THE CARING COMMODITY

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

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Department of Geography,
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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 MATERIALISM

Positivism 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 inabilities 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 pakeha 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, recommodification 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. Recommodification 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 'decommodified'.

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 because 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 achnowledge 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 materialst 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 relationshps 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.

SETTLING FOR THE STATE

(c. 1840 – c. 1900).

2

CHAPTER TWO

SETTLING FOR THE STATE (c.1840-c.1900)

Franklin (1978:1) asserts that to write about New Zealand commits one to writing about a specific form of capitalism associated with an economy of predominantly British origins. Health care provision in New Zealand's early years reflected the transfer and modification of health care institutions derived from British capitalist society. This chapter begins with a look at a trilogy of medical developments which laid the basis for the establishment of a health care system which effectively brought doctors and patients into mutually sustaining relationships. The three developments cover private and voluntary care and limited State services. It is argued that the simple doctor-patient exchange relationship was, in the period c.1840-1900, especially problematic as patients were often unable to pay for doctors' services. The local response to this situation, principally initiated by local residents, was the formation of friendly societies. This ensured the mobilisation of adequate funds to support a reasonable number of doctors and also defined a path for the circulation of money and capital. For some years the State played a very minor part in the health scene, confined essentially to the provision of assistance for the Maori population. However, these rudimentary relationships were severely strained during the first major New Zealand depression. The principal consequence of the depression was the inability of patients to purchase doctors' attention, even with assistance through the friendly societies. Popular support, centred around the initiatives of Major Harry Atkinson and Dr G.W. Grabham in particular, persuaded the legislature to allocate State funds to health care provision through newly created local Hospital and Charitable Aid Districts. Legislation ensured the availability of, and payment for, medical care and formalised economic relations between the providers and recipients of care which were to stand for many years. Pressures stemming from labour influences upon political attitudes and the introduction of refrigeration and new medical technology in conjunction with an ageing and urbanising population in the colony promoted growing consumption of more accessible medical facilities. The State's newly acquired functions, in combination with these forces, saw it penetrating further into the health care arena. In parallel with enlarged demands for

hospital care came the establishment and development of a recognised medical profession. The subsequent arrangements amongst doctors conditioned the production of health care. By about 1900 medical care production and consumption had become firmly linked and in ways which were to shape subsequent relations between doctors, patients, and the State. Interactions between these groups were also to be conditioned by the nature of the State's apparatus of health care administration. In addition to hospital management the State had become involved in the domain of public health. This involvement was minimal until a plague scare which threatened to disrupt economic activity hastened efforts to reorganise public health administration. The Ministry of Health which was formed had extensive powers to influence local community health standards. Not only did the Ministry of Health act to prevent some of the conditions likely to produce ill-health but it also served as a basis for co-ordinating interests expressed through the State.

Throughout consideration of this early period of New Zealand's health care history the actions of individuals, and the intended ends of those individuals are examined. This is accompanied by a more penetrating evaluation of the functional effects of those actions upon the circulation of capital.

Immigration, Integration and Imported Ideas

The "cultural baggage" (Davis, 1984:104) transported to New Zealand by early European settlers conditioned the emergence of a tripartite health care system comprising a mixture of private, voluntary and State services. Despite a shortage of substantiating historical information (1) it can be assumed that, in line with overseas custom and the prevailing laissez-faire ideology, New Zealand's early full-time doctors practised on a fee-for-service basis. It is also likely that they established themselves in large settlements or in those areas most densely settled by the pakeha. Here, problems of gaining access to income producing patients would have been minimised and conditions of practice would have been more favourable than elsewhere. Reminiscences of Dr T.H.A. Valintine (Inspector-General of Hospitals) in a speech to a meeting of representatives of friendly societies in Taranaki in 1908 portray the conditions of early practice and the attitudes of doctors very well:

> "I often look back to those days, when the district was by no means so easy for a doctor to work in as it is now; when many of the rivers were unbridged; and when the general facilities for practising medicine were practically non-existent...
>
> In those days I had to do the best I could under the many adverse circumstances, and...at times I must confess to having envied the many professional advantages that my brethren were enjoying in the towns..." (H1: B.107 149/-).

A voluntary sector catering for health care provision also emerged in these early days of European settlement (Fraser, 1984:56; Oliver, 1977:3; N.Z. Government, 1975:12; N.Z. Department of Health, 1969:9; Condliffe, 1959:280). This sector took shape primarily in the form of friendly societies. New Zealand's first friendly society was formed in Wellington during 1843 and in the ensuing year others were set up in Nelson and Auckland. Friendly societies rapidly gained public acceptance and by late 1850 there existed at least eleven of them in the country. All belonged to the Manchester Unity Independent Order of Oddfellows (Chilton, 1968:6). By means of subscriptions from members, friendly societies supported medical facilities for those who could not avail themselves of the limited 'charitable' State services. Lodge members also hoped that funding would come from philanthropic donations made by the wealthy. Based directly on British experience, this expectation was inappropriate in the new colonial context and, according to Fraser (1984:56), resulted in the demise of voluntary hospitals. Unlike Britain, New Zealand had few people able and willing to provide substantial financial assistance for medical services:

> "The pioneers of New Zealand were not from the highest, nor were they from the most down-trodden sections of British society. They were people, who, while poor, ... [were] usually from the upper working class or the lower middle class..." (Sinclair, 1980:101).

In all probability those who may have been able to contribute sizeable sums of money were too comfortable at 'Home' to warrant emigrating to a far-flung and hostile colony. In general, the friendly societies and their hospitals were established in the largest settlements (Fraser, 1984:56) and at the goldfields (N.Z. Government, 1975:13). Presumably, such locations reflected both the need of the societies to have as large a contributing population as close to the hospital as possible and the requirements of the population to be as close to the hospital for which they were paying. The spatial distribution of health care facilities provided through friendly societies was the product of economic relations between individuals and organisations.

The first State steps towards medical services - aside from the appointment of Colonial Surgeons in 1841 (2) - came in 1846 under the direction of Governor (later Sir George) Grey. Governor Grey hoped to provide Maoris with the 'benefits' of European life - health care, financial wealth and education - and in his efforts to achieve this encouraged and arranged the subsidisation by British government of both mission school development and industrial school establishment. He also ensured that sufficient funds were available for the construction of four modest hospitals at Auckland, Wellington, Wanganui and New Plymouth (3) (N.Z. Government, 1975:12; Robb, 1940:55; Sinclair, 1980:86). These hospitals, although financed through the State, were not public hospitals in the modern sense. In accordance with the voluntary tradition of the colonial homeland, the State - as owner - took upon itself the right to nominate deserving patients. Both Maoris and Europeans were admitted although Maoris gained access without question, whilst only poor Europeans, on orders from the Colonial Secretary, were eligible for treatment (Fraser, 1984:56; N.Z. Government, 1975:13; N.Z. Department of Health, 1969:9; Sutch, 1966:45).

> "By restricting European admissions to the indigent, the State merely followed the English custom of organising State hospital services on the basis of economic need rather than of social equality." (N.Z. Government, 1975:13).

This part of the cultural legacy inherited by New Zealand's British immigrants had its origins in Elizabethan Poor Law which was characterised by notions of lesser eligibility, beneficence, parsimony, and inferior service and benefit (4). Whilst an obvious stimulus promoting initial State intervention in health care in New Zealand was the compassionate attitude of Governor Grey, his actions must be considered in the context of New Zealand's first major economic crisis (5). Capitalist relations of the time were expanding into other cultures and economies. In particular social formations, one culture, capitalism, gained ascendancy either by force or by peaceful initiative. Although Governor Grey's action in establishing welfare services for the Maori population was fundamentally motivated by humanitarian concerns it had implications for the integration of the Maori population into capitalist relations. Indeed, Grey himself hinted at this process:

> "In the early eighteen-fifties Grey was confident that he had established a basis for 'peaceful co-existence',...that the two

> races were well on the way to the humanitarian goal of 'amalgamation'. The Maoris seemed to be adapting themselves to the politics of the sovereign state and to the economy of the market. He reported to the Secretary of State that 'both races already form one harmonious community, connected together by commercial and agricultural pursuits, professing the same faith, resorting to the same Courts of Justice, joining in the same public sports, standing mutually and indifferently to each other in the relation of landlord and tenant, and thus ostensibly forming one people." (Sinclair, 1980:87).

The inclusion of indigent Europeans in the health care provisions intended essentially for the Maori population was probably to assist 'economic refugees'.

Six provinces - Auckland, Taranaki, Wellington, Nelson, Canterbury and Otago - were created with the promulgation of the Constitution in 1852 and two years later Provincial Executive Councils were given jurisdiction over hospitals. Although New Zealanders never formally adopted a Poor Law, the impress of the English system was present. During the 1850s the responsibility of the provincial governments for charitable aid and relief of the poor was passed to hospitals. These responsibilities were almost inevitable in view of the nature of the health care system which aleady catered for indigent Europeans, and marked the commencement of a "New Zealand tradition of associating poor relief with medical services" (Royal Commission of Inquiry, 1972:39). In addition to these new charitable aid functions the provincial hospitals were also allowed to authorise emergency admissions, although general admissions had to be considered by the government (N.Z. Government, 1975:13). Growing State involvement in the provision of health care to New Zealand's inhabitants perturbed a Committee on the Colonial Hospital which reported to the Wellington Provincial Council in 1854. The Committee members were surprised to find that New Zealand's public hospitals were State financed and controlled (Sutch, 1966:47) and could find no reason why there had been a departure from the English example. This new 'welfarist' principle was judged to be the wrong model (Sutch, 1966:47):

> "The committee said that 'purely charitable institutions' paid for out of revenue and conducted by the Government tended to 'lessen the self-reliance of the people, and to foster a dependence on the public hurtful to the public morals', that public hospitals should be conducted as they were in England; it would 'teach the people how to take care of themselves'" (Sutch, 1966:84-5).

However, the Committee did not think it wise to proceed with closure until some alternative could be implemented. In the meantime though,

and in keeping with the laissez-faire ethic of the time, the Committee recommended that doctors have "free access to patients who might desire to be treated by them" (Committee on the Colonial Hospital cited in Sutch, 1966:47). The pressure exerted by the Committee saw the production of new, formalised relations which made the form of user-provider interactions more enduring. To some degree the character of capitalist production was also enhanced at the provincial level by efforts to stimulate voluntary contributions to the provincial hospitals. The method adopted to achieve this end - which would reduce State expenditure required to maintain hospitals - was the promotion of local public control of hospitals. Such a step represented a reversal of traditional patterns of financing and responsibility. The English tradition of allowing the donors of money or capital a say in administration was turned on its head. It was assumed that after granting more direct administrative responsibility to the public, voluntary funding would be forthcoming. Thus, ideals of democracy were fulfilled; State expenditure was reduced; English historical legacies, though twisted, were maintained; health services were provided; and relations more functional for capitalist reproduction were perpetuated.

Meanwhile, endeavours were being made to lure British immigrants to New Zealand farms and other ventures. Official handbooks available in Britain advertised that New Zealand had no workhouses (Sutch, 1966:47). Workhouse-type assistance was available in New Zealand however, but in forms sufficiently alien (and misrepresented) to potential migrants that the impression that poverty did not exist in New Zealand was conveyed.

The incorporation of charitable aid with hospital activities; the continuance and extension of free access to hospitals; and the recommendation of the Committee on the Colonial Hospital all represented steps in the unique structuring of medical care provision in New Zealand. The changing nature of health and welfare systems can arguably be interpreted as follows. First, humanitarian systems of medical relief supplemented the attractiveness of New Zealand to immigrants. Second, in order to effectively maintain the reproduction and vigour of labour the State was compelled to provide some welfare facilities. This had been achieved in Britain largely through the activities of wealthy philanthropists - few of whom had emigrated here. Third, the shaping of private medical practice within the State system

facilitated the extraction of maximum incomes by doctors under new arrangements. Doctors could obtain a fee from the State for serving the poor, that is, from those who would otherwise have been unable to afford medical services and, additionally, they could independently charge the more affluent who chose not to accept complete State-mediated charity.

By the end of the Provincial period then:

> "There was...the nucleus of a hospital system, though the resources required to operate them (sic) were not fully assured, coming as they did from a variety of sources. Self-help, and assessments of economic need, based on the then pervasive logic of 'benevolence', which was buttressed by notions of discipline and the deserving poor, rather than explicit ideas about social equality or universalism, were the keys to the forms of medical care which developed in the early decades of the colony." (Fraser, 1984:56).

Furthermore:

> "the distinction between public and private care though ambiguous was already apparent, along with the stereotypes and stigma which typically embroider the distinction." (Fraser, 1984:56).

The nascent patterns of these early years developed, in many respects, into a framework upon which subsequent developments hung. Imported concepts were transformed and became New Zealand legacies. There emerged an embryonic State sector which had a specific target population and which fostered an early but important distinction between public and private care. The early spatial pattern of health care provision was characterised by 'private' hospital development near the goldmines and largest settlements of the South Island, and 'public' hospital establishment in North Island settlements with a large Maori population. The overriding point to emerge from the consideration of health care in the earliest days of New Zealand settlement is that its shape was a specific product of globally and locally expanding capitalism. The patterns and character of the emerging health care system were both constituted by processes of capitalism and constitutive of those processes.

Depression and the Confirmation of Community Care

The end of the Provincial period came during 1875-6 following the Abolition of Provinces Act which was passed during October 1875 and

which became operative in November of that year. Aside from Otago and Canterbury, each sustained by landsale revenues, the Provinces could not meet the costs of maintaining their own administration without Central Government assistance and in 1867 they lost their power to raise overseas loans. This drew many Provincial functions into the domain of Central Government (McLintock, 1966:883-4). Centralisation facilitated the expression of capitalist interests on a more co-ordinated and countrywide basis. Influence exercised through the State could encourage activities especially useful to capital (e.g. justice, railways and health care)- and on 1 November 1876, after the Abolition of Provinces Act, control of all hospitals in New Zealand was assumed by Central Government (N.Z. Department of Health, 1969:9). This period, like that of about 1845, was one of financial depression for New Zealanders. Indeed, the nadir of the Depression was reached at almost the same time as the Government took responsibility for the country's hospitals.

Despite the overall administration of hospitals by Central Government, the depression period until the late 1880s was one of organisational turmoil. A variety of Bills relating to hospitals were introduced; financing systems altered; national insurance schemes were mooted; and notable individuals made their mark upon health care enterprise. Depression bore witness to unproductive capital, whilst alerting the public to the unsatisfactory nature of health services availability. Condliffe and others have seen this period as being one of 'innovating impulse' in New Zealand's history (Royal Commission of Inquiry, 1972:40). As evidenced by legislative and administrative confusion, struggle between capital and labour was occurring in the domain of the State to resolve contradictory demands for profit and welfare.

In 1876 with the passage of the Financial Arrangements Act, revenues from the sale, leasing, letting or other disposal of local Crown waste lands were used to create a provincial district Land Fund from which districts financed, amongst other things, charitable institutions and hospitals. Should insufficient funds have been available to provide for such requirements, the Colonial Treasurer was empowered to advance from the Consolidated Fund any sum necessary to meet costs. Government had been virtually obliged to take over hospitals owing to prevailing economic circumstances; to political and humanitarian pressures to safeguard the welfare of the people; and to the pressures from

different businessmen, and consequently found itself the primary source of finance for hospital provision in the colony. However, it had no direct control over the hospitals, as these were still run by elected committees. So, the Government provided most of the finance for hospitals but had very little say in their functioning. In consequence, after having stated in May 1877 their intention to legislate for hospitals and charitable aid, the Government (Hon. D. Reid) presented a Charitable Aid Bill on 27 July 1877. The Bill had been prepared on the basis of incomplete nationwide information; and took much of its form from the personal experience of its drafter, Hon. D. Reid, and from English and Australian reports on public charities. The Bill also reflected prevailing Cabinet opinion which emphasised voluntary charity and local control. Local control was to be allied to voluntary contributions:

> "If 50 or more people each subscribed not less than 1 pound a year (or 10 pounds in one donation) to an institution, they were entitled to elect their own board of management and thus wielded considerable power." (Chilton, 1969:98).

Hospitals were to be funded in accordance with the provincial experience of Otago which had seen voluntary contributions supplemented pound for pound by the provincial government (Chilton, 1969:98-108). However, parliamentary criticism of the financial basis of the Bill and its provisions for management proved severe. Eventually, Government chose to postpone a decision until more information became available, but in the following fortnight came the demise of the Atkinson government and with it the Charitable Aid Bill.

A short time later, in 1878, Hon. J. Ballance proposed in a circular to local bodies that they administer hospitals and charitable aid with Government subsidising pound for pound money from local body funds and subscriptions (Chilton, 1969:113). Vincent, Clyde and Cromwell Borough Councils and the Municipal Corporation of Alexandra adopted the scheme with some degree of success whilst similar attempts in Westland failed (N.Z. Government, 1975:16; N.Z. Department of Health, 1969:9; Chilton, 1969:114). In general however, the scheme was not favoured, with many local bodies seeking further Government assistance. The consequence of this was that Ballance and the Colonial Secretary, feeling that the mood of people prevented the general application of such a scheme, contented themselves with four clauses in the Financial Arrangements Bill [1878] which recognised two systems:

> "(1) those hospitals which preferred to be supported by the Government, in which the latter would control the institution and simply deduct the cost from the local body subsidies, and -
>
> (2) those where the hospital was locally controlled and the Government subsisised pound for pound the contributions of local bodies and voluntary subscriptions" (N.Z. Department of Health, 1969:10).

In spite of Ballance's lack of success in introducing a comprehensive measure to administer hospitals and charitable aid another Bill was presented in July 1879, but this lapsed with the downfall of the Grey ministry some months later (Chilton, 1969:115).

In late 1879 a further Bill dealing with hospitals and charitable aid was introduced. This one reflected a particular interest of Hon. J. Hall who was chairman of the county with the largest charitable aid expenditure in New Zealand and who, more than anyone else, endeavoured insistently to rationalise the hospital system (N.Z. Department of Health, 1969:10). Under this Bill proposals were made to subdivide the country into many small hospital and charitable aid districts, but it too failed to come to fruition - this time owing to the pressures of other Parliamentary business (Chilton, 1969:115). In 1881 Hon. J. Hall again introduced a similar Hospital and Charitable Insititutions Bill although on this occasion favour was expressed for larger districts (N.Z. Department of Health, 1969:10; Chilton, 1969:119). The aim of this was to counter arguments from local districts about the problem of 'settlement' - that is, rating difficulties caused by a migratory population. Nevertheless, Hall met great problems in convincing the different districts that the Bill was in any way suitable to them and, in order to avoid risking his Government, withdrew his proposals (N.Z. Department of Health, 1969:10). A short time later, in April 1882, the Whitaker ministry took office. The Colonial Treasurer was Major (later Sir Harry) Atkinson, who suggested a scheme of national insurance to Parliament. Atkinson hoped to replace private saving with compulsory insurance against accident, widowhood, orphanhood, old age and ill health (N.Z. Government, 1975:36; Royal Commission of Inquiry, 1972:41). Basically, this scheme provided for a central fund to which all citizens would contribute and from which those in poor circumstances (including ill-health), through no fault of their own, would receive an allowance. Major Atkinson moved that:

> "provision should be made against sickness and pauperism by

> compulsory national insurance, to secure the following benefits: (1) Sick-pay for every single person, male and female, between the ages of eighteen and sixty-five years, of not less than 15s. per week during sickness. (2) Sick-pay for every married man of not less than 22s. 6d. per week, and for every married woman 7s. 6d. per week during sickness. (3) A superannuation allowance of 10s. per week for every person, male or female from sixty-five years of age to death. (4) An allowance of 15s. per week for every widow with one child, increasing according to scale with the size of family to 30s. per week, until the children are fifteen years of age." (PD, 1882:42, 190).

As he proclaimed at its presentation, Atkinson's proposal was not entirely original. The concepts it embodied were derived from Collected Essays on the Prevention of Pauperism by an English vicar, the Reverend W.L. Blackley (PD, 1882:42, 183; Chilton, 1969:122) who had himself taken the idea from a suggestion made to the Friendly Societies' Commission (Sutch, 1966:86). Furthermore, a similar scheme had been presented to the British House of Lords by Lord Carnarvon in 1880, although no consequent action resulted (PD, 1882:42,203; Chilton, 1969:122). Despite the lack of originality, Atkinson's efforts remain as the first effort in New Zealand to introduce a virtually universal system to ameliorate the consequences of poverty and ill-health.

> "The attraction of compulsory national insurance was that it provided an alternative to any form of poor law, appeared to encourage self-reliance and channelled some of the money dissipated in early manhood into a worthwhile investment." (Chilton, 1969:122).

Despite the attractions, general reaction to the scheme was both sceptical and hostile. Although writers of the time expressed interest, they were very doubtful about the practical applications of Atkinson's measures. Failure of the scheme, perceived as being highly likely, would do great harm within the community (Chilton, 1969:123); the scheme would not meet the needs of the destitute, nor could it help those people on low incomes with large families and intermittent work who would have found it virtually impossible to pay the required rates of contribution (Royal Commission of Inquiry, 1972:41). In addition, the element of compulsion in payments was a matter of contention (PD, 1882:42, 189). Most damning however were the protests based on concerns with public morals. Atkinson's proposal was overwhelmed by those who argued that it would "sap the independence of persons relieved and jeopardise Christian concern for one's brothers" (N.Z. Government, 1975:36) and:

> "encourage idleness and thriftlessness, undermine the self-reliance of the people, and break up families" (Royal Commission of Inquiry, 1972:41).

Sir George Grey was particularly disparaging in his comments:

> "I say it is a blow at Christianity itself. It is a blow at the family. It is an attempt to make every single individual part of a great communistic society." (PD, 1882:42, 194).

Introducing his national insurance motion, Major Atkinson had obviously anticipated some possible criticisms and so endeavoured to pre-empt them. With regard to the question of compulsory payments he argued that thrift and personal provision for lean times and/or misfortune were already necessary and that insurance would remedy 'prodigal son' problems:

> "...some gentlemen have told me that it is against the liberty of the subject to make insurance compulsory. No doubt that is quite true, if liberty means the right to spend all we have and then to demand sustenance from those who have something left. I would point out, however, that we have compulsion already. We are compelled to keep the necessitous. That duty is now a charge upon the thrifty..." (PD, 1882:42, 189).

Atkinson also used the popular friendly society movement as a lever in introducing his scheme. First, he acknowledged their significant contribution to the welfare of 20 000 of New Zealand's 140 000 males and their families (PD, 1882:42, 184) (6) but pointed out that because of the nature of their organisation, including membership constraints, the friendly societies could not deal with welfare problems on a national scale. Second, he proposed that those citizens who belonged to a friendly society should be exempt from membership of the national scheme (PD, 1882:42, 189). Third, he hoped to forestall the 'communistic' criticisms by pointing out that his proposed scheme was simply an enlarged version of existing friendly society activities (PD, 1882:42, 189). However, perhaps one of the most significant sections of Atkinson's introductory monologue dealt with the role of the State in the provision of welfare services. The comments made reflect movement at the time towards greater State intervention in national affairs:

> "I am told we are going outside the proper functions of Government. Well, I would be very glad it any honourable gentleman who thinks so can tell me what the proper functions of Government are. I entirely disagree with writers of the Herbert Spencer class who would confine the functions of Government simply to police duties. I would ask, what is the meaning of civilization but combination; and what is the meaning of a State

> but that we all band together to do certain things and to promote certain ends that we desire? In this country the Government has already done many things which fifty years ago the greatest Radical would probably have declared beyond the functions of Government. We have State railways, State telegraph, State post office savings-banks and...State education, all of which have in their time been declared beyond the proper functions of Government, and ruinous to the independence of the people who adopt them. But...nothing can be done nowadays without combination, and...the practical wisdom of a nation is shown not in talking about what are and what are not the proper functions of Government, but in deciding whether a particular object which it is desired to promote can with best advantage be undertaken by the Government or by private enterprise." (PD, 1882:42, 188-9).

The arguments are indeed interesting. Intervention by the State in various fields had, in the past, been necessitated by the realities of an isolated and unfamiliar environment, Now, the very existence and success of that intervention was being used as an argument for even greater State participation. Atkinson, undoubtedly reflecting (and shaping) the views of many others, was beginning to see the State as an acceptable means to achieve certain ends. It was another relational arena in which interests could be pursued and through which they could be effected. Despite his foresight and arguments, Atkinson's plans were thwarted and he abandoned public support for the scheme.

It is intriguing to note that just a short time later, in 1883, and in a vastly different social, geographical and political context, Bismarck introduced a similar compulsory national insurance scheme against ill-health, industrial accidents, invalidity and old age in Germany (Hanson, 1980:13; Gough, 1979:58; Starr, 1982:237). This system of insurance was inaugurated by Kaiser Wilhelm I in a speech to the Reichstag on 17 November 1881 and although humanitarian reasons may have underlain its introduction, Bismarck's desires to dampen the flame of socialism and to upset the Social Democrat Party seemed to override this (Lovell-Smith, 1970:52; Starr, 1982:235 and 239; Gough, 1979:59; Offe, 1978:286). Another reason also underpinned Bismarck's shrewd legislation:

> "Bismarck did not promote social reform out of love for the German workers; sympathy and affection had never been his strong point (sic). His object was to make the workers less discontented or to use a harsher phrase, more subservient. He said in 1881, 'Whoever has a pension for his old age is far more content and easier to handle than one who has no such prospect...'...A.J.P. Taylor [1966:Bismarck: The Man and the Statesman] goes on, [national insurance] 'has suddenly made the masses less independent everywhere yet even the most fanatic apostle of independence would hesitate to dismantle the system which Bismarck invented...'"

