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THE CARING COMMODITY

Transformations in the Exchange Character
of Medicine in New Zealand
(1840-1985)

A thesis presented to the
Department of Geography,
Massey University
in complete fulfilment of
the requirements for the degree of
Master of Arts.

Iain Mill Hay

1985

A cloud does not know
why it moves in just such a
direction and at such
a speed

It feels an impulsion...this is
the place to go now. But the sky knows
the reasons and the patterns
behind all clouds,
and you will know too, when
you lift yourself high enough
to see beyond
horizons.

(Bach, 1977:90-1)

"...the method of presentation must differ in form from that of inquiry. The latter has to appropriate the material in detail, to analyse its different forms of development and to track down their inner connection. Only after this work has been done can the real movement be appropriately presented. If this is done successfully, if the life of the subject-matter is now reflected back in ideas then it may appear as if we have before us an a priori construction."

(Marx cited in Williams, 1981:32).

ABSTRACT

Retrospective analysis of actions and interactions connected with health care makes evident their place as constituted and constitutive components of capitalist social relations. The contextually constrained activity of individuals to achieve certain ends has contributed to the production of outcomes which appear to be beyond individual control and which shape the social world. In explaining the main transformations in the character of medical services since the early days of European settlement emphasis is placed upon the multiple and differentiated emergence of various structures of relationships between, principally, doctors and patients, doctors and doctors, and those who, at various stages, have attempted to intervene in those relations.

Over the period 1840-1985, medical practice has been transformed from a service provided on a user-pays basis, to one of collective provision, and back towards the 'private' sector. In the six decades after 1840 medicine and the State became enmeshed. Some moves towards the State provision of health care services occurred. The period 1900-35 saw the supporters of both free enterprise and socialistic medicine inexorably drawn towards advocacy of some grand scheme of collective care, the character of which was extensively debated from 1935 until 1942. The outcome brought 'free' provision of most medical care to those in need and also served the long term interests of capital. Since then, health care has been returning to the market. In part, the broad sweep from, and back to, commodity relations has arisen from actions to 'solve' problems of health care provision and use. The solutions arrived at, however, have been compromises between conflicting demands. Although at times 'solutions' may have facilitated the more humane allocation of medical services, the general tendency is for them to reproduce capitalist social relations.

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LIST OF ABBREVIATIONS

The following abbreviations have been used throughout this thesis:

ACC	Accident Compensation Commission until 1981. Thereafter, Accident Compensation Corporation.
AJHR	Appendices to the Journals of the House of Representatives.
BMA	British Medical Association
BMA (N.Z. Branch)	British Medical Association (New Zealand Branch). [Except where ambiguity is likely to arise BMA (N.Z. Branch) is shortened to BMA.]
DUG	Distribution Unions' Group.
FOL	Federation of Labour.
GMS	General Medical Services Benefit.
IWW	Industrial Workers of the World.
MANZ	Medical Association of New Zealand.
MP	Member of Parliament
NHIC	National Health Insurance Committee (A Committee of the BMA (N.Z. Branch)).
NHIIC	National Health Insurance Investigation Committee (A Committee of Government).
NZMA	New Zealand Medical Association.
NZMJ	New Zealand Medical Journal.
PD	New Zealand Parliamentary Debates.
SACHSO	Special Advisory Committee on Health Services Organisation.
SDP	Social Democrat Party.
ULP	United Labour Party.

PROLOGUE

This thesis began as an endeavour to examine and explain the growth and consequences of medical insurance and private medical practice in New Zealand. After some months of study, guidance and discussion, it became evident that the patterns of today had their roots firmly embedded in the past. In fact, in some matters these roots could be traced back to the first days of European settlement in New Zealand. An information gathering exercise revealed that there was an underlying sameness to aspects of health care provision over more than a century in this country. The place of both medical insurance and the recent re-emergence of private medical practice became clear in historical context, as did many other elements of health care enterprise. The problem was how to outline an approach which allowed comprehension of recurrent dilemmas in new health care situations. The emphasis of the thesis moved from a simple explanation of one characteristic of the network of health care activity to an explanation and understanding of the totality of social transformations in New Zealand medicine. Such explanation represents the most important of three aims of, and justifications for, this lengthy thesis. The second justification revolves around the aim to provide the first detailed examination of the whole span of medicine in New Zealand. To date, most studies have extracted short sequences of events and relations from their context with little or no regard for, or knowledge of, the place of the extraction and, although the medical field is being more thoroughly examined now than in the past, there remain periods which attract little attention. The neglected periods are investigated in this thesis and are placed alongside temporally located relations already subjected to extensive scrutiny. Given these first two aims and the research approach adopted, it should become clear that the following pages can be read at two levels. At the first level they provide any reader with a comprehensive discussion of all of New Zealand's health care history. At the second level is presented a relational view of medical care in our society. Although the first level can be divorced from the second, the reverse is not possible. The final aim draws upon both these levels of interpretation. It is hoped that this thesis will facilitate further study of health care activity by virtue of the extensive empirical detail made available and through the provision of a framework which will allow the better interpretation and examination of social interaction connected with health care.

SETTING

OUT

1

CHAPTER 1

SETTING OUT

Since 1961 the number of New Zealanders covered by private medical insurance has grown from 900 to more than one million, the latest numbers representing about one-third of the country's population (pers. comm., Medicaid Fund Society Limited; Southern Cross Medical Care Society; Mutual Health Society, Group Health Co-operative Society, January, 1985).

