular conditions. Ideally, these three components ought, if they are to change at all, to change together and in the same proportion. In practice, this has not occurred. Doctors fees have not been stabilised, government and fund benefits have been increased independently. Therefore, the coverage for people in various circumstances at different points in time has varied very considerably.

From the early years of the Scheme, it was apparent that fee stabilisation was an essential element in its successful operation. On 23 February, 1953, the A.M.A. adopted a resolution to the effect that 'Federal Council , in view of all the information bearing on the question, is concerned with the need for the stabilisation of medical fees, especially in view of the fact that the success of the service will depend on such stabilisation; and requests the Branch Councils to give serious thought to means of achieving this purpose'.[29] In August, 1955, Federal Council decided to request Branch Councils to approach the matter with a view to discouraging haphazard adjustments, and to base fee adjustments on known variations in the cost of living, the value of the currency, the incidence of taxation and their impact on the conditions of medical practice. Above all, every effort was to be made to maintain a relationship between medical fees and the benefits received by the public under the National Health Scheme. All this was seen as essential to 'ensure that the popularity of the National Health Scheme would be maintained'.[30]

The need for fee stabilisation remains as important today, probably more so, as it was twelve years ago. Yet official stabilisation of fees has occurred only once in the seventeen years that the Health Scheme has been in operation and even then only in principle. In May, 1963, as part of an arrangement with the Association, the Commonwealth subsidy on 400 of the 1,000 items listed in the Commonwealth Schedule of Benefits was increased. In return the A.M.A. agreed, in principle, to stabilise its fees. This decision was warmly received by government, the funds, and, of course, the general public. In the event, some Branches did not stabilise fees, and the A.M.A. has not since been able to impose stabilisation.

The idea of fee stabilisation has, over the years, come to be something of a 'bete noire' to the profession. Many doctors have argued that the emphasis now being placed upon fee stabilisation places almost exclusive responsibility on doctors to maintain the viability of the National Health Scheme; and consequently, insufficient responsibility upon other groups involved in its operation. The Commonwealth Government, they argue, is not committed to increasing their payments. Further, contributors, unlike doctors, are rarely urged to be aware of their responsibilities; /or to ensure that their rate of fund benefit will be at its highest level by increasing premium payments along with increases in the level of wages and the cost of living index.

Some doctors also insist that, quite apart from the question of responsibility, their fees have not kept pace proportionately with rises in certain important economic indices, such as the basic wage (which is in any case only a proportion of the total wage). As one doctor has emphatically put the matter, 'not only has the medical profession not taken the increases to which it was entitled, but when increases were made in fees they were made long after the change that justified an increase had occurred in the economy'.[31]

There was a need, he went on, to secure a formula 'capable of reflecting changing cost circumstances and of being paralleled by increases in contributions and benefits' in an orderly and justifiable way.

On the face of things this is a reasonable enough suggestion. But the real problem is how to ensure that such a formula could be implemented in a manner which is consistent with the ever-present emphasis on 'freedom' and minimum control. Ideally, within the present ideological framework of the Scheme, the profession itself should undertake to be responsible for this periodic

review. A medical-fee review committee appointed as a standing committee of each State A.M.A. Branch could perform this function. Some such proposals would obviate the necessity for reliance on external and specifically disciplinary body to undertake this task. The funds could be told of the proposed change and given reasonable notice in order / that they could alter their schedules and make adjustments to the contribution and scales of benefit. So far nothing along these lines has been implemented.

To some extent, doctors appear to be in a dilemma. And many thoughtful practitioners would admit this. Doctors constitute in Australia, as in most countries, a prestigious group. Criticism of their position in the National Health Scheme has recently become more vocal. Some critics have fastened exclusively on the apparently high relative incomes of the profession. Others resent the freedom they enjoy under the National Health Scheme - operating largely under conditions of private practice but with government guarantees on income matters. On the first point: the present scheme certainly gives doctors continued and fairly certain incomes.[32] In contrast, before 1950, their financial position was less secure. Certain patients, such as pensioners and the very poor, were unable to meet all doctors' bills. But nowadays, the financial burdens of illness are supported by the National Health Scheme. Doctors' bills are met irrespective of whether the patient himself is fully covered. On the second point, also, it is clear that the medical profession is privileged in some aspects of its working conditions. They have no control or even surveillance imposed upon them in the important matter of medical fees (unlike their partners in the system, the pharmacists and the Funds). Nor is the quantity or scope of the services (to contributors as

distinct from pensioners) which they provide, called into question in any systematic or authoritative way. Their only discipline in this sense is a self-imposed one operated by their peers on the Medical Services Committees of Inquiry - and then mainly for evident or gross abuses of the profession's role in the Scheme.[33]

Within the profession, as well as outside, the pros and cons of the doctors' situation in society are frequently debated. Some doctors who would admit that abuses are not entirely absent claim that the system itself rather than doctors is at fault. The existence of financial assistance for patients itself may undermine the doctor's social conscience. There is little need for the doctor to meet the personal problems of the indigent patient by charging him a reduced fee or waiving it completely. Nor, for the same reason, need he limit his visits to the old or chronically ill to those which are absolutely essential. Payment problems are shifted to other bodies - the funds or the Government. In short, some members of the profession appreciate that the doctor's social conscience and humanitarian interests may be insufficiently exercised within the structure of the National Health Scheme.

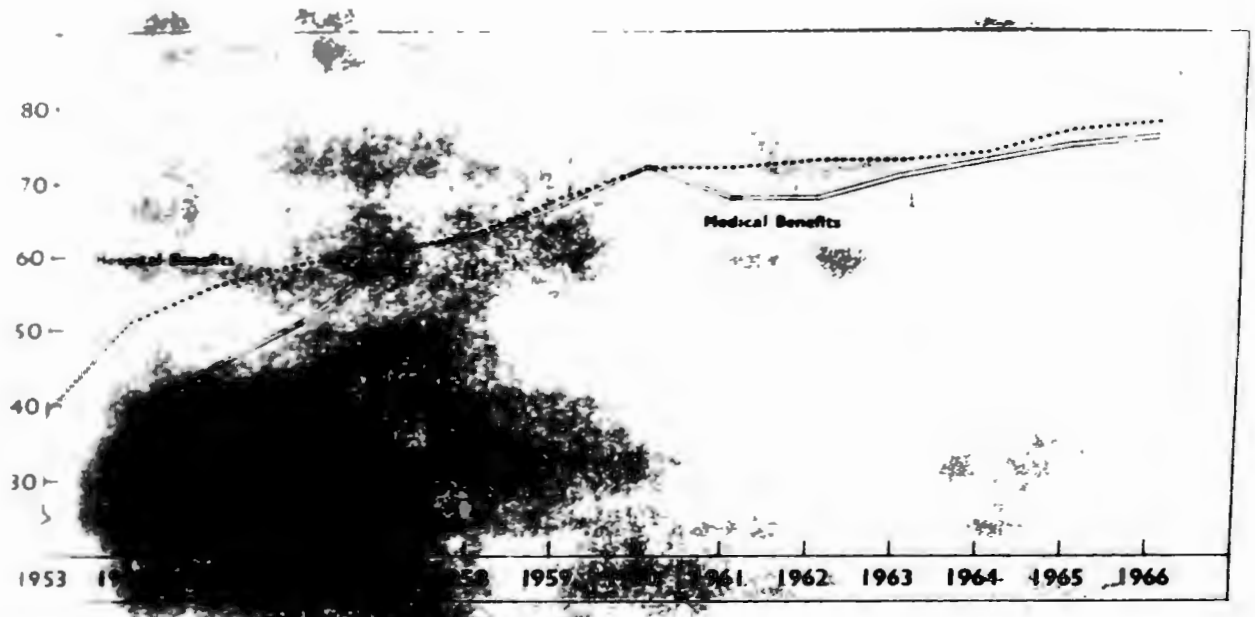
There is another aspect of this problem. If a doctor does have a strong and genuine interest in the welfare of his patients, this often can be made to coincide with a legitimate desire to enhance, or at least preserve, his income. This difficulty arises particularly in an area such as the Pensioner Medical Service - where the psychological and humanitarian aspects of the work are of great significance. Much is said about the emotional/and social problems of the old: their isolation, their feelings of uselessness, of rejection by society. Who is to judge that a doctor acts 'unethically' by multi-

plying visits to an old patient even though he knows that,, in the strict medical sense, little is achieved by it? Or, a similar point, is it 'over-servicing' a patient to supply a bottle of medicine or pill when this may induce the feeling that medicine has some mitigations and comforts to offer old age or chronic illness?