(Lovell-Smith, 1970:52-3).

Social control was an explicit aim of Bismarck's social insurance scheme. Perhaps this end has been desired at some times by some people for all social welfare proposals. Despite the intentions, the German plan was the first major move towards social security in the world.

Major Atkinson's proposal had not been without some influence in a society apparently ready for change. According to Chilton (1969:127), it stimulated sufficient interest in hospitals and charitable aid to demand that legislation be introduced. Although Atkinson's proposal provoked thought on the subject, it was not the only agent for the changes which were to be effected in the next few years. On 7 November 1882, G.W. Grabham MD, MRCP (London) was appointed as Inspector of Asylums and Hospitals. This followed the death of the incumbent, F.W.A. Skae MD, FRCS (Edinburgh) (N.Z. Department of Health, 1969:10; Chilton, 1969:50; McLintock, 1966:523). Grabham had had quarter of a century of hospital administration experience in England (N.Z. Department of Health, 1969:10) and held dear two notions regarding hospitals and health care. First, he felt that power should be in the hands of government to approve proposed hospital buildings and staff appointments, and to deal with any irregular occurrences (N.Z. Department of Health, 1969:10). Second, he firmly believed in voluntary local finance and local management (N.Z. Government, 1975:17). The New Zealand Government (1975:17) has considered that Grabham's views led to Vogel's presentation of the Hospitals and Charitable Institutions Bill to Parliament in June 1885. In part, this may be true, but it is unlikely that Grabham's beliefs - or Atkinson's national insurance proposal - were the causes of the introduction of the new Bill. Insight to some of the other factors which prompted action can be gained from an examination of the principles underlying the Bill (7). The three principles were as follows:

1. That the committees of hospital management should be essentially local and amenable to public opinion by being locally elected.

2. That expenditure should be somewhat localised.

3. That the Government, out of consolidated revenue, should meet a reasonable proportion of the cost of the institutions, but should not be looked upon as the last resort of local boards.

(N.Z. Department of Health, 1969:11; N.Z. Government, 1975:17).

The second of these principles belies a primary objective of the Hospitals and Charitable Institutions Act. It was hoped to lower the demands upon national consolidated funds by placing most of the financial burden for hospitals and charitable aid upon local bodies "without at the same time drying up the springs of charity" (AJHR, 1892:H-3,2). As is shown in Appendix One, the three years prior to the introduction of the Bill in 1885 saw the Government providing nearly 75 percent of the funds required to support hospital services. Consequently, in the midst of its Depression austerity, the Stout-Vogel ministry sought to rid itself of an economic albatross. The third principle offered formal acceptance to the idea that public hospitals were the joint responsibility of local and Central Government. This arose from the belief, voiced by Vogel, that in the absence of a uniform means of administration, difficulties and incongruities in the hospital system had grown since the Abolition of Provinces Act 1876 (Chilton, 1969:128). An intended role of the Hospitals and Charitable Institutions Bill was to remedy these problems. Under the Bill's provisions the country was divided into twelve Hospital and Charitable Aid Districts, but before it was passed parochial interests saw this number increased in committee to 28 (N.Z. Government, 1975:20). This reduced the effectiveness of Vogel's efforts to rationalise the provision of health care services. The disintegration promoted by desires for local autonomy perpetuated the backdrop against which resources - administration, built environments, labour power - had to be duplicated. Each hospital district was to be administered and controlled by an annually elected distict board. The hospitals within each district were to be financed by endowments and land profits (including rent), voluntary contributions, bequests, grants from contributing local bodies and a government subsidy of 10 shillings for one pound (the subsidy was later increased to pound for pound to ensure passage of the Bill). The Government also made provision for 'separate institutions' in an effort to encourage voluntary contributions and to allow autonomy for the independently minded. Such institutions were entitled to receive funds from rates and Government subsidies (McLintock, 1966:523) if they could provide a list of subscribers who could contribute 5 shillings or more annually to the institution and whose total contributions exceeded 100 pounds. The 'separate institutions' still fell under the overall control of Hospital and Charitable Aid Boards but were internally managed by an elected group

of trustees (Chilton, 1969:128-30). Condliffe comments on the Hospitals and Charitable Institutions Act 1885. The Act:

> "compromised between the principles of local and central finance, and between public service and commercial operation. The [Hospital and Charitable Aid] boards had power to levy local rates, but received subsidies from the Government. An effort was made to collect fees from patients, but these were never adequate or fully realised. At the time, in the midst of a long depression, the 1885 Act took a long step towards the public provision of hospital service and poor relief as a right of citizenship. The system of Hospital Boards created in 1885 endured with little change of principle until the passing of the Social Security Act of 1938. The Government then took responsibility for their upkeep but did not change their constitution." (Condliffe, 1959:294).

Thus, the Act achieved long term acceptability by facilitating the co-existence of public and private - collective and capital - interests in the same milieu. The 1885 Hospital and Charitable Institutions Act's responsiveness to pressures exerted upon health services by both labour and capital allowed it to survive some 50 years until overbearing pressure from those who sought a socialist form of health care service saw it replaced by the Social Security Act 1938. The implications of the Hospitals and Charitable Institutions Act go still further than 1938. In effect, it can be considered to have provided a base for certain patterns which have endured to the present day. The subdivision of the country into separate hospital districts is one element of this. The other is that the Act formalised the distinction between what may now be termed 'public' and 'private' hospitals. With the passage of the Hospitals and Charitable Institutions Act on 14 September 1885 the 'dual' system achieved legislative recognition.

Keys to the Doors: Putting the Public in Hospital

Doctor Duncan MacGregor was appointed to the position of Inspector of Hospitals and Charitable Institutions on 1 April 1886 (N.Z. Department of Health, 1969:11). He was to have a considerable impact upon the health care system for over two decades. MacGregor long held firm views on the roles of public assistance and charitable aid in the community believing that State intervention represented a retrograde step from the British laissez-faire system; an abandonment of one's duties to provide for oneself and one's family; and an encouragement of the procreation of the degenerate - people whom he felt would eventually cause society itself to degenerate (AJHR, 1898:H-22, 1-7).

Citing Bosanquet, MacGregor incorporated some of his personal beliefs into the annual Hospitals Report of 1885:

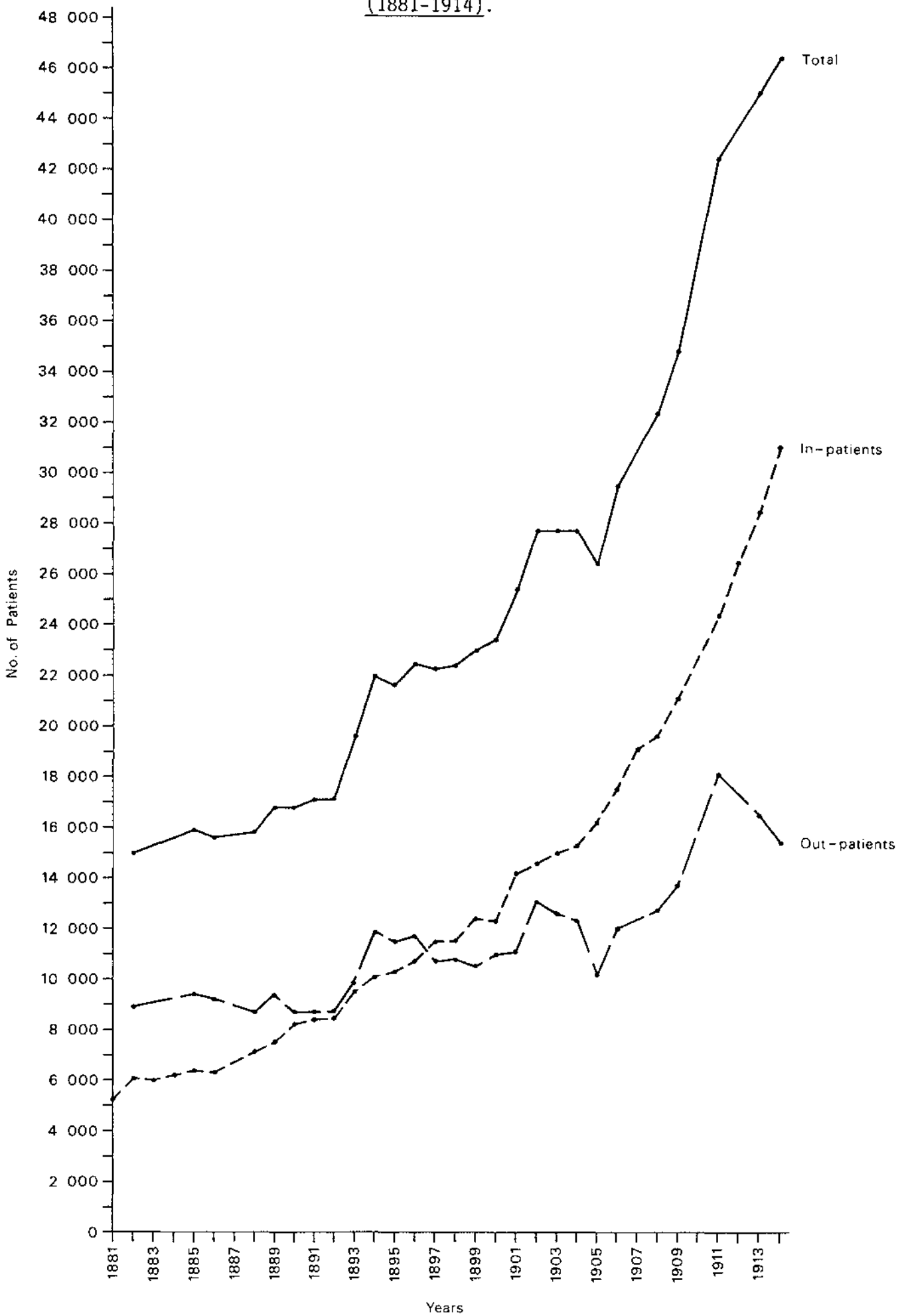
> "I believe in the...right and duty of civilised society to exercise initiative, through the State, with a view to the fullest development of the life of its members; but I am also absolutely convinced that the application of this initiative to guarantee without protest the existence of all individuals brought into being...is an abuse fatal to character and ultimately destructive to social life." (AJHR, 1895:H-22, 2).

During his term in office, which ended with his death in 1907 (N.Z. Department of Health, 1969:12) MacGregor had two main effects on the health care system. First, he maintained a high level of efficiency (Chilton, 1969:148) in the newly adopted system and his attitudes undoubtedly ensured that Government assistance to hospitals was not abused. Any marked growth in the share of Government funding to hospitals is sure to have sparked a re-evaluation of the provisions of the Hospitals and Charitable Institutions Act. Second, MacGregor provided a steadying (Chilton, 1969:147-8), retrospective influence in a health care environment which was undergoing considerable technological and institutional change. However, despite the fact that:

> "MacGregor fought a rearguard action against the pressures of egalitarianism and State socialism in so far as they affected the hospital system." (N.Z. Government, 1975:38)

he found that by "the end of his career he could no longer keep the hospital doors shut" (N.Z. Government, 1975:38). The doors of the hospitals were opened by several keys during MacGregor's time. One of the more prominent of these was the political power of labour. In parallel with trends in other western countries, the late 1880s - early 1890s saw a labour movement, with an urban focus, emerge as a major force in New Zealand society. The power of this movement was expressed in the wake of a major maritime strike of 1890 when workers' votes contributed to the election of a Liberal Party sympathetic to labour interests (Sinclair, 1980:166; Sutch, 1966:97; Oliver, 1960:138-9).

FIGURE 2.1: Hospital Patients - New Zealand (1881-1914).



Data source: A.J.H.R. 1882-1915

"From that time on the unions have had the ear of the politicians" (Oliver, 1960:139). Other processes also encouraged the public into hospitals. The introduction of a new technology which permitted the refrigeration of cargo from the late 1880s (Oliver, 1960:49) had profound implications for the whole fabric of New Zealand society. Development of the family farm - this being the fundamental productive form within the 'refrigeration economy' - assisted, through linkages, growth in the new manufacturing and service sectors and rapid urbanisation (Fougere, 1984:77). In the changing settlement and work environment new health problems were created:

> "some of which were met through the regulation of work and living conditions and some of which gave rise to new curative services, for the most part privately provided" (Fougere, 1984:77).

Access to these services was characteristically rationed by the pricing mechanism which, under conditions still prevailing, led to further reliance on charity provision (Fougere, 1984:78). Settlement trends themselves also produced interesting results. Urban areas often provided a sufficiently large and localised population to warrant more dense provision of medical services than had ever been possible before. Hospital growth was also stimulated by an increasing population; by the ageing character of that population (Chilton, 1969:151); and by advances in medical technology. As is borne out by Fig. 2.1 more people were entering hospitals. Increasingly, people began to see hospitals as acceptable, and even desirable, places in which to gain medical treatment. Numerous advances in the field of medical technology were fast removing the days when a stay in hospital was likely to create as much ill-health as was cured. During the latter stages of the nineteenth century many of the globally popularised medical developments purportedly most beneficial and attractive to patients had been introduced on a wide scale in New Zealand. Amongst the most important of these were anaesthesia (8) (9) and antisepsis with later developments bringing the more effective asepsis. In conjunction with technological developments, many of which were based on Pasteur's germ theory of disease, came a new type of nurse trained in accordance with the beliefs and ideas of Florence Nightingale. Nightingale had begun the first nursing school in England at St. Thomas' Hospital in 1860 (Hector, 1973:23), and educated nurses according to the philosophy that a nurse:

> "should be not merely a mistress of a handicraft, but responsible

> for the patients' hygienic environment, concerned with the preservation of health as well as the care of the sick." (Hector, 1973:23).

In the eyes of Dr. Duncan MacGregor, the new nurses who began to arrive in New Zealand in the late 1800s (pers. comm. Irena Madjar, Nursing Studies Department, Massey University) with ideas of hygiene and attitudes of professionalism, were of a different mould from the nurses of the past. In his annual hospitals report of 1887 he passed comment on those nurses working at Wellington Hospital:

> "The nursing staff struck me as being particularly satisfactory. They are all well trained, intelligent, and ladylike, being evidently drawn from a class very much superior to the old-fashioned hospital nurse of former times." (AJHR, 1887:11-19, 23).

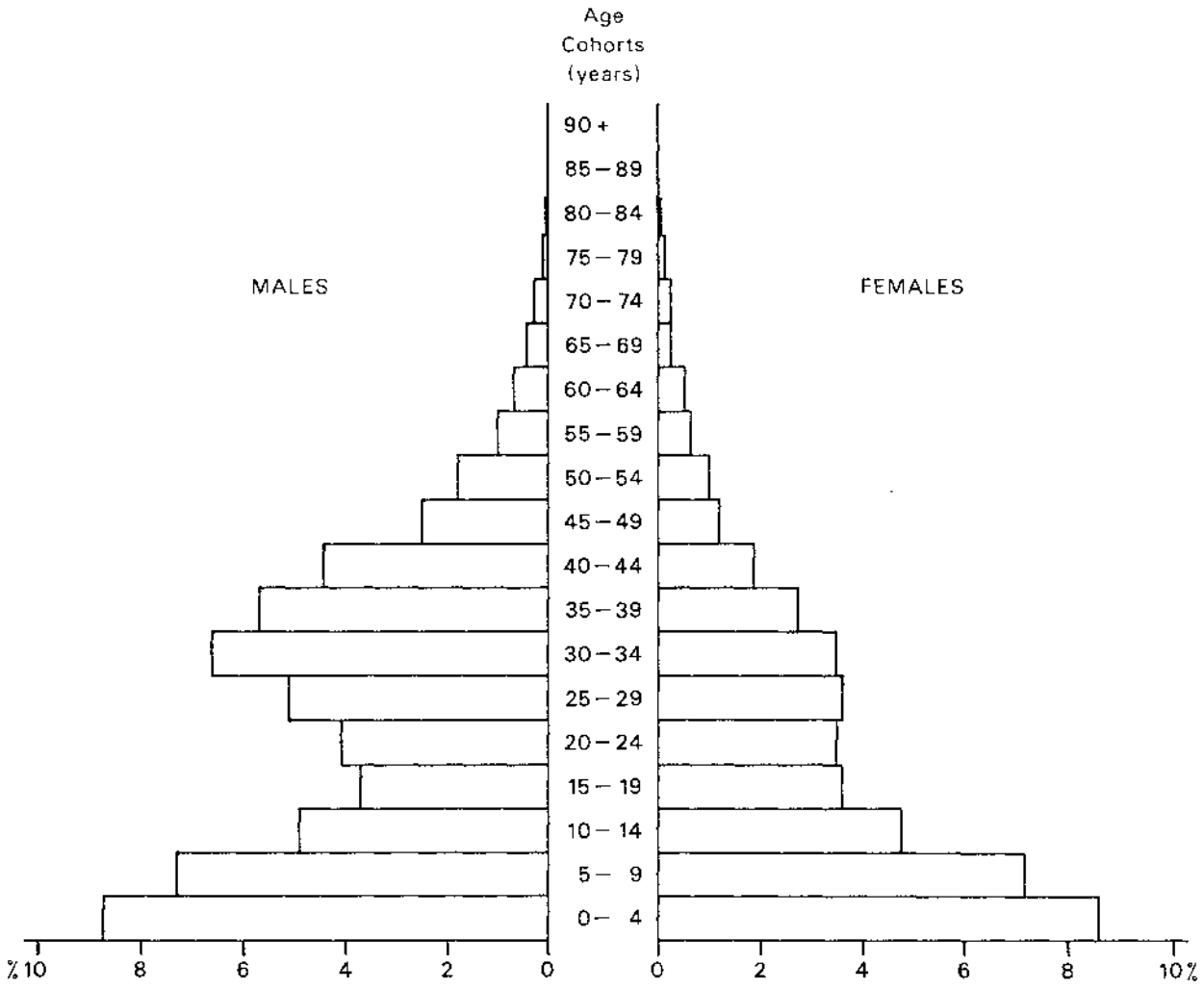
Thus, new, educated personnel staffed more hygienic, efficient and technologically advanced hospitals. Obviously, this was a source of attraction for many patients, but there also existed a 'push' factor which drove many people, who had in the past sought the care of private practitioners, to the hospital wards. The private sphere costs of obtaining the benefits of new technological advances were often beyond the grasp of many previously 'private' patients. These people were now attracted to 'public' hospitals. This appears to be borne out by Appendix One which shows that prior to 1886 patients' payments represented approximately 6-7 percent of the colonial hosptials' income. Following the Hospitals and Charitable Institutions Act of 1885 and its Amendment of 1886, the payments by patients steadily rose and after 1891 formed about 12 percent of hospital income:

> "This proportionate increase, in a period of severe depression, can hardly have been the result of careful administration [by MacGregor] alone. It seems likely that it was largely due to the admission of more patients able to pay for their treatment to the hospitals of the colony." (Chilton, 1969:151).

The content of the 1885 Act, which required citizens to support hospitals through government taxes and, more noticeably to the public, through local body rates indubitably persuaded many people that receiving hospital aid was no longer tantamount to accepting charity, and prompted their use of the facilities for which they had paid.

Finally, the ageing character of the population had obvious implications for the general level of health within the community. Ageing presented peculiar problems in New Zealand which, as a newly

FIGURE 2.2: New Zealand: Age-Sex Pyramid (Non-Maori Population) (1874).



Source: Neville, 1979 : 158

Sex Ratio (Male/Female) = 1327/1000

Population = 298 917

settled country, had an assymetrical age-sex structure (See Fig. 2.2). In the first years of European settlement the population was predominantly youthful and male, but by the 1880s-90s these men were reaching ages of increased physical dependence upon others (10). Although the people of Britain and other western countries had non-institutional means to cope with this problem - women who cared for the sick and invalided within the home - the same avenue was not as evident here because so few women had accompanied the first settlers to the rugged and distant colony. The absence of an informal network of care saw the old and sick seek care from other sources.

The movement of people to 'public' hospitals fitted into a broad pattern of thought and action favouring increased State penetration of many spheres of human activity. The late 1800s were marked by the emergence and adoption of a general belief throughout the western world that within an environment of laissez-faire economics and individualism State intervention was the only effective panacea for a people's ills (Sinclair, 1980:172). Indeed, some went so far as to hope that the State would guarantee "the nurture, education and comfortable maintenance of every individual from the cradle to the grave" (Bellamy cited in Royal Commission of Inquiry, 1972:46). The New Zealand Liberal Party accepted elements of such philosophies, this move being endorsed in the election of December 1890 by a public which is said to have hoped that "political action would buy the Utopia of Edward Bellamy or the nationalised land of Henry George" (Sutch, 1966:97). Sinclair (1959:172-3) suggests that the global move to State intervention was certainly no chance occurrence and that it appeared to be stimulated by widely accepted intellectual thought:

> "The political ideas of the New Zealand Liberals were similar to those of the Fabians and other socialist groups in England; the Nationalist Clubs, the Knights of Labour, and the Populists of the United States; the Labour Parties of Australia. This was no accident, for they had all drunk from the same intellectual springs. Scholarly radicals knew the works of John Stuart Mill, and perhaps also those of A.R. Wallace, the English land nationalizer. The ordinary man, who read few books and read them well, was more likely to know Progress and Poverty by the 'single taxer', Henry George, or Looking Backward, a portrait of a socialist Utopia written by another American, Edward Bellamy. These books were extraordinarily popular. Through them, millions of people became acquainted, not only with the concepts of the classical economists and J.S. Mill, but with the heady socialist theories of Saint-Simon, Fourier, and Lassalle. Fabians, Populists and antipodean Labour and Liberal Parties alike received inspiration from their pages." (Sinclair, 1980:172-3).

Whilst intellectual activity would appear to have been an element in the move towards State intervention, it is unlikely that these views could have gained such broad acceptance under social conditions unfavourable to their development. The actions of individuals within the community, whether those people were workers moving from country to city; those developing new medical technology; nurses practising their skills; farmers exporting refrigerated products; or businessmen engaging in new enterprises, created a whole new environment which, in turn, reacted upon the activities and attitudes (e.g. use of, and perceptions of, medical care) of individuals. Enmeshed within this interaction came the emergence of the State as a major force within the community. Its role grew and changed in response to both the personal desires of the actors and to their actions (e.g. voting public, Dr. Duncan MacGregor). Although some expansion of State mediated activity arose from deliberate actions to achieve that end, much was inadvertantly promoted by interactions in other domains.

Breaking Free: Professionalising Medical Practice

During the mid to late nineteenth century there was an increase in the number of 'professions' throughout the world. Thirteen professional associations were established in England between 1818 and 1895 and thirteen in the United States between 1840 and 1897 (Larson cited in Coburn et al, 1983:426). Attempts to confirm the place of the medical profession in New Zealand society began in 1873, two years before the establishment of this country's first medical school at the University of Otago. Initial efforts to form a medical association were made by Dr. T.M. Hocken in Dunedin but these proved fruitless (McLintock, 1966:532). For a period thereafter attempts to strengthen the place of a New Zealand medical profession met with only limited success:

> "In 1876 Dr. Coughtrey, the first Professor of Anatomy in the University of Otago, succeeded in forming an Otago Medical Association, which two years later changed its name to The New Zealand Medical Association. Its influence, however, does not seem to have extended beyond Otago. In 1879 an attempt was made by the profession to have set up a General Medical Council which would appoint medical boards in the various provincial districts to undertake the registration of medical practitioners, to adjudicate on all matters relating to medical ethics, and to consider matters of public importance requiring professional consideration. Provincial district associations were also envisaged. A Bill along these lines was introduced in the

> Legislative Council and passed, but was rejected by the House of Representatives." (McLintock, 1966:532).