Whilst bringing a marked change to health care provision in New Zealand, medical insurance is not unusual throughout the world, and has become increasingly common since WWII. The Australian population has health insurance cover; insurance has been compulsory in Belgium since 1945; Brazil's Golden Cross organisation continues to show strong growth; since the passage of the Voluntary Health Insurance Act 1957 in Ireland the percentage of that country's population belonging to voluntary schemes climbed to 4.65 percent in 1962, 10 percent in 1967, and 17.5 percent in 1975 despite continued provision of the 'free' service by the state; membership of Jamaica's Blue Cross has increased by an average of about 13 percent per annum since its inception in 1956-7; 78 percent of the United States' civilian population is covered by private medical insurance; and even in Zimbabwe medical insurance continues to exist (International Federation of Voluntary Health Service Funds, 1976).

The geographic spread of health insurance is both symptomatic of, and conducive to, the progressive commodification of the relationships between the providers and recipients of medical care. It is part of long-term social relations.

MOVING FROM POSITIVISM TO HISTORICAL MATERIALISMPositivism Proves Passe

Positivist social science has recently encountered criticism on a variety of fronts: for its inverted methodology (Slater, 1977:41)

which has seen the promotion of data determined research; the assemblage of vast amounts of information which obscure the real nature of human activity (Slater, 1977:42); the illegitimate representation of 'soft...facts' by precise numbers (Anderson, 1973:2); the dissociation of variables from their social and historical context (Pred, 1981b:6; Ferretti, 1981:3; Chouinard et al, 1984:353; Eyles and Lee, 1982:118 and 121; Slater, 1977:42; Anderson, 1973:3; Harvey, 1977a:215; Sayer, 1978:82-3; Marx cited in Sayer, 1978:82); and the related inability to explain underlying processes which give rise to surface social and spatial appearances (Sayer, 1978:80-1; Sayer, 1979b:1058-9 and 1063; Sayer, 1979a:35; Sayer, 1982b:119; Slater, 1977:43; Ferretti, 1981:3) or indeed to distinguish between causal and coincidental relations (Sayer, 1982b:119). Positivist research in social science has also been attacked for its production of a partial, atomistic, fragmented vision of our society (Wallerstein cited in Taylor, 1982:16; Taylor, 1982:16; Sayer, 1979b:1056; Sayer, 1979a:36; Anderson, 1973:2 and 3); its confusion of regularities with laws and explanation (Eyles and Lee, 1982:121; Sayer, 1979b:1059); the transferral of mathematical logic to social processes (Sayer, 1978:80; Sayer, 1979b:1060); and the assumption that observation and facts are ethically and theoretically neutral, and that theory merely facilitates the assembling of 'factual' knowledge in a deductive structure (Jessop, 1982:213; Eyles and Lee, 1982:120; Walker, 1981:6 and 8; Harvey, 1977a:213-4 and 217; Sayer, 1978:82 and 84; Sayer, 1979b:1062). The world is held to be external to the observer (Harvey, 1977a:217). Positivist thought is also seen to have various and damaging political consequences (Harvey, 1977a:240).

In efforts to purge human geography of positivist problems and to seek the 'real' causal mechanisms underpinning surface appearances a number of social scientists have accepted a 'realist'(1) view of the world, a derivative of which is historical materialism, alternatively labelled Marxism.

Now let's be 'realistic':

Realist social science rests on five premises (Chouinard et al, 1984:357-8). First, empirically observable outcomes are shaped by real structures which exist independently of our knowledge of them (Robinson, 1983:231; Jessop, 1982:215). The object of realist social

science is to uncover these real structures and the changes in their nature. Second, because realists believe that real structures exist, despite the fact that only effects are visible (Harvey, 1977a:227), they necessarily dissociate epistemology (the manner in which we develop knowledge) from ontology (what is considered to exist). Whilst positivist science builds knowledge upon the observable, realism seeks to know more about the observable in order to develop knowledge (Chouinard et al, 1984:358; Jessop, 1982:252). An awareness of the nature of the relationships between the people gives a fuller understanding of the surface appearance. Unlike non-realist social science, the logical constructs of which preclude the existence of unobservable metaphysical causes, realism acknowledges a relationship between structure and observable outcome.

Third, in realism, social scientific laws portray tendencies, not empirical regularities. Tendencies result from causal mechanisms but they are not always observable. If society was not an 'open' system in which innumerable possibilities of action existed it would be possible to observe a tendency as an empirical regularity.

Fourth, because society is an open system and, accordingly, causal mechanisms cannot be guaranteed to produce effects in certain forms, realist social science cannot be predictive. Instead, explanation of past events based upon theoretically informed analysis is the goal. Finally, real structures are the product of reciprocations between actions and social context (Sayer, 1982a:81). Individual actions shape the social world and that world shapes actions.

"...the mechanisms of the social world, which generate social activity, are themselves social products. They cannot be empirically identified as separate from the activities they generate. Social structures which cause social activity, being social products can change. These social structures are historically institutionalised pressures which constrain human choices: they are therefore more than the sum of individuals' actions at one time, but are not merely static entities since they must continually be activated by human action." (Chouinard et al, 1984:358).

Structures then are enduring, although not permanent, forces or mechanisms which mould the world around us. In turn, structures are shaped by the world in which they exist. They condition behaviour and shape thinking, but changing contexts, individual thoughts, and individual actions may eventually result in structural changes. Structures shape life patterns, just as everyday activities contribute

to the greater whole of the society and structures which form the social context in which we live. Life and structure are inextricably enmeshed with one another. "Society produces men who produce, or create, society" (Pred, 1981b:7).