If, indeed, it is the system which is at fault, the irony is that the organised medical profession must take a substantial share of the responsibility. From a historical point of view, the issue of professional freedom was a fundamental condition for the participation of doctors in the Scheme. Subsequently, it became an essential element of Liberal-Country Party policy. As a perceptive practitioner wrote in the Medical Journal of Australia, in 1965, this freedom in itself creates dilemmas.[34] Freedom to charge a fee-for-service (under the umbrella of subsidised voluntary insurance) may absolve the doctor from worrying unduly whether his patient can pay for the service. Freedom to prescribe may lead to excessive prescribing which in turn threatens the economic viability of the scheme. Freedom to decide how often a patient may be visited may result in 'over-servicing'. And freedom to discipline themselves may, in practice, mean too little exercise of this prerogative. If individual doctors are really in a dilemma one cannot avoid the conclusion that it is one which has been created by the A.M.A. - and the A.M.A. has at least a partial responsibility for the removal of the conditions which create the dilemma.[35]

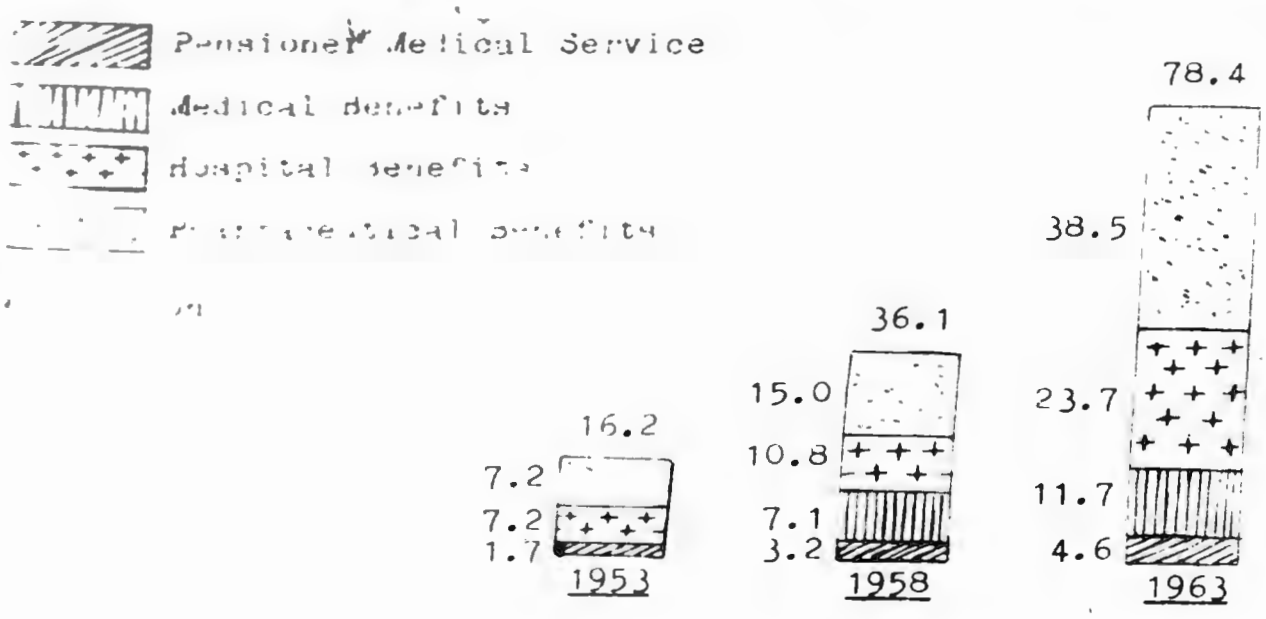
CHART IV TO CHAPTER TEN

Percentages of the Population Covered by Contributory Health Benefits



Source: Bank of New South Wales Review No.60, June 1967, p.13

Government Spending on Health under the National Health Act



Source: A.M.A. Quarterly Survey, July 1964, Vol.XIII, No.4, p.17

FOOTNOTES (CHAPTER TEN)

1. Strictly, 77 per cent are covered by the Hospital Benefits Organisation, and 74 per cent with Medical Benefits Fund. This figure does not include Pensioners and those covered by Repatriation Benefits. (Figures from Commonwealth Department of Health, 28 Oct. 1968). See also Chart IV, p.314.

2. A.B. Lee, 'Voluntary Health Insurance in Australia', M.J.A., Vol.1, No.24, 16 June, 1962, pp.917-23.

3. Sir . Fox, 'The Antipodes: Private Practice, Publicly Supported', The Lancet, Vol.1, No.7286, 20-27 April, 1963.

4. C.C. Jungfer, 'General Practice in Australia', Annals of General Practice, Vol.X, March, 1965. The Jungfer survey was carried out mainly to obtain information on the nature and quality of medical services given by general practitioners in Australia to their patients. The survey covered 213 practices. Of these, 114 constituted the core of the survey; the other 99 were visited infrequently, as time permitted. The practices chosen were widely distributed, equally representative of single individual practice, partnerships and group practices.

5. [illegible] Medical Services Review Committee Report, May 1965.

6. Voluntary Health Insurance Council of Australia, The Story of Voluntary Health Insurance in Australia', 1964, p.17.

7. J.A. Forbes, A Remarkable Record of Achievement, Oct. 1966, p.3, Department of Health, Canberra.

8. Between 1959 and 1966, hospitalised patients on special accounts were eligible for a benefit of $3.60 per day for undefined periods instead of the previous 80 cents for a limited period. The aged and the chronically-ill were also catered for more fully by the provision of $2. a day to those treated in hospitals approved under the Act. Even so, the patient who was entitled to $3.60 a day, if he is

(8, continued)

being treated in a public hospital, would still be required to pay another $2.40 a day, perhaps more in some States, to meet the cost of hospitalisation. And in approved nursing homes charges rarely fall below $54. a week. Therefore, some patients, in such approved institutions, may have to find as much as $40. a week to meet their bills. On 1 Jan. 1967 standard rate benefit was increased from $3.60 to $5 a day

9. R.B. Scotton, Voluntary Health Insurance in Australia, p.14. Paper delivered at the 1968 A.N.Z.A.A.S. Conference.

10. Report of the Joint Committee of the Victorian Council of Social Service and the Australian Council of Social Workers, 1968, p.6. The Hospital and Charities Commission, Victoria, Annual Report for 1966, showed the total number on waiting lists for admission to aged and benevolent homes was 818 male, 2,111 female, and 35 married couples.

11. It should be noted that expenditure on 'health services' cover much more than expenditure on national health insurance. They include 'all payments to private professions and business groups, plus all payments by public authorities and non-profit organisations for goods and services used within the current year'. J. Deeble, 'The Costs and Sources of Finance of the Australian Health Services', The Economic Record, Vol.43, No.104, December, 1967, p.520.

12. R.B. Scotton, op.cit., pp.14-18.

13. In 1966-7 approximately 7 million medical claims were submitted (involving over 29 million medical services to be checked and compensation paid for); 1.2 million hospital claims were also processed.

14. Commonwealth Department of Health, Guide to National Health Benefits, 1964, p.12.

15. Figures from Department of Health, 12.9.68.

16. M.J.A., Vol.II, 17 April, 1954, p.615; Vol.II, 28 Oct. 1967, pp.817-8.

17. A.M.A. Medical Services Review Committee Report, pp.18-20.

18. See Chap.IX.

19. Thelma Hunter, 'Some Thoughts on the Pharmaceutical Benefits Scheme', Australian Journal of Social Issues, Vol.1, No.4, Spring 1963, pp.32-5.

20. The Manufacturers' Association insist that prices can be and have been reduced, only when economics of scale have become operative. But the timing of the price reduction can scarcely be ignored.

21. J. Deeble, op.cit., pp.536-7.

22. C.C. Jungfer, op.cit., pp.31-2.

23. R.B. Scotton, 'Voluntary Insurance and the Incidence of Hospital Costs', Australian Economic Papers, Vol.6, No.9, Dec. 1967, pp.176-91.

24. In 1958 the Commonwealth additional benefit met 33⅓ per cent of Victorian public ward fees; in 1964-5 it met only 15 per cent of the fees, and in 1967 only 12 per cent. An insured patient in a Western Australia country-hospital in 1966-7 paid 400 per cent more than in 1958-9, while the State Government subsidy had only increased by 1 per cent over these years. Figures supplied by Commonwealth Department of Health, 22 Oct. 1968.

25. The average wage is the average weekly earnings per employed adult males, multiplied by 52. Scotton, op.cit., p.128.

26. Press Statement, 29 April, 1963, Department of Health, Canberra.

27. A report prepared for the New South Wales Department of Public Health, by the Professor of Preventive Dentistry at Sydney University, estimated that about 8 million Australians needed treatment for dental decay; the average child of 6-14 years suffers from more than a dozen decayed teeth. (The official reason for the absence of dental insurance is that the insurance premium would be too high and that there are not enough dentists in Australia).

28. H. Gold, 'A Health Policy', Dissent, Winter, 1964, p.12.

29. M.J.A., Vol.I, 18 April, 1953, p.564.

30. M.J.A., Vol.II, 24 September, 1955, p.594.

31. J. Bain, 'Fee Stabilisation: A Doctor's View', M.J.A., Vol.I, 15 June, 1963, pp.906-9. The evidence to support this was based on a comparison of basic wages in N.S.W. in 1933 [when it was $6.75 and in 1963 when it was $29, an increase of 328 per cent. In 1933 the consultation fee was $1.05; in 1963, it was $2.50 - an increase of 139 per cent over the 1933 figure].

32. The difference between Doctors' incomes and those of the rest of the community is not as great as is generally assumed. Advertisements of gross incomes are misleading. For example, a gross income of, say, $22,000, may be reduced from anything between 30 to 50 per cent by the expenses of practice, especially in single-doctor practices, as distinct from group practices where the overheads can, to some extent, be spread over a number of doctors.

33. See Chap.IX.

34. L.J.J. Nye, 'The Practice of Medicine Yesterday, Today and Tomorrow', M.J.A., Vol.2, 1965, pp.524-527.

35. One important deficiency of the Medical Benefits Scheme

needs mentioning. The Scheme tends to discourage preventive medicine by individual general practitioners because they receive the same fee for a single visit irrespective of the time spent with the patient.