It is possible that these first endeavours were unsuccessful owing to the small number of medical practitioners registered in New Zealand. The total in 1868 was only 133 (11). By 1890 however this figure stood at 427 (McLintock, 1966:529). McLintock's statements regarding the fate and influence of the Otago Medical Association are somewhat misleading. In 1887 the Association was amalgamated with similar organisations in the other main centres of the time (Jamieson, 1939a:8) - Auckland, Wellington and Christchurch (McLintock, 1966:532) - to form the New Zealand Medical Association. In 1896 this became the New Zealand Branch of the British Medical Association (Jamieson, 1939a:8; McLintock, 1966:532). As with so many other occurrences of this era the formation of New Zealand medical associations were firmly embedded in British (notably English) experience. The British Medical Association was founded at Worcester by Dr. (later Sir Charles) Hastings in 1882 as the Provincial Medical and Surgical Association. At that time, the health of many members of the public was poor, sanitary conditions were appalling, and mortality was high. Further, there was no clear distinction between formally, informally, or non-trained physicians (Jamieson, 1939a:6-7). Hastings' association was to remedy these problems by promoting the collection and dissemination of medical knowledge and by fostering "the harmony and good feeling which ought to characterise a liberal profession" (Provincial Medical and Surgical Association cited in Jamieson, 1939a:7). By 1856 the idea of an association and its tenets were sufficiently widely accepted to warrant a change of title to British Medical Association (Jamieson, 1939a:7). The Association then began international expansion, setting up its first overseas branch in South Australia during 1879. Subsequently it became established in every British Dominion, Colony and Dependency (Jamieson, 1939a:7-8). In effect, the pursuit of the goals of knowledge and unity fostered standardisation of practice and professional control of economic activity within medicine. Another influence promoting these same ends was that of the increasing emphasis placed upon formal medical education. In the first half century or so of European settlement, New Zealand's physicians had gained any medical qualifications they held from overseas organisations. However, the overall 'success' of the colony, its considerable population expansion, and the undoubted desires of local politicians and doctors to increase their domains of power, to provide better services to the public, and to raise the

status of the colony, all encouraged the founding of New Zealand's first medical school in Dunedin in 1874 (12). In the earliest days of the school only the first two years of training could be undertaken here, with most students completing the remaining two years of training at Edinburgh University, but by 1885 it became possible to do the entire degree course at Dunedin (McLintock, 1966:530). New Zealand's second medical school, at Auckland, did not take its first students until 1968 (University of Auckland, 1984:24). The move towards medical associations and the establishment and growth of a medical school represented interesting steps in the institutionalisation and overall development of the place and power of the medical profession in New Zealand society. Initially, New Zealand's doctors often held positions of influence within the community by virtue of the high level of formal education they had received relative to the bulk of the population, elements of their individual characters, and by extensive close knowledge of individual patients. Whilst fulfilling other personal and public aims, the establishment of a medical school and the development of medical associations served, in part, to institutionalise doctors' status. There is evidence of similar trends elsewhere (e.g. U.S.A. [Starr, 1982:19-20]). In effect, the medical school and, to a lesser degree, the medical associations served to place the contemporaneously accepted position and responsibility of doctors within a formal framework which facilitated the transfer of that status from one generation to the next. An integral part of this framework was the very competitive selection of candidates for medical training which made apparent to the public that not only did such an education require years of study, but also that candidates were an elite within the community. The notion that scarce products attract high prices probably also underpinned medical school admission rates. Aside from the more apparent reasons for setting up a medical school in New Zealand there exists a supplementary explanation. Under the pre-medical school and medical association conditions, doctors in New Zealand had neither control of the number of their colleagues who practised here, nor of their quality - an important factor amongst practitioners struggling to promote their professional status. To solve these problems came unification and education. Unity in the form of an association allowed individual doctors to gain greater collective power to protect and further their interests in a society and a healing art experiencing tumultuous change. In the early years when allopathic practitioners took to their bosoms new scientific armamentaria, healing became increasingly technical and specialised. The consequent

subdivision of knowledge had the potential to separate medicine into a series of disunited and overlapping and/or competing disciplines. Unity and the increasing control of medical practice facilitated by a national medical school drew New Zealand's medical practitioners together under a single umbrella and allowed them to exercise considerable control over the nature of competition which existed in and entered their market (chiropracters are an obvious example). The British Medical Association in New Zealand was an integral part of the transformation of a system which would have seen suppliers competing in the same market to one in which suppliers mutually assisted one another and together expanded the total demand for medical services. Jamieson hints at this argument:

> "Few members of the association [BMA] even,...are aware how great an influence it has had in building up the structure of the health services of the Empire. An organisation had come into being through which the learned physician, the distinguished surgeon, the academic teacher and researcher and the common work-a-day doctor were to come together on a common footing. Few realise how potent an agency this has been to transform the opposition of competitors into the healthful rivalry and co-operation of colleagues, as the touch of the philosopher's stone was believed to transmute base metal into noble." (Jamieson, 1939a:7).

Education, with the establishment of the medical school, represented a step by the New Zealand medical profession towards greater control over the number and nature of medical practitioners within the community. Prior to 1874, the competition local practitioners experienced depended considerably upon the vagaries of overseas opportunities and migration. The presence of a medical school ensured that doctors would be trained here and, in consequence, would be likely to commence practice in New Zealand. It allowed New Zealand doctors to regulate the number of graduates and to promote selected disciplines within the overall training programme. Quite simply, New Zealand's doctors had found and were firmly grasping and manipulating Adam Smith's invisible hand (of supply).

Not only had the medical profession found a method of moving the hand of supply, but they could also move, to a lesser degree, the hand of demand. An example and its development will help to convey some idea of how this occurred. In the late 1880s Thames Hospital - a separate institution under the terms of the Hospitals and Charitable Institutions Act - became the target of criticism by Dr. Duncan MacGregor. In his annual report MacGregor pointed out that Thames Hospital employed a surgeon who was given no right to practise

privately and that the hospital was operating a charging system which served to severely undercut the payment levels sought by local doctors:

> "...the Trustees have thrown open the outdoor department of the hospital to all persons whatsoever, whether rich or poor, who are willing to pay 5s. per week for advice and medicine. The result is that the general body of the taxpayers of the colony have, through the Government subsidy, to contribute towards giving cheap medical advice to the Thames people, by enabling the Trustees to undersell the local medical men by the competition of a salaried officer, and by the same means towards injuring the druggists and the self-respect of the people." (AJHR, 1888:H-9, 1).

Further, Dr. MacGregor was informed that:

> "...in order to leave Dr. Williams [Thames Hospital surgeon] free to overtake his rapidly-increasing demand for his services on these terms, the Trustees desire to relieve him of all charitable-aid work, which they want the local doctors, whom they are starving out, to undertake!" (AJHR, 1888:H-9, 1).

Events at Thames saw both the numbers of very wealthy members of the local community using the facilities for which they had paid an 'insurance' contribution and outpatient numbers at the hospital skyrocket. 430 outpatients received attention during 1886, but this number soared to 1339 in 1887 (AJHR, 1887:H-19, 39; AJHR, 1888:H-9, 1). Obviously, these two factors had serious repercussions for the incomes of local doctors. Indeed, they were affected "most injuriously from a pecuniary point of view" (Payne cited in Chilton, 1969:153). Although most members of the Thames community were undoubtedly happy with the local arrangements, as is borne out by their use of the facilities, other people were not. If the system was to have spread, the strength, independence and income of the entire medical profession could have been seriously affected. The result was that Dr. MacGregor corresponded with the hospital's trustees in August 1888 urging the abolition of the system; local doctors boycotted the hospital; and finally, the NZMA wrote to the Colonial Secretary in April 1889 supporting MacGregor's stand (Chilton, 1969:154). The pressure was sufficient to see the hospital's trustees revert to previous arrangements and there followed a rapid and considerable decline in outpatient numbers (228 in 1890 [AJHR, 1891:H-7, 30]).

This example is a specific instance of the type of influence the medical profession was beginning to have upon the shape of the changing New Zealand health care environment. The specificities however draw one to the broader context of processes. As is shown in Figure 2.1, there was, at the close of the nineteenth century, a dramatic rise in

hospital inpatient numbers throughout New Zealand. In contrast, outpatient figures climbed very gently and it was only for a short time after 1908 that they showed a rate of increase comparable with that of inpatient figures. As has been hinted at in the Thames example, the static nature of outpatient figures was not simply a chance occurrence. Outpatient facilities impinged upon the local market for doctors' private services. Although some - such as MacGregor and other doctors - considered it reasonable to expect the destitute to use any available hospital services, it was perceived as unjust 'poaching' by the hospitals on local doctors' territory if outpatient facilities were available to those who could afford to pay independently for the assistance of a medical practitioner. The arrangement which existed to prevent any physician from being deprived of allegedly legitimate income was simple but, quite obviously, effective:

> "The honorary staff of each hospital often acted in the capacity of a local watchdog and, at the colonial level, private doctors' interests were guarded by the New Zealand Medical Association and the colonial inspector." (Chilton, 1969:152).

Thus, individuals within the profession guarded their own interests and those of other practitioners whilst the newly created NZMA advanced the interests of all. The medical profession had emerged as a potentially powerful element within New Zealand society. Individual practitioners wielded some influence by virtue of various personal attributes, but in their new association they exerted a far greater influence than would otherwise have been possible. In their unity members of the medical profession had taken considerable control of the nature of competition within their market and had also found a means by which they could alter the nature of demand. Although the medical market remained a mystery to most of those within it, retrospective analysis makes evident the factors which motivated 'invisible' hands.

Plague and Problems: Public Health Arrives

The history of public health administration in New Zealand can be subdivided into two distinct periods. The first period, which ended in 1900, was characterised by a general lack of interest and organisation. Any administration of public health which occurred was conducted in rather an ineffective manner by local authorities with no national co-ordination (Maclean, 1964:11). In 1872 an attempt was made to organise a system of public health under the Public Health Act. There

were two causes underlying the emergence of this legislation (Maclean, 1964:11). Although the colony's population was small and thinly spread, there was a relatively large town at Dunedin. This had grown rapidly after South Island gold discoveries, and the conditions which subsequently arose there prompted some demand for sanitary control. Second, smallpox outbreaks originating from ships arriving at New Zealand ports at about this time had occurred in Auckland and Wellington. Under the provisions of the Public Health Act 1872 a Central Board of Health was established in each of the six Provinces and power was given to each local authority to act as a Local Board of Health for its district (McLintock, 1966:536). Most of the Provincial Boards of Health remained virtually inactive for the duration of their four year existence although Auckland administered an effective and lasting public health policy. The Local Boards did little better than their Provincial counterparts (McLintock, 1966:536). When the Provinces were abolished in 1876 a new Public Health Act promulgated the establishment of a revamped Central Board of Health for the colony. The Act also contained provision for the continuance of function of local authorities as Local Boards of Health. Most local authorities still showed little interest in that role and they received minimal support from the Central Board (Maclean, 1964:12; McLintock, 1966:536) which for the 24 years between 1876 and 1900 was virtually non-functional. It met infrequently and, on those rare occasions when it was convened, tended to deal with matters of quarantine only (McLintock, 1966:536; Maclean, 1964:12). The overall result was that almost nothing was done to improve the conditions of public health in the colony prior to 1900. In that year however, a calamity prompted major change. A pandemic of plague which had begun in China in 1894 diffused to South Pacific countries during 1900. Concern was expressed through the Government that the disease might spread here and so, in April 1900, Government appointed sanitary inspectors to make recommendations on methods to keep the possible spread to a minimum (Maclean, 1964:14). The first case of the disease occurred in Auckland in June 1900 - just before the 1900 session of Parliament. As a result, the Bubonic Plague Prevention Bill was the first piece of legislation placed before the House (PD, 1900:111, 94; Maclean, 1964:14; N.Z. Government, 1975:22). The Bill was passed and was approved by the Legislative Council the following day (PD, 1900:111, 122).

"The very extensive powers provided by the Act and the size of the

> penalties for obstruction or neglect [(13)] are a measure of the very great apprehension felt by the Government and the public at that time. The Act was self-limiting, and the last section provided that it was to be deemed to be repealed on the tenth day after the close of the session in which it was passed. It was in fact repealed by the Public Health Act 1900, which was passed towards the close of the session." (Maclean, 1964:15).

Although various authors (McLintock, 1966:536; N.Z. Government, 1975:22-3; Oliver, 1977:12; McKay, 1969:18) have implied or stated that the bubonic plague scare led to the eventual creation of the Public Health Department, other evidence points to the suggestion that the plague simply hastened existing efforts to reconstitute the ineffective administrative machinery of public health. Just prior to the third reading of the Bubonic Plague Prevention Bill, Hon. J.E. Jenkinson stated that he:

> "...would like to impress upon the Minister the fact that, if ever there was a time in New Zealand when everything pointed to the urgency that exists for the Government to establish a Department of Health with a Minister at its head, it is now." (PD, 1900:111, 121-2).

The response from the Minister of Education and Immigration, Hon. W.C. Walker, was that Government was already considering the establishment of such a Department (PD, 1900:111, 122). This reply was scarcely surprising as the Central Board of Health, whose ex officio chairman was the Colonial Secretary, had not met at all in the preceding four years! (Maclean, 1964:12). However, it was during the eventual debate surrounding the Public Health Bill of 1900 that the ineffectiveness of the existing framework crystallised as a factor underpinning the Bill's introduction. This was made quite clear by Mr. J.G. Ward whilst putting the Bill before the House:

> "Under the law as it stands there is a Central Board of Health, that is absolutely powerless for the purpose of carrying on the functions it was intended to discharge when the Board was created under the present Public Health Act...As it stands at the present time, there is divided authority...the Local Board of Health is invariably the Borough Council, and if the Health Officer considers it necessary for the material well-being of the people that something should be done, he is at once confronted by the fact that the Local Board of Health, which is the municipal body, has pressure brought to bear on its members from the ratepayers, with the result that undesirable and unsanitary buildings cannot be removed, or objectionable nuisances dealt with. Local pressure is brought to bear upon the municipal body, and a state of affairs is allowed to continue which is not conducive to the health or well-being of the people." (PD, 1900:113, 190-1).

The Public Health Act of 1900 grew primarily from problems perceived to

exist within the existing administrative framework, but its detail was shaped, and passage hastened, by a catalyst in the form of bubonic plague (just as the threat of smallpox had facilitated the introduction of its predecessor). The Act represented the point of subdivision of New Zealand's public health history into the two distinct periods to which Maclean refers (1964:11). The provisions of the new Act saw the establishment of the first Ministry of Health in the world (14) (Lovell-Smith, 1966:13). Under this Ministry, which was initially headed by J.G. Ward, there was appointed a Department of Public Health, a Chief Health Officer - responsible to the Minister - and six District Health Officers who oversaw the health related activities of local bodies in their respective districts (15) (Maclean, 1964:16; Lovell-Smith, 1966:13; N.Z. Government, 1975:23; Heggie, 1969:31; McLintock, 1966:536; McKay, 1969:18). Each of the officers of the Department of Public Health - which formally commenced activities in 1901 - had vested in him (her) very extensive powers, and although supposedly the advisers to local authorities on health matters, were able to exert a degree of coercion upon them (Maclean, 1964:16). Nevertheless, the officers used their influence to good effect and consequently sanitary conditions throughout the country were vastly improved.

By 1900, and as the result of a number of distinctive interactions, most of the arrangements and many of the organisations which were to characterise New Zealand's health care system in the twentieth century had been created. From a backdrop of intended goals the nature of the emerging system was, in fact, the product of functional effects of interactions between individuals and/or organisations. At the heart of the emergent structure were attempts to establish effective means for linking health care producers with health care consumers - attempts which, when considered in retrospect, were guided less by social needs and more by income levels for doctors. At all levels, provision of health care embraced production for exchange and opened up the possibility of the health care system forming part of the secondary circuit of capital. A major and complex feature of this period was that the field of medicine penetrated and partly redefined the relationships of the State. Labour-capital conflicts came to have their 'resolution' increasingly expressed through State activity. In the following three decades such conflict and its amelioration were to have profound implications for the organisation of the New Zealand health care system.

FOOTNOTES

1. Any documentation which may have existed is likely to have been destroyed in the wreck of the "White Swan" when transporting the appurtenances of Government from Auckland to Wellington (N.Z. Department of Health, 1969:9).

2. Appointed to major settlements, Colonial Surgeons met the medical needs of the imprisoned, the insane and the indigenous (N.Z. Government, 1975:12).

3. As these State hospitals were provided mainly for the Maori, none were in the South Island.

4. For a detailed discussion of Elizabethan Poor Law and its implications for the early arrangements of medical care in New Zealand see Davis (1984:104-5).

5. In fact, the Government was bankrupt (Sinclair, 1980:81).

6. Almost no women were admitted to friendly societies.

7. For a most comprehensive investigation of the history of the Hospitals and Charitable Institutions Bill see Chilton (1969), especially Chapter 6.

8. Anaesthesia by chloroform was greatly popularised by Queen Victoria's use of it in childbirth (pers. comm. Irena Madjar, Nursing Studies Deptartment, Massey University).

9. The first New Zealand operation under anaesthetic was conducted by Drs. Fitzgerald and Monteith at Wellington in September 1847 (Gluckman, 1976:63).

10. In 1867 the male/female ratio was 1327/1000. That year 34 percent of the male population were aged 65 or more. In 1886 this figure stood at 37 percent and by 1901 it was 41 percent (Neville,

1979:151 and 158). The changing age-sex strucuture was acknowledged by the passage of the Old Age Pensions Act of 1898.

11. This figure, and that for 1890, excludes those practitioners registered with addresses outside New Zealand.

12. This date, 1874, was provided by G.L. Brinkman, Dean of the Otago Medical School (pers. comm., 11 June 1984). McLintock however suggests that the medical school was founded in 1875 (1966:530).

13. Fines for direct or indirect obstruction or hindrance were 50 pounds. The penalty was 50 pounds for every day the offence continued. Medical practitioners who failed to notify authorities of known plague cases were liable to a fine of 50 pounds and to a suspension of practice for 6 months (Maclean, 1964:15).

14. The New Zealand Government states that N.Z. was the first Commonwealth country to take such a step (N.Z. Government, 1975:23).

15. These were Auckland, Hawke Bay (and East Coast), Wellington, Westland (and Nelson-Marlborough), Canterbury and Otago (N.Z. Government, 1975:23). These areas corresponded roughly with the old Provincial boundaries (Maclean, 1964:17).

CLASSES AND CONFLICT. CONSOLIDATING COLLECTIVISM

(c. 1900 – c. 1935).

3

CHAPTER 3

CLASSES AND CONFLICT. CONSOLIDATING COLLECTIVISM (c.1900-c.1935)

Over the period 1900-35 inequalities in the distribution of wealth and emerging class distinctions became increasingly evident in New Zealand society. From this background a political party representing labour's discontent arose, although the embryonic party's activities were quickly overshadowed by World War I. It was during the War that a major step towards the decommodification of health care was taken. In a spell of economic security, the Government assured free medical assistance to the wives and dependants of servicemen, thereby contributing to the alteration of attitudes with regard to 'free' health care provision whilst encouraging military enlistment. Assistance to injured servicemen followed. This 'imposed' change, induced by wartime demands upon the community, was matched by alterations internal to existing organisational frameworks. As doctors' charges rose, greater numbers of people found lodge systems of capitation payments to doctors for medical services attractive. Consequent growth in the friendly society movement upset the nation's doctors, many of whom were bound to lodges by rigid arrangements which had once enhanced their income-earning potential but now restricted it. Subsequent appeals by doctors for Government arbitration in the matter of their purportedly unfair treatment drew suggestions of a State take-over of friendly societies! Whilst interactions altering the characteristics of the provision of medical services were occurring, other influences encouraged the expansion of the State's health care activities. Politicians' suspicions about the standards of practice in private hospitals led to Government licensing. Stringent requirements appear to have forced many private hospitals into closure, thereby contributing to demands for Government provided facilities. State intervention in the health care arena was further promoted by an influenza pandemic during 1918. In the wake of poor handling of the crisis under public health statutes, reorganisation and broadening of Government concerns were effected. Urbanisation, North Island settlement and changing technology also generated pressures for the centralised State control of hospitals. Although unrealised in the form of effective centralising legislation, these pressures altered the character of inter- and intra-hospital board relations.

By the 1930s, considerable impetus for further State intervention was evident and, amongst other things, the Great Depression encouraged considerable electoral support for a Labour Party which advocated the crystallisation of apparent community feeling. The first 60 years of New Zealand's health care history had seen the production and consumption of medical provision drawn together. The next 35 years (processes in which are also dealt with in Chapter 4) were witness to the emergence of struggle to alter the nature of doctor-patient relation to the economic benefit of both sets of participants. This chapter deals with some of the processes both within and external to the health care organisation which contributed to decommodification of the doctor-patient relationship. Although some elements of medical services were decommodified during the period 1900-35, legislative expression of the processes underway at this juncture did not emerge until after the election of the Labour Party in 1935.

Working Class Unity

During the early 1900s prosperity tended to be unevenly distributed, with wage earners receiving much smaller incomes than farmers and the self-employed (Brooking, 1981: 226) and, although unemployment was lower than it had been at times in the past, it still hovered, in an intermittent and seasonal manner, at around 10 percent (Brooking, 1981: 226). These factors, amongst others, contributed to the existence of a "definite class consciousness of the people" (Sutch, 1966: 99) which an American, Dr. Victor S. Clark, reported to his Government in 1903. Clark went on to advance another reason for this social feeling:

> "He gave as a reason the lack of opportunity of workmen in New Zealand to become owners or rich men as compared with the United States. He also observed that the term 'unearned increment' occurred often in speeches at labour meetings, and that workers desired the 'ultimate nationalization of the land'." (Sutch, 1966: 99).

Feelings came to be expressed in an organisational form: union membership climbed from about 8 000 in 1896 to 57 000 in 1910 and around 100 000 in 1927 (Olssen, 1981: 266). This prolific growth was also encouraged by industrialisation and by rapid urbanisation (see Table 3.1), both of which drew large groups of workers together.

TABLE 3.1: Urbanisation: 1896-1921 (European population only)

	1896	1901	1911	1921
European population in towns larger than 8000 as a percent of total European population	29.46	31.07	37.68	47.8

Adapted from: Olssen, 1981: 254

Although there were few strikes in the first years of this century, the fifteen years following 1900 were certainly not without activity by radical workers to foster better living and employment conditions. The workers, many influenced heavily by socialist doctrine and united in their opposition to a society perceived as operating on inherently unjust bases, struggled to gain greater control of their own lives and livelihoods. Whilst activity was usually related to specific incidents, the overall consequence of separate actions was the proliferation of socialist ideas. In 1901 socialist groups formed the tiny Socialist Party (Richardson, 1981: 207; Sutch, 1966: 102 (1); Sinclair, 1980: 202). As from 1902 the Trades and Labour Councils passed resolutions calling for nationalisation of the essential means of production and the establishment of a state bank (Sutch, 1966: 101) and in 1904 they set up the Independent Political Labour League (Sinclair, 1980: 201; Sutch, 1966: 101; Richardson, 1981: 207). Global labour movements directly influenced the shape of the New Zealand scene after the establishment of the French Confederation Generale du Travail and the American Industrial Workers of the World (I.W.W.) which was founded in 1905 (Sutch, 1966: 102). 1908 saw the formation of the New Zealand Socialist Party which, although small, imported tonnes of books and was notable for its dissemination of I.W.W. ideas (Sinclair, 1980: 202; Sutch, 1966: 102). That same year the Federation of Miners was established to be joined in 1909 by other unions to form the Federation of Labour - the 'Red Feds' (Richardson, 1981: 208). Conflict over strike action at the Waihi goldmine in 1912 (Oliver, 1960: 166; Richardson, 1981: 211; Sutch, 1966: 110) prompted the Federation of Labour to hold a Unity Congress in June 1913 (Sutch, 1966: 112) from which emerged the Social Democrat Party (SDP) and the United Federation of Labour (UFL). Together these organisations were intended to unite the nation's workers both politically and industrially (Richardson, 1981: 211-2; Sutch, 1966: 112; Sinclair, 1980: 210; Oliver, 1960: 166). No sooner had the United Federation of Labour been formed than it took

control of a major waterside and mine strike. The Federation was, however, violently defeated by the Massey Government (Oliver, 1960: 166-7; Sutch, 1966: 114-5; Richardson, 1981: 212; Sinclair, 1980: 210-1):

> "Revolutionary unionism was defeated; and the political wing, the SDP, was severely hit. In 1916 at a meeting of the SDP, the ULP and Labour Representation Committees, the present Labour Party emerged, with its leadership chosen mainly from the young men of the SDP; its objective became simply the socialisation of the means of production, distribution and exchange." (Sutch, 1966: 120-1).

The formation of the Labour Party marked the overt placement of employer-worker relations in the political arena. The new party established a firm position in this new milieu by gaining the votes of the working class people in central urban areas (Bassett, 1967: 32). Influence was subsequently extended to suburban regions. Urban settlements were becoming politically oriented towards a party with left-wing tendencies and amidst the growing dominance of cities in New Zealand this move was to have important implications for the provision of health care. Although political primacy still rested with the farming community (2), the future was to bring this ascendancy to urban dwellers, thereby drawing the allocative decisions of Government more firmly into the urban environment.

The new Labour Party capitalised on the remains of a strong division which had emerged between rural and urban dwellers during the 1913 waterfront strike, but the major factors which came to most strongly unite Labour supporters were their dislikes of First World War conscription and of a system which allowed "cockies and capitalists to prosper while others fought in their place" (Plumridge cited in Richardson, 1981: 214). The Labour Party expressed the view that war profits should be confiscated and used to improve soldiers' pay and conditions. This would render conscription unnecessary. In the midst of wartime fervour such a policy was controversial and undoubtedly overshadowed the Party's other hopes for state owned shipping, banks, land and factories. Labour also sought a 40-hour working week and a nationalised and free medical service (Bassett, 1967: 32; Sinclair, 1980: 243; Sutch, 1966: 123). Despite the dominance of the anti-conscription issue, Labour's whole election platform was popular with the urban working class, and in its first election contest the Party was rewarded with 24.2 percent of the vote, gaining 8 of the 76 seats (Wilkes and Shirley, 1984: 291).

War for Freedom

It is certain that World War I (WWI) served to stifle emerging feelings of economic unrest within the country over the period 1914-19. For the politically dominant farmer the war brought prosperity as markets were readily available for all that could be produced:

> "With the help of settlement schemes for returned soldiers, rural land values shot up, farmers' cheques suddenly enlarged, and the general atmosphere of prosperity during the war helped to consolidate the pattern of economic development that had emerged in the early 1900s." (Brooking, 1981: 227).

The war was fought half a globe away in a time of slow communications. New Zealand was under no threat of invasion, it experienced no internal calamity, there was virtually no shortage of necessities, and the economy was more buoyant than it had recently been. Politically, the people sided with Britain and so were united against a common foe. It was within this secure economic and political environment that the human consequences of war were perceived in New Zealand. For compassionate reasons, and in an economic flush, the Government changed the basis by which eligibility for free public hospital treatment was determined. New provisions extended free care to the dependants of soldiers on active service, regardless of ability to pay. Dr. J.P. Frengley in his capacity as Acting Chief Health Officer and Acting Inspector-General of Hospitals outlined the policy in the Public Health Department's Annual Report of 1918:

> "With a view to assisting the dependants of those at the front it was decided that the Department should afford free maternity treatment at the St. Helen's Maternity Hospitals to the wives of soldiers on active service. The Department also pays the fees charged by the Hospital Boards for treatment in hospital of the wives and children of all men on active service outside New Zealand. Free treatment at the Department's expense is also given to the brothers, sisters, and parents of such men if they are solely dependent upon the soldiers in question." (AJHR, 1918: H-31, 8).