Finally, because human society is aligned into power hierarchies, it is evident that within the bounds of contextual constraints the separate actions of some key individuals, or agents, are likely to be of more consequence to the broad shape of society than those of others. The effects of significant individuals however have necessarily to be mediated by other individuals for without them the actions would have no meaning.

Things to Come: Historical Materialism

Historical materialism can be considered to be a variant of realism differing essentially in its premise that material production is the fundamental sculptor of social life (Harvey, 1977a:227; Chouinard et al, 1984:360; Peet, 1977:21; Peet, 1983:112). Realist social science has as a major task the identification of the causal mechanisms or structures which are being activated by human action (Chouinard et al, 1984:358). Historical materialists are concerned to identify how it is that individual social actions have reproduced and/or modified particular modes of production (Gough, 1979: 18-9; Chouinard et al, 1984: 338-60; Peet, 1977b:21) of which capitalism is but one (Gough, 1979:6). This necessitates an holistic view of time, place and social action. Despite an awareness of the need for holism, many historical materialist writers have abandoned consideration of historically and spatially specific situations in the quest for theory (e.g. Marx in Capital; Harvey, 1982; Taylor, 1982; Peet, 1983a). This thesis is an attempt to integrate one perception of reality with a theory of that reality.

Capitalism: Conflict and Competition

"Classes are groups of people sharing a common relationship to the means of production" (Gough, 1979:17). Class divided societies contain at least two antagonistic classes - capitalists, who own the means of production (the basic material prerequisites for production), and

labourers, who do not own those means. Ownership of the means of production gives capitalists command over the work process, which is organised to produce profit, whilst the labour class may sell its labour power as a commodity on the market (Harvey, 1982:22; Harvey, 1978:101). It is fundamental to Marxism that if capitalists are to reproduce themselves they must continually expand the basis for profit (Harvey, 1978: 101-2). As profit is derived from the domination of labour by capital a number of forms of conflict arise. First, there is class conflict between capital and labour as capital meets resistance in its continual endeavours to extract more labour from workers. Second, there is intra-class conflict between capitalists in their competition to produce profit. These two forms of conflict and the relations between them were identified by Marx as forming the essential structure of the capitalist mode of production (Chouinard et al, 1984:359). It seems however that Marx omitted consideration of labour-labour conflict as workers struggle to sell their labour power in order to earn a living wage.

These causal relations of capitalism condition, in an interactive manner, the phenomena of the social world we see. That is:

"social phenomena may be explained with reference to tendencies, insofar as the phenomena are the product of the basic necessary (i.e. causal) processes which generate tendencies" (Chouinard et al, 1984:359).

Thus, like other social phenomena, the character of medical practice is moulded by contradictory human relations. Medicine is not an instrument controlled by the owners of capital but instead is located in a mutually conditioning relationship with the class struggle. It is "the specific material condensation of a relationship of forces among classes and class fractions at a specific conjuncture" (Navarro, 1983a:189).

Capitalism is driven by the perpetual quest for profits (Harvey, 1982:120; Harvey, 1988b:264; Forrest and Williams, 1984:1164) with the consequence that commodity relations expand into non-capitalist societies or into domains of capitalist societies which previously operated on non-commodity bases (Castells cited in Forrest and Williams, 1984:1164). This is a process known as commodification.

Commodification is not simply an economic process. It is produced by, and leads to, changing social relations and attitudes. Commodification

is accompanied by:

"...the permeation of values, of aspirations, and of belief in a normality communicated explicitly through the legal and educational systems and more subtly through the twists and turns of our day-to-day existence" (Forrest and Williams, 1984:1164).

However, all of this is not to imply that the reverse process, decommodification, cannot occur, for as will be shown later, it does. Decommodification in one social arena usually sees capital endeavour to expand commodity relations elsewhere. This may take form in efforts to return other decommodified elements of human interaction to the market, thereby recommodifying those relationships.

Although there has always been some market provision of health care in pakehā New Zealand, the shift from the household to the market place as the fundamental area of production and consumption of care for the sick and ill - the commodification of health care - has been one of the more important movements in the changing character of medicine in New Zealand society. At times considerable conflict emerged as efforts were made by especially the labour class to either curb commodification or to decommodify medicine altogether. Commodification has been paralleled by the professionalisation of medicine - with the appearance of a growing number of medical 'experts' seeking niches of economic livelihood amongst the social relations of medicine. The profession's acquisition of trust, burgeoning medical technology, and the expansion of medicine as a commodity relation have been accompanied by the progressive transformation of attitudes from those favouring kith and kinship dependencies in the provision of health care to those which favour institutionalised provision of health care services. Socially produced pressures to lower the cost of the latter services, to compensate for irregularities and social sensitivities which arise in and from investment activities, and to facilitate investment (Harvey, 1982:404; Castells cited in Forrest and Williams, 1984:1166; Forrest and Williams, 1984:1166) have brought state intervention in the medical sphere of human relations. As we shall see shortly, working class struggle has forced the state to decommodify some aspects of health care provision under New Zealand's capitalist system. Subsequent pressures by the capitalist class to recommodify have occurred against a backdrop on which previously existent social networks (e.g. kinship ties) have disintegrated under the demands of capital. This has undermined the capacity of many families, for example, to reabsorb the responsibilities they once undertook with regard to providing medical

care. Thus, re Commodification can rarely be replaced by non-commodity relations and, without struggle in the domain of the state, the labour class find it necessary to engage in exchange transactions for relations which once were existent as non-commodities. Working class antagonism towards such an outcome appears to have partly facilitated the emergence of private medical insurance in New Zealand. Re Commodification of some elements of health care has seen the development of a means to pay for care in ways compatible with patterns of labour exploitation which have evolved whilst medical care was 'de Commodified'.