CHAPTER ELEVEN

REFORM OR CHANGE ?

Appreciation of the inadequacies of the National Health Scheme is growing. The Labor Party has pressed successfully in the Senate for the setting up of a Select Committee of Enquiry - an event to which we shall presently refer - and the Liberal-Country Party Government also has been stimulated by growing criticism to establish a three-man independent Committee of Inquiry. The findings of these two committees will no doubt yield a greater body of material evidence than is as yet available for or against reform on which it will then be open to the Government to act.

What, at the moment, appear to be the alternatives? And in which direction should Government move? Should it reject the National Health Scheme in its present form in favour of radical change; or should it content itself with/more modest reform? These are questions which, strictly speaking, are outside of the main scope of this volume. Nevertheless, the remarkable revival of interest in health policy shown by the political parties over the last year prompts some comment on current developments in the light of the political history of National Health as we have surveyed it in this work.

Historically, the finance, content and administration of Australia's National Health Scheme has been influenced strongly by three major political forces. First in importance were the ideological orientations of the parties which initiated the Scheme. Second, there were considerations of a constitutional nature. The Commonwealth had to seek and secure authority, through an amendment to the Constitution, to legislate in certain specific areas of health policy. The majority of

health powers were then left with the States. Subsequently, the Constitution was invoked successfully on two occasions to invalidate health legislation. Third, and at certain crucial points in time, this was the most important factor, there was the refusal of the organised medical profession to cooperate in the implementation of Commonwealth legislation except on terms which suited its own interests and ideas.

These considerations all remain important today. The basic principles on which Liberal-Country Party Governments justify their approach to National Health - and to health insurance in particular - have remained virtually unchanged for seventeen years. The Australian States still retain the powers left to them after the 1946 amendment; at the same time the anti-civil-conscription proviso, written into the Constitution to placate the A.M.A., remains potentially a significant weapon accessible to groups antagonistic to change including, of course, the States themselves. Finally, there is no evidence that the A.M.A. has altered its attitude on what it regards as desirable and essential attributes of National Health Insurance. On the contrary, the Jungfer Report, and more recently, the Medical Services Review Committee report, have indicated a high degree of satisfaction with the present arrangements and, by implication, a desire to cling to them.[1]

This combination of forces, for so long as they continue to influence policy, is likely to place substantial obstacles in the way of any radical alterations to the National Health Scheme. For example, any attempt to adopt a system similar to the British National Health Service, with its emphasis on central government ownership, direction and control, almost certainly would fail. Modest reform rather than radical change, therefore, appears to be the

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more practicable alternative. If this is so, there are certain obvious and fundamental deficiencies in the National Health Scheme which should be eradicated - most of which have been noted in the preceding chapters. For example, the insurance elements of the scheme must be made less regressive. The financial burdens of ill health should be made to fall less heavily on those families least able to afford them. Similarly, the chronically ill and aged should have adequate insurance cover. It is important also that the activities of the funds be more effectively controlled or reorganised. And agreement with the organised medical profession on the matter of fee stabilisation should be arranged.

Immediately one lists the more important of the defects of the existing scheme, it is clear that most of them are built into, or are a result of, the system of voluntary health insurance as it has developed in this country. And that the simplest and most practicable framework in which to create worthwhile reforms is that of compulsory insurance, while maintaining otherwise intact certain other basic components of the Scheme - in particular, the fee-for-service method of payment for professional services.

The advantages of compulsory over voluntary forms of health insurance have been asserted and reiterated in Australia intermittently, since the nineteen twenties. But they require re-emphasising. Consider these points: Compulsory insurance with contributions levied as a percentage of all income-earners' annual incomes, as distinct from flat rate contributions on behalf of individuals or families, could be used to ease the financial costs of health insurance for the less-well-off groups of the community. Below a certain, very low, income, no levy would be required. Given a comprehensive coverage of the income earning (and income receiving) persons of the

community the actuarial basis of the scheme would be more sound; greater benefits in certain areas would be possible. The phenomena of the uninsured and the under-insured would be ended. And a greater uniformity of benefit payments - including more effective cover for the chronically ill - would be possible. Given an appropriate government agency to administer compulsory insurance, much of the present multiplicity of organisation and function would be removed. A smaller and less cumbersome apparatus would be found appropriate. If, in addition, contributions were levied through an already existing Commonwealth Government agency - the Taxation Department is the most obvious candidate - the operation would be that much more efficient and economical. Some of those 'mountains of paper' proliferated by a voluntary system which caters for varying contributions, claims on different scales, and different financial standing, would disappear. In all, compulsory insurance makes an excellent vehicle for the generation of a more equitable system of contributions and benefit payments and would rid the present scheme of its most unfortunate built-in regressiveness.

Support for the compulsory principle and its application to health insurance has been growing in Australia - although, so far, outside of Government circles.

One such carefully thought out set of proposals for appropriate alteration of the present system came from a Melbourne medical practitioner, Dr Hugo Gold. He states that they would 'involve no radical change in economic planning'; and implies that they could be implemented by a Liberal-Country Party, or a Labor Party, Government without departing very greatly from past financial commitments to health policy. (Although it is clear that on one point at least - the principle of voluntary insurance - a Liberal-Country Party Government would be compelled to renounce a past commitment). His

proposals to revise the National Health Scheme can be summarised,[2] as follows:

(i) A system of compulsory contributions graduated by income and collected by the Taxation Department.

(ii) A continuation of the fee-for-service system of payment to doctors and hospitals. Reimbursement of bills would take place through the Department of Health or a special branch of the Post Office.

(iii) Medical Benefits: a higher level of reimbursement (up to 90 per cent) and then extension to include refunds for hospital out-patient charges.

(iv) Hospital Benefits: a refund equal to the cost of a public hospital bed; that is, public hospital beds would be free.

(v) The elimination of the special accounts category of beneficiaries.

(vi) Dental Health: a 90 per cent refund for children until sixteen years of age; and a gradual extension of the scheme to cover the whole population.

(vii) Appliances: a 90 per cent refund on approved articles.

(viii) Pharmaceutical Benefits: to be included in the contributor's insurance arrangements with a 90 per cent refund on costs of pharmaceutical products to 'make both doctor and patient aware of the costs'. The government could ask for tenders from potential drug suppliers and contract with drug manufacturers on the basis of price, quality and safety in order to eliminate a great deal of wasteful advertising and duplication of reserves.

(ix) A fee schedule covering all National Health Scheme Services subject to yearly service by an independent arbiter.

As Dr Gold outlines his proposals, the total of moneys to be raised would not be greatly different from that presently going into the National Health Scheme and a similar proportion would continue to come from general taxation. Consequently, both components of finance would contain a progressive element. The use of the Taxation Department as a collector of contributions is an eminently feasible suggestion since that agency already arranges weekly or fortnightly deductions from practically all wage and salary earners in Australia. Those persons not subject to regular deductions could pay their health

insurance levy, in advance, at the time of the annual income tax settlement. It is not difficult to agree with Dr Gold that this far-reaching, yet eminently practicable set of proposals, would provide 'complete financial protection for the whole population without arbitrary changes in medical practice' being required. It would retain freedom of choice for both patient and doctor and continue to make full use of all existing private and public facilities. Administration appears to offer no outstanding problem; and Commonwealth expenditure need not be increased significantly, thus leaving revenue for other uses. The scheme requires a minimum of time for organisation and initiation.

But perhaps the most interesting feature of Dr Gold's proposals is the clear statement that efficient, equitable, compulsory health insurance, with contributions graduated according to income, is perfectly compatible with the fee-for-service form of payment and avoids direct collision with the interests of the organised medical profession. His views are a recognition that, at the centre of any reforming proposals, the fee-for-service form of payment is strategic; the medical profession is unlikely to concede much on this matter - even a partial withdrawal.

In any event, there are some advantages to be remarked in favour of the fee-for-service payments system as it has operated in Australia. Where medical and hospital bills are paid for by the patient in the first instance, a sense of responsibility is induced. Responsibility is reinforced where a proportion of the bills remain uncovered by the insurance reimbursement. That is to say, where there is a clear price fixed to a service (it is not free or apparently free to the public), individuals observe greater care before calling upon medical and hospital resources. Yet at the same time

the insurance cover, if adequate, removes the cause of financial anxiety. Further, if patients are fee-paying individuals who are free to choose, and re-choose, their own doctor, this does much to ensure a viable and animosity-free doctor-patient relationship - on both sides. Foreign observers, and medical practitioners formerly employed in the British Health Service, have frequently commended this aspect of the Australian system.[3]

Another proposal recently was voiced by the Leader of the Australian Labor Party.[4] E.G. Whitlam suggested a compulsory insurance scheme along lines very similar to those of Dr Gold, save that the financial provisions were projected in greater detail. In an address to a post-graduate seminar at the Royal Prince Alfred Hospital in July 1968, he put forward for consideration a system of 'universal' insurance, to be administered by a Commonwealth Health Insurance Commission. The revenue of the 'National Health Insurance Fund' for the scheme would be derived from:

(a) a health insurance contribution, assessed and collected as a 1¼% surcharge on income tax;

(b) a matching Commonwealth government contribution, in part funded by withdrawing income tax concessions now granted for voluntary contributions to insurance funds; and

(c) a levy on compulsory insurers equal to their present liability for medical and hospital care under third party insurance and workers' compensation insurance.