The implied extent of such coverage was immense as some 103 000 men served abroad (McLintock, 1966: 567) whilst New Zealand's population throughout WWI was only about one million. Although compassionate reasons can be suggested to account for the new stance of Government with respect to the charging of hospital fees, it is possible to view this action as representing both an element of persuasion to encourage

the reticent to enlist for active service and a measure to lessen opposition to conscription. By removing some concerns, and excuses, about the fate of dependants in the absence of the breadwinner, the Government was drawing able-bodied men more tightly to the war. WWI also had other implications for New Zealand health care enterprise for, although war took a large percentage of the population to foreign soils, the proportion of doctors actively engaged in military medical service was considerably higher. In fact, one-third of all New Zealand medical men were fully employed in the military (AJHR, 1918: H-31, 7; Dominion, 1918: 12 October). The obvious consequence of this amongst a population restructured in such a way that the very young, the old and the ill were uncharacteristically over-represented was that increased pressure was placed upon those doctors remaining in civilian service and upon hospital facilities. Not only were more people entitled to free treatment, but many more sought hospital care for ailments which might previously have been dealt with by a private practitioner. Increasingly, hospitals became embedded in the public 'consciousness' as places to which all medical problems could be referred and for which no charge might be made. Hospitals were fast becoming essential, egalitarian and de-stigmatised. Encouragement along these lines continued with the return to New Zealand of wounded and/or ill servicemen. In all, over 35 000 New Zealand men were injured in Belgium and France - this representing approximately 5 percent of this country's population. Upon their return home these men could apply for medical treatment for problems "caused or aggravated by military service" (AD 1: 23 128). From one standpoint such assistance represents a normal human reaction to treat one's 'saviours' most generously. Elements of such an attitude are evident from a question put to the Hon. Sir J. Allen (Minister of Defence) by Mr. Brown (Napier) in the House of Representatives. It was asked:

> "...whether the Government will take steps to see that the soldiers returning from the front are treated as heroes, and not as undesirable and unwelcome characters?" (PD, 1918: 112, 276).

The Minister of Defence replied that returned soldiers were treated neither as undesirable nor as unwelcome and that the fullest arrangements were made for their welfare (PD, 1918: 182, 276). From another viewpoint one can consider that the policy of free medical assistance arose from servicemen's demands, anticipated by politicians, for some return from the interests they had given their good health to defend. Perhaps expecting adverse election responses to

non-intervention the Government took steps its members deemed appropriate in the repatriation of troops. Thus, the health care interests of one group within the community were fulfilled with no need for deliberate, overt protest action to precipitate results.

If discharged soldiers furthered community support for Government-assisted provision of medical services, so too did those men considered unfit for military service at the time of enlistment:

> "...the normal rejection rate up to late 1915 was in the vicinity of 25 per cent before more stringent medical examinations were imposed. From 1 July 1917 until the exhaustion of 1st Division, (single men) 29 740 were medically examined and 17 184 were rejected. These rejections represented 57.8 per cent. This high proportion of unfit personnel is accounted for by the fact that this class of the male population ranging in age from 20 years to 46 years had already contributed many of its fit men by voluntary enlistment." (AD 1: 23 128 Hon. P.G. Connolly [Minister of Defence] replying to a question from Mr Walsh [Tauranga], 27 July 1959).

Despite the early volunteering of the more fit and the non-appearance in the literature of any word of concern, the high percentage of the country's young men who were ineligible for military service surely sowed a seed of worry in the minds of politicians and public alike. Although New Zealand had a healthful climate and adequate food supplies, it was now evident that many of the supposedly fittest members of the community were not healthy enough for combat. The resultant, but almost imperceptible feeling that something, somewhere, must be wrong is likely to have influenced attitudes towards health care activities just after the war. Further, the defensive capability of New Zealand was at risk if its population was as unhealthy as recruiting statistics implied.

'Free' Practice: Friendly Societies and Doctors as Foes

The first twenty years of this century saw relations between friendly societies and doctors at their lowest ebb. Over the period 1883 to 1920 friendly societies grew considerably in stature with membership numbers increasing four-fold and financial resources multiplying by ten as is illustrated by Table 3.2.

TABLE 3.2: Friendly Society Membership and Funds (1883-1920)

Year	Number of Members	Total Funds (pounds)	Average Capital per Member (pounds)	(s.)	(d.)
1883	18 843	232 000	12	6	7
1890	26 013	431 000	16	10	2
1900	40 257	766 000	19	0	9
1910	68 006	1 367 000	20	2	1
1920	74 210	2 321 000	31	5	7

Source: McLintock, 1966: 755.

Compared to population growth, that of friendly society membership is quite remarkable (Table 3.3), even more so when it is remembered that most lodge contracts covered the dependants of members.

TABLE 3.3: Friendly Society Membership Relative to Population (1887-1918)

Year	Population	Friendly Society Membership
1887	100	100
1890	103	105
1902	118	127
1908	133	174
1914	159	234
1918	181	297

Note: Relative scale taking 1887 as the base year for comparative purposes.

Sources: H 1: B.107 149/- Addresses delivered at friendly societies' conference by J.A. Hanan (Minister in Charge of Friendly Societies) and A.M. Myers (Minister in Charge of National Provident Fund).

Although not all friendly society members entered medical funds, one could assume that by 1920 up to 25 percent of New Zealand's population

paid for medical expenses through lodges. The antipathy of doctors to the friendly societies stemmed from a number of factors. Lodges allowed individuals to insure one another, and in most cases each other's families, against the costs of ill-health. Contributions were primarily for the provision of medical treatment by a doctor although other assistance could be made available as the following extract from an Oddfellows lodge handbook exemplifies:

> "The objects of the fund are to make provision for medical treatment for and attendance upon its members and the persons entitled to such benefits as hereinafter provided, and if thought fit for the establishment of beds in hospitals, nursing and convalescent homes, and to provide assistance in maternity cases, and to raise funds for such purposes by contributions from members or in such other manner which the Lodge at a special meeting may deem advisable." (Oddfellows, c. 1919).

The contributions of members were used to pay doctors as lodge surgeons on a flat rate fee. Effectively, the system was one of capitation. In the earlier years of friendly society operation, membership had been drawn predominantly from those higher paid groups of wage earners who were of a "thrifty disposition" (H1: B.107 149/-. Memo. from Dr. T.H.A. Valintine [Inspector-General of Hospitals] to Registrar of Friendly Societies, 10 July 1908). However, from the late nineteenth century the societies had attracted wealthier members of the community who desired to insure against the growing expense of medical fees (Bolitho, 1979: 3). This movement brought the displeasure of the medical profession upon the friendly societies. Whilst physicians had been willing to treat lodge patients who would otherwise have been unable to pay for care, they resented the facts that those who could well afford private care were abusing their charity through the friendly societies and that the profession had to take lodge contracts at all - permanently in regions populated by the poor, or temporarily whilst building up a practice in many other areas. Doctors felt that practice through the friendly societies reduced the dignity of the profession and that the contract system placed doctors at the beck and call of the lodges (Bolitho, 1979: 4). Whereas in the past the lodges had provided an avenue for physicians to extract a higher income than would otherwise have been possible, new processes were reducing income earning potential. The capitation system run by the lodges, rising medical fees and the surge of people to friendly societies were substantially undermining the autonomy and economic and social sovereignty which the medical profession had so recently won. As a result, friendly societies became the subjects of vitriolic criticisms

in the pages of the New Zealand Medical Journal (Bolitho, 1979: 4). In subsequent years there even appeared implications (not the "admissions" which Bolitho, 1979: 4 suggests) in the literature that lodge patients were worse treated than private patients (Blanc, 1949: 92; NZMJ, 1936: XXXV, 186, 190). Doctors also endeavoured to have income limitations placed upon friendly society members who chose to belong to the medical funds but the lodges were not at all co-operative in this matter, for the medical schemes represented a less important area of activity for them than unemployment or sickness benefits and it would have been most difficult for the societies to exclude members from one form of benefit but allow them to join others (Bolitho, 1979: 3). It would appear that there was a simple solution for the doctors in this issue - that being to cease dealings with friendly societies. Unfortunately for the doctors this would have aggravated their predicament rather than ameliorating it. Had they withdrawn from formal relations with the lodges the country's doctors would undoubtedly have alienated that section of the community which belonged to friendly societies; they would have removed one of the mechanisms which facilitated income maximisation; and they would have destroyed a useful "means of establishing practice" (NZMJ, 1937: XXXVI, 192, 96). Despite the inability of the doctors to give effect to their complaints, their attitudes led members of the friendly societies to take affront. Many lodges became hostile towards the medical profession and retaliated to criticism by making friendly society contracts with doctors increasingly restrictive and, at times, unreasonable (Bolitho, 1979: 5 and 6). Doctor-lodge relations were also strained by the progressive extraction of more and more effort from physicians for little change in remuneration. Primarily, this arose from the conjunction of changing medical technology with the character of the doctor- patient relationship as conditioned by lodge contracts. The situation is lucidly explained by Dr. T.H.A. Valintine:

> "In these days, in addition to the use of ordinary instruments of diagnosis, the Stethoscope, the thermometer, the Opthalmoscope and the testing of urine - no examination can be regarded as complete without the estimation of the opsonic index, the bacteriological examination of secretions and a blood count, to say nothing of serum therapy and feeding experiments, etc. An efficient conduct thereof not only takes up a great deal of a practitioner's time but the material used costs a great deal more than the bottle of medicine of his Victorian brother." (H1: B.107 149/- [Memo. from Dr. T.H.A. Valintine to the Minister of Public Health, 1 May 1916]).

New technology and methods of diagnosis took more of a physician's time

than had been the case in the past, and they were also more expensive. Despite these changes in the character of medical practice many doctors remained enmeshed in remunerative arrangements which had not altered apace. Eventually, circumstances were perceived by the BMA to be so bad that it took the issue of doctor-lodge relations to the Minister of Public Health in April 1916. Fundamentally, the Government's assistance was sought in the hope that arbitration would lead to increases in the fees which medical practitioners could extract in respect of lodge practice. Surprisingly, the BMA gained robust support from the Inspector-General of Hospitals (Dr. T.H.A. Valintine) in their claims. Although Valintine rarely sided with the Association, especially in medico-political or ethical matters, he felt obliged to speak up for them on this occasion, for it appeared to him that the friendly societies were not dealing fairly with their doctors (H1: B.107 149/-). Whilst maintaining some of his characteristic cynicism of the motives of the BMA, Dr. Valintine acted as its advocate in correspondence to the Minister of Public Health:

> "Having a very fair idea of the professional line of argument, I have very little doubt but that the members of the deputation [BMA] which waited on you last week were able to show a very fair case in support of their claim for increased fees, and it is not likely that I can adduce any further argument in support thereof, especially as I am not reacting to that strongest of stimuli - the pocket prompt.
>
> Nevertheless I feel it my duty to inform you that in my opinion, the present scale of lodge fees, though ample for the less conscientious type of medical practitioner, is by no means adequate for his more conscientious professional brother, who does his duty by his patients in making full use of those means, and methods of diagnosis and treatment that were practically unknown in those mid-Victorian days when the scale was first fixed." (H1: B.107 149/- [Memo. from Dr. T.H.A. Valintine to the Minister of Public Health, 1 May 1916]).

Valintine went on to propose to the Minister that the issue might adequately be settled if the Government was to assume responsibility for the friendly societies, thereby bringing many doctors under the wing of the State. It seems likely that Valintine's proposal was, in part, promoted by knowledge of the operation of national health insurance schemes in more than 20 countries (Hanson, 1980: 19). Probably the most important of these for New Zealand, with its still strong colonial ties, was the system introduced in Britain by Lloyd George during 1911 (Lovell-Smith, 1970: 49). Valintine's suggestion also smacks to a degree of empire building as indicated by his thoughts that nationalised friendly societies could prove a useful starting

point to the eventual introduction of a national, State-run health care system. It also appears to reflect a personal commitment to socialised medical practice. Despite the radical nature of his proposal, Dr. Valintine anticipated few problems. Without citing the specific details of his proposals, Valintine's suggestions were as follows:

> "In the event of a deadlock between the Friendly Societies and the BMA, the question of the State (by means of the Department) taking over the Friendly Societies might be considered.
>
> If a scheme of this sort were adopted it might prove the nucleus of a State medical service.
>
> There would be comparatively little difficulty in the Government taking over the united Friendly Societies, in the four chief centres, but there could be some difficulty in the smaller centres...
>
> If the proposed Friendly Society service were administered by the Health Department, it would largely obviate difficulties with the profession, though the BMA would try to scotch the idea. The profession as a whole could not object to medical men working under the Health Department...
>
> If this scheme were established and proved a success, the other centres might follow suit and the scheme would become...the nucleus of a State service. Good men could be promoted from the Friendly Society branch to the hospitals, which would of necessity become part of the State service." (H1 : B.107 149/- [Memo. from Dr. T.H.A. Valintine to the Minister of Public Health, 1 May 1916]).

The response of the Minister of Public Health, George W. Russell, is interesting, for, in it, he claimed to have already commenced work in that direction:

> "I am working already on the lines you suggest, and have sounded some of my colleagues as to State appointments for Friendly Societies." (H1: B.107 149/- [Minister's notes on memo. from Dr. T.H.A. Valintine to Minister of Public Health, 1 May 1916]).

The eventual outcome of Valintine's proposals, Russell's enquiries and the debate between doctors and lodges proved of little immediate consequence in the conditioning of the New Zealand health care system. However, the tale does bear witness to one set of relations and processes in the inexorable move by the people of New Zealand towards a system of State administered health care and to the producer-consumer conflict which arose from that move.

Thoughts of a national medical system were also occurring in other settings at about the same time. In a letter of 18 October 1917, the

Secretary of the Buller Hospital and Charitable Aid Board wrote to the Minister of Public Health conveying the Board's resolution that the time was ripe for the nationalisation of the medical profession in New Zealand (H1: 170/3). For political reasons the suggestion was quashed by the Minister. On 26 April 1918, a Mr. Henry Wilkinson of Blenheim wrote to his M.P. , Mr. T. McCallum, suggesting the implementation of a national health insurance scheme and providing details of its possible mode of operation. Wilkinson's suggestion was motivated essentially by concerns arising from the high fees demanded by doctors:

> "The poor people and very often the rich, suffer a great deal with their sickness and injuries before they call in a Doctor or go to him for medical or surgical attention attention (sic) just because they cannot afford to pay his fee or they consider it is large very often for the amount of attention they have received from him. And also the charges that are made at the hospitals; we are all lead (sic) to believe that if you cannot afford to pay for the hospital you are not forced to do so. But that is not the question because any person that had to call on that institution for the necessary privileges and attention feels very much hurt or will not go there to be attended to because they cannot afford to pay for the treatment..." (H1: 54 32 [Letter from H. Wilkinson to T. McCallum, 26 April 1918]).

Wilkinson's letter is evidence that private medical assistance was becoming less readily available to large sections of the population by virtue of its price. Undoubtedly, doctors in private practice were achieving such an income from those patients they did see that they did not have to treat others. Health care distribution in the 'market place' was seen to be creating inequalities in access to medical services. Further, the stigma of charity was still tied to those patients who could not afford to pay for hospital treatment. This was promoted by the application of a means test:

> "free medical services were available only to those who passed a 'poverty test', administered by the more well-to-do (the medical profession and the elected representatives of the ratepayers and their officials)." (Oliver, 1977: 16).

Wilkinson implies later in his letter that the stigma of charity would be dispelled if all members of the public were required to contribute regularly to a health care fund in return for free treatment in times of sickness. Apparently McCallum perceived the same problems as Wilkinson for he passed the letter on to the Minister of Public Health. Correspondence was subsequently sent from the Acting Prime Minister to New Zealand's High Commissioner in London seeking all possible information on the British National Insurance scheme. Unlikely as it

may seem, communications on the matter appear to have ceased at this stage. Again however, there is evidence of pressure within the community for the implementation of some scheme which, on a collective basis, would ensure the availability of medical services to all members of the community.

Private Hospital Licensing and Decline

The first private hospital licence in New Zealand was issued in 1903 (Heggie, 1970L 55; N.Z. Department of Health, 1969: 19) under the provisions of the Health Act which regulated inspection and licensing but required neither qualifications on the part of the licensee nor standards of the hospital. Private hospitals were left largely to their own devices but with increasing standards of medical care available, the country's politicians soon considered necessary legislation which would provide for the placement of private hospitals under supervision and proper management (PD, 1906: 138, 255):

> "In the past we have had instances of deaths in private hospitals under circumstances which would probably give rise to the suspicion that had the hospitals been under proper supervision such deaths might not have occurred". (AJHR, 1919: H-31A, 35-6).

To reduce the possibility of deaths and to effect State control, the Private Hospitals Bill was introduced by Hon. Mr. Pitt (Attorney-General). The Bill provided a definition of private hospitals, required all such establishments to be licensed, and made compulsory the inspection and approval of private hospitals by the Inspector-General of Hospitals (PD, 1906: 138, 255). Shortly after the acceptance of the Bill, as the Private Hospitals Act 1906, the number of private hospitals in New Zealand plummeted from 293 in January 1907 to 191 in 1908 (N.Z. Department of Health, 1969: 20). It would appear that State controls on private hospitals were so restrictive that many were forced into closure. As the number of licensed private hospitals declined the only alternative for many potential patients was to seek assistance in public hospitals. The plight of the private hospitals in the early years of this century was a sorry one. Relations amongst workers, and with the owners of capital in the industrial arena were changing in ways which facilitated growing acceptance of publicly provided hospitals; technological changes and the expenses they entailed for private hospitals wishing to remain medically competitive made it progressively more difficult for private

hospitals to maintain parity with their public counterparts; and urban growth made larger hospitals more viable - this creating an unfavourable context for the development of private hospitals. Private hospital growth was restricted while, at the same time, public hospitals became increasingly important.

Rationalising Public Health and Hospitals

In the first years of the twentieth century a national economic surge (3), the acquisition of land from the Maori, the opening of the Main Trunk Railway on 6 November 1908 (McLintock, 1966: 34) and the refrigeration-induced profits associated with dairying saw many people drawn to the North Island (4).

The cultural landscape which was created there was the product of the small scale of the new farms in combination with the support services required to meet the needs of developing dairy enterprise. Small towns comprising saleyards, shops, schools, churches, banks, doctors' surgeries, stock and station agents, and dairy factories emerged. The resultant pattern of close-knit rural communities differed considerably from the dispersed and isolated sheep-based settlements or crowded and transient gold-towns of the South Island. The new character of the landscape was reflected by considerable alterations in the distribution of hospitals between the two islands. There developed a distinct trend for hospitals to be established in North Island areas (AJHR, various years). Compounding the changing nature of distribution was the fact that the North Island was favoured with larger hospitals. Of those hospitals with thirty or more beds in 1910, nine were in the North Island whilst only five were in the South Island (AJHR, 1910: H-22, 42-3). The hospital scene was also marked by a proliferation of hospitals (Fraser, 1984:59) as is brone out by Table 3.4. This expansion arose from growing needs, which were increasing with population, and demands, which were promoted within the community by a variety of factors including the availability of high qualify care provided by trained nurses in technologically advanced hospitals.

TABLE 3.4: General Hospitals and Beds in New Zealand (1905-15)

Year	No. of General Hospitals	No. of Beds	Proportion of Beds per 1000 Population
1905-6	52	2186	2.49
1906-7	53	2331	2.58
1907-8	53	2347	2.54
1908-9	53	2502	2.65
1909-10	56	2689	2.75
1910-11	57	2863	2.87
1911-12	60	3057	3.00
1912-13	63	3176	3.03
1913-14	63	3292	3.06
1914-15	65	3531	3.22

Source: AJHR, 1915: H-22, 5.

Such a situation should have been conducive to the generation of increasing numbers of private hospitals as well as State administered ones. However, the expense of providing the benefits of highly trained staff and constantly changing and progressively more expensive medical technology(5) made it extremely difficult for private hospitals to keep up to date (Bolitho, 1979:2). An obvious, but paradoxical, consequence of this was that during the early years of this century the standard of medical care received by poorer patients treated at minimal or no cost in public hospitals was better than that received by those who could afford to pay for their own private treatment. Growth then was occurring in North Island and public hospitals whilst relative decline was the experience of private and South Island establishments. This situation, in conjunction with the 'wasteful' expenditure of public funds by Hospital Boards, the rise of nursing and the dispensary movement, and advances in medical and surgical techniques (N.Z. Government, 1975:26; Fraser, 1984:58) encouraged the perception of need for rationalisation of New Zealand's medical servies. Improved communications saw images and realities of time-distance shrink, drawing previously isolated areas and people more tightly into administrative heartlands. It became possible for single authorities to effectively manage increasingly large areas. Whilst Dr. Duncan MacGregor had advocated a reduced number of hospital districts, the circumstances of transport and accessibility had made numerous small districts more practical. Now, despite MacGregor's death in 1906 (N.Z. Government, 1975:24), his commitment to a lesser number of districts was continued in a new communications milieu by his successor, Dr. T.H.A. Valintine, who hoped that the country could be subdivided into administratively manageable areas, taking into account

population, rateable value, and natural avenues of transport and communications. Valintine envisaged that these districts would be 20 in number and that each would be sufficiently large to warrant and maintain one fully equipped base hospital with several subsidiary hospitals in outlying areas for emergency or temporary purposes (Lovell-Smith, 1966:18). Proposals were made public on 9 June 1908 when the Hospitals and Charitable Institutions Bill 1906 was presented to the first conference of the Hospital and Charitable Aid Boards (AJHR, 1908, H-22A, 1; N.Z. Government, 1975:27). The Boards' reactions were discussed in Valintine's 1908 annual report:

> "...it was only to be expected that there would be considerable opposition to the proposal to divide the Dominion into larger hospital districts. Many of the smaller hospital districts naturally object, on more or less reasonable grounds, to being merged into one large district. Nevertheless everything goes to show that efficiency and economy of administration are more likely to be effected by large than by small districts..." (AJHR, 1908, H-22A, 1).

Despite the attractions of efficiency and economy the proposed alterations to hospital districts became dominated by local pressures which, through their effects upon political considerations, disintegrated Valintine's 20 districts. The Hospitals and Charitable Institutions Act 1909 was less successful than its predecessor of 1885 for, by repeated alterations to the schedule after the passage of the Act, Parliament allowed a total of 47 hospital districts (Lovell-Smith, 1966:18). The new Act also had as an underlying theme the notion that control over hospital affairs should be apportioned according to sources of finance (N.Z. Government, 1975:27). The stimulus for this general theme was essentially financial as the Chief Health Officer hinted in 1903:

> "That the Government, required as it is by statute to provide half of the total expenditure on hospitals, should have absolutely no say in the spending of the money is ridiculous, and tends to extravagance." (AJHR, 1903, H-31, iii).

A consequence of the new legislation was that the number of autonomous separate institutions was reduced to three as all of those which relied on Hospital Board finance were brought under the control of the Hospitals Department. The Act also saw an alteration made to the finding formula such that more central government control over New Zealand's hospitals was achieved. As Appendix 1 illustrates, central government provided some 35 to 40 percent of Hospital Boards funds, this being about 10 percent more than was contributed by local

authorities. Patterns of expenditure however were determined by the autonomous Hospital Boards, whose decisions on spending were often perceived by the Health Department as proving wasteful (N.Z. Government, 1975:27; Fraser, 1984:58). The new funding formula operated on some of the principles for which Valintine had hoped - rating and population criteria - and provided for the allocation of greater Government subsidies to poor districts than rich, although the Dominion-wide average subsidy rate worked out at pound for pound (N.Z. Government, 1975:27). The subsidies served also as a tool of Government power:

> "The ultimate weapon in the Government's armoury was to withhold subsidies or to direct the Inspector-General to rectify any shortcoming at the Board's expense." (N.Z. Government, 1975:28).

The complexities of this funding mechanism meant however that by 1920 the system was again in need of major reform (Fraser, 1984:59). Nevertheless, the principle of greater central control over the activities of Hospital Boards was a legacy which was to remain despite subsequent changes to legislation.

State control was also promoted by the occurrence of an influenza epidemic in New Zealand during 1918 (AJHR, 1919:H-31, 1; Heggie, 1969:33; N.Z. Government, 1975:30; Bassett and Harris, 1978:2). The 'flu' killed over 5500 people (AJHR, 1919:H-31, Appx.A., 3; Sinclair, 1980:223), a toll which it was thought could have been smaller had the Public Health Department been more responsive in dealing with the emergency - even allowing for the fact that the Department was considerably weakened by wartime demands on staffing (AJHR, 1919:H-31A, 27; N.Z. Government, 1975:30). However, the Influenza Epidemic Commission which was appointed in the wake of the pandemic was most critical of public health statutes, which it felt had been hastily conceived and which failed to adequately define the powers and responsibilities of the various agencies and officers acting under their provisions (AJHR, 1919:H-31A, 27-8 and 35-6). The Commission commented that there existed:

> "extreme complexity and diffuseness in this department of law, making it most difficult for any but specialists to have a knowledge of the requirements and obligations of the various statutes." (AJHR, 1919:H-31A, 35-6).

The Commission's criticisms were accompanied by recommendations to simplify and consolidate public health legislation (AJHR, 1919:H-31A,

39-40). The basic tenet underlying these recommendations was that authority with respect to public health activity should resemble the relationship between senior and junior partners in a business:

> "The proper relations of the local authorities to the Public Health Department...appear to have been a matter of some doubt for some considerable time. As a general principle we submit that the two authorities should stand in the relation of associates working towards common ends. The Health Department as the authority having a responsibility for caring for the public health throughout the whole Dominion, and being constituted for the purposes of specialising in that direction alone, ought to possess powers of supervision over the acts of all local authorities relating to matters of public health." (AJHR, 1919:H-31A, 30).