Interests in Power?

The expansion of commodity relations is inevitably a point of concern for the labour class which will constantly struggle, through the medium of the state, to secure the de- or non-commodification of relationships. The outcome of struggle will shape the nature of state policies with respect to commodities, for the state is the tool of neither capitalist nor worker. It is instead a non-unified force which is committed, as a result of class struggle, to the perpetuation of accumulation and legitimation and to reproducing commodity relations (Fincher and Ruddick, 1983:47). State power is the "form-determined condensation of the balance of forces in struggle" (Jessop, 1982:235).

Class struggle, individual actions and state responses can only advance within socially defined bounds however. Existing structural limitations prevent the complete introduction of either commodity or non-commodity forms of relations; the characteristics of past relations shape policies and organisations such that struggle is modified; and social mechanisms may limit the options open to individuals and organisations (Fincher and Ruddick, 1983:48-9). These limitations upon actors in given situations can be subdivided into two groups (Jessop, 1982:252-3).

Structural constraints are those elements in society which cannot be changed by agents during a given time period. Conjunctural constraints, on the other hand, are those social elements which can be altered over a set time. These constraints do not act uniformly upon agents/actors. A structural constraint for some may at the same time appear to be a conjunctural element, capable of transformation, to

others. Hence, comparative and/or potential power of different agents in specific situations can be assessed in terms of the structural and conjunctural constraints impinging upon them.

Power is the production of specific effects by agents within the bounds set by structural and conjunctural constraints. Although stemming from the interaction of relevant actors in a given situation it is difficult, if not impossible, to link the outcome of such interaction to a single agent involved in power relations. Instead, it is necessary to consider the interactions of the different agents and to endeavour to analyse their various contributions to an outcome which is produced within structural and conjunctural limits. The exercise of power is not the product of any uncomplicated clash of wills but has social and material conditions of existence. Possibilities of action, and thereby power relations, are conditioned by the attitudes, abilities and patterns of thought of all significant agents (Jessop, 1982: 253-6). Furthermore, power relations are:

"rooted in the previously becoming of individual and society, in the historically unbroken and dialectically intertwined process of individual socialisation and social reproduction and transformation which, in turn, is one with the past channeling of individual paths into and out of institutional projects at specific geographical and temporal locations, and thereby with past power relationships." (Pred, 1981:35).

In the midst of power and other social relations agents pursue interests which they hope may provide the greatest comparative advantages in the shaping of their ways of life. They seek to gain the greatest benefits or to minimise losses by acting in certain ways at given conjunctures. Hence, consideration of the interests of an agent must proceed in intimate partnership with an awareness of structural and conjunctural constraints and opportunities influencing that agent at that time. It should also be borne in mind that frequently the complexity of relations in which an agent is embedded may create such conflicts that the agent has no single, non-contradictory set of interests capable of realisation. This relational mode of analysis of the pursuit of interests implies that:

"...interests...can only be assessed in terms of the alternative outcomes in particular situations for specific subjects interpellated in a particular manner." (Jessop, 1982:257).

The pursuit of interests and the exercise of power are constrained by the historical and contemporary products of human actions. This is not

to deny organisations and individuals any choice of action(s) but merely to make clear the point that agents do not act in manners independent of others, or without other forms of constraint.

Circuits of Capital

In Capital Marx explored three essential circuits of capital - the primary, the secondary, and the tertiary (Harvey, 1978:103).

In the primary circuit capitalists are involved in a perpetual competitive struggle with one another. In order to survive each capitalist must extract continually greater profit from his/her enterprise. This may be achieved by the lengthening of the working day; the division and co-operation of labour; and/or by applying machinery (fixed capital) to the work process. Because each capitalist continually seeks to achieve more profit by implementing production techniques more efficient than the norm there is a tendency for the capitalist class as a whole to overaccumulate. More capital is produced than can be usefully employed. The symptoms of overaccumulation include the overproduction of commodities. That is, a glut occurs on the market; rates of cash profit fall; productive capacity lies idle; opportunities to invest money become scarce and/or there occurs un(der)employment and/or a growing exploitation of labour power (Harvey, 1978:104; Fine cited in Forrest and Williams, 1984:1164). This surplus capital may be rechannelled(2) from the primary circuit to the secondary circuit of capital (Harvey, 1978:103-6; Harvey, 1982:218-9).

In simple terms, the secondary circuit comprises capital flows into fixed asset and consumption fund formation (Harvey, 1978:106; Harvey, 1982:236; Taylor, 1982:30). Fixed capital items are long term aids to the production process, as opposed to raw material inputs. The consumption fund comprises those commodities such as stoves, houses and roads which function as aids to, rather than direct inputs to, consumption (Harvey, 1978:106). On an individual basis it would be difficult for capitalists to rechannel capital from the primary to the secondary circuits, particularly as some elements of the secondary circuit are large-scale, difficult to price in conventional ways, and often open to use by other capitalists. Obvious examples include roading and broadcasting. These problems can be overcome by the

actions of a powerful group of financiers, but more usually the State which, under certain circumstances, can be seen to act in the collective interests of all capitalists. Essential actions of the State or financiers in rechannelling lie in the creation of money values equivalent to the surplus product achieved in the primary circuit of capital and the placement of that money in circulation in say, the construction of a hydro-electric dam or a road. Thus, the State rechannels surplus primary circuit capital into the secondary circuit. This operation requires abilities to centralise surplus capital, to direct that capital into the creation of use values, and to wait often lengthy periods for a return. Although the flow of money is not matched by any immediate commodity exchange it will lead to increased employment and capital expansion in such ways that primary surpluses are used - until capitalist competitiveness recreates them (Harvey, 1978:107; Harvey, 1982:265-6 and 409; Jessop, 1982:235-6).