The benefits available would include: (i) Hospital benefits to cover fully, without means test, the cost of hospitalisation in public ward beds in public hospitals. Patients who choose to use intermediate or private wards would benefit; but additional costs would then be financed by voluntary health insurance charges. (ii) Medical benefits would cover 85 per cent of 'current standard fees'. (iii) A modest charge would be imposed for 'patient initiated' services of doctors and

specialists. And (iv) medical practitioners would be free to charge directly t: the patient their customary fee (recoverable through the Insurance Fund) or bill the Fund directly for the 85 per cent reimbursement.

Aside from the similarities there are three small but fairly important differences as between Whitlam's view of compulsory insurance scheme and that of Dr Gold. Whitlam's suggested methods of financing the Insurance Fund include, as well as the matching Commonwealth contribution, a withdrawal of tax concessions at present allowable on voluntary insurance. Thus, to this degree, the scheme is more progressive in its incidence on incomes. Second, he suggests the establishment of a Commonwealth Health Insurance Commission to administer the scheme rather than Gold's proposal to use the Department of Health - an idea which possibly would commend itself to the A.M.A., bearing in mind the profession's aversion to Departmental administration. A third important difference is that Whitlam fails to mention specifically any provision for the stabilisation of fees through arbitration; although,one passage which refers to negotiations between the Commonwealth, the Insurance Commission and the A.M.A. on schedules of benefits payable, could be construed to mean that fee matters would be settled around a conference table.at the same time and in the same breath, so to speak, as benefits are fixed. Experience of past negotiations between the A.M.A. and governments leads one to doubt that this process will be so painless.

One final but important point of difference between Whitlam's scheme and that of Dr Gold: Whitlam lays great emphasis on the establishment of a National - Hospital System based upon regionalisation. The use of the system would be voluntary for both patient and doctor. Patients could, if they so preferred it, use and pay for

private practitioners to attend them in hospitals. Similarly, doctors could attend patients privately on a fee-for-service basis, as at present, or they could join the National Scheme. In the latter case, they would be paid on a salaried or sessional basis. The main objective of the national hospital system would be to make the hospitals the centre of medical care and not 'adjuncts to the doctor's surgery'.[5]

Compulsory health insurance has also been suggested by a Joint Committee of the Victorian Council of Social Service and the Australian Association of Social Workers (Victorian Branch).[6] The Committee emerged as a result of the concern felt by Victorian social workers in their professional contact with the social aspects of ill health. It was set up in June 1967 and was charged with the following tasks: (i) to consider deficiencies in existing hospital and medical benefits schemes; (ii) to recommend alternatives to such schemes; (iii) to determine to whom evidence of deficiencies and recommendations of possible alternatives should be presented. The findings of the report were less precise than those produced by Melbourne University's Institute of Applied Economic Research. The members of the Committee were mainly social workers, not expert economists. Nevertheless, they did substantiate - and in more concrete human terms - the Institute's findings concerning the personal distress caused to many people in Victoria by the operation of the National Health Scheme. Its principle recommendation was 'that consideration be given to introducing a government controlled scheme of medical and hospital benefits for all, with contributions graduated according to income, which would leave the individual free to choose his own doctor, yet give medical practitioners a guarantee of due payment of fees. Other suggestions made by the committee included: that the

Commonwealth should make direct capital and maintenance grants to benevolent institutions and State Governments in order to increase facilities for nursing home care for chronically-ill persons; the abolition of the special accounts system; and a public inquiry into the deficiencies of the Scheme.

The Joint Committee's report received little encouragement from the Government. The Minister of Health, Dr Forbes, reacted by stressing in his comment the Government's loyalty to the existing system. 'The keynote of the Australian Scheme is voluntary health insurance'.[7] And on the other recommendations of the Victorian Joint Committee he made it clear that the Government already had in mind its own committee of inquiry to examine the National Health Scheme.

Indeed, by March-April of 1968, two officially-inspired lines of inquiry into the operation of the National Health Scheme - especially into its insurance aspect - were under way. As indicated by the Minister of Health, an 'independent' Committee of Inquiry was appointed by the Liberal-Country Party Government which, increasingly, has become sensitive to widely-expressed criticism of the many anomalies and deficiencies of its Health Scheme. And, second, a Select Committee of the Senate was empowered to investigate medical and hospital costs in Australia. The former is a privately-conducted inquiry; the latter is a review by means of public hearings followed by a report to Senate. It is worth noting that the Select Committee, appointed on April 2, 1968, on a motion from the Leader of the Opposition, Senator Murphy, and agreed by a majority of two (25 - 23), was the culmination of a succession of promises and pressures on the part of the A.L.P.[8] since 1961 to set up a Committee of Inquiry into National Health. The full terms of reference

are: 'To inquire into medical and hospital costs in Australia and, in particular, to examine the operation and administration of the medical and hospital benefit schemes and to recommend such legislative and administrative measures by the Commonwealth as will, having regard to the constitutional division of legislative power in Australia, enable the provision of the optimum standards of medical and hospital care for all'. These are wider terms of reference than those given to the Government's Committee. And while the findings of the Select Committee, due for report by 31st December, 1968, are not likely to secure sympathetic consideration from the Liberal-Country Party Government, its proceedings, publicly held and reported widely, may well force the Government to go further in reform than its own inclinations otherwise would allow.

The subject of the Committee of Inquiry was introduced by the Gorton Government in March 1968 at the opening of the first Parliamentary Session.[9] The Governor-General, in his opening address, announced that the Government intended 'to arrange an independent inquiry... into the operation of the Medical and Hospital Insurance Funds...and to consider whether any further measures be taken to improve the operation of the scheme'. The rider was added, 'at the same time preserving the principle of freedom of choice on which it is based'. The character of the announcement, and the private nature of the inquiry, suggest that the Government does not intend the Committee to deviate too far from the framework of the present scheme. The specific terms of reference of the Committee of Inquiry, later announced in Parliament, strongly reinforce this view. The Committee is required to investigate no less than sixteen aspects of medical and hospital insurance, all of them concerned with benefits, contributions, special accounts, competition between the funds, and suchlike matters.[10]

Substantially, they are those features of health insurance criticised and brought to the notice of the public by Scotton and Deeble of the Institute of Applied Economic Research in Melbourne University. But, a point of the utmost importance, the Committee is required to make its recommendations 'within the context of a <u>voluntary</u> health insurance scheme and the obligations at present accepted by the State Governments'.

Evidently, this committee is a creature of the Government. And, given the Liberal-Country Party's attachment to the voluntary system, together with the pressures likely to be exerted within the party as well as from without to retain this system, it seems most unlikely that any proposals ensuing as a result of the Committee's inquiries, will be other than minor modifications of the present scheme. <u>Plus ca change, plus c'est la meme chose</u>.

FOOTNOTES (CHAPTER ELEVEN)

1. See Chap.X. p. 277.

2. H. Gold, 'A Health Policy', Dissent, Winter 1964, pp.11-15.

3. Survey of British Doctors in Australia, Voluntary Health Insurance Council of Australia, February 1968, p.6.

4. E.G. Whitlam, 'The Alternative National Health Programme', Australian Labor Party, Information Release, No.1/68.

5. At the time of writing the final draft of this chapter (August 1968), yet another voice has been raised in favour of compulsory insurance. The proposals differ only in detail from those already mentioned. But they are closer to those of Whitlam rather than Dr Gold, in the importance attached to a simultaneous attempt to re-organise our hospital system on a regional basis, and on the emphasis given to the quality of medical and hospital care as well as to improvements in the National Insurance Scheme. J.S. Lawson, Australian Hospital Services, a Critical Review, pp.92-102.

6. Report of Joint Committee of the Victorian Council of Social Workers (Victoria Branch) on Hospital and Medical Insurance - 1968, pp.1-12.

7. The Age, 20, 21 Jan., 1968.

8. C.P.D., 2 April 1968, p.526. The request for an investigation into the Scheme was made for the first time at the Labor Party Conference of 1961. See Appendix.

9. C.P.D., 12 March, 1968, p.11.

10. The terms of reference of the Committee are as follows:

A. To inquire into (i) the types of and amounts of benefits provided by benefit tables; (ii) the extent to which the fund benefits available average against the cost to provide contributions for medical and hospital treatment; (iii) the rates of contributions payable by contributors having regard to the effect of these contribution rates on the willingness of individuals to insure; (iv) the limitations imposed by the rules (including the Special Account rules) of registered organisations in respect of benefit payments; (v) the limitations imposed on individuals by the rules of registered organisations on becoming a contributor to an organisation or transferring to a different benefit table in the same organisation; (vi) the policies pursued by registered organisations in the application of their rules relating to the transfer of contributions to Special Accounts; (vii) the methods used by registered organisations in paying benefits; (viii) the methods used and costs incurred by registered organisations in collecting contributions including the rates of commissions and fees paid to collection agencies; (ix) the expenses including the payment of benefits; (x) the level of reserves maintained by registered organisations for hospital and medical insurance purposes; (xi) the policies followed in the investment of such reserves and other monies arising from contributions to hospital and medical benefit funds; (xii) the overall management, administration and financial operations of the registered organisations; (xiii) the extent to which there is effective contribution representation in the administration, and policy-making, of registered organisations; (xiv) the effects of activities pursued by registered organisations in competing for members; (xv) the extent and form of competition that is desirable between registered organisations; (xvi) whether the interests of contributors would be better served if there were a greater or lesser number of registered

(10, continued)

organisations. B. To make such recommendations to the Minister in relation to the above matters as the Committee deems necessary. C. To make such other recommendations to the Minister as the Committee deems necessary in relation to the provision of adequate financial protection against the cost of illness in the ~~case~~ context of both a voluntary health insurance scheme and the obligations at present accepted by the State Governments.