The Commission's report and recommendations were received too late to permit immediate preparation of legislation, but Dr. Valintine's own recognition and acknowledgement of the inadequacies of public health administration in conjunction with the mandate of the Commission encouraged high priority for reform in 1920 (N.Z. Government, 1975:30). The Public Health Act 1920 which resulted remained unaltered for some twenty years (AJHR, 1920-1:H-31, 2; Maclean, 1964:24). Health services became the combined responsibility of a Board of Health, a reshaped Department of Public Health (to be called the Department of Health) and territorial local authorities. The relationship between the latter two was much as the members of the Influenza Epidemic Commission had hoped. The new administrative patterns also featured a subdivision of the Health Department into various Divisions - this following on from public health emergency, British and American methods of organisation and also from various needs perceived as warranting special attention (particularly in the area of child welfare as recently had been promoted by Sir Truby King) (Heggie, 1969:33; N.Z. Government, 1975:31). Amongst the new sections of the Department of Health was the Division of Hospitals, headed by D.S. Wylie - a man who had firm beliefs regarding the organisational and spatial arrangements of hospitals in New Zealand. Wylie thought that medical technology and specialisation had brought the time when equal development of all hospitals was impractical. Many of the smaller and medium-sized hospitals were too self-reliant and there existed difficulties in transferring cases from one hospital to another. It was suggested by Wylie that hospitals ought to be grouped together to enable the transferral of certain classes of case between hospitals (AJHR, 1920-1:H-31,18). The nature of, and logic behind, Wylie's views are most adequately expressed in the following extract from his first annual report:

> "'No single person can any longer hope to obtain equal skill in the use of the many instruments and procedures of diagnosis. And the same might be said of modern therapeutic technique. No general practitioner, no surgeon, no physician, can any longer unaided give to patients the benefits they can in the more obscure cases derive, and have a right to expect, from his efforts when combined with the properly co-ordinated (and subordinated) activities of a group of adequately trained medical and surgical specialists.' To secure to the community the benefits of treatment as described must be one of our aims. To enable it to be accomplished certain hospitals must be classed as base hospitals, their special departments strengthened, and the affiliated hospitals given the right to arrange for the transfer of certain classes of disease to these base hospitals." (AJHR, 1920-1:H-31, 18).

The ideas of Wylie were subsequently to contribute to the characteristics and spatial distribution of hospitals throughout the country. Had it not been for activity in other domains however it is unlikely that Wylie's ideas would have emerged in, let alone be formative of, the New Zealand health care system. For example, the influenza pandemic prompted the creation of a new legislative framework in which Wylie's ideas were given greater weight than might otherwise have been the case. In addition, the 'flu' and subsequent administrative changes to the Department of Public Health had contributed to the growing acceptance of national supervision of health care activities.

Moving Left to Labour

The first one-third of the twentieth century was marked by few Government steps towards provision of social security measures (Burdon, 1965:234; Sutch, 1966:151-3). The Reform Government's precarious rural mandate (Sinclair, 1980:289) and an unstable post-war economy did not provide a suitable backdrop for the implementation of welfare policies. Despite its best efforts to maintain electorate support. Reform began to lose rural votes when significant economic problems emerged in the 1920s:

> "Price fluctuations - a down swing from 1921 to 1924, a recovery in 1925, a drop down again in 1926 to 1927, a further recovery in 1928, and thereafter a fall which merged into the full bitterness of lasting depression - left the farmer bewildered, annoyed and suspicious. Productivity, especially in the meat and dairy industries, actually increased during the decade. The farmer, producing more and earning less, was sure to become perplexed and

> sometimes angry. While prices were unreliable and often low, credit remained expensive and the mortgages exacting. All this conspired to turn the farmer, in the North Island especially, into an unpredictable voter." (Oliver, 1960:183).

Whilst farmers became less tied to one political party Labour learned from its election defeats of those policies required to secure the backing of the influential rural sector. "By 1928 Labour had begun to grapple with the real problems faced by struggling small farmers" (Richardson, 1981:219). In order to gain farmers' votes however, Labour had to foresake or amend some of its more 'radical' policies. Growth in the political power of Labour was also promoted by urbanisation (N.Z. Official Yearbook, 1931:97), driven in large part by rural-urban migration which itself arose as the product of both labour-substituting agricultural technology and the economic hardship experienced by novice farmers who had been assisted onto farms through large-scale post-war government resettlement schemes (Oliver, 1960:172; Sinclair, 1980:244). Labour Party support, and indeed the entire fabric of New Zealand society, was most significantly altered during the Great Depression of c.1926-35. The Depression saw heightening political consciousness within the working class; changed voting patterns throughout the Dominion; growing collective activity; greater awareness of the relationships between capitalist and worker; and the party which traced its origins to the 'Red Federation' emerge as a major political entity:

> "When external circumstances defeated the self-reliance of even the most deserving and when depression swelled the ranks of those both deprived and virtuous, it was hard to resist the argument that self-reliance had to be supplemented by greater self-reliance upon the resources of society as a whole." (Oliver, 1977:13).

Labour's political gains from the Depression may not have been so great as were subsequently substantiated had it not been for Reform's J. Gordon Coates. From the political "back seat" (Sinclair, 1980:264) Coates worked to restore New Zealand's precarious Depression economy to 'stability'. Coates' policies were very stringent (Oliver, 1960:181; Sutch, 1966:167; McLintock, 1966:366; Sinclair, 1980:263) and by 1935 he was probably the most despised person in the country (McLintock, 1966:366; Sinclair, 1980:264; Oliver, 1960:181). "He became to a great number of New Zealanders the hated symbol of Depression government" (McLintock, 1966:366) and in the election of 1935 the public "snarled at the author of [its] disappointment" (Burdon, 1965:76). Despite Coates' lack of popularity, his policies contributed to a sound economic base from which Labour could work.

Labour was also fortunate enough to take power at such a time that it "rode a wave of growth in the international economy" (Hawke, 1982:155). By the time it had assumed political control, the Labour Party's philosophies, although reflecting socialist origins, had been modified to appeal to as broad a spectrum of the voting public as possible (Grant, 1980:116). The aim of the Party had become the pursuit of action which would:

> "turn capitalism quite painlessly into a nicer form of capitalism which would eventually become indistinguishable from socialism" (Anonymous cited in Sinclair, 1980:267).

Radicalism was tempered with political pragmatism.

In the specific field of medical care, the Labour Party expressed, in 1916, its intentions to nationalise medical services and to provide free medical treatment for all (J. Campbell cited in Hanson, 1980:32). However, it was not until 1926 that Labour Party members developed a separate platform for health policies which, in addition to the above, included free dental and maternity attention and the establishment of baby clinics at which free attention would be available to mothers and infants (J. Campbell cited in Hanson, 1980:32). Despite these proposals there appears to have been no firm comprehension within the Party of the exact scope of the intended nationalisation of the medical services (Hanson, 1980:32). Opinions differed from one person to another. Nevertheless, Labour was the first Party to forthrightly declare any intention to provide a universal health scheme for the people of New Zealand. The Reform Party, as government, lagged not too far behind however, for, in the 1920s, it began to toy with the idea of nationwide sickness, invalidity, old-age, and widows' benefits (Hanson, 1980:27; Royal Commission of Inquiry, 1972:45). To suggest that Reform's first thoughts of invalidity and sickness payments occurred in 1925 is to malign the Party somewhat, for in the elections of 1911 and 1914 it had promised to introduce a scheme for sickness and unemployment insurance along the lines of Lloyd George's British scheme (Hanson, 1980:27). This promise was not kept but presumably the rise of the Labour Party during the 1920s with its health policies provided sufficient incentive within Reform for further thought about the suggestions of the previous decade. Reform members not only believed in contributory insurance on the basis of principle, but also because it possessed the advantage of being cheaper to run than a 'non-contributory' scheme - an especially pertinent consideration in

view of national economic difficulties and a growing pensions budget (Hanson, 1980:27). A 1924 statement by G.J. Anderson, Minister in charge of Pensions, epitomises thought within the Party:

> "I believe that a contributory scheme is the solution to all these difficulties [of extending the pension system], and that they cannot be satisfactorily resolved in any other way. It is quite impracticable...to give an adequate pension for invalidity or for any other cause unless during their lifetime individuals provide for such cases...
>
> Most of the systems in operation in other countries are on a contributory basis, which, to my mind is the only satisfactory principle to adopt if improvements of a radical nature are to be effected. If the pensions scheme in this country was extended much further - the taxation of the people would be very considerably increased." (AJHR, 1936:H-30, 12 cited in Hanson, 1980:27).

A contributory scheme would accord with contemporary philosophies on payment and charity, follow overseas example, and prevent politically unwise increases in the taxation burden. Eventually however the idea was not pursued because of other commitments (Hanson, 1980:27) and the difficulty of ensuring that those most in need of benefits could regularly pay adequate insurance contributions (Royal Commission of Inquiry, 1972:45-6).

Despite mounting pressure for increased State involvement in health and welfare services during the 1920s and 1930s the Reform Government was so hamstrung by the rural vote that had it tried to comply fully with public demands it would probably have been expelled from office. Compounding the political factors which did little to promote the provision of social services was national economic instability and the efforts by Coates during the latter part of this period to 'safeguard' the public from too great an economic list. New Zealand trailed the rest of the more developed world in the creation of frameworks to facilitate the provision of welfare assistance to the sick, the old, and the destitute. By 1930 more than 30 nations including Japan, most of those in Europe, and some in South America had adopted some forms of pension system, maternity payments, family allowances and contributory health, unemployment or old-age insurance schemes (Hanson, 1980:14). New Zealand society had only the rudiments of some of these services and the extent of their coverage was intended to be quite small. There emerged however a variety of forces pressing towards some form of collective health care provision. In tune with still-dominant laissez-faire ideologies and with existing systems of community medical

services provision, thoughts on collective care largely centred around some form of contributory scheme. At the same time however a political party with strongly socialist roots was becoming increasingly dominant in the Dominion. Though in favour of community care for individual misfortune, the Labour Party's leaders eventually proved to favour a 'non-contributory' system of health care provision. Their attitude was vindicated during the Great Depression when even the most prudent and thrifty were beset by misfortune. Although collectivism was being consolidated in numerous ways, its character was in no way clear or obvious.

During the early years of New Zealand's European-dominated history medicine had been provided by doctors to patients on an exchange basis although in subsequent years there was developed an 'insurance' mechanism, in the form of lodges, which facilitated patient payment of doctors' charges. Not all people however could afford either doctors' fees or lodge subscriptions. For these people State mediated provision became available with selected needs being catered for with funds channelled by the State to doctors. From small-scale beginnings State activity in the medical arena steadily extended during WWI and following the 1918 Influenza Epidemic. Running in parallel with these changes were alterations in the character of production-consumption relations. Although exchange between doctors and patients still occurred on the basis of (medical) need, there had also developed a 'need' to preserve the exchange character of the doctor-patient relationship. It was this 'need' over which conflict between the producers and consumers of medical care developed. In examining elements of this conflict and the processes contributing to decommodification this chapter has also introduced some of the conjunctural and structural elements which saw various actors drawn into efforts to preserve the commodity nature of the doctor-patient relationship. Amongst other things it is with these efforts that Chapter 4 deals.

FOOTNOTES

1. Sutch claims that this occurred in 1900 (Sutch, 1966:102).

2. As from the 1880s the electoral system had incorporated a 'country quota', which by adding an imaginary 25 percent to the rural population when electoral boundaries were defined, gave country dwellers an equivalent extra amount of political representation (Sinclair, 1980:209; Oliver, 1960:159).

3. For details see Sutch, 1966:97-8; Sinclair, 1980:192; Brooking, 1981:226; Oliver, 1960:154.

4. By 1901 the North Island had overtaken the South Island both in population and goods production (Oliver, 1960:150).

5. It has proved impossible to quantify the changing costs of medical technology. However, Mr. Bates, Treasurer of the Palmerston Hospital Board (pers. comm., 9 April 1985) states that not only did (and have) real costs of technology grow(n) but that increasing specialisation in medicine has necessitated expensive services expansion.

POUNDS AND PRINCIPLES.

PAYING FOR CARE

(c. 1910 – c. 1935).

4

CHAPTER 4

POUNDS AND PRINCIPLES: PAYING FOR CARE (c.1910-c.1935)

Whilst processes within the community were apparently driving towards the decommodification of health care provision, various actors endeavoured to ensure the continued place of medicine within the sphere of commodity relations. The nature of those endeavours proved to be contradictory, for as personal payment for medical services moved further from the grasp of many people and as public pressure for collective systems of medical care provision mounted, the providers of care were motivated to seek some means which would preserve the exchange character of the relationships between doctor and patient. Just as the consumers of care moved towards collectivism, so a variety of interactions saw providers drawn towards serious consideration of large-scale insurance-type relations.

Rating demands upon the public contributed to growing feelings that public hospital services ought to be available free (or at little charge) to all. This feeling, and its observable consequences, emerged in the form of a conflict between honorary doctors - who worked for no payment in public hospitals - and hospital boards. The 'honoraries', finding that they were treating many people who could well afford private care, demanded that income limitations be placed upon public hospital patients by hospital boards. Supported in their stand by the Department of Health, the boards did not concede to the doctors' demands and eventually many hospital boards resolved to employ only full-time salaried officers - that is, they 'closed' their hospitals to honorary practitioners. New problems emerged however and the 'closed' hospitals were perceived as having detrimental effects upon overall standards of medical practice within the community. Difficulties between doctors and hospital boards led both groups, plus the Department of Health, to consider the entire issue of hospital staffing and payment for services. The attention of all three bodies was caught by a suggestion that pay wards be introduced to public hospitals. This motion was lent additional credence by two important American visitors. The pay ward proposal was transformed into one in which patients were to be subdivided into three categories. Categorisation was to be reflected by patient payment and by the extent of patient choice of

doctor. Although elements of this three tier proposal remain to this day, the specific scheme faded into obscurity largely because its advocates held different conceptions of its character.

Another bid to preserve patient payment was made by hospital boards in the wake of WWI. Many hospital boards entered into special arrangements with lodges such that contributors to friendly society medical schemes would receive discounted hospital treatment. In return, the societies were to make regular payments to the hospital boards. Thus, boards received some financial compensation for providing treatment to those who might otherwise have experienced difficulty in paying for care, whilst, at the same time, patients were able to avoid any stigma associated with charity care. So attractive were these arrangements to the hospital boards that there emerged wide-spread suggestions that they be introduced on a national scale.

By the 1930s doctors' income-earning potential had been so severely eroded through numerous influences that members of the BMA felt moved to commence consideration of some form of nationwide insurance scheme which would facilitate patient payment for practitioners' services. The move was also sparked by the apparent inevitability of a State service being established and the consequent desire amongst doctors to pre-empt anything which might prove disadvantageous to the medical profession.

No Place for Honour: Closing Hospitals

Although doctors and friendly societies maintained their mutual distrust of one another during the 1920s, the attention of the BMA appears to have been directed at the relations between its members and the administrators and patients of public hospitals. Bolitho (1979: 6-7) considers that the medical profession had three major and genuine grievances with respect to hospitals. First, doctors were unhappy about the conditions of appointment of medical staff to hospitals. Second, they expressed concern about the role of hospitals as charitable insitutions and, third, they were dissatisfied with the systems of administration which were perceived as being both inefficient and parochial. The objections of the medical profession to conditions of appointment and the role of hospitals as charitable institutions stemmed from the doctors' place within a system which saw

their selection to serve at local hospitals on an unpaid honorary basis:

> "Some hospital boards used the patronage which the power to appoint honoraries gave them in a capricious and arbitrary way. Other boards may have used this power to control and discipline the local doctors. This was done by appointing doctors to the hospital staff and then failing to reappoint them after one or two terms, these doctors might then be reappointed after an interval of one or two years, or ten, or not at all...Boards seemingly paid no attention to the qualifications or experience of candidates for honorary appointments. Such actions could not fail to worsen the relations between organised medicine and the hospital boards. (Bolitho, 1979: 8).

Selection by a hospital board to work in an honorary capacity bestowed upon the chosen doctor some degree of social distinction, often proving valuable to any private practice in which he/she engaged. It also worked to the doctors' advantage:

> "by virtue of the fact that he could divert patients from the public hospital into his own" (NZMJ, 1924: XXIII, 503-4).

The service provided by an honorary physician was established to assist only the indigent, but as the hospitals grew in public favour so grew the number of patients whom the honoraries knew could full well pay for private treatment (NZMJ, 1934: XXXIII, 177, 264; Bolitho, 1979: 6). Doctors often exerted quite unprofessional pressure upon patients in order to persuade them to seek care in private hospitals:

> "In many cases doctors diverted patients from public hospitals into private hospitals by bullying and other means, and...they used undue influence to draft patients into private hospitals when they expressed the wish to go into the public hospital." (NZMJ, 1924: XXIII, 118, 504).

Despite the doctors' actions and the fact that many medical practitioners' livelihoods were being threatened under existing arrangements, the hospital boards refused to restrict the classes of patients they chose to have treated. This unwillingness on the part of local hospital boards to bow to the wishes to their doctors arose primarily through the 'logic' of local body politics. Hospital board members had been elected by ratepayers since 1910 (N.Z. Department of Health, 1969: 12) and were certainly aware that over time there had become established a notion amongst the public that the payment of rates entitled one to free treatment at public hospitals. Any hospital board choosing to become more restrictive with respect to admission procedures would have risked losing both the money and the votes of

local ratepayers. The stand of the hospital boards was however supported by a statement emanating from the Department of Public Health in 1914. In response to a resolution by the New Zealand Farmers' Union that legislation be changed so that:

> "...all persons if they desire can claim admission by right to the publich (sic) Hospitals during time of illness and so do away with the stigma of receiving charity even when they pay the fees charged by the Board", (Provincial Secretary, New Zealand Farmers' Union, Southland District to Minister of Public Health, 4 June 1914 cited in N.Z. Government, 1975: 39)

the Department of Public Health concluded:

> "The law at present is that any person is entitled to admission to a Public Hospital provided he undertakes to pay certain fees not exceeding the costs of maintenance...The whole question seems to be whether it would be inconsistent with the Act that a bylaw should be made, prohibiting persons above a certain income from using the hospital or in any way restricting the right of persons to admission. I [Chief Clerk] don't think such a provision has ever been inserted in a bylaw, and therefore, if a person undertakes to pay the fees as laid down in the bylaws he could not be excluded..." (Chief Clerk to Chief Health Officer, 11 June 1914 cited in N.Z. Government, 1975: 40).

By means of their admission policies then, hospital boards were able to limit the incomes of general practitioners through the provision of free or subsidised in - and out-patient services, and to curtail the activities and income earning potential of surgical specialists (Bolitho, 1979: 10).

> "Over most of New Zealand the density of population was such that there was insufficient work to support specialist surgeons and physicians who were perforce compelled to work as general practitioners and to carry out specialist work as they could get. Public hospitals could seriously affect the income of these men by admitting patients for specialist treatment (usually surgical) which would otherwise have been carried out in a private hospital." (Bolitho, 1979: 10).

Over time, these factors, in combination with the decreasing popularity of private hospitals (AJHR, 1924: H-31, 5), put greater pressure upon public sector administrators to admit and/or treat all who presented themselves (Bolitho, 1979: 10-1). A classic, but little noted, example of doctor-hospital-patient confrontation surfaced in Palmerston North during June, 1923. Suffering from a case of appendicitis, Miss Jessie Bryce of Kiwitea was admitted to Palmerston North Hospital for surgery on the recommendation of a Dr. Cameron of Feilding. This followed an initial refusal of admission by Dr. E.C. Barnett - an

honorary surgeon at the hospital. As it turned out Jessie came under the care of Dr. Barnett, it being his week of duty. Jessie was examined by Barnett but he refused to operate on the grounds that he did not consider the case urgent - despite the admission order granted by Dr. Cameron - and, more importantly, because Miss Bryce's father, John Joseph Bryce, could afford to pay for private treatment of the condition. Accordingly, Jessie was discharged and operated on shortly afterwards by another doctor at a private hospital in Feilding. Mr. Bryce, who was a Kiwitea County Councillor and ex-member of the Palmerston North Hospital Board, was firmly opposed to the drafting of patients by members of the medical profession and, after some difficulty, succeeded in having a public enquiry of the case conducted (NZMJ, 1924: XXIII, 118, 500-1; NZMJ, 1934: XXXIII, 177, 204-5 and 264-6; Bolitho, 1979: 11).

> "It was the principle of the thing he [Bryce] was seeking to bring forward. His object was to bring about what he considered should be an alteration in matters affecting public hospitals generally. Briefly the hospital belonged to the public, and to his mind the public should have the right to use that institution. It was maintained and controlled out of public funds, and by what he called a class tax the ratepayer paid maintenance fees for the hospital...The hospital should be there for the use of the people who paid for it." (J.J. Bryce to J.P. Innes, Palmerston North Hospital Board reported in NZMJ, 1924: XXIII, 118, 502).

Views similar to Bryce's were widely held in the community, this being substantiated by the medical press (Bolitho, 1979: 12), but firm opposition was offered in the case by the BMA, Dr. Barnett, and other honorary physicians at the Enquiry. The end result was that John Bryce's stand of principle was vindicated by the Commissioner, although the suggestion was made that fees sufficient to cover the whole cost of treatment should be charged to those able to pay (NZMJ, 1934: XXXIII, 177, 266; Bolitho, 1979: 12). Despite the importance of this decision and the acknowledgement of its implications in the annual report of the Health Department (AJHR, 1925: H-31, 6), very little was achieved as the result of the Commissioner's decision. A resolution to implement his findings was placed before the 1924 Conference of the Hospital Boards Association only to be overwhelmingly defeated. Board members considered that if the Commissioner's decision was to be effected there would be no appreciable increase in revenue and that to charge such high fees as would be necessary would prevent some people from seeking required medical treatment (NZMJ, 1934: XXXIII, 177, 266). Any other action over this issue may also have been arrested by the existence of feelings during the period 1921-32 that some form of

major revision was soon to occur in the organisation of hospitals, thereby heralding new arrangements governing patient admissions and a new age of co-operation between the agencies involved in hospital administration. Responsibility for the emergence of this belief can largely be attributed to the development of another point of contention between hospital boards and doctors.

In view of the facts that the honorary system proved unfair to many doctors and that it is was also poorly regarded by some hospital boards because of the lack of administrative control it engendered over those who were considered to be board staff (AJHR, 1925: H-31, 7; NZMJ, 1934: XXXIII, 178, 356) some boards opted to solve the problem by 'closing' their hospital(s) (Bolitho, 1979: 12). Only salaried, full-time doctors were employed in 'closed' hospitals, with local private practitioners being excluded from service (AJHR, 1925: H-31, 7; NZMJ, 1937: XXXVI, 192, 98). Although this solution rid hospital boards of the problems associated with the honorary system it more than adequately compensated with problems of its own. The hospitals' medical officers had to carry a considerable administrative burden as well as dealing with a wide variety of medical specialties. Because allopathic medical practice of the time was subject to considerable change (AJHR, 1924: H-31, 5; NZMJ, 1926: XXV, 126, 106) and because hospitals normally employed only a few doctors, it was quite improbable that hospital doctors could provide patients with the best locally available care in all medical specialties (NZMJ, 1926: XXV, 126, 106; NZMJ, 1937: XXXVI, 192, 98-9). Outside the hospitals the local doctors were restricted in the practice of their medical skills, particularly in surgery. The stipendiary doctors had too great a variety of work to do, whilst the private practitioners had too little. Further promoting the decline of medical practice which the 'closed' hospital system appeared to sustain was the professional isolation of doctors which developed:

> "In towns where the hospital operated as a 'closed hospital' it was not uncommon for the full-time medical staff and the local medical practitioners to be split into almost exclusive groups with little or no consultation between the two, either over general matters or over individual patients." (Bolitho, 1979: 13).

Such a situation was hardly conducive to the provision of top quality medical treatment to members of the community - particularly in the private arena. It is also of note that under such conditions, and

despite the excessive workloads upon the public hospitals' stipendiary doctors, the public became increasingly aware that the best medical care in the community was to be obtained at public hospitals, for it was in these establishments that the best equipment and greatest range of medical experience, especially in more complicated procedures, was to be found (NZMJ, 1934: XXXIII, 177, 264). However, in conjunction with the decreasing ability, and increasing reluctance, of many patients to meet the costs of care, the mounting pressure upon public hospital facilities and staff proved to be a problem for the hospital boards. It was at this stage that doctors, hospital boards and the Department of Health - which sought a more rational approach to hospital staffing and a reduction in the number of hospital boards for reasons of efficiency - began to liaise in order to consider methods by which they might surmount their mutual difficulties (Bolitho, 1979: 14; NZMJ, 1934: XXXIII, 178, 354).

Pay Wards Perhaps?

In searching for a solution to their problems, the attentions of the BMA, the hospital boards and the Department of Health were caught by the notion of pay wards in public hospitals. This appealed especially to members of the BMA who accepted pay wards as a policy worthy of implementation during their 1920 annual conference (Bolitho, 1979: 14; NZMJ, 1934: XXXIII, 178, 354). The subsequent support of the BMA for pay wards stemmed from the Association's recognition of the "need for better medical care for those able to pay for public services" (N.Z. Government, 1975: 40). The BMA's proposals for pay wards sprang more obviously from the work of one of its committees set up in 1920 to consider a National Medical Service. This committee had itself been established in response to the fact that during WWI there had emerged such difficulties in reconciling civilian needs, public and private, with military needs that the question of organising the profession on the basis of a national service was mooted. Although the war passed without any action on this front the idea had taken root, being also fostered by certain contract practice disputes and beliefs held by some of the profession that National Insurance and a State Medical Service might be introduced (NZMJ, 1934: XXXIII, 177, 267). BMA pay-ward proposals included the following points:

'98.1 Provision of a building in or near the grounds of the

general hospital where private patients could be treated.