Primary surplus capital may also move into the tertiary circuit of capital. The tertiary circuit can be said to comprise two parts. First, there is surplus capital investment in science and technology with the aim being to foster continual technological revolution in the productive process. Second, capital may be used to foster the reproduction of a co-operative labour force. This may be achieved, for example, through the provision of health care services, education facilities, and a police force. Not only do social investments improve the quality and quantity of labour power but, through a variety of means, may influence discipline and respect for authority and enhance the strength of the work ethic: that is, they act as means by which the owners of capital dominate the labour class.

In spite of an awareness of the benefits likely to accrue from social and technological change individual capitalists may find it very difficult to make investments which will effect such change. Accordingly, capitalists are compelled to act as a class, through the agency of the State, to channel surplus primary circuit capital into the tertiary circuit. Although social and technological expenditures can be of immense value to the working class, they constitute no loss to capital provided the consequent gains in surplus value production more than match the necessary and often lengthy increase in the turnover time of capital which the capitalist class constantly strives to reduce (Harvey, 1982:400-2; Harvey, 1978:107-8; Taylor, 1982:30; Frankel, 1983:75).

The capitalist class seeks the rechannelling of capital into tertiary circulation with the proviso that gains be made. Workers on the other hand simply desire as many of the benefits capital investment in the tertiary circuit can provide. Herein lies a foundation of conflict. A similar basis for conflict lies in rechannelling capital into the secondary circuit. Although roads, hydro-electricity, and houses are of mutual benefit to labourer and capitalist the different meanings - use values - to each antagonistic group will undoubtedly lead to conflict. The nature of the outcomes of these conflicts will depend, in part, upon class struggle (Navarro 1983:189; Harvey, 1978:108). Thus: "Medicine is not a thing; it is a social relation in which class relations are the key" (Navarro, 1983:189). The battlefield in which class relations or struggle occurs tends to be the State (Harvey, 1978:108).

The State and Research:

The State is not a real and unified subject (Jessop, 1982:223; Frankel, 1983:11-9). It does not act according to coherent interests (Frankel, 1983:70). It is instead the relational arena in which capitalists and proletariat compete over the reappropriation of surplus value (Fincher and Ruddick, 1983:46). The outcomes of that competition will shape the nature of surplus value investment in either the secondary or tertiary circuits and, in consequence, will condition the nature of society. The extent of class conflict is constituted by societal characteristics whilst those characteristics heighten or subdue inter- and intra-class antagonism.

Despite the impression which may be conveyed above, the State and society as a whole comprise more than just economic relations, for all individuals are inextricably enmeshed in constant and mutually interactive relations with one another. Although Marxist social analysts are partly concerned with the existence and ramifications of relations of production, the State is derived from a vastly more complex social formation. The State is the site of non-class relations as well as class relations. Whilst one can certainly conduct examinations of state-economy relations only, an adequate historical materialist analysis of any sphere of society should also include consideration of the non-economic relations of that society (Jessop,

1982:220-2). The decisions and the actions of 'officialdom' (in given official specialities) and 'people' find reason amidst a host of influences. Each person is a multifaceted individual engaged in many interdependent relations and to subdivide people into groups of discrete, economic antagonists is a simplification which ought, always, to be questioned and remembered. Social actions and relations impinge in many ways upon the economic and social character of society. To omit them from study is to make the fullest understanding of process impossible.

Different Artists, Different Critics, Different Pictures: A Look at the Literature:

Until recently, critical inquiries of the nature of the relationship between medicine and capitalism have met with limited popularity in academic circles (let alone geographic ones!) despite the fascination the topic holds for fireside conversationalists.

Most publications dealing with social, geographic, political, and economic aspects of medicine and medical practice omit explicit consideration of the place of medicine within New Zealand society. Superficial links are made between many factors but few analysts seem to probe deeper. Answers to questions such as: why are people turning to medical insurance? (Chetwynd et al, 1983; Fougere, 1974); should doctors charge us more? (Gordon, 1984); how shall we pay doctors? (Easton, 1974); what shaped the Social Security Act 1938? (Hanson, 1980); why do private hospitals offer little or no wait surgery whilst public hospitals have extensive waiting lists? (Salmond and O'Connor, 1973; Wills, 1983); what are the implications of price and insurance for hospital use? (Klarman, 1965); what determines the public's use of health care services? (Dixon, 1970); what are the reasons for the privatisation of the welfare state? (Klein, 1984); why do doctors locate where they do? (Voss et al, 1979); why do we have a 'dual' health care system in New Zealand and what are its implications? (French, 1977) are all embedded within conventional positivist wisdom. Few academic writers consciously endeavour to integrate their findings into the broader scheme of social activity. This lack of integration, the characteristics of inquiry, the subdivision of a unified social reality into segments and the consequent surface scratching of that reality are products of "bourgeois modes of thought and analysis"

(Slater, 1977:48) which deny the possibility of understanding and explaining capitalist society. Atomisation of inquiry has proved to be self-reinforcing for as more is learned about segments of our world, holism seems increasingly unattainable (Slater, 1977:49). The subdivision of knowledge is part of a misleading conception of reality which disintegrates the social whole and proves useful to rulers as a mechanism of control (Anderson, 1973:3).