The members of the Committee are: Mr. J.A. Nimmo, Deputy President of the Commonwealth Conciliation and Arbitration Commission (Chairman); Sir Leslie Melville, Vice Chancellor of the Australian National University, and an ex-chairman of the Tariff Board 1953-60; / Mr. N.H. McIntosh, Chartered Accountant.

APPENDIX A

Summary of Recommendations of Royal Commission on National Insurance First Report 1925

Your Commissioners recommend:-

(a) that a National Insurance Fund be instituted which will provide for the payment of sickness, invalidity, maternity and superannuation benefits to insured members, and

(i) that membership of such fund be compulsory;

(ii) that a sickness benefit of 30s. per week be payable to adult insured members during the first six months when incapacitated for work as the result of sickness; (iii) that a sickness benefit not exceeding 20s. per week be payable to insured members under 21 years of age during similar incapacity; (iv) that equivalent benefits be payable to insured members when incapacitated for work as the result of accident, and that the question of including workers' compensation legislation under the National Insurance Fund administration be fully considered; (v) that an invalidity benefit of 20s. per week be payable to insured members during that period when incapacitated for work as the result of sickness or accident extending beyond six months' duration; (vi) that a maternity benefit of 20s. per week be payable for a period of two weeks prior to and for four weeks after the confinement of a female insured member, or the wife of an insured member; (vii) that, as the cost of the existing maternity allowance is at present borne solely by the Commonwealth, this responsibility should continue with respect to the maternity benefit provided under the National Insurance Fund; (viii) that a superannuation benefit of 20s. per week be payable to male insured members after attainment of age 65 and to female insured members after attainment

of age 60; (ix) that the existing rights of pensioners under the Commonwealth Invalid and Old-age Pensions Act 1908-23 should not be interfered with; (x) that a child allowance of 5s. per week, in respect of each dependent child under age 16, be payable to the insured member when incapacitated for work;

(b) that a National Health Scheme be instituted which will provide adequate medical treatment for the people, and which will provide the requisite machinery for the prevention of sickness and accident, and

(i) that such scheme be dissociated from the administration of the National Insurance Fund;

(ii) that the functions and objects of the Health Department be extended in such manner as will enable provision to be made as early as possible for the effective supervision of adequate medical services, especially with respect to maternity treatment.

As previously indicated, the inquiry in connection with unemployment and destitute allowances is now proceeding, and, as the questions of membership, finance and administration of any proposed National Insurance scheme must be considered in relation to all sections of the inquiry, these questions will form the subject of a further report when the inquiry with respect to unemployment and destitute allowances has been completed.

In order that a comparison may be made of the main features of the schemes in operation in various countries, your Commissioners have compiled a conspectus of the legislation which has been enacted in the several countries with respect to the provision of (a) sickness, maternity and funeral benefits, and (b) old-age, invalidity and survivors' benefits. The conspectus, which has involved very considerable and detailed research, is appended to this Report.

Source: Commonwealth of Australia First Progress Report of the Royal Commission on National Insurance, pp.38-9.

APPENDIX B

Summary of Recommendations of the Royal Commission on Health, 1926

I. Ill-health in the Commonwealth

That standardized statistical investigations into the extent and character of morbidity in the Commonwealth should be instituted and maintained.

That definite and formal cooperation should be established between the Statistician and the Health Department by associating a Medical Officer of the Commonwealth Department of Health with the Commonwealth Statistician's Office to supervise the collection, tabulation and analysis of morbidity, mortality, and other vital statistics.

That legislation, where necessary, should be enacted to provide that such statistics as are required shall be furnished by Government Departments, Friendly Societies, industrial and other bodies such as public hospitals, and by medical practitioners, to the Commonwealth Statistician.

II. Co-ordination of the Medical Services of the Commonwealth

A. Medical Services of Civil Departments.

B. Medical Services of Repatriation and Defence Departments.

[6 Recommendations]

III. Co-operation of Commonwealth and State Health Authorities

That Section II (b) of the Quarantine Act 1908-24 should be amended by the addition of the words 'and in promoting public health'.

That legislation should be passed by the Commonwealth Parliament to provide funds for the establishment of a Health Council on the lines we have recommended.

That funds should be made available to provide for the extension of the Commonwealth Department of Health, in conformity with its prescribed functions.

That legislation should be passed by the Commonwealth Parliament to provide University and other training for experts in public health; also for the training of the technical personnel for all public services both in the Commonwealth and in the States.

That legislation should be passed to provide subsidies to measures approved by the Commonwealth Department of Health, which State or local authorities are unable to finance alone - with appropriate conditions attached in order to secure efficiency.

That legislation should be passed to provide for the establishment of laboratories, or subsidies to State laboratories.

IV. The prevention of the outbreak, development, or spread of disease.

That the Commonwealth Department of Health should formulate a model outline of general principles of Health administration, along the lines we have suggested, and that the Commonwealth should subsidise States for expenditure on Health, provided that their Health administration sufficiently conforms to such model.

That in the Commonwealth Department of Health, Divisions of Epidemiology and Tuberculosis should be established to investigate problems of infectious disease, and advise generally in regard to all efforts to control infectious diseases.

That the Commonwealth Department of Health should formulate the principles of a comprehensive campaign against the spread of tuberculosis, and the Commonwealth should make conditional subsidies to the States for carrying out such a campaign, similar to those for venereal disease.

That the Invalid Pensions Act should be amended to allow of payment of pensions to the dependants of patients suffering from infective tuberculosis while they are undergoing treatment in sanatoria or hospitals.

That the system of diagnostic laboratories should be extended, and that laboratories should be distributed in places that would probably be centres in health districts in the future.

That the system of inquiries into special infectious and other diseases and of experiments concerning their control should be continued.

That the system of Conferences with State representatives on special aspects of sanitary engineering, industrial hygiene, and other problems of health should be continued.

V. The prevention and control of venereal disease

[13 Recommendations]

VI. Uniform legislation with regard to the purity of food and drugs

[2 Recommendations]

VII. Maternity Hygiene

That in the Commonwealth Department of Health a Division of Maternity Hygiene should be established.

That conditional subsidies should be granted by the Commonwealth to States in order to provide facilities for attention to women, before, during, and after childbirth, according to standards approved by the Commonwealth Department of Health.

That the Maternity Allowance Act should be amended - (a) to provide that the application for the allowance shall be made at least five months before the date of the expected childbirth, and that the allowance be not paid unless a medical certificate be produced to the effect that the mother has had pre-natal supervision; and (b) by the addition to Section 5 (2) of the words 'No child shall be deemed to be a viable child which measures less than 35 c.m. [approximately 14 inches] in length'.

VIII. Child Welfare

[4 Recommendations]

IX. Industrial Hygiene

That the Work of the Division of Industrial Hygiene in the Commonwealth Department of Health should be extended in the following directions: [4 Recommendations]

X. The Encouragement and development of research work

That the Commonwealth, by Act of Parliament, should:- (1) Establish a Health Research Council. (2) Provide a special appropriation endowment of £30,000 per annum in aid of health research.

XI. The relationship which should exist between public health authorities and medical practitioners in regard to the prevention of disease

That legislation, where necessary, should be enacted to provide that such statistics as are required shall be furnished by medical practitioners to the Commonwealth Statistician.

That the Commonwealth should require as a condition of subsidies to States for general health administration, that their legislation should provide for the active participation of medical practitioners in local health administration on the lines suggested in the report.

That the Commonwealth should endeavour to arrange for the transfer to the Commonwealth from the States of their powers with regard to registration of medical practitioners.

XIII. The publication of information relating to matters concerning public health

[4 Recommendations]

Source: Commonwealth of Australia, Report of the Royal Commission on Health, 1926. pp.51-4.

APPENDIX C

Medical Benefit Clauses of the National Health and Pensions Insurance Act 1938

Definition of Medical Practitioner

'Medical practitioner' means a person who is registered, or entitled to practise, as a medical practitioner under the law in force in any State or part of the Commonwealth.

Medical Benefit

47. Medical benefit consists of such proper and necessary medical services as are prescribed and the provision of proper and sufficient drugs and medicines and of the prescribed medical and surgical appliances and the supply of such medical certificates as are required for the purposes of this Act, but does not include medical services involving the exercise of such special skill or experience as general medical practitioners cannot reasonably be expected to possess or treatment or attendance in respect of a confinement or such other medical services as are prescribed.

48. A juvenile contributor shall, notwithstanding that he has ceased to be employed, be entitled to medical benefit until the thirtieth day of June or the thirty-first day of December, as the case may be, whichever next follows the date on which he attains the age of sixteen years and six months.

49. (1) A person shall not be disqualified from receiving medical benefit under this Act by reason that his sickness has been caused by his own misconduct.

(2) A voluntary contributor whose total income from all sources exceeds Three hundred and sixty-five pounds per annum shall not be entitled to medical benefit.

50. Where an insured person who is entitled to medical benefit attains the maximum age and is or becomes entitled to receive an old-age pension, he shall be entitled to receive medical benefit during the remainder of his life.