98.2 Patients in such a building would be charged maintenance fees in accordance with the room provided for them, and its location, aspect etc.

98.3 Patients should be able to select their own doctor.

98.4 Fees paid for nursing attendance would be on the private hospital scale.

98.5 The fees paid to the doctor would be a matter between him and his patients.

98.6 Profits arising from such a venture would be used in the finance of the general hospital." (N.Z. Branch of the BMA, 1920: Interim Report of the Committee on National Medical Service, cited in N.Z. Government, 1975: 40).

The pay ward system was seen by its advocates as one which would allow satisfaction of the wishes of administrators involved in the provision of health services by facilitating a continuation of the charitable functions undertaken by hospital boards; it would allow the perpetuation of the honorary system of hospital staffing; and would release many doctors from having to treat non-indigent patients for little or no charge in public hospitals. Accordingly, proposals to introduce pay wards tended to dominate the discussions between hospital boards, the Department of Health, and the medical profession during the 1920s and 1930s. Just one year after the BMA's stated support for the scheme, the Hospitals Commission (1921) recommended the introduction of pay wards (N.Z. Government, 1975: 40; Bolitho, 1979: 14). The general proposals advocated by both the BMA and the Hospitals Commission were supported by visiting United States experts on hospital management. These men, Dr. F.H. Martin and Dr. M.T. MacEachern, represented the American College of Surgeons in the capacities of Director-General and Director of Hospital Activities respectively (N.Z. Government, 1975: 40-1). Their visit, prompted by the BMA, and subsidised and encouraged by the Government, brought them to the first Round Table Conference on Hospital Policy from which emerged advocacy for 'community' hospitals similar to those operating in North America at the time (Bolitho, 1979: 14). It is scarcely surprising that the arguments of MacEachern, who was primarily responsible for a report submitted to the Conference, favoured community hospitals, as it was this system of provision he had experienced most personally and from which he had undoubtedly benefitted occupationally and financially. Community hospitals were characterised by the presence of private wards as an integral part of 'public' hospitals. American community

hospitals simply embodied those concepts already deemed worthy of promotion in New Zealand by the BMA and the Hospitals Commission. However, the supporters of pay wards now had the backing of overseas 'experts'.

Under the community hospital system it was proposed to subdivide patients into three classes on the basis of income (Bolitho, 1979: 14-5; NZMJ, 1934: XXXIII, 178, 354):

> "Class III patients would pay full rates, both for their accommodation and their treatment, they would be admitted to be treated only by the doctor of their own choice and the fee for medical attention would be a private matter between the patient and his doctor. The wards accommodating Class III patients would be under the control of the Medical Superintendent of the hospital but neither the Superintendent, nor the residential staff, nor any of the part-time stipendiary staff were to undertake any treatment of these patients. Those patients who could afford to pay only accommodation fees were to be accommodated in public wards and attended by part-time stipendiary staff appointed from among suitable local medical practitioners. These were Class II patients. Class I patients, who could not pay anything were to be accommodated in the same ward and treated under the same arrangements as Class II patients." (Bolitho, 1979: 14-5).

As an aside, it is interesting to observe the transposition of labels, reversing the usual positions of the first and third classes! It was envisaged that under the community hospitals scheme the State would be the medium through which the capital costs of constructing appropriate wards for Class III patients would be met. The means by which the proposed system was to solve the problems which had been encountered by hospital boards, the Department of Health, and the medical profession was adequately and succinctly outlined by J.P.S. Jamieson in 1934:

> "The objects lying behind these proposals were to make the facilities of the public hospitals available to all classes of the community without dislocating the traditional relationship of the private medical practitioner to his patient, and at the same time to centre the interests of the profession in the hospital, spreading the opportunities of hospital work as widely as compatible with efficiency among members in the locality; also to remove the anomaly of honorary staffs attending well to do patients on the basis of charity, and to do away with the system obtaining in the lesser hospitals in many parts whereby practically all of the work of a district came into the hands of one whole time medical officer, with perhaps a small junior staff and finally, to promote cooperation between private medical practitioners and the local hospital authorities, central and local, who have been drifting steadily apart with the transition from voluntary to state and rate hospitals." (Jamieson cited in Bolitho, 1979: 15).

Although the BMA's proposals seem to represent a meritorious endeavour to remedy various problems, there emerge two major points of interest. First, the system Jamieson discusses is likely to have come as a death blow to small public hospitals for, under its provisions, doctors, particularly specialists, would have been wise to set up practice in areas of large population near the biggest hospitals. Here, they would have had a large base from which to draw Class III custom. In addition, large hospitals were (are) more likely to possess a greater range of medical resources than small hospitals, thereby attracting both patients and practitioners. Small hospitals could only provide a limited range of medical resources and were situated in less populous areas. Overall, there would surely have been a steady movement of patients, staff, and other resources to the larger hospitals in more populous areas. Second, the community hospitals system would have proved a useful mechanism for the pecuniary gain of members of the medical profession:

> "In essence it would have provided him [the doctor] with a state subsidised workplace whilst leaving him free to set charges for the well to do members of the sick community without any community control." (Bolitho, 1979: 15).

These two points however did not underlie the eventual demise of the community hospitals proposal. This, in fact, arose from concerns within the Department of Health that any change to existing organisational characteristics should not create an additional drain on the nations precarious financial resources (AJHR, 1925: H-31, 7), something which would inevitably have occurred under the terms of the BMA's scheme. An explicit requirement of the Health Department was that private patients should pay for treatment and contribute to the costs of hospital construction (NZMJ, 1934: XXXIII, 178, 355-6). This would have kept all but the most wealthy away from the Class III wards of any public hospital (Bolitho, 1979: 16-7). Thus, although the Department of Health thought community hospitals a good idea, its conception of their nature differed from that held by the BMA. The hospital boards took a third view of community hospitals. Their attitudes stemmed, in part, from the belief that the:

> "medical staff of a hospital are as much the employees of the institution as are the nurses, engineers, clerks, or any other employee" (Chairman, Hospital Boards' Association cited in NZMJ, 1934: XXXIII, 178, 356).

Very briefly, hospital boards considered that public hospitals were

primarily for the use of the indigent but that any spare beds could be made available to private patients who were permitted to make their own arrangements with their personal medical practitioner (Bolitho, 1979: 17).

Throughout the 1920s then the BMA, the Health Department, and the Hospital Boards advocated the community hospital concept. Their impressions of its nature were irreconcilably different however (NZMJ, 1934: XXXIII, 178, 355). Nevertheless, in March 1930, representatives of the three groups met at the Second Round Table Conference on the Hospital Service and produced a list of ten definitive principles to regulate hospital admissions (AJHR, 1930: H-31, 29; NZMJ, 1934: XXXIII, 178, 363; Bolitho, 1979: 19; N.Z. Government, 1975: 41), these being shown at Appendix Two. The principles drawn up at this meeting would have proved extremely difficult to work in a practical situation for many of the points appear to have been likely to promote considerable conflict between doctors and hospital boards. However, the national economic situation of the time was such that the Government was more concerned with the problems of unemployment and trade deficits. Accordingly, and in view of the fact that the adoption of the proposals would have involved "very radical departures form the present practice" (AJHR, 1930: H-31, 29), no action was taken in the matter.

A Change of Scale? Hospitals, Lodges and Insurance

For a variety of reasons hospital boards became strongly motivated to investigate schemes facilitating the provision of, and payment for, medical care to the poorer and less fortunate members of the community. After WWI it was decided that the control of sick and wounded soldiers - discharged or still serving - by the Department of Health would cease and that responsibility would be assumed by the Defence Department (H1: 54 33). In effect, hospital boards would continue to treat servicemen suffering from war related complaints but payment would be met by the Defence Department or the Pensions Department (H1: 54 33). In practice this simple scheme frequently proved unsatisfactory to hospital boards for, on occasion, the weekly post-treatment claims would not be met by the Defence or the Pensions Departments if it was considered by the appropriate Department that the injury or illness had not been caused or aggravated by war service (H1: 54 33). At times

the refusal of Hospital Board claims by these Departments seemed to defy reason. An example was the case of Edmund S. Brewster. Suffering from lymphangitis of the legs, apparently due to active service, Brewster had been treated by the Southland Hospital Board over the period July-October 1931. At the time of treatment his application for a war pension was under consideration by the Pensions Department. Eventually Brewster was granted a pension, effective from only September 1932, and accordingly the Pensions Department notified the Southland Hospital Board that the Department could not accept responsibility for Brewster's hospital treatment (H1: 54 33). The absurdity of the situation is readily apparent, for the Pensions Department had granted Brewster a pension on the basis of his war injury but failed to accept responsibility for the medical treatment of exactly the same affliction. Such post-war problems, which continued into the 1930s, meant that hospital boards were often forced to bear the expense of treating servicemen. As one would expect, the hospital boards of New Zealand were thus provided with an incentive to lend consideration to any scheme which would prevent such incidents. An additional motive was the growing inability of many patients to meet the full costs of hospital treatment. In part, this had eventuated from the increasingly expensive technology of medical care but it had also arisen from the depressed nature of the economy and the general expenses which confronted all hospital boards:

> "From 1914-15 to 1925-26 hospital building expenditure had gone up 350 per cent, and the cost of construction had increased 52 per cent since the war; in the same period of 11 years maintenance costs had increased 129 per cent..." (Dominion, 3 February 1928).

Escalating costs, plus the fact that it was still "both a legal and moral obligation for persons or their relatives, if able, to pay full hospital fees." (Draft circular to Hospital Boards from Secretary of Public Health, Hospitals and Charitable Aid, 27 June 1918 in H1 B107 149) drove both the hospital boards and the public to consider means by which provision could be made for the payment of hospital charges. The friendly society movement appeared to offer the greatest benefits, although lodges could not cater for the whole community because their requirements for regular monetary contributions precluded many of the irregularly employed and poor from membership. Nevertheless, by the mid 1910s many hospital boards had entered into arrangements with friendly societies whereby special accommodation and medical concessions were offered by the boards to society members. For example, the Wairoa and Coromandel Hospital Boards offered free

treatment at the time of use to friendly society members on payment of five shillings and one pound respectively per annum. The Patea Hospital Board reduced maintenance fees from 6s. to 4s. 6d. per day for lodge members (H1: B.107 149). By 1918 such contracts existed in more than half of the hospital board districts of New Zealand (H1: B.107 149). The nature of the contracts varied considerably from one board district to another, and as a result of interdistrict discrepancies and because of the growing difficulties faced by hospital boards in receiving payment from non-lodge members for services rendered, some efforts were made to institute a comprehensive and cohesive scheme applicable to all boards and lodges. The approximate average weekly cost for any occupied bed in the Dominion was two pounds two shillings and it was suggested in a memorandum (dated 23 May 1918) from the Secretary of Public Health, Hospitals and Charitable Aid to the Minister of Public Health that arrangements be made to offer all friendly society members a 28s. discount on this fee (H1: B.107 149). The Secretary went on to outline his fundamental reason for this proposal:

> "I thing the Boards would benefit by such an arrangement, it being remembered that members of the Friendly Societies though doubtless a provident type of person, yet, generally speaking, are members of the less affluent classes, and it is doubtful if Hospital Boards would recoup under ordinary conditions two-thirds of their ordinary maintenance charges if such Friendly Societies Members had to pay their own fees, bearing in mind that only one-third of their fees receivable are recovered annually by Hospital Boards." (H1: B.107 149).

An underlying hope apparent from this statement was that State-lodge co-operation would make friendly societies more attractive and thereby expand that proportion of the population capable of making sizeable contributions towards the payment of any hopsital expenses they incurred. In effect, the scheme was a rudimentary form of non-compulsory, nationwide, State backed hospital insurance. Despite the appeal of this proposal to hospital boards, the Department of Health and the friendly societies, the scheme appears to have unaccountably faded into obscurity for some years. However, the issue of State-lodge relations re-emerged in 1925 and was marked by the advocacy of Dr. T.H.A. Valintine, the Director-General of Health - with his Minister's approval - for the adoption of a collective health scheme of sorts:

> "...Hospital Fees [should be] placed on some better footing,

> possibly more or less in the nature of an insurance scheme or universal tax, several modifications of which are at present being considered in other Dominions, so as to spread more equitably over the whole community the cost of Hospital treatment, which at present is borne to an extent of more than half by the ratepayers alone." (T.H.A. Valintine to Secretary, North Canterbury Hospital Board, 29 January 1923 in H1: B.107 149).

Any such scheme, if implemented, would not only have satisfied Valintine's apparent desire for social justice but, quite obviously, would also have strengthened his occupational domain through the enhancement of the financial status of many hospital boards. Extending the scope of the friendly society movement was but one of the methods suggested to facilitate the provision of medical assistance in a manner consistent with existing modes of exchange. Other methods were also proposed, these tending to revolve around the principle of insurance. At the 1924 Annual Conference of Hospital Boards a National Health Insurance Scheme was extensively discussed with the resolution emerging that some kind of contributory scheme should be introduced (Lovell-Smith, 1966: 19). Despite their intial resolve, the hospital boards appear to have engaged in very little direct action over the next few years to achieve the implementation of such a scheme, although they did make intermittent investigations (Hanson, 1980: 28). The matter was again raised at the Hospital Boards' Annual Conference of 1929. On this occasion a firmer resolution was passed urging the executive to enquire into the practicability and advisability of encouraging a compulsory insurance scheme for free treatment of wage earners and their dependants (Lovell-Smith, 1966: 19; Bolitho, 1979: 21). At the next meeting of the executive a preliminary report presented by the President and Secretary was considered and it was decided to collect and evaluate detailed information on overseas contributing insurance schemes. This occurred in December 1930 and it was perceived that many schemes, particularly that operating in England, had been most successful and had also provided a major source of revenue to participant hospitals (Lovell-Smith, 1966: 19-20). However, as the schemes examined by the executive operated in densely populated industrial regions it was thought that they might not be entirely applicable to the New Zealand scene, marked, as it was, by scattered communities and sparsely populated areas. The nature of New Zealand's settlement pattern would have necessitated the establishment of some considerable administrative machinery to regulate hospital benefits. As a result, the executive formed the opinion that justification for such a scale of administration could only be provided if all medical expenses were covered by a compulsory scheme (Executive

of the Hospital Boards' Association, 1934 cited in Lovell-Smith, 1966: 20).

Preserving Profession and Payment

While wrangling was underway in the hospital system to devise a scheme through which the medical profession, the hospital boards and the Department of Health could each further their own interests, activity was also occurring with respect to the provision of physicians' services to those people who experienced difficulties paying doctors' fees.

From the standpoint of the BMA there existed a number of factors encouraging action. First, the increasing technology associated with medical care raised the costs of medical care to levels which very many members of the community found difficult, if not impossible, to pay. This is adequately illustrated by Dr. E.S. Stubbs:

> "in relation to modern costs, the majority of our artisan and middle classes are also poor. Some at times cannot pay in full for attendance needed; others pay, but do so with undue difficulty and hardship. In a case that came under my notice, a man had paid for three serious illnesses in his family within three years; he told me he had thereby dissipated the whole savings of the previous twenty-five years." (NZMJ, 1933: XXXII, 169, 171).

Quite obviously this sort of situation had serious repercussions for the state of health and welfare within the community - both of these being concerns of the medical profession. Second, the problems of payment which many people experienced intensified during the Depression years of the late 1920s and early 1930s and, in consequence, doctors' incomes fell drastically (Blanc, 1949: 18; Bolitho, 1979: 24). Indeed, the editor of the New Zealand Medical Journal stated in 1934 that as few as ten per cent of patients were paying full fees (cited in Bolitho, 1979: 24). Assuming this to be true, doctors certainly had a strong incentive to consider or promote any scheme which might restore the fee-paying potential of their patients. Third, doctors were concerned that the Government would create a State medical service with little regard of its consequences for the profession. The option open then for the doctors was to pre-empt Government action by recommending a scheme of their own:

> "We must choose a scheme of contributory insurance which we may help to formulate, or a distasteful scheme forced on the profession, or a poor law medical service, or free treatment by medical practitioners of all who cannot pay for medical attention." (NZMJ, October 1932 cited in NZMJ, 1933: XXXII, 169, 171).

This attitude that the BMA should act promptly in order to avoid a scheme which might prove undesirable to physicians was confirmed in 1933 by Mr. Sommerville Hastings when speaking of the New Zealand situation whilst in London:

> "Some form of State service is inevitable. If the profession waits and does nothing, the politicians will force on it some incomplete scheme...The alternative is to be aware of what is coming, and to endeavour to mould public opinion, so that when the change is made a service can be formulated advantageous alike to the profession, to the science of medicine, and to the public." (NZMJ, 1933: XXXII, 169, 171).

It is interesting to note the necessity to 'mould public opinion'. Presumably, any scheme to be formulated by the medical profession would have contained benefits which might not have been immediately apparent to the general public! Finally, the medical profession continued to experience difficulties with the lodge system.

The problems facing the BMA and those confronting the Hospital Boards brought the two groups together to formulate a solution. In December 1933, the Executive of the Hospital Boards' Association conferred with several medical practitioners and there emerged a sub-committee comprising three prominent members of the BMA and three of the Hospital Boards' Executive to report on the suggested 'insurance' scheme. The final report of the combined sub-committee recommended that a limited, compulsory, contributory scheme of national health insurance be introduced. In return for their contributions employed persons between the ages of 16 and 65 earning low incomes (and their dependants) would be eligible for free general practitioner service, hospital treatment and pharmaceuticals, as well as laboratory, dental, specialist and opthalmic services. To administer the benefits it was suggested that the existing machinery of the Health Department and Hospital Boards would be suitable on general and local scales respectively. It was also estimated that total community expenditure on the scheme would amount to 1.75 million pounds per annum (Lovell-Smith, 1966: 20-2; Hanson, 1980: 28; Bolitho, 1979: 22). These were the first detailed suggestions for a health insurance scheme in New Zealand. The joint committee's report appeared at a time when various individuals and

groups within the community were expressing great interest in some form of insurance, and many saw it as a practical expression of their aims (Hanson, 1980: 28).

The sub-committee's report and proposals were placed before the biennial conference of the BMA on 26 February 1935 at Dunedin. Here the suggestions were accepted as the basis of future policy and a number of resolutions were passed including one which established the BMA's National Health Insurance Investigation Committee (NHIIC) and one which indicated the Association's willingness to co-operate with the Government in formulating a scheme of national insurance (Lovell-Smith, 1966: 24; Bolitho, 1979: 23). From the general tenor of the resolutions, in combination with the nature of the latter, one can see that the medical profession, perhaps justifiably, saw itself as having a guiding role to play in any reorganisation of the nation's health services. Members of the BMA also considered that by mounting their own investigation they would be able to formulate a scheme which would be "advantageous...to the profession" (NZMJ, 1933: XXXII, 169, 171). To facilitate the Association's enquiries, its Council requested each provisional and regional Division to appoint a representative to serve on the NHIIC. This committee was set up in the light of realisations that members of the New Zealand medical profession were insufficiently informed on the important issue of national health insurance and that it would be difficult for separate Divisions to arrive at stable conclusions (Lovell-Smith, 1966: 24). There was perhaps also a worry that the Divisions would have reached conclusions incompatible with those which the Council perceived as being in the long term interests of the entire profession. The formation of the NHIIC represented an initial, decisive effort by doctors in New Zealand to achieve strength and unity in an issue which would markedly shape the future of medical activity in New Zealand.

The medical profession had been moved to its consideration of a health insurance scheme somewhat reluctantly (Bolitho, 1979: 24-6). The inability of many patients to pay for medical care; falling medical incomes; problems faced by doctors with regard to lodges; and political moves towards some form of collective provision of health care had conditioned the situation in which doctors now found themselves. Similar motivating factors had also led the hospital boards and political parties to consider health insurance of some type. All of these groups acted in a mutually persuasive manner. Each goaded

the others on along the path towards something popularly imagined to be a nationwide health insurance system. There was no single event or moment which initiated this move to insurance despite popular views that the Great Depression inspired social welfare action.

The first three decades of the twentieth century bore witness to efforts to decommodify medical practice and also to efforts to maintain the exchange character of medical relationships. These moves were usually inadvertant - the product of human action to achieve certain ends within the social milieu. Nevertheless, they saw medicine inexorably drawn towards the well-documented conjuncture of the mid 1930s. Overt conflict in the domain of the State then occurred over the place of medicine as a commodity relation. It is with this conjuncture that Chapter 5 deals.

DEGREES OF FREEDOM

(c. 1935 – c. 1942).

5

CHAPTER 5

DEGREES OF FREEDOM (c.1935-c.1942)

The period 1935-42 was marked by the end of the Great Depression and by the crystallisation of conflict between those agencies stressing the decommodification of medicine and those promoting the continued exchange character of doctor-patient relations. Clashes involving the State eventuated, with the newly elected Labour Government pushing against the medical profession towards socialised medical practice. Individuals within these groups - Government and doctors - gave expression to antagonistic forces within society and conditioned the character of those forces. The Social Security Act 1938, which was eventually to emerge, was not simply the outcome of struggle between Government and doctors. It was instead the product of decades of interactions which had inexorably drawn those providing and seeking medical services to a point of overt dissension from which the Act arose.

It is interesting to observe that in the midst of Depression, there was considerable investment, mediated by the State, in the secondary circuit of capital. Shortly after the worst social consequences of the Depression had passed, public demands saw extensive moves made towards tertiary circuit investment, especially in superannuation and health care areas. Whilst such activity was to be of great benefit to the working classes who pressed for it, there is little doubt that there existed benefits for others.

Such were the pressures within the community for some form of collective health care scheme that even before the election of 1935, the Coalition Government had conducted inquiries into health insurance. The fruit of these investigations were removed however when the Coalition was ousted from power. After Labour's election success on 27 November 1935 (Wilkes and Shirley, 1984:291; Sinclair, 1980:269; Social Security Department, 1950:35) with a manifesto giving prominence to the introduction of national superannuation and a free medical service (Grant, 1980:142) the BMA selected J.P.S. Jamieson to be its leader in health insurance negotiations. Jamieson's strong personality, in conflict with those of the Labour politicians who

became most closely embroiled in the social security debate, was to have considerable bearing upon the shapes of negotiations and outcomes. Issues were not solely ones of principle and economics but also of character and compatibility. Within the Labour Government were Dr. McMillan and Rev. Nordmeyer, both of whom had had extensive local involvement with contract medical practice modified from overseas schemes. At this time the personal experience of these men gave substance to trade union aspirations and provided much of the basis for Labour Party thinking on a community health care system. The experience of Nordmeyer and McMillan conditioned Labour's (people and party) possibilities of action in this issue at least as much as any other constraint. At the first Government - BMA meeting the country's doctors outlined 'Ten Principles' under which they were prepared to work and Peter Fraser assured them that the BMA would be allowed some input in the shaping of health care legislation. However, the 'lack' of consideration given to the medical profession when the Government eventually set up its insurance investigation committees incensed the BMA which, under Jamieson's direction, immediately began a campaign of unification and resistance. Initial Government hearings on a scheme of collective care revealed widespread support for any kind of system which would reduce or remove the financial barriers between patients and appropriate care. The only opposition came from doctors who proposed a highly unpopular four-tier system which required means testing of patients and payment for medical services in accord with income. The Government's Health Insurance Investigation Committee eventually produced a report which strongly bore the stamp of Dr. McMillan and which subsequently formed the basis of the Social Security Act 1938. In the meantime, Sir Henry Brackenbury - Vice President of the BMA - arrived in New Zealand at the request of the BMA (N.Z. Branch). His attitudes towards the doctor-patient relationship were to confound Jamieson who, nevertheless, successfully silenced most of that which did not suit the interests of the BMA (N.Z. Branch). After Sir Henry had departed, Government-doctor relations broke down completely - in large part due to a natural antipathy between Nash and Jamieson. Some time later, and after considerable work, Nash and Fraser presented Cabinet with proposals for a contributory health scheme. Although these two men had backed away from their socialist principles for a variety of reasons, an irate Cabinet maintained its strong support for a system funded through taxes only. The proposals made by Nash and Fraser had arisen in the midst of certain relationships which had imposed peculiar restrictions. Now, new

relations provided further, different limitations. In consequence, a new set of proposals was formulated and made public by Savage. These met with great acclaim although there was some scepticism of the financial feasibility of the scheme. At ensuing Select Committee hearings came continued support from all interested parties except the medical profession and when the Social Security Bill was drafted the doctors officially withdrew their co-operation. The Bill - still strongly reminiscent of McMillan's original suggestions - went to the House where a contextually hapless. Opposition could only criticise the proposal on actuarial bases. The Bill was passed into law in August 1938. In endeavouring to implement the provisions of the Social Security Act 1938, the Government faced further intransigence from the medical profession. As a result, only some of the benefits under the Act came into operation and did so slowly. No tactics could sway the medical profession to co-operate and, eventually, in the face of mounting public pressure for action, the Government proposed a system of doctor payment which proved satisfactory to the BMA's NHIC. Jamieson however considered this acceptance to be a loss and succeeded in changing the NHIC's decision! Government members were extremely upset and hardened their attitudes towards the doctors and in return the BMA resolved to disregard any government policy unless acceptable to the medical profession. Fraser, a long-time conciliator and well-liked by the doctors, stepped in and suggested that practitioners be entitled to charge a sum over and above the social security payment. Although Cabinet was unhappy, Fraser's view prevailed and a new general practitioners' payment scheme was introduced. In effect, the doctors had succeeded in their demands.