Despite the fact that their works have perpetuated both the political/economic/social status quo and the subdivision of knowledge, the efforts of those writing in a positivist mode should not be completely disregarded. Their questions mirror the historical concerns of capital and their findings can be incorporated into an understanding of the actions and processes shaping society. To abandon the results of research conducted within 'conventional' philosophies would be to 'throw away the baby with the bath water'. Accordingly, in this thesis extensive use is made of the results of traditional inquiries although they are fitted into an alternative mode of analysis.

Amongst health care researchers there do exist some who make efforts to tie society with the broad span of medical services use and provision. Of these few there are three of particular note and relevance to this thesis. They are Vicente Navarro, Ian Gough and Paul Starr, whose individual approaches are discussed shortly. Each of these writers tries to explain how capitalist society and changing conceptions, use, and provision of health care, medicine, and medical practice are inextricably linked. Each transcends 'traditional', 'safe' methodologies in order to grasp and explain the root causes of actual patterns. In order to achieve this power of explanation all three have adopted historical materialist or Marxist approaches in their works. The success of their efforts have not been equal however. Although the research of Navarro and Gough is very useful, their works show evidence of a misplacement of some of the elements which they acknowledge as being fundamental to their lines of inquiry. This is an error Starr does not make.

Despite any individual errors they may have made the approaches followed by Navarro, Gough, and particularly Starr, provide the most substantial and meaningful methods of analysing an 'open' social system. Each of these three authors avoids the extreme myopia of the positivists although, with the exception of Starr, they do appear to be

stricken with a short-sightedness of their own.

Vicente Navarro is probably the most prolific academic writer on the subject of health and medicine under capitalism. Publishing mainly through the radical International Journal of Health Services, of which he is long-time Editor-In-Chief, he adheres to a Marxist philosophy to explore the workings of capitalism. In many of Navarro's papers the nature of medical practice and levels of health seem to be portrayed as the outcome of capitalist processes rather than the product of mutually influencing interactions between individuals and institutions (See, the examples, Navarro 1982a: 1983b). For example:

"...in order to understand the changes in occupational health and safety we have to comprehend the changes in the labour process and in the process of capital accumulation in Sweden, as well as the changes within the Swedish state. Both are a result of the process of class struggle." (Navarro, 1983b:558).

Although Navarro has expounded the bases and nature of his Marxist philosophy (1983a) declaring an awareness that "...medical practice is a social relation..." (1983a:182) and that historical materialist analyses must include study of:

"ideological, political and economic levels within the specific type of medicine and the articulation of each level with the corresponding mode of production of which it is a part." (Navarro, 1983a:184)

his writing seems to be characterised by the 'top-down' approach. The relationship between individuals and capital seems to be unidirectional. Individuals exist in a world of forces quite beyond their influence. Despite Navarro's proclamation of his beliefs (1983a) his intent does not altogether match his deeds. The end results are statements which tend to be laden with incompletely articulated theory and deficient in historical content. Gough (1979) follows a similar path.

In his 1979 publication, The Political Economy of the Welfare State, Gough examines, from a Marxist perspective, the welfare state as a constituent feature of capitalist societies. In particular, he investigates the contradictory nature of the welfare state using Britain as his principal study example. Despite an awareness of the importance of individual actions in creating the conditions of life (1979:10), Gough knowingly substitutes detail with generalisation (1979:15-6):

"...an approach that focuses on the links between the capitalist mode and social production...inevitably carries the danger of unwarranted generalisation and a level of analysis too abstract to bear on the specific concerns of people working within or studying the social services. Wherever possible, concrete examples are given to illustrate the points made. Ultimately, however, one can only hope that the gains from synthesis outweigh the loss of detail in analysis." (Gough, 1979:15-6).

This abstraction of reality from historical account promotes inadequate explanation of a social reality, for the separation of individuals and their actions from the social world misrepresents the character of human society.

Gough (1983) adheres to a similar approach in "The Crisis of the British Welfare State" in which he analyses the implications for welfare states of moves towards right-wing conservatism.

Both Gough and Navarro then seem to have forgotten that 'theory' goes further in the company of historical example than either do alone.

Starr (1982), by contrast, and in a masterfully written publication entitled The Social Transformation of Medicine in America presents a detailed theoretically informed historical analysis of the changing nature of medical practice in the U.S.A. since 1760. In this two book volume Starr examines the rise of medical authority, the shaping of the U.S. medical system, and the interactions between doctors, the public, the State and corporate interests.

In claims which are both quite unjustified and acknowledged as being contrary to those made by other reviewers (e.g. Numbers, 1983; Hiatt, 1984; Haller, 1983; Ubell, 1983), Berliner (1983:671) criticises Starr for his ahistoricity and superficiality and considers that the subdivision of the volume into two books is "historically misleading and artificial" (Berliner, 1983:671). Such criticisms indicate a habit of historical determination and a failure to realise that Starr's use of two books facilitates the coherent pursuit of different strands in the immense web of medicine in the U.S.A.

At first blush the detail of description leads one to wonder about the explanatory power and theoretical value of Starr's magnum opus but closer examination reveals that the extent to which meaning is given to events and circumstances is quite extraordinary. An absence of jargon

belies extensive theoretical insight.

Although some amusing criticisms are directed at Marxist accounts of our social world (Starr, 1982:16-7 and 227-8) - "shameless red-baiting" Berliner (1983:673) calls it - it is apparent that Starr's approach is that of an historical materialist. The central metaphor of Book Two is the "dialectical interpretation of history..." (Berliner, 1983:673).