51. (1) The Commission may, as prescribed, make arrangements whereby medical services in accordance with this Act and the Regulations will be supplied by medical practitioners to insured persons.

(2) The Commission may, as prescribed, enter into contracts or agreements with medical practitioners by whom medical services are to be supplied under any arrangement made under the last preceding sub-section.

(3) Any medical practitioner may, subject to the prescribed conditions, secure participation in an arrangement made under sub-section (1) of this section.

(4) A list shall be prepared and published as prescribed, from time to time, showing the names of the medical practitioners who are parties to any contract or agreement made under this section in respect of any State or part of the Commonwealth.

(5) Any insured person may, subject to the prescribed conditions, select from the appropriate list the medical practitioner by whom he desires that medical services shall, subject to the consent of that practitioner, be supplied to him.

(6) Medical services shall be supplied to an insured person who has not made a selection under the last preceding sub-section, or to whose selection the selected medical practitioner has not consented, by such medical practitioner on the appropriate list as is selected by the Commission in the prescribed manner.

52. If the Commission is satisfied that an arrangement made under section fifty-one of this Act in respect of any State or part of the Commonwealth is unsatisfactory or is inadequate to provide medical services or that no satisfactory and adequate arrangement can be so made, the Commission may suspend or cancel any existing arrangement and make such other provision for the supply of medical services as it thinks fit, or it may suspend, for such period as it thinks fit,

in respect of insured persons in that State or part of the Commonwealth, their right to receive medical services and may provide for the payment, to each insured person affected by the suspension, of the whole or part of a sum, bearing the same proportion to the amount specified by the Commission as being the annual cost at the time of supplying medical services to an insured person, as the period of suspension bears to a year.

53. (1) The Commission may, as prescribed, enter into contracts or agreements for the supply to insured persons of proper and sufficient drugs and medicines and of such appliances as are prescribed, where such drugs, medicines, and appliances are ordered by any medical practitioner attending an insured person under and in accordance with this Act.

(2) Such drugs, medicines, and appliances shall be supplied by persons with whom the Commission has entered into a contract or agreement under the last preceding sub-section.

(3) No contract or agreement under this section shall be made with any person unless -

(a) he is a pharmaceutical chemist; or

(b) he undertakes that all medicines supplied shall be dispensed by or under the direct supervision of a pharmaceutical chemist:

Provided that, in such special circumstances or cases as are prescribed, but not otherwise, a contract or agreement may be made with a medical practitioner for the supply by him of drugs or medicines to an insured person.

(4) A list shall be prepared and published as prescribed, from time to time, showing the names of persons who are parties to any contract or agreement made under this section in respect of any State or part of the Commonwealth.

(5) Any person with whom the Commission may enter into a contract or agreement under this section may, subject to the prescribed conditions, secure participation in the supply of drugs, medicines and appliances to insured persons, subject

to his entering into such a contract or agreement.

54. (1) If the Commission is satisfied, after such inquiry as is prescribed, that a contract or agreement made under section fifty-one or section fifty-three of this Act should, in the interests of insured persons, be cancelled, it may cancel the contract or agreement, and its action shall be final and without appeal.

(2) Where the Commission has cancelled any contract or agreement made under section fifty-one or section fifty-three of this Act, the person with whom the contract or agreement was made shall not be entitled, unless and until the Commission otherwise determines, to participate in any arrangement, contract or agreement under this Part.

55. Where the Commission - (a) has cancelled a contract or agreement made under this Part for the supply of drugs, medicine and appliances; or (b) is satisfied that, in respect of any State or part of the Commonwealth, it is impracticable to make a satisfactory contract or agreement under section fifty-three of this Act for the supply of drugs, medicines and appliances, the Commission may make, in lieu of the contract or agreement so cancelled or in respect of that State or part of the Commonwealth, as the case may be, such other provision as it thinks fit for the supply to insured persons of drugs, medicines and appliances.

56. (1) For the purpose of enabling the Commission to determine the terms of any contract or agreement proposed to be entered into by it under this Part for the supply of drugs, medicines and appliances, the Commission may, by notice in writing, call upon any manufacturer or wholesale distributor of drugs, medicines and appliances to furnish to it, within such time as is specified in the notice, such books and documents and such information as the Commission thinks necessary in relation to drugs, medicines and appliances the subject of any such contract or agreement.

(2) Any person who, without reasonable excuse (proof whereof shall lie upon him) fails, after receipt of a notice under the last preceding sub-section, to comply with the requirements of the notice, shall be guilty of an offence.

Penalty: Fifty pounds, or imprisonment for three months.

57. (1) For the purposes of this Act, there shall be: Medical Benefit Council consisting of -

(a) persons representing -

(i) medical practitioners rendering service under this Act; (ii) pharmaceutical chemists (including pharmaceutical chemists representing friendly societies' dispensaries) supplying drugs, medicines and appliances under this Act; (iii) employers of insured persons; and (iv) insured persons who are members of approved societies; and

(b) persons selected by the Minister.

(2) Each member of the Medical Benefit Council shall be appointed by the Minister and shall hold office for such period and upon such conditions as are prescribed.

(3) The number of persons to be selected by the Minister, and the number of persons representing each class specified in sub-section (1) of this section, to be appointed members of the Medical Benefit Council, and the method of selecting the persons to be appointed as representing each such class shall be as prescribed.

(4) The Medical Benefit Council shall give advice to the Commission with respect to any matter relating to medical benefit which is referred to it by the Commission and shall have such other powers and duties as prescribed.

58. The Commission may, after consultation with the Medical Benefit Council, decide whether or not any substance or preparation is, for the purposes of this Act, a proper or sufficient drug or medicine.

59. (1) For the purposes of this section, the Commission may divide the Commonwealth into districts.

(2) The Commission may, subject to and in accordance with the Regulations, establish a District Medical Benefit Committee in any such district.

(3) A District Medical Benefit Committee shall have -

(a) such powers and duties in relation to complaints by insured persons, medical practitioners, pharmaceutical chemists, friendly societies' dispensaries and approved societies in connection with medical benefit in the district for which it is appointed; and

(b) such other powers and duties, as are prescribed.

60. If a Medical Practitioners Committee is appointed by medical practitioners, the Commission may, if it considers the Committee to be representative of the medical practitioners in the Commonwealth who are parties to such contracts or agreements, refer to the Committee for report matters relating to the administration of medical benefit under this Act, and shall consider any representatives relating to such administration which are made by such medical practitioners and submitted to the Commission through the Committee.

61. If a Pharmaceutical Chemists Committee is appointed by pharmaceutical chemists, the Commission may, if it considers the Committee to be representative of the pharmaceutical chemists and friendly societies' dispensaries in the Commonwealth who are parties to such contracts or agreements, refer to the Committee for report matters relating to the administration of medical benefit under this Act, and shall consider any representations relating to such administration which are made by such pharmaceutical chemists and friendly societies' dispensaries and submitted to the Commission through the Committee.

Medical Benefit Account

62. (1) There shall be kept in the Health Insurance Fund an account to be called the Medical Benefit Account in which shall be credited from time to time, out of the moneys standing to the credit of the Health Insurance Fund, such amounts as are, in the opinion of the Commission, necessary to meet the cost of medical benefit under this Act.

(2) The cost of medical benefits under this Act shall be met out of amounts from time to time standing to the credit of the Medical Benefit Account.

Insurable Employment.[1]

(a) Employment in Australia under any contract of service or apprenticeship, written or oral, whether expressed or implied, and whether the employed person is paid by the employer or some other person, and whether under one or more employers, and whether paid by time or by the piece or partly by time and partly by the piece, or otherwise, or without any money payment.

(b) Employment under such a contract as aforesaid as master or a member of the crew who is either domiciled or has a place of residence in Australia of any British ship of which the owner, or, if there is more than one owner, the managing owner or manager, resides or has his principal place of business in Australia.

(c) Employment in Australia as an outworker, except if or so far as such employment is excluded by the regulations.

The expression 'outworker' means a person to whom articles or materials are given out by another person to be made up, cleaned, washed, altered, ornamented, finished, repaired or adapted for sale for the purposes of the trade or business of that other person where the process is to be carried out either in the home of the outworker or in some other premises not being premises under the control and management of that other person.

The person who gives out the articles or materials shall, in relation to the person to whom they are given out, be deemed to be the employer of that person for the purposes of this Act, but the Commission may, by special

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[1] Part I of the First Schedule

order, provide that as respects any outworkers or any class of outworkers specified in the order a person specified in the order shall, instead of the person who gives out the articles or materials, be deemed to be the employer and thereupon that person shall be deemed to be the employer.

(d) Employment in Australia of such classes as the Commission specified by special order, being cases in which a person undertakes otherwise than by a contract of service the performance either wholly or in part by himself of manual labour in relation to a trade or business carried on by the person for whom the labour is performed. The person for the purposes of whose trade or business the labour is performed shall, in relation to the person so undertaking to perform the labour, be deemed to be the employer of that person for the purposes of this Act.

(e) Employment in Australia by or under any authority under the Commonwealth or a State constituted by or under any Act or State Act, except in so far as such employment is excluded by the Regulations.