In the wake of the new provisions the lodges were concerned about the future of their medical schemes which were now much less attractive than in the past. Interactions between doctors, Government and the friendly societies, intended to produce a conclusion which would save lodge medical schemes, in fact ended with their decline and the virtual disappearance of lodges from the health care scene for several decades.

This chapter gives clear expression to a specific example of the way medical practice is moulded by contradictory human relations. Doctors endeavoured to preserve the commodity character of medicine, despite considerable pressures for relationships that de-emphasised the exchange character of the service. The Goverment-BMA clash was the:

> "specific material condensation of a relationship of forces among classes and class functions at a specific conjuncture." (Navarro, 1983a:189).

There is ample evidence too of the specific circumstances which gave various agents/agencies their power over one another. Conjunctural and structural limitations successively conditioned the relative influence of one individual/group over another.

An Alternative Future: The Coalition Plan

During their last days in power, the Coalition Government received an Interdepartmental Committee Report on National Compulsory Superannuation and Health Insurance (AJHR, 1935: H-30, 1; Hanson, 1980: 28; Fraser, 1984: 61; Sutch, 1971: 40). Set up in March 1935, the Committee was appointed by Government to investigate and report on both national compulsory contributory pensions and health insurance schemes (AJHR, 1935: H-30, 1; Lovell-Smith, 1966: 28). It is not entirely clear why this Committee was established although Hanson (1980: 28) suggests that it may have been the combined product of efforts to maintain electoral support, lessons learned from the Depression, and an ideological desire for a collective, contributory scheme. The Committee's Report, submitted to Government on 17 August, put forth conclusions similar to those of the joint Hospital Boards-BMA report presented earlier in the year. In the light of evidence arising from a review of existing and proposed health insurance schemes overseas it was considered that certain principles should shape any such system introduced into New Zealand. The guidelines were that any scheme should be:

> "(a) Compulsory:
> (b) Contributory:
> (c) No longer restricted to wage earners, but widened to include all those below a certain income-level:
> (d) Of a family character, medical benefits being provided for dependants of the insured:
> (e) Complete so far as medical care is concerned - general practitioner, hospital, specialist, maternity, dental, and other services being provided:
> (f) Separated from schemes for the provision of cash benefits."
> (AJHR, 1935: H-30, 12).

The scheme proposed by the Committee essentially adhered to these principles and allowed for the plight of the unemployed, suggesting that the Unemployment Fund might pay the insurance premium for this

section of the population (AJHR, 1935: H-30, 12). In essence, the Committee's Report suggested that for a sum not exceeding two pounds ten shillings per annum all wage and salary earners and those self employed people who chose to join the scheme would be entitled to medical and hospital benefits provided through an administrative system which was to bear the greatest possible resemblance to private practice. Comments in the Report with regard to administration are of interest and could perhaps have proved useful information to the Labour Party in its early dealings with the medical profession:

> "Medical opinion in English-speaking countries is strong on the point that insurance medical practice should follow closely the lines of private medical practice, and the following principles have found general acceptance:- (a) The right of every legally qualified doctor to undertake the medical care of persons under the scheme. (b) The freedom of choice as between physician and patient. (c) Effective participation of insurance physicians in the administration of the scheme. These principles can be readily agreed to. It is reasonable that the medical profession should as far as practicable, be made responsible for the quality of medical service and for the discipline of its own members. The experience of the United Kingdom in these respects, and the method of administration in that country, might well be taken as a guide." (AJHR, 1935: H-30, 13).

A number of points of interest arise from this brief extract. First, it is quite obvious that the Committee's assessment of National Health Insurance was strongly influenced by its members perceptions of schemes in operation overseas - particularly that of the United Kingdom. When one considers this matter in conjunction with the fact that the Committee was established to investigate a scheme of health insurance (as opposed to, say, health provision funded through taxes) it is quite obvious that its final proposals were of a virtually predetermined nature. A second point, and one which substantiates the first, has to do with the comment regarding the acceptability of a doctor-shaped health scheme. Whilst politicians overseas had evidently been prepared to give doctors primacy in policy-making on health matters it was soon to become apparent that many Labour Party members (and the public) could not , or would not, understand the demands voiced by doctors here in New Zealand. The nature of the Interdepartmental Committee's Report is of considerable interest for it provides great insight to the system of health care provision which might have come to fruition had the Coalition won the 1935 general election (Hanson, 1980: 29). Despite the fundamental differences in the funding of their respective schemes, Labour's eventual legislation and the Coalition's proposed course of

action had two important similarities. First, the aims of both schemes were virtually identical. Each Party sought to introduce a scheme which, in the "social interest" (AJHR, 1935: H-30, 3), would protect all citizens from the hazards of old age, sickness, orphanhood, and widowhood whilst avoiding any notion of charity. Second, and presumably in recognition of Depression experiences, the two schemes acknowledged that protection should be afforded to the entire community, not simply to sections of the population (Hanson, 1980: 30). It seems likely that the Coalition scheme could have been passed into law with less difficulty than was encountered by the Labour Party by virtue of the consideration expressed for the suppliers of medical care. The Labour plan, which was subsequently to be introduced, was conceived from the stand of the consumers of medical services (Condliffe, 1959: 305-6) whilst the Coalition plan appears to have given more weight to the opinions of the providers of those services. Leniency towards the doctors, coupled with the fact that their scheme would have provided the medical profession with the bad-debt prevention service it desired (Bolitho, 1979: 45) would undoubtedly have cleared the Coalition's path towards the amicable introduction of a nationwide, collective health scheme.

The Antagonists and their Champions

Just prior to the election of 1935 the medical profession was apprehensive about the possible introduction of some form of health insurance in New Zealand (Bolitho, 1979: 34) as indicated by its establishment of the National Health Insurance Committee (NHIC) and the arrangement by the Council of the BMA to meet with the Minister of Health in 1936 following the election (Lovell-Smith, 1966: 30). Because both main political parties advocated some form of collective health scheme the BMA considered that it should make itself available to offer assistance and guidance to whichever one assumed office. It appears then that by the mid-1930s the Association considered some form of contributory scheme to be almost inevitable and, accordingly, that any Minister of Health would be committed to the implementation of a health insurance scheme (Lovell-Smith, 1966: 30-1; Bolitho, 1979: 34).

In recognition of these factors the BMA set up its own Committee - the NHIC - with a very broad term of reference requiring it only to conduct

investigations on the question of insurance (BMA cited in Bolitho, 1979: 34-5). For purely practical reasons the composition of the NHIC closely resembled that of the Council of the BMA. Each Division of the Association was required to appoint a delegate to the NHIC who would travel to Wellington for meetings of that Committee. As the Council meetings were held on the same day as those of the NHIC it proved less expensive for Divisions to nominate a single delegate to represent them at both meetings (Bolitho, 1979: 35):

> "The National Health Insurance Committee thus represented a cross section of the leadership of the organised medical profession in New Zealand, being a miniature of the Council of the Branch and, one can assume, representative of those attending meetings of the Divisional Councils." (Bolitho, 1979: 35-6).

Bolitho (1974: 36-7) goes on to analyse the composition of the NHIC and finds that of those members who most frequently attended its meetings over the period 1935 to 1940 only 25 percent were general practitioners. In view of the fact that most of the debate with the Government was to focus on the general medical benefit payable to general practitioners it is interesting to note that the Committee was so unrepresentative of the 62 percent of the nation's doctors who were engaged in general practice. Of the few general practitioners who did serve on the Committee one who was to have an immense impact on the course of events was Dr. J.P.S. Jamieson. Although Dr. (later Sir Charles) Hercus presided over the first meeting of the NHIC, he noted that his duties as Dean of the Otago Medical School would prevent him from giving adequate time to his Committee position and also pointed out that a general practitioner would be a more appropriate chairman than an academic. Accordingly, he moved that Jamieson be appointed to fill the role (NHIC cited in Bolitho, 1979: 39; Lovell-Smith, 1966: 25). The motion was passed unanimously. There appear to have been other likely reasons for Jamieson's appointment (Bolitho, 1979: 39). He had recently had articles criticising the nation's health service published in the New Zealand Medical Journal (1); he was a born leader; and had a most dominant personality. The final factor favouring him was his deeply conservative nature which would serve as a foil to any anxiousness within the BMA to see some form of health insurance introduced. This latter characteristic was important, for although "the National Health Insurance Committee was ostensibly set up to negotiate with the Government, its main purpose was obstructive." (Lynch cited in Bolitho, 1979: 43). The combination of Jamieson's conservatism and tenacity with the professional composition of the NHIC

produced a Committee eminently suited to its role. The NHIC was to prove almost unshakable when the issue of a universal, free general practitioner service arose. Jamieson - the man who was to become the BMA's champion in its dealings with the Goliath of Government could probably not have been matched as an advocate by anyone in the medical profession at the time. Various favourable descriptions of his character portray him as an extremely literate and articulate person, capable of arguing logically from doubtful premises and making the premises appear plausible. He was able to maintain level-headedness in crises and coupled his conservative attitudes towards change with an almost mystical conception of the doctor-patient relationship (Oliver cited in Bolitho, 1979: 40-1; Lovell-Smith, 1966: 26; Bolitho, 1979: 40-3). These elements of character and his dominant nature were to make Jamieson a formidable adversary for Labour Government politicians. His opponents considered him to be pertinacious and cunning and, in later years, made observations regarding his ability to convincingly mislead (Nordmeyer cited in Bolitho, 1979: 41; Sinclair cited in Bolitho, 1979: 41). "As the leader of the medical profession's fight against the Labour Government, Jamieson was 'dominant and dominating.'" (Bolitho, 1979: 43).

Prior to the 1935 election then, the medical profession and the Coalition had each expressed their readiness to consider the implementation of a nationwide health scheme. Labour too advocated such a scheme although the character of its scheme; an electoral backlash against the "Spartan and unimaginative regime" (Lovell-Smith, 1966:32) of the Coalition Government; and the characteristics of Labour's leader - Michael Joseph Savage - proved more attractive to voters in 1935 than the Coalition alternative. Despite efforts by the National Coalition and the conservative elements of the press to create the illusion that a socialist Labour Party would sweep away both freedom and fortune (Grant, 1980: 132) the demeanour and appearance of M.J. Savage totally contradicted any such suggestion. Savage's avuncular character could not have differed much more from the popular image of a socialist as a heartless, barricade storming rebel (Scringeour et al 1976: 59; Lee, 1973: 9; Grant, 1980: 132). He was:

> "a benign political uncle, cozy, a good mixer, with a warmly emotional appeal. He smelt of the church bazaar and not at all of the barricades." (Sinclair, 1980: 266).

After the election, Savage, as Prime Minister, personally appointed his Cabinet Ministers, most of whom had spent many years with him in Parliament. A good number of them had been members of the 'Red' Federation of Labour (Sinclair, 1980: 269). Despite their past associations, the Cabinet was seen to represent the Right Wing, as its members had come to consider socialism as a safeguard against the worst extremes of capitalism rather than an end in itself. A Left Wing was also present in the Parliamentary Labour Party and comprised mainly younger men including John A. Lee, Dr. D.G. McMillan, and the Reverend A.H. Nordmeyer. Many of this latter group felt unjustly denied the Cabinet rank which their abilities and viewpoints justified (Lovell-Smith, 1966: 33; Grant, 1980: 132) and the cleavage this created was later to promote dispute during the planning of the Social Security Act.

The Kurow Cure: Complete and Collective Care

Amongst the Labour Party's Left Wing were two politicians who each played a considerable part in the formulation of Labour's popular health care proposals (Bassett and Harris, 1978: 3; Sutch, 1966: 243). These men were Dr. McMillan and Rev. Nordmeyer. McMillan was a young medical doctor who, whilst working at Kurow during the Depression, had been engaged in a form of contract practice with the unions representing workers employed on the Waitaki hydro-electric project(2). This contract system was, in fact, an adaptation of the English National Health Insurance System which McMillan found he could run very successfully. This borrowed, adapted, and reduced scale scheme provided the basis upon which McMillan and Nordmeyer - who was the Presbyterian minister at Kurow church for ten years - subsequently drew up the philosophy and structure of a comprehensive health scheme which stressed nutrition and preventive medicine as much as it did free medical services (Sutch, 1966: 243; Lovell-Smith, 1966: 38; McLintock, 1966: 691). The nature of the scheme and the Labour Party view on a comprehensive health scheme were crystallised by McMillan during a speech made to the annual Party Conference during Easter of 1935 (Sutch, 1971: 42). The ideas presented there were set out later that year in a pamphlet entitled A National Health Service: The New Zealand of Tomorrow (Lovell-Smith, 1966: 37; Hanson, 1980: 34; Sutch, 1971: 42) the foreword of which included comments by Peter Fraser, Labour's first Minister of Health, to the effect that

McMillan's proposals were generally in line with Labour's policy on health and that they represented a sound basis for a detailed programme of action (Sutch, 1971: 42; Hanson, 1980: 35). Dr. McMillan's pamphlet condemned the English National Health scheme on the bases that it was neither universal nor comprehensive in its coverage (Lovell-Smith, 1966: 37) and went on to outline suggested improvements and recommendations for a New Zealand service. It was proposed that a free national health service to cover every citizen of the country be adopted. The service was to be based on the provision of a family doctor for every person, with patients being permitted free choice of doctor. Arrangements were to be made to compensate people for income lost through illness and for the provision of all facilities for the diagnosis and treatment of disease. Research was to be encouraged and the fundamental aim of the scheme was to be the prevention of disease (McMillan cited in Lovell-Smith, 1966: 37; Sutch, 1971: 42-3; Sutch, 1966: 243-4; Hanson, 1980: 35; Ward and Asher, 1984: 90). In addition to these proposals McMillan suggested that hospitals should be "reasonably close to people's homes" (Sutch, 1971: 43) with emergency wards located in small villages. Two possible forms of funding for this scheme were envisaged. Finance could be provided by annual levies on breadwinners in accord with their ability to pay, or the costs could be met from the Consolidated Fund. Of the two options the latter was considered superior on the grounds that non-contributory insurance was believed to be cheaper and simpler to administer (Hanson, 1980: 35; Lovell-Smith, 1966: 37; Sutch, 1971: 42). Hanson (1980: 35) suggests that McMillan's scheme was significant for two reasons. First, it provided the details which the trade union movement and Labour Party would otherwise not have had the expertise to outline but which coincided with their aspirations. Second, it was an endeavour to link a health scheme with a social insurance scheme in order to "sustain the family, cure the patient" (McMillan cited in Hanson, 1980: 35). Although such a juncture between health and social insurance would prove administratively cheaper than two separate schemes, the suggestion seems more indicative of a desire to create a system which in a practically Christian, or socialist, way would provide comprehensive care for all. The ideas which McMillan had expressed in his pamphlet were incorporated into the Labour Party's 1935 election manifesto (N.Z. Government, 1975: 43) and also provided the foundation of the health provisions of the Social Security Act 1938:

"It was as yet only a vaguely formulated ideal; McMillan did not

> appear to have in mind at this stage any well-defined social security scheme. Nevertheless, it is significant as an example of the co-ordinated approach to social welfare policy, and indeed to the problems of New Zealand society as a whole, that was to characterize Labour's 1935 election manifesto, and to influence its actions in the following three years." (Hanson, 1980: 36).

The BMA's Battle Lines

Within three months of Labour's election to power the new Minister of Health, Peter Fraser, had met with a BMA delegation (Burdon, 1965: 144; Lovell-Smith, 1966: 40; Hanson, 1980: 105). The BMA members commenced the meeting by indicating their desire to co-operate with the Minister to the greatest degree in any efforts to maintain and improve the state of health within the community (Lovell-Smith, 1966: 40). They also indicated that the Association was already giving consideration to national health insurance and, although they had no firm proposals, there existed some general principles believed essential to any scheme contemplated. The Association held that the fundamental basis of the treatment of the sick lay in the confidential and personal relationship between doctor and patient and that relationship nothing should be done to disrupt that. In addition, expression was given to the view that nothing liable to adversely affect the standards and status of the medical profession should be implemented (NHIC cited in Lovell-Smith, 1966: 40). Fraser's responses were to the effect that Government had not yet considered national health insurance - although it was so obliged in the wake of preliminary investigations conducted by the previous administration. Whilst Labour did not intend to promote any health schemes during 1936, it would certainly consult the medical profession and all other concerned parties prior to bringing down any legislation. Should agreement not be reached with regard to any of the Government's future proposals then the best would be done in the public interest and making use of the utmost co-operation attainable. The Minister also commented that he did not wish to disturb the relationship between doctor and patient (NHIC cited in Lovell-Smith, 1966: 41). From the occasion of their first meeting the doctors were most impressed with Fraser and in the long course of their dealings he was held:

> "in an esteem bordering on affection, and although on several occasions Party discipline forced him to withdraw from positions that he had assumed, never once did they hold his integrity in doubt." (Lovell-Smith, 1966: 42).

Shortly after the initial meeting between Fraser and the BMA, the Association's NHIC, chaired by Dr. Jamieson, presented its annual report in which it was stated that in view of the still uncertain consequences of national health insurance upon the medical profession the Association was not prepared to advocate the implementation of such a scheme (NHIC cited in Lovell-Smith, 1966: 43). However, should any such scheme be deemed "economically practical" (NHIC cited in Lovell-Smith, 1966: 43) the Association would be prepared to accept it provided that:

> "(1) Better medical service than at present exists is ensured for those unable to obtain it for themselves;
>
> (2) The standards, status, and interests of the medical profession are adequately safeguarded."
>
> (NHIC cited in Lovell-Smith, 1966: 43, and N.Z. Government, 1975: 44).

Jamieson's personal views with regard to a national health insurance scheme qualified those of the Association. He felt that the benefits of any insurance scheme should be provided only for those persons unable to obtain a doctor's services through their personal resources. In addition, Jamieson considered that in view of the expense associated with the growing technology and expertise of medicine it would be legitimate to implement contributory insurance to defray the costs of diagnostic, specialist and hospital services for all people. This would reduce the difficulties already being faced by well-circumstanced people availing themselves of effective medical treatment (NZMJ, 1938: XXXVII, 198, 77). Jamieson had realised then that existing systems of payment did not allow even the wealthy to meet the costs they were likely to incur in obtaining modern and efficient medical treatment. It would appear that his efforts over the following years were, in part, a struggle to have implemented a system by which the expensive technology of medicine would be paid for by collective means whilst the personal services rendered by doctors remained a matter between them and their patients. The profession would remain relatively unhindered by bureaucracy and lay control yet would be able to maintain its income earning potential through the creation of artificially low prices for its total service. It was considered by the NHIC that the aims of the BMA would best be achieved if a system of insurance adhered to the following extensive list of principles. Any system introduced should provide for:

"1. Maintaining and strengthening the confidential basis between the family doctor and his patients and fostering satisfactory relationship (sic) between the general practitioner, specialist, consultant and hospital.

2. The statutory right of every registered medical practitioner to undertake national health insurance service.

3. Adequate remuneration to ensure the best quality of service.

4. Free choice as between doctor and patient.

5a. Adequate representation of the medical profession on both central and local administration.

5b. The constitution of a statutory local medical committee in each insurance area recognised as representative of the medical profession of the area.

6. The administration of the medical benefits should be separated from the administration of the cash benefits, the medical benefits to be administered by a body specially constituted for the purpose, on which the profession should be adequately represented.

7. Professional discipline to be maintained by tribunals, professional in constitution as in the British system.

8. Income limit to be fixed for those eligible.

9. Hospital benefits if included to apply to private hospitals as well as in public hospitals.

10. A central medical authority to be set up by the profession to adjust the inter-relation of specialist and general practitioner services." (NHIC cited in Lovell-Smith, 1966: 44).

These principles, subsequently referred to as the "Ten Principles" were circulated and signed by more than 90 percent of the members of the BMA. (Lovell-Smith, 1966: 44). They marked the battle lines delimited by the profession for its eventual confrontation with Government.

Errors of Omission: The National Health Insurance Investigation Committee

Mid 1936 saw the Government take its first formal steps towards a programme of nationwide collective health service provision. In July Peter Fraser set up a Parliamentary Committee - the National Health Insurance Investigation Committee (NHIIC) - of five Labour members chaired by Dr. McMillan to investigate the provision of medical and other treatment services and in August a Cabinet Committee headed by

Mr.(later Sir Walter) Nash was created to form the basic structure of pensions and health legislation (Sutch, 1971: 49; Hanson, 1980: 45-6; Lovell-Smith, 1966: 45; Chapman, 1981: 343; Lovell-Smith, 1970: 55). The latter of these two committees was informed by Nash that the Government wished to provide comprehensive health services to all who required medical attention regardless of their financial position. It was also stated that half of the necessary funds for the scheme should be collected from ratepayers on an income basis at a flat rate. The remainder would be provided by government from current revenue and benefits would be equally available to all (Hanson, 1980: 46-7). The only significant difference between these proposals and those of 1935 lay in their financial characteristics. When electioneering Labour had made no mention of contributions but was now considering the creation of a special tax to fund the benefits. This would appear to have been prompted by Treasury calculations conducted early in 1936 which indicated that some form of taxpayer contributions would be necessary to make a universal scheme financially feasible (Hanson, 1980: 47). The other committee - the NHIIC - comprised equal numbers of right and left wing Labour caucus members, all of whom believed that health schemes would probably best be funded from taxes (Sutch, 1971: 50). The composition of the NHIIC dismayed the medical profession because of its solely Labour party membership and the fact that it was presided over by:

> "a member of the medical profession, whose highest qualification was a political one, a man who had already strong pre-conceived ideas on the subject, based on no personal knowledge of conditions of medical practice except his own relatively limited experience in this country." (NZMJ, 1938: XXXVII, 201, 240).

The doctors also thought that:

> "men distinguished for their ability, their knowledge, breadth of human experience, and impartiality of outlook would have been chosen, as well as distinguished and experienced members of the medical profession, who alone could have full knowledge of the scientific and professional problems involved." (NZMJ, 1938: XXXVII,201, 240).

Despite its partisan and non-distinguished membership, the NHIIC held true to Peter Fraser's 1935 promise to the BMA and began its investigations by accepting representations from whomever wished to express an opinion, although, for some time, no direct approach was made to the BMA. This eventually came when the NHIIC despatched questionnaires seeking the views of bodies engaged in a host of health

and insurance related activities (Sutch, 1971: 50). Amongst these bodies was the NHIC which had been completely ignorant of the extent of the NHIIC's investigations and whose members were amazed at the unheralded arrival of the questionnaire half an hour before one of their regular meetings. It was then plain that the medical profession was not going to be taken into the Government's confidence in the matter of health 'insurance' and to this Jamieson's committee and the profession took great affront (Lovell-Smith, 1966: 45). The NHIC's reaction to the rebuff it felt it had received from McMillan's committee was almost instantaneous. The Government's questionnaire was circulated to all members of the BMA to allow Divisions to formulate representative answers. This process was aided considerably by the fact that the NHIC was careful to suggest tentative answers as subjects for debate by each provincial Division (Lovell-Smith, 1966: 46). Although Jamieson sought prompt replies and the provision of model answers, open to debate, was ostensibly to facilitate this, there is no doubt that the Committee was endeavouring to create the responses it wanted. In addition to this means of moulding the profession's attitude Jamieson toured the country on what could only be described as a propaganda mission. He spoke with as many doctors as possible, conferred with Divisions (Lovell-Smith, 1966: 50), and sent memoranda to all Divisions:

> "to the effect that the profession should as a tactical manoeuvre, place its emphasis on research and environmental medicine and suggest that health insurance was not as important a priority. He wrote in December 1937, 'our policy should be to do everything to secure delay for investigation, deliberation, discussion and full understanding by the whole people.'" (Sutch, 1971: 51).

In the midst of this flurry of events there was also a request sent to the London headquarters of the BMA for a representative, preferably Sir Henry Brackenbury - the Association's British Vice President - to assist the New Zealand Branch in its preparations to meet impending legislation (Sutch, 1971: 50-1; Lovell-Smith, 1966: 46). Brackenbury agreed to this request although he did not arrive until September 1937 (NZMJ, 1937: XXXVI, 196, 347; NZMJ, 1937: XXXVI, 192, 135; Lovell-Smith, 1966: 60).

Stating the Case - 'Casing' the State?