In his commencement of Book One which deals essentially with the rise of medical authority and the shaping of the medical system Starr declares his premises: first, change is something which demands simultaneous structural and historical analysis. One must necessarily identify the structural relations which explain observed events and trace those patterns to the human actions which brought them about (Starr, 1982:7-8). Second, the development and shaping of any structure, relationship or organisation takes place within the bounds of broad power and social structures and may not be comprehensible by reference to superficially connected forces and influences:

"The development of medical care, like other institutions, takes place within larger fields of power and social structure. These external forces are particularly visible in the conflicts over the politics and economics of health and medical care." (Starr, 1982:8).

Third, to understand power we must comprehend and incorporate an understanding of both culture and institution - these being dialectically related to one another.

These premises, in conjunction with Starr's adherence to the principles they embody, lead to a brilliant analysis of historically placed events. Starr's book "refracts through a single prism the larger society of which the institution [of medicine] is a part" (Bell cited in Starr, 1982:Back Cover) and in English language accounts of medicine and society is probably unsurpassed.

It could be said that this thesis trudges indelicately over a similar path to that so gracefully followed by Starr. Quite by chance, Starr's work and this thesis represent endeavours to understand the continual emergence of similar social phenomena, although this writer has been obliged to make links between the general and the specific somewhat more explicit. The ideas of writers such as Gough and Navarro are

integrated into this thesis - but not their flaws it is hoped - as are the results of positivist research, as they all provide the paints used in this portrait of the transformation of health care in New Zealand since 1840. At times paints or brushes were missing - the product perhaps of ideological, social, economic and/or other constraints - but, nevertheless, a general conglomerate portrait has been created. Of course, this is not the only picture which can emerge: another artist at another time will paint a different portrait. But...this picture is not mine for the past was created by others. However, the way I have recreated and depicted that past is mine alone...but then...the picture which you unfold in the following pages is not mine - it is ours. Different artists, different critics, different pictures.

This Picture:

This thesis is an articulation of a relational view of health care provision in New Zealand. The attempted explanation of the main structural transformations in the character of medical services since the early days of European settlement emphasises the multiple and differentiated emergence of various structures of relationships between, principally, doctors and patients, doctors and doctors, and those who, at various stages, have attempted to intervene in those relations. The approach facilitates the effective portrayal of what might broadly be conceived as a single 'process' with its own history and geography. The status of the process is however historically specific and relational. Once defining relationships have been identified, at whatever time is of interest, attention can be turned to explaining quantitative and qualitative changes in interaction. "Settling for the State", the second chapter, includes an examination of the implantation of colonists ideas of medicine; the establishment of organisational forms of medical care in New Zealand; the influence of, and constraints upon, significant individuals in one sphere of society; and the beginnings of initial consolidation of a drift towards State intervention in health care which was to shape many subsequent interactions. "Settling for the State" explores the processes which saw the State assume growing responsibility for hospital care; and the reasons for, and reactions to, mounting demands for institutionalised medical assistance. It also clearly illustrates the embeddedness of New Zealand medicine in contemporaneous movements

of capital. Aside from catering for the health needs of the ill, health services of the time facilitated the integration of the Maori population into capitalist spheres of activity and abetted the attraction of labour from countries in which the labour process was becoming increasingly mechanised.

Most other works dealing with this period of 'establishment' in New Zealand's medical history are essentially descriptive (3) or only superficially explanatory (e.g. Royal Commission on Social Security, 1972; Chilton, 1969; N.Z. Government, 1975; N.Z. Department of Health, 1969). "Settling for the State" is a departure from this pattern, its content offers interpretation of, and explanations for, the actions of individuals and organisations within their mutually produced and constraining environment.

In the third chapter consideration is given to the enlarging role of the State in the provision of health care; centralising influences upon health services; and the various processes which contributed to growing demands for and acceptance of collective medicine. The experiences of the First World War altered New Zealanders' attitudes towards State involvement in health care. To encourage enlistment and, in consequence, fostering the interests of British Empire capitalists (e.g. through the contradictory aims of protecting capital; making use of surplus capital; and destroying capital which would necessarily be replaced, hence providing opportunities for profit), the State provided free hospital care for the dependants of servicemen. The State was also obliged to provide free medical assistance for wounded returning soldiers. Political pressures from a working class which was growing in solidarity also had considerable bearing upon the character of the country's health services. The period from about 1900-35 was that in which the working class of New Zealand gained some measure of political representation in the form of the Labour Party. Chapter 3 briefly outlines the emergence of that class awareness and the processes which drew the working class to temporary political dominance. This chapter also deals with the implications of a public health crisis upon the administration of medicine; the pressures which saw private hospitals become less attractive as places of treatment to the general public; and the relations between the growing friendly society movement - which can itself be conceived as being part of the move towards collectivism - and doctors. All of these relations and processes can be seen to be integral to the centralisation of health

care administration.

"Pounds and Principles: Paying for Care" deals fundamentally with the responses of doctors, hospital boards, and the Department of Health to growing demands within the community for 'free' health care. This fourth chapter can in some ways be considered to be an examination of the 'other side of the coin' considered in Chapter 3, as the country's doctors and health administrators were, for various reasons, seeking to maintain the commodified nature of medicine against pressures favouring decommodification. In their interactions the public, the country's physicians, the Department of Health, and the hospital boards were facing problems arising essentially from public pressure for 'free' medical services in conjunction with institutional and organisational characteristics which could not accommodate that new and growing pressure. For political reasons hospital boards were compelled to provide free care for those who demanded it whilst the doctors were outraged at the consequences of this for their private incomes and practices. The interests of doctors were incompatible with the context in which they were located. The temporary solution to the conflict between doctors and hospital boards upset standards of medical practice and to some degree enhanced the appeal of 'public' hospitals to the ill and injured. The 'solution' also aggravated financial difficulties already experienced by hospital boards, doctors, and the Department of Health. In consequence, these three groups acted collaboratively in endeavours to effect a remedy for their mutual problems. Different conceptions of appropriate measures led however to a stalemate. In the end, the changing characteristics of their interrelations and of those with the public propelled the three bodies into consideration of some form of national health insurance scheme. Although pursuing different interests, doctors, hospital boards, and the Department of Health were each drawn to a consideration of some collective form of health care. Although arriving at a similar place, the path they had taken was quite different to that followed by the public.