(f) Employment in Australia in plying for hire with any vehicle or vessel the use of which is obtained under any contract of bailment in consideration of the payment of a fixed sum or a share in the earnings or otherwise, and the person from whom the use of the vehicle or vessel is so obtained shall be deemed to be the employer for the purposes of this Act.[1]

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[1] Part II of the First Schedule excluded from the provisions of the Act Commonwealth and State Government employees whose terms of employment already covered them for the benefits given by the Act. It also excluded people employed as agents who were paid by commission or fees and who derived their income from more than one source. Next, it imposed an income limit of $730 and excluded casual workers and the Aboriginal population of the Australian and Pacific Island Territories. Finally the Act excluded people employed by their husband or wife or in a family business where the employment was such that the administration of insurance benefit was impracticable.

APPENDIX D

A Bill for an Act to Provide for the Establishment of National Health Services, and for Other Purposes. 1948

Be it enacted by the King's Most Excellent Majesty, the Senate, and the House of Representatives of the Commonwealth of Australia, as follows:

1. This Act may be cited as the National Health Service Act, 1948.

2. In this Act, unless the contrary intention appears -

'national health service' means a service provided, or arrangements for the provision of which are made, under this Act;

'the Director-General' means the Director-General of Health.

3. A person shall not be appointed as Director-General of Health unless he is a legally qualified medical practitioner of not less than ten years' standing.

4. The Director-General shall have the general administration of this Act, but the exercise of any power or function by the Director-General under this Act shall be subject to any directions of the Minister.

5. (1) The Director-General may, in relation to any particular matter or class of matters, or to any particular part of the Commonwealth, by writing under his hand, delegate to any officer, or to any person included in a prescribed class of persons, all or any of his powers or functions under this Act (except this power of delegation) so that the delegated powers or functions may be exercised by the delegate with respect to the matter or class of matters, or the part of the Commonwealth, specified in the instrument of delegation.

(2) Every delegation under this section shall be revocable at will and no delegation shall prevent the exercise of any power or function by the Director-General.

6. The regulations may make provision for and in relation to the establishment, maintenance and conduct of a scheme for the payment by the Commonwealth, on behalf of persons who

have received professional services from medical practitioners who are for the time being participants in the scheme, of the prescribed proportion of the fees prescribed in respect of those services.

7. (1) The Director-General may, on behalf of the Commonwealth, but subject to this Act, provide, or arrange for the provision of, prescribed medical services and prescribed dental services.

(2) Without limiting the generality of the last preceding subsection, the services referred to in that subsection may include -

(a) general medical or dental practitioner services;
(b) consultant and specialist services;
(c) ophthalmic services;
(d) maternal and child health services;
(e) aerial medical and dental services;
(f) diagnostic and therapeutic services;
(g) convalescent and after-care services;
(h) nursing services; and
(i) medical services and dental services in universities, schools and colleges.

(3) The Director-General may, on behalf of the Commonwealth, do, or arrange for the doing of, anything which is incidental to the provision of any medical service or dental service under this section.

(4) In particular, and without limiting the generality of the last preceding sub-section, the Director-General may, on behalf of the Commonwealth -

(a) establish, maintain and manage hospitals, laboratories, health centres and clinics;
(b) provide, or assist in the provision of, scholarships or training for university graduates in medicine or dentistry and for persons who have completed courses of training, approved by the Director-General, in, or in relation to, medicine or dentistry;
(c) establish, maintain or develop, or assist in the establishment, maintenance or development of, courses of training in nursing (including dental nursing), dental hygiene, radiography, radiation-therapy, physiotherapy, bio-chemistry, dietetics and other matters related to medicine or dentistry;
(d) undertake or develop, or assist in the undertaking or development of, measures (including research and epidemiological investigations) for the improvement of health (including maternal and child health) and for the prevention of disease;

(e) encourage group practice by medical practitioners and dentists; and
(f) disseminate information relating to health and the prevention of disease.

8. The Minister may make an arrangement with any other Minister for the performance by that other Minister of any service in connexion with a national health service.

9. (1) The Governor-General may enter into an arrangement with the Governor of a State for the performance by that State of any service in connexion with a national health service.

(2) An arrangement entered into under this section may provide for payments by the Commonwealth to the States in respect of capital expenditure or maintenance expenditure incurred by the State at the request of the Commonwealth in connexion with the service performed by the State.

(3) Any arrangement entered into under this section which provides for payments by the Commonwealth to a State in respect of any expenditure referred to in the last preceding sub-section shall provide for information to be supplied to the Minister by such persons, at such times and in such manner and form as he requires.

(4) An arrangement entered into under this section shall provide -

(a) that any property the cost of which, or part of the cost of which, has been paid by the Commonwealth to the State under the arrangement shall not, except with the approval of the Minister, be used otherwise than for the purpose for which the property was acquired; and
(b) for the indemnification of the Commonwealth -
(i) in the event of the acquisition by the Commonwealth of property the cost of which has been paid by the Commonwealth to the State under the arrangement - against payment by way of compensation for the acquisition of that property; and (ii) in the event of the acquisition by the Commonwealth of property the cost of which was paid in part by the Commonwealth to the State under the arrangement against payment by way of compensation proportionate to the cost so paid.

10. The Governor-General may enter into an arrangement with the Governor of a State for the taking over by the Common-

wealth from the State, for the purposes of a national health service -

(a) of any medical service or dental service provided by the State;
(b) of the whole or part of any hospital, laboratory, health centre or clinic owned or provided by the State; and
(c) of any property used in or in connexion with any such hospital, laboratory, health centre or clinic.

11. The Director-General may, on behalf of the Commonwealth, enter into an agreement for the taking over by the Commonwealth, for the purposes of a national health service -

(a) of any medical service or dental service;
(b) the whole or any part of any hospital, laboratory, health centre or clinic; or
(c) any property used in or in connexion with any hospital, laboratory, health centre or clinic,

not being a service, hospital, laboratory, health centre, clinic or property owned or provided by a State.

12. The Minister may establish a committee to manage, on behalf of the Commonwealth, but subject to any directions of the Director-General, the whole or any part of any medical service, dental service, hospital, laboratory, health centre or clinic taken over by the Commonwealth under either of the last two preceding sections.

13. The Director-General may, on behalf of the Commonwealth, make an agreement with any person for the performance by that person of any service in connexion with a national health service.

14. The Minister may, on behalf of the Commonwealth, arrange for, or undertake, the manufacture for the purposes of a national health service, of medical and dental supplies, appliances and equipment, including visual aids and hearing aids.

15. (1) The Director-General may, for the purposes of this Act, compile and publish a list of medical practitioners or dentists recognised by him as being specialists in any field of medical science or dental science.

(2) A person shall not be recognised, for the purposes of the last preceding sub-section, as being a specialist in any field of medical science or dental science unless the Director-General is satisfied -

(a) that his practice is wholly or mainly devoted to work in that field and that he is generally recognised by medical practitioners or dentists, as the case may be, as having special skill and experience in that field; or

(b) that he possesses special academic qualifications in that field and that he has recently held, or holds, a hospital or other appointment affording opportunities for acquiring or demonstrating special skill and experience in that field.

(3) For the purpose of satisfying himself as provided in the last preceding sub-section, the Director-General may have regard to any list compiled by the appropriate authority of a State, or by an appropriate professional body, of medical practitioners or dentists who are recognised by that authority or body as being specialists in any field of medical science or dental science.

(4) A person who desires his name to be included in a list compiled under sub-section (1) of this section shall make application to the Director-General accordingly.

(5) The Director-General may refer any such application to an appropriate advisory committee established under this Act for consideration and report and, where an application is so referred, the Director-General shall take the report into consideration before granting or refusing the application.

16. The Minister may establish such advisory committees as he thinks fit for the purposes of this Act.

17. Officers and other persons employed by the Commonwealth for the purposes of this Act shall be employed under the Commonwealth Public Service Act, 1922-1948.

18. An officer of the Commonwealth who is registered as a medical practitioner, dentist, nurse, pharmacist, physiotherapist or otherwise under the law of any State shall be entitled to perform his duties, in relation to any

national health service, in any other State or in any Territory of the Commonwealth, notwithstanding that he is not registered in that other State or in that Territory.

19. Where an agreement between the Government of the Commonwealth and the Government of any other part of His Majesty's dominions, or the Government of any foreign country, provides for reciprocity in matters relating to the provision of medical or dental services or benefits, the regulations may provide for modifying or adapting this Act in its application to persons affected by the agreement.

20. The Minister may, subject to the approval of the Treasurer, make payments to universities or other appropriate bodies for the purposes of -

(a) promoting and assisting investigation and research;
(b) providing courses of training, in medical science or dental science.

21. (1) There shall be payable out of the Trust Account established under the National Welfare Fund Act, 1943-1945, and known as the National Welfare Fund, all expenditure under this Act other than expenditure of a capital nature and expenditure in respect of administrative expenses incurred by or on behalf of the Commonwealth.

(2) Other expenditure under this Act shall be paid out of moneys from time to time appropriated by the Parliament for the purpose.

22. The Governor-General may make regulations, not inconsistent with this Act, prescribing all matters which are by this Act required or permitted to be prescribed, or which are necessary or convenient to be prescribed, for carrying out or giving effect to this Act, and in particular -

(a) for prescribing matters for or in relation to - (i) the establishment, maintenance or conduct of any national health service; (ii) the terms and conditions (including terms and conditions as to payment) subject to which a national health service may be made available; (iii) the persons or classes of persons to whom a health service may be made available; (iv) the duties and functions of persons performing any services in connexion with health services; and (v) the payment of remuneration and allowances of persons providing professional services for the purposes of a national health service.