Within the broad sweep of New Zealand's health care history the period from c.1935 until c.1942 has attracted much academic interest. Writers such as Bolitho, 1979; Hanson, 1981; Lovell-Smith, 1966; and Sutch, 1971 have described at length the period in which the Social Security Act 1938 - an historical landmark in New Zealand health care transformations - was drafted and implemented. While their works have proved useful in this thesis, most of these earlier writers have not

informed with theory their description of this period in which doctors and collectivists were drawn together and into conflict over issues of 'freedom of practice, freedom of use'. "Degrees of Freedom", the fifth chapter of this thesis, represents an endeavour to plug this academic gap. The chapter is a theoretically informed analysis of the relations between those individuals and organisations involved in the 1938-42 negotiations over the Social Security Act and provides a comprehensive, example-specific examination of the State as a relational arena. In addition, the chapter contains consideration of the pursuit of interests and the exercise of power by various agents within conjunctural and structural constraints. "Degrees of Freedom" also highlights the implications of significant individuals and their relations with others for the grander scale of human activity.

In Chapter 6, "More Money Matters", attention is directed at some of the processes which contributed to the progressive recommodification of medicine in the wake of Labour Government activity. Although medical practice had been almost completely decommodified with the passage of the Social Security Act 1938 and its various Amendments, the legally formalised relations between doctors-patients-hospitals-State mechanisms were such that changing societal characteristics over the period c.1942-60 fostered recommodification and means to facilitate further returns of doctor-patient relations to the 'market place'. For example, hospitals were subjected to mounting demands for assistance as the result of changes in the size and character of New Zealand's population; the demobilisation of soldiers; and the growing acceptability of government-subsidised or 'free' assistance. As hospitals were funded largely by a Government subject to pressures to spend in other domains, efforts were made to find means to reduce government expenditure on health care. A variety of processes such as this saw some aspects of medical practice driven rapidly back to 'free enterprise'. Despite the important implications of recommodification there has been negligible analysis of this period of New Zealand's medical past.

By contrast, some of the subject material dealt with in Chapter 7, "The Chains of Choice", has been extensively scrutinised in the literature. Barnett, J.R., 1984; Dixon, 1970 and 1974-6; Fougere, 1974; French, 1977; Gordon, 1973; Hay, 1984; Rae, 1982; Wall, 1983; and Wills 1983b are amongst those who have examined the character and/or causes of the patterns of health care provision which have confronted us in

recent years. Although Fougere's 1974 analysis of the decay of the State provision of hospital care can be placed within positivist research, his findings clearly illustrate the intertwined and conditioning relationships between individual and society and he shows some consequences of that for the nature of our health care system. Fougere's subsequent analyses of medicine and society (e.g. 1978, 1981, 1984) are very enlightening and contribute solidly to an understanding of at least one element of New Zealand society. Most other research dealing with the events and processes of the period c.1960-c.1984 has emerged from conventional perspectives, and although contributing to more searching analyses, is characterised by superficial explanation with little or no attempt to integrate the appearances of today with long-term patterns and processes.

"The Chains of Choice" is, in part an analysis of the continuing process of recommodification in medicine and the public response to that process. Although Government assistance in health care remains sizeable, new relationships have reduced the effectiveness of that assistance. The pressure upon private medical services which has ensued has made the emergence and growth of medical insurance acceptable - even desirable - to the general public. This form of intervention between patient and doctor, patient and hospital, hospital and doctor...is both a response to, and a promoter of, the recommodification of health care. Structural and conjunctural constraints have induced many people, including those amongst the labour movement who most ardently uphold State mediated medical services, to contribute to the rapid expansion of medical insurance. In the midst of these influences other factors have seen the State drawn into tight involvement with a comprehensive accident compensation scheme under the terms of which the Government is obliged to meet the costs of private and public medical expenses of injured New Zealanders. Chapter 7 examines the emergence of this system which appears to be a pronounced contradiction to other contemporary trends in the health care scene.

"The Chains of Choice" is also an examination of efforts to reorganise the New Zealand health care system. One such effort has seen the development of a formalised relation between public and private hospitals which makes public sector growth or decline inversely dependent upon private sector shifts. The general tenor of this relationship is that if the private sector does not find health service

provision 'worthwhile', the State will compensate. This represents a distinct change of attitude from that just 40 years ago. Developments portrayed throughout the latter stages of the thesis should demonstrate how this change has emerged.

FOOTNOTES

1. "More properly, transcendental realism, to distinguish it from naive or direct realism." (Johnston, 1983:101).
2. Harvey's writings describe the transfer of capital from one circuit to another as a "switch" (Harvey, 1982:219 and 265; Harvey, 1978:106). Herein "switch" has been replaced by "(re)channel" as the latter word does not have the same implications of sudden change, deliberate action, or a break in connection from other parts of the same system.
3. Fougere (1984) and Fraser (1984) are noteworthy exceptions to this trend.