(b) for providing for the payment of compensation to a medical practitioner or dentist who -
(i) on the date on which a hospital, health centre or clinic is established at any place in connexion with a national health service, is in practice in or near that place; (ii) undertakes to make his professional services available exclusively for the purposes of a national health service; and (iii) has thereby suffered or will suffer loss arising from a diminution in the value of his practice;

(c) for prescribing the constitution, powers, functions, duties and procedure of committees established under this Act;

(d) prescribing the fees and allowances payable to members of committees established under this Act, other than members who are officers of the Public Service of the Commonwealth or of a State;

(e) for the making and recovery of charges in respect of medicines, materials and appliances supplied in connexion with a national health service or in respect of the replacement or repair of any appliance so supplied; and

(f) for prescribing penalties not exceeding a fine of fifty pounds, or imprisonment for a period not exceeding six months, for any offence against the regulations.

APPENDIX E

Decisions taken on National Health at Federal Conferences of the A.L.P. 1915-67

Earlier Decisions

At the 1915 Federal Conference, national insurance - covering sickness, accident and life insurance in much the same fashion as the 1911 British Act - was adopted as part of the Labor platform. And in 1919 nationalisation of public health was also included in the platform. The 1936 Federal Conference resolved that 'until such times as the nationalisation of health is given effect to' the Commonwealth government should accept responsibility for a reasonable proportion of the cost of public health services in the various States. In 1942 and 1943 there were two Special Conferences in which the federal platform was endorsed in respect of national insurance and nationalisation of health. At the same time, the Commonwealth Government was requested to bring in comprehensive social insurance and health bills to cover all forms of sickness, medical service and free ante-natal and post-natal treatment. At a General Conference in 1943 support was declared for a referendum to include (i) National Health in cooperation with the States; and (ii) a Social Security Act providing for adequate old age and invalid pensions, funeral benefits, medical services and benefits, dental services and benefits, unemployment-insurance benefits, etc. etc. In 1945, no additional decisions were taken and at the 1948 Federal Conference it was resolved 'that the Federal Government take the necessary steps to ensure' a comprehensive hospital scheme including out-patient services; also, that 'all special treatment' be made free and available to all.

1949 Onwards

Since 1949 Labor policy has undergone a series of changes which, at times, have appeared confused, even inconsistent. Until 1965 the party has appeared uncertain

how far it should revert to its original nationalisation platform, and how far it should compromise with present government policy and concentrate on repairing its major deficiencies. These confusions were finally resolved in 1965 when Labor clarified its position and in particular specified how, in practice, its proposed policies would affect the existing structure of medical and hospital practice.

Between 1949 and 1955, probably as a result of its 1940-9 experiences with the organised medical profession, Federal Conference decisions, in their tenor and emphasis, began to move towards policies which would remove some of the anomalies of the existing Scheme without, at the same time, making any fundamental change in it. As the operation of the National Health Scheme under the Liberal-Country Party revealed some significant omissions and deficiencies, Labor at first took the pragmatic position that it should gear its policy objectives towards rectifying them. For example, the 1951 conference specified that the party would eliminate the qualifying period which existed before sick people became entitled to sickness benefits; and also establish a complete range of free medical benefits for pensioners. The 1953 conference went further, and pledged a future Labor Government to re-establish the free hospital scheme set up under the Labor Government in 1945; and to widen the free medical scheme. In 1957, on the initiative of the New South Wales Branch, the Federal Conference reverted to what seemed substantially its 1942 and 1943 conference decisions and approved 'the establishment on a national basis of a complete health service to be both curative and preventative in its activities. On the other hand, it did not specify clearly how medical and hospital practices were to be organised and controlled. The 1959 conference

decisions only partly clarified the position. On the medical side, group practices on a salaried basis were to be 'encouraged'. On the hospital side, the national system was to include free hospital treatment as in 1945-9 but - a more significant departure for the Labor party - voluntary insurance was to be encouraged for both hospital and medical benefits. The present scheme was to be made more comprehensive and extended to include dental and optical services. Other conspicuous omissions and deficiencies of the scheme were to be corrected. The requirement that contributors must be members of benefit societies in order to qualify for Commonwealth medical benefits was to be waived and the means test requirements of the pensioner medical service were to be abolished. By 1959, therefore, it seemed that the Labor Party had decided to retain much of the existing scheme and, at the same time, attempt to establish a parallel government service as the 1957 decisions suggested. But the relationship between the two, the existing scheme and the new government service was, to repeat, not clearly stated until 1965.

The 1965 conference offered a precise and clear-cut statement of Labor's health objectives and, in particular, the relationship which it now envisages between public and private medicine.

The preamble to the conference decisions is in itself symptomatic of a new precision as well as a flexibility in Labor policy. The party is now committed to a comprehensive government health service, specifically intended only for those 'who choose to use it' and staffed by those 'who choose to serve on it'. For the first time, the importance of choice for the patient and, probably more important, for the doctor, was unambiguously stressed. In this respect alone the 1965 plat-

decisions only partly clarified the position. On the medical side, group practices on a salaried basis were to be 'encouraged'. On the hospital side, the national system was to include free hospital treatment as in 1945-9 but - a more significant departure for the Labor party - voluntary insurance was to be encouraged for both hospital and medical benefits. The present scheme was to be made more comprehensive and extended to include dental and optical services. Other conspicuous omissions and deficiencies of the scheme were to be corrected. The requirement that contributors must be members of benefit societies in order to qualify for Commonwealth medical benefits was to be waived and the means test requirements of the pensioner medical service were to be abolished. By 1959, therefore, it seemed that the Labor Party had decided to retain much of the existing scheme and, at the same time, attempt to establish a parallel government service as the 1957 decisions suggested. But the relationship between the two, the existing scheme and the new government service was, to repeat, not clearly stated until 1965.

The 1965 conference offered a precise and clear-cut statement of Labor's health objectives and, in particular, the relationship which it now envisages between public and private medicine.

The preamble to the conference decisions is in itself symptomatic of a new precision as well as a flexibility in Labor policy. The party is now committed to a comprehensive government health service, specifically intended only for those 'who choose to use it' and staffed by those 'who choose to serve on it'. For the first time, the importance of choice for the patient and, probably more important, for the doctor, was unambiguously stressed. In this respect alone the 1965 plat-

form is a significant breakaway from all previous conference decisions on national health.

Labor now aims at the 'establishment of a comprehensive health service providing both government and private service'. Clearly, Labor wants to set up a government service. But it is equally clear that it does not intend to abolish the existing system of voluntary health insurance for sound political as well as constitutional reasons. It will be retained with considerable improvements - broadly along the lines already suggested in earlier conferences.

Patients are, therefore, to get the best of all possible worlds: those who want to and <u>can</u> provide for themselves may continue to do so, and are assured of improved services; those who either cannot or will not will be provided with a government service.

The A.L.P. also has eliminated everything in its proposals which could be interpreted as implying compulsion. The general practitioner service is to be st affed by salaried medical practitioners 'willing to join'. The use of the proposed national hospital service, a crucial aspect of Labor policy, is also permissive. Labor envisages the development of a system of medical care of which the hospital becomes the centre and services increasingly are provided by salaried and sessional staff. Its other hospital policy objectives (apart from the provision of a free public ward service to patients) aim to lower hospital costs by extensive rationalisation and, if necessary, by the establishment of a regional hospital system. It is proposed to give additional grants to the States willing to extend specific services including, significantly, salaried in-patient and out-patient specialist staff and to participate in regionalisation proposals. A unified policy may therefore be secured

without the need to seek additional Constitutional powers. Significantly, Clause 19 of the 1965 platform which specified 'a referendum to give the Commonwealth Parliament the power to make laws with respect to health; or reference by the State to the Commonwealth Parliament for the power to make laws with respect to health', does not appear in the 1967 platform.

The Labor Party has, then, arrived at what is undoubtedly its clearest, most precise and, in many respects, most realistic policy on national health.

APPENDIX F

List of Ministers for Health 1909-66

Senator R.W. Best	2 June 1909	As
F.G. Tudor	29 April 1910	
L.E. Groom	24 June 1913	Ministers
F.G. Tudor	17 September 1914	
W.M. Hughes	29 September 1916	for Trade
W.O. Archibald	14 November 1916	
J.A. Jensen	17 February 1917	and
W.A. Watt	13 December 1918	
W.M. Greene	17 January 1919	Customs
W.M. Greene	10 March 1921	
A. Chapman	9 February 1923	
L.E. Groom	29 May 1924	
H.E. Pratten	13 June 1924	
N.R. Howse	16 January 1925	
S.M. Bruce	2 April 1927	
N.R. Howse	24 February 1928	
F. Anstey	22 October 1929	
J. McNeill	3 March 1931	
C.W.C. Marr	6 January 1932	
W.M. Hughes	12 October 1934	
J.A. Lyons	8 November 1935	
W.M. Hughes	26 February 1936	
E.C.G. Page	29 November 1937	
Senator H.S. Foll	7 November 1938	
F.H. Stewart	26 April 1939	
H.V. Thorby	14 March 1940	
F.H. Stewart	28 October 1940	
E.J. Holloway	7 October 1941	
Senator J.M. Fraser	21 September 1943	
Senator N.E. McKenna	18 June 1946	
E.C.G. Page	19 December 1949	
D.A. Cameron	11 January 1956	
Senator H.W. Wade	22 December 1961	
R.W.C. Swartz	21 November 1964	
A.J. Forbes	26 January 1966	

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