The NHIIC began hearing submissions in February 1937. The bulk of the evidence received from groups and organisations such as the friendly

societies, Chemists' Service Guild, Order of St. John, Hospital Boards, opticians and the New Zealand Dental Association indicated a great measure of support for the idea of a national health insurance scheme (Sutch, 1971: 50; Hanson, 1980: 57). None of the respondents to the Committee's questionnaire denied the need to remove the financial barriers which were increasingly restricting access to medical services and many suggested the introduction of a scheme similar to that operating in Britain, providing benefits to specific sections of the community. The oral submissions however indicated greater flexibility of attitude and there were neither objections to a universal scheme nor any marked preferences for particular systems of funding. In effect, most bodies indicated that they were prepared to co-operate in any type of scheme, provided acceptable arrangements were made between government and the medical bodies providing the benefits (Hanson, 1980: 57). Most organisations were agreeable to the idea of becoming elements in the framework of a national health service. The only major objections came from the country's apostles of Hippocrates - the doctors. The BMA first made its stance on the issue of national health insurance known in December 1936 in a letter accompanying its answer to the NHIIC's questionnaire (Hanson, 57-8; Lovell-Smith, 1966: 47). The Association pointed out that overseas experience indicated that health insurance schemes had not had appreciably beneficial effects on health because they concentrated on the treatment of disease after it had occurred. Accordingly, any scheme in New Zealand should make the greatest possible provision for preventive medicine (BMA cited in Lovell-Smith, 1966: 47-8 and Lovell-Smith, 1970: 55). The letter went on to argue that because of New Zealand's small proportion of industrial workers, its low population density, high wages and existing health care services, medical treatment was seldom unavailable to anyone. Insurance would also be costly to administer in view of the country's scattered population (BMA cited in Hanson, 1980: 58 and in Lovell-Smith, 1966: 48). The Association did submit however that one group within the community - comprising the unemployed, disabled and aged poor - required assistance, and suggested that domiciliary medical attendance could be provided. In addition to these general arguments against health insurance the BMA insisted that the standard of medical practice in New Zealand had evolved to a very high level under existing conditions and that the standard achieved was considerably higher than that under National Health Insurance wherever practised. Finally, on

the strength of its arguments, the Association recommended the adoption of some restricted scheme which would disturb the existing system as little as possible, and also requested further opportunities for consultation during the preparation of legislation (BMA cited in Lovell-Smith, 1966: 49). These arguments were reiterated when the BMA presented oral evidence to the NHIIC in February 1937, although Jamieson, as the Association's spokesperson, also rejected capitation as a method of payment. Jamieson claimed that capitation had proved unsatisfactory in England as it was unfair to the doctors and he suggested that payment should be on the basis of services performed (Hanson, 1980: 58). McMillan's committee however could not comprehend the Association's attitudes (Hanson, 1980: 58; Lovell-Smith, 1966: 49). The feeling proved to be quite mutual. Whilst the NHIIC agreed that preventive medicine was of great importance, its members argued that this aspect of medicine fell within the domain the Department of Health and that the Committee was simply endeavouring to make existing services available to all (NHIC cited in Lovell-Smith, 1966: 49-50; Hanson, 1980: 58-9). McMillan also stated that the Committee did not intend to interfere with the way doctors should practice, nor did it wish the profession to be financially penalised under a national health scheme (Hanson, 1980: 59). This point on remuneration was quite important as the Committee apparently did not believe Jamieson's claims that a universal scheme would lead to a deterioration of medical standards and considered that the protests disguised fears of low incomes and perpetual servitude to the Government. McMillan pointed this out and endeavoured to clarify the Government's intentions:

> "The Government did not consider interfering in any way with what doctors should practice. The only concern that the government has is how the doctors' services shall be paid for. My own feeling - and Dr. Stout (3) confirmed it when he said 'poor remuneration' - is that a lot of the lack of enthusiasm is because you fear that you will get a poor man service, a lot of work for a poor wage, and I would like to take this opportunity of assuring you that the government has no such system in mind." (NHIC cited in Lovell-Smith, 1966: 50).

The Committee added later that the object of health insurance was to bear each others burdens and to spread the cost of medical care throughout the community (NHIC cited in Lovell-Smith, 1966: 51). Eventually the BMA refused to commit itself to anything until it had received some indication of the scheme in mind and until it had consulted with Sir Henry Brackenbury (Hanson, 1980: 59). Peter Fraser, who had joined the meeting towards its close, agreed to wait

until Brackenbury's visit and in the meantime official liaisons between the NHIIC and the BMA were postponed (Hanson, 1980: 59; Lovell-Smith, 1966: 51). After the meeting the representatives of the BMA sought some indication from McMillan of the lines along which the NHIIC was proceeding. Requiring the confidence of the profession, McMillan informed Jamieson of the tentative views of the Committee (Lovell-Smith, 1966: 52). More or less in return, McMillan was afforded the opportunity to visit and discuss the Government's scheme with members of the medical profession at Divisional meetings of the BMA (Hanson, 1980: 59; Lovell-Smith, 1966: 53). McMillan's words to the Divisions were certainly not greeted with warmth and appreciation. In short, he told members of the medical profession that the government proposed a capitation system of employment for general practitioners (specialists were not at that time included in the scheme). In addition to this, public hospital services would be provided free, private hospital costs were to be subsidised, and ambulance services and drugs would be free. An important point made by McMillan was that if the profession was free from economic worries the standard of medical practice ought to go up (Lovell-Smith, 1966: 53). At this stage McMillan's views represented only his own hopes for the likely path of medical practice in New Zealand. They were not the official attitude of government. Apparently McMillan was endeavouring to convince the members of the BMA that they were being misled by their Association leaders in a number of respects and also that the scheme he had in mind would be to their economic advantage (Hanson, 1980: 60). According to Lovell-Smith (1966: 54) McMillan also worked under the assumption that all people have a price and that he simply had to drown the doctors' fears in a sea of money in order to wash them towards his current thinking. McMillan's proposals unsettled the medical profession and soon drew a response.

In July, Dr. Jamieson sent a letter - subsequently published as A Plan For National Health Insurance - to the NHIIC. This correspondence contained a scheme which Jamieson believed might be developed with less 'disadvantage' than that proposed by McMillan (Jamieson cited in Hanson, 1980: 60-1). Very briefly, it was suggested that the community be divided into four groups on the basis of income. The first group, consisting of those people on incomes equal to, or less than, old age pensions, unemployment or sustenance benefits would receive a complete, free medical service without payment of any kind. People in the second and third categories would have to make some

financial contribution, the one for a complete medical service and the other for a partial service. The fourth group, comprising the most affluent members of society, would contribute through taxation to the cost of the scheme but would not be entitled to any of its benefits (Burdon, 1965: 244; Sutch, 1966: 244-5; Sutch, 1971: 52-3; N.Z. Government, 1975: 45; Hanson, 1980: 60-2; Lovell-Smith, 1966: 55-6; Chapman, 1981: 343; Fraser, 1984: 62). Although the BMA's proposals contained some suggestions of merit with regard to health care administration and hospital organisation it was the four-class notion which attracted the greatest amount of attention (Lovell-Smith, 1966: 55; Hanson, 1980: 62). Perceived by some as an income maximising scheme for doctors (Sutch, 1966: 244), the proposals were strongly criticised from all sides:

> "The Star-Sun, Christchurch, had warned editorially on 20 July 1937: 'However, it can be said at once that the association's scheme fails at the outset because of a fundamental defect. It proposes to divide the community into classes: the very poor who are to get everything for nothing; the relatively poor who are to get something for nothing, but not everything; the better class who will pay their own bills but contribute to a special fund for hospital and specialist services; and the well-to-do who will carry on as at present...If the Medical Association had consulted one or two people who knew something of political psychology its scheme would never have been allowed to see daylight." (Sutch, 1971: 63).

Even some doctors were upset over their Association's scheme despite its provisions which would have take care of bad debts and allowed doctors to practice freely (Sutch, 1966:245). The reaction of McMillan's committee to the BMA's scheme is best expressed in the oft-quoted paragraphs of the NHIIC's main report presented to Cabinet on 4 September 1937. This report contained the Committee's own proposals and strongly rejected the idea of any categorisation of the community:

> "We do not hesitate to state that we consider the universal principle the most important single factor in our Health Insurance Scheme and one from which we dare not depart if we are able to obtain a service natural to our national outlook and democratic ideals.
>
> This is the foundation stone which will determine the status of the service...Unlike overseas people, self-respecting, freedom-loving New Zealanders will never respect or tolerate a Service which gives one type of service to the poor and another type to the well-to-do. Any scheme which savours of a poorman service, of charity, which divides the people into two groups, those able to pay private fees and those unable to do so; which

> differentiates in the mind of the doctor either consciously or unconsciously (sic) between patients, would be foreign to the ideals and aspirations of the Government in particular and the people of New Zealand in general.
>
> We visualise people being treated as patients, not as members of a class.
>
> We visualise our National Health Service operating upon the same principles as our education service, all contributing to its upkeep, all able to participate freely in its benefits if they so desire.
>
> With the science of medicine freed from the economics of medicine, and with economically secure medical men able to give single minded devotion to the science of medicine, we will obtain a fuller and more efficient medical service than is in existence today." (NHIC cited in Hanson, 1980: 62-3).

The NHIIC's final report firmly established that the government would never contemplate a means-tested national health service. The proposals outlined in the report differed markedly from those put forward by Jamieson. The introduction of a host of free medical benefits was recommended - free general practitioner service, free anaesthetics and medicines, free maternity treatment, free dentures and extractions, free public hospital treatment and subsidisation of private hospital care. It was also suggested that at a later date a range of ancillary benefits such as specialist and consultant treatment, full dental treatment for all aged sixteen years or less, physiotherapy, home nursing services and optical benefits be introduced (Chapman, 1981: 343; Sutch, 1971: 53; Hanson, 1980: 63; Lovell-Smith, 1966: 58-9). The Committee considered that these latter benefits should be introduced once the scheme was functioning smoothly. These general proposals formed the major thrust of the NHIIC's final report of September 1937 and bore a considerable resemblance to the ideas presented by McMillan to the BMA during his talking tour earlier that year. McMillan's speeches had, in turn, followed the ideas he expressed in his 1935 pamphlet A National Health Service: New Zealand of Tomorrow. There can be little doubt that in drafting its report the NHIIC was strongly influenced by McMillan's beliefs and ideas (Hanson, 1980: 64). The political affiliations of the Committee also made the report much more a political document than an impartial study of the need for and desirability of a national health scheme in New Zealand. The evidence heard by the NHIIC seems to have been evaluated in a most discriminatory way, with little notice being taken of those submissions contradicting the preconceived ideas of the Committee's members (NZMJ, 1938: XXXVII, 201, 240; Hanson, 1980: 64; Lovell-Smith, 1966: 58).

The end result was a report which contained an "extraordinary hodge podge of fact and opinion" (Lovell-Smith, 1966: 58). Despite these problems, the report of the NHIIC - which, in the course of subsequent negotiations was never seen by the BMA (NZMJ, 1938: XXXVII, 201, 240; Lovell-Smith, 1966: 58) - formed the basis of the Social Security Act 1938 (Hanson, 1980: 64).

The Brackenbury Relationships

In September 1937 Sir Henry Brackenbury arrived in New Zealand to commence a six week advisory tour (NZMJ, 1937: XXXVII, 196, 347; Lovell-Smith, 1966: 60; Hanson, 1980: 67). Brackenbury was the Vice President of the parent body of the BMA and a former Chairman of its Council. A lifetime of medical experience had made him a firm believer in national health insurance (Lovell-Smith, 1966: 60) and the wealth of that experience saw him in demand by both the BMA and the government to whom he made his services equally available (NZMJ, 1937: XXXVII, 196, 347; Hanson, 1980: 67; Sutch, 1971: 64-5). Brackenbury brought with him the idea that despite its minor flaws, the capitation system of payment, as operating in Britain, was the most practical means of funding national health insurance medicine (Lovell-Smith, 1966: 60).

Unfortunately for the local branch of the BMA, Sir Henry held the opinion that fee-for-service medicine reduced medical practice to the status of selling packets of goods over a counter, instead of fostering the principle of the doctor being the professional health adviser to the individual (Jamieson cited in Lovell-Smith, 1966: 60-1). Brackenbury had a few other ideas which quite totally contradicted those of local doctors. He considered that the decision regarding who should be covered by a medical scheme was that of a social reformer, not a doctor, and that the method whereby a doctor is paid for his/her services was not an essential characteristic of the proper relationship between physician and patient. Indeed, in 1935, Brackenbury had written:

> "...any doctor who has been engaged in National Health Insurance or in poor-law medical practice must often have rejoiced that the particular method of payment arranged for under those schemes enables him to give full attention to his patients without worrying about the presentation of an account." (Brackenbury,

1935: 111).

According to Sutch (1971: 64) it made little difference to Sir Henry how the doctor was to be paid. "He [doctor] may be paid quite privately, or through an insurance scheme,or in any other way" (Brackenbury cited in Sutch, 1971: 64). Brackenbury held a firm notion on the nature of the doctor-patient relationship, considering it to be:

> "a unique one: there is nothing quite like it. It has many elements. It presents for instance, the contrasts between ignorance and knowledge, dependence and skill, weakness and strength, subordination and superiority." (Brackenbury, 1935: 68).

He also thought that the relationship between doctor and patient should not be dominated by other relations and that it should be entirely free, with both patients and doctors able to select one another without impediment (Brackenbury, 1935: 135). Brackenbury had much to say on the interaction between doctor and patient and it appears that he may well have crystallised a previously unarticulated notion of this relationship in the minds of many New Zealand doctors - notably Jamieson - who went on to misuse the nature of the relationship for their own pecuniary and professional gains.

Whilst in New Zealand Sir Henry was also given the opportunity by McMillan to see the NHIIC's report in draft. He reported that it was an able and satisfactory document requiring the serious consideration of the New Zealand medical profession. He also said:

> "The securing of early and adequate medical attendance and ancillary services is an extremely desirable and valuable thing, and that the most satisfactory method of securing this is by a compulsory insurance scheme." (Brackenbury cited in Sutch, 1971: 64).

Brackenbury's beliefs seemed incredible and disturbing to Jamieson:

> "...I am frightened of him. For example, he will have it that the panel system has raised the standard of practice in England which I just don't believe; he will have it that it does not diminish incentives, where I am positive that it must in this country at any rate [diminish] the right kind of incentive; he will have it that the drug tariff is no detriment to the individuality of prescribing, which again I don't believe." (Jamieson cited in Lovell-Smith, 1966: 61).

The problem then was that Jamieson held quite different views on the

subject of national health insurance from Brackenbury, whose expert advice had been sought, presumably under the assumption that it would support the stand of the local doctors. The real views of Brackenbury however do not appear to have reached the country's politicians or doctors. According to the editor of the New Zealand Medical Journal (1937: XXXVI, 196, 348) Sir Henry entirely approved of the steps taken by the BMA's New Zealand Branch and he also assisted in the preparation of a memorandum which was submitted to the Minister of Health. Lovell-Smith substantiates this with his comments that Brackenbury "cheerfully accepted the views of the local Association and dutifully reiterated them to the Parliamentary Committee" (Lovell-Smith, 1966: 61). The overall implication of this set of circumstances is that some foul play was occurring. This is borne out by the words of Jamieson himself:

> "We had to discipline old 'Brack' a bit, and I felt rather boorish and mean sometimes. We told him what we wanted him to emphasise and what not to emphasise and what not to say, even if he thought it. This clearly was a pretty difficult position for 'our adviser', but it did do some good, though I can't say the last part of the instruction was implicitly observed. Two or three things are going to ricochet later." (Jamieson cited in Lovell-Smith, 1966: 61).

It would appear then that Jamieson was not prepared to listen to any advice or arguments contrary to his hard and fast stand, nor was he averse to employing underhand tactics to achieve his ends. Clearly, the medical profession under Jamieson's leadership was not going to be easily persuaded to accept any universal scheme for health care provision.

Clashes of Character and Cause: Government - Doctor Relations Collapse

Soon after Brackenbury's departure the BMA and the Government - represented primarily by Fraser and Nash, Ministers of Health and Finance respectively, and Dr. McMillan - engaged in three months of irregular but noteworthy meetings (Hanson, 1980: 68; Lovell-Smith, 1966: 64). These meetings produced no agreement and seemed to worsen relations between the bodies. In part, this deterioration can be attributed to a natural antipathy between Nash and Jamieson. Whilst Fraser was genial and accommodating, his colleague seemed both pertinacious and paranoid (Lovell-Smith, 1966: 68-9). Such a clash of characters was scarcely a timely ingredient for negotiations at this

point.

The Government-BMA meetings lasted from December 1937 to February 1938 (Hanson, 1980: 68) and were dominated by the issue of universality. The first meeting prompted Fraser to write to Jamieson asking for answers to a number of questions relating to the BMA's attitudes towards patient care and physician payment under a State service. Jamieson and the Hon. General Secretary of the BMA, Dr. P.P. Lynch, replied in a lengthy letter dated 7 February outlining, amongst other things, the necessity for cash transactions to maintain the doctor-patient relationship and the problems likely to emerge in a State service:

> "...We insist that full liberty to the doctor and his relationship with the patient and vice versa can only be assured when the individual requiring and the individual rendering the service are completely free to make their own personal arrangements. Apart from the inadmissable assumption, the point involved is tersely summed up in the common saying that people do not value what they do not pay for directly...The relationship which is established immediately a patient summons a doctor has and always will be, a strictly personal relation of a special sort - independent of fee or of the standing of the patient. Medical service has a personal and confidential character which is as many sided as human nature itself...Medical practice does not lend itself readily to terms of contract like the supply of a definite number of standard articles, or the giving of so many hours of specified work...If only part of the doctors' services are on a contract basis, the stimulus of private practice tends to maintain the standard of his contract work...[Medical standards are] set by the best voluntary uncontrolled private or honorary service, which it is therefore important to preserve in as large a body as possible...We regard with no less apprehension the inevitable danger of infringement of the liberties of the profession as a body...Under the universal scheme suggested the tendency would be for the activities of these professional organisations to be merged in greater or less degree in the bureaucratic control of the State..." (Jamieson cited in Hanson, 1980: 69 and Lovell-Smith, 966: 70-3).

On the basis of a twisted interpretation of Brackenbury's analysis of the doctor-patient relationship Lynch and Jamieson were endeavouring to sanctify financial demands which otherwise would have been more clearly interpreted as being untenable with the humanitarian role of the medical profession. It is interesting to note the apparent contradiction between this stand and that made earlier by the BMA in advocating its four tier system of health care provision. The tiered system would have made free care available to a section of the community - apparently contravening principles which the Association was now claiming were fundamental to the effective practice of medicine. Jamieson and Lynch's forthright statement brought the

Government and BMA together for a final meeting on 26 February to attempt to reach some accord. The meeting failed in its aim and came to mark a major breakdown in negotiations between the two bodies. The collapse however was not formally acknowledged until a letter was sent from the BMA to the Government six months later (Hanson, 1980: 70). Only one other formal liaison was to occur before the Social Security Act was passed. It appeared then that all the efforts of Jamieson and the BMA to dissuade Government from implementing a universal scheme were to be to no avail. In the meantime however, Government fortitude was being tested elsewhere.

Costs, Caucus, Constituents and Other Concerns: Facing the Public

To assist with preparatory research into the financial aspects of proposed Social Security Act, the Government had invited a British Actuary, G.H. Maddex, to visit the country. Maddex arrived in mid 1937 and commenced work with Nash, Nash's assistant J.S. Reid, and B.C. (later Sir Bernard) Ashwin, the latter two of whom had played important parts in the interdepartmental committee which had submitted its report in 1935 (Burdon, 1965: 236; Hanson, 1980: 70-1; Chapman, 1981: 343). Despite Nash's previous support for a universal, free scheme for the provision of social welfare benefits and facilities, the newly formed group spent most of its time considering the introduction of a system of insurance. It has usually been thought that Nash's change of heart stemmed from his conservative approach to financial matters (Hanson, 1980: 71). However, it seems likely that two other reasons accounted for the change of opinion. First, Nash thought that in fulfilling its election promises to provide superannuation in old age, the Government would have to impose very high levels of taxation upon income earners. Second, he saw (or had been so persuaded during a trip to Britain in 1937) that a contributory scheme would provide an extra source of government revenue which would allow him to more easily pay off the national debt (Hanson, 1980: 71-2). On 10 February 1938 the results of investigations by Nash, who now favoured a contributory insurance scheme, and Fraser, who was ready to submit in the face of financial problems and the intransigence of the medical profession (Chapman, 1981: 343), were presented to a Caucus which had been totally unaware of any work towards the introduction of social security (Hanson, 1980: 74; Thorn, 1952: 156; Chapman, 1981: 343). Although little is known of the details of the proposals submitted to

Caucus it is certainly clear that the reaction of the Parliamentary Labour Party was explosive. Apparently Fraser and Nash advocated a levy of 1s. 6d. in the pound on all incomes and the investment of the proceeds in a vast interest bearing fund. From this fund small pensions would be paid. On the health front, Fraser wanted a health service for those deemed unable to pay (Lee cited in Hanson, 1980: 74-5). Labour backbenchers and the 'Left Wing' led by John A. Lee were aghast and united in their demands to force the 'Right Wing' to hold to Party policy (Chapman, 1981: 343; Hanson, 1980: 74-5; Thorn, 1952: 156). Caucus members eventually decided that an alternative scheme be presented at its next meeting on 4 March 1938 (Chapman, 1981: 343; Hanson, 1980: 75). At the March meeting Savage or Nash proposed to establish a Select Committee comprising four Opposition members, four Cabinet members, and three Caucus members. This was seen by the 'Left Wing' as a ploy to avoid any controversial issues and their reaction saw the establishment of a Caucus Committee with a 'Left Wing' majority (Hanson, 1980: 78; Chapman, 1981: 343-4; N.Z. Government, 1975: 45). The Committee's proposals were quickly drafted and were laid before Caucus at the end of March to be confirmed as Government policy (Chapman, 1981: 344; Hanson, 1980: 78). The Committee commenced its report with a statement of the principles it felt should underlie a health and superannuation scheme:

> "The Committee, throughout its deliberations, has adopted the position that the general promises of the Government could best be met by one comprehensive social security scheme. A further guiding principle has been that contributions to such a scheme should be according to means while benefits from the scheme should be according to needs. While the cost of the benefits proposed to be conferred is likely to rise appreciably, particularly for some items, in future years, the Committee felt that the Government would be justified in anticipating that this position would be met in view of the prospects of increased incomes due to the expanding productivity of the Dominion. Without this expansion the scheme might experience grave difficulties in the not too distant future. The Committee believes that a scheme of the nature proposed will distribute the national production more equitably than at present and is also calculated to increase the demand for consumable goods." (Caucus Committee on Health and Superannuation cited in Hanson, 1980: 78-9).

The plan submitted by the Committee included provision for universal free health care , extended benefits, and an old age pension of three shillings per week for men and women at age sixty (Chapman, 1981: 344). Despite the suggestion of State control, the Committee did nothing to actively discourage private hospitals. It was thought that if people wanted to make use of the private sector, they should be

entirely free to do so (French, 1977: 411). Half of the cost of this single comprehensive social security system was to be met from general revenue, with the remainder coming from specific levies (Chapman, 1981: 344). Despite their wide-ranging scope, the Committee's suggestions were intended to form but the starting point in the provision of social security to the community (Caucus Committee on Health and Superannuation cited in Hanson, 1980: 79).

Now, the Labour Government was ready to make its proposals public. On 2 April 1938 the Prime Minister, M.J. Savage, announced on radio the nature of the Government's proposals for social security (Grant, 1980: 142; Burdon, 1965: 236 and 244; Hanson, 1980: 81). Amongst other things Savage stated that his Government intended to provide a free, universal general practitioner service for all, free maternity treatment, and free mental hospital care. Later, specialist services were to be introduced (Burdon, 1965: 244). The proposals were published shortly afterwards as the social security legislation the Government intended to place before the House of Representatives. It was intended to make services and benefits available or payable from 1 April 1939 (Sutch, 1971: 53; Lovell-Smith, 1966: 76). The announcement of Labour's intentions met with almost instantaneous and great public acclaim, although most newspaper editorials raised questions about the source of money for the scheme and its likely implications for community standards. Even the Government's most ardent opponents admitted that the plan was desirable but seriously doubted its financial practicability (Hanson, 1980: 81-2; Burdon, 1965: 236). Doubts and problems were aired at Select Committee hearings which commenced on 6 April 1938 (Burdon, 1965: 237; Hanson, 1980: 82-3). The Select Committee comprised six Government members, four from the Opposition and one Independent, and was headed by Rev. A.H. Nordmeyer. These men heard evidence from more than one hundred individuals and organisations reflecting a wide range of viewpoints. In general, there was wholehearted support for the Government scheme with the only real points of difference lying in the precise nature of its provisions (Hanson, 1980: 82-3; Burdon, 1965: 237). There was however opposition from the BMA which now had some support from the Chamber of Commerce. The doctors submitted a statement condemning the Government's scheme as being unwarranted, misdirected, unsound in method, of no advantage over the existent syster of treating disease, discouraging to individual initiative, contrary to principles of liberty and likely to have an adverse effect

on the standard of medical work (Burdon, 1965: 245). As they had in the past, the BMA insisted that a complete, free medical service was necessary only for those unable to make adequate provision for themselves. Before making their criticisms the doctors also warned that if the Government chose to pursue its stated plans, the BMA could not promise the willing assistance and co-operation of its members (Burdon, 1965: 245). Despite this threat from the doctors and the general concerns of those who made submissions to the Committee with regard to the financing of the scheme, the final report of the Select Committee of late May 1938 supported the health care provisions suggested by Government. The Select Committee considered that the work done previously by McMillan's Parliamentary Committee was of great value and found no reason to deviate greatly from the recommendations made by McMillan. Much of the section on health in the Select Committee's Report was devoted to discounting the arguments of the medical profession and justifying a universal scheme. Arguing against the doctors' claims that a universal scheme was unwarranted as many people could, and indeed preferred to, pay for treatment, the Committee commented that very few people could ever be certain that they would be able to pay for their own medical services and that:

> "this is no more an argument against a universal service than is the suggestion that because a man can afford to pay for his child's schooling, education should not be freely available to all." (Select Committee on National Health and Superannuation cited in Hanson, 1980: 88).

Citing the work done by salaried university, hospital, and public health doctors, the Committee rejected the notion that a universal scheme would lead to a deterioration in the standard of medical practice (Hanson, 1980: 88). Finally, the Committee completely dismissed the BMA's four tier system on the bases that it would be unwieldy to administer and that it would present the temptation to doctors to afford better treatment to those who paid directly for services than to those whose medical costs were met by the State (Select Committee on National Health and Superannuation cited in Hanson, 1980: 88). The opinions of the Select Committee were not unanimous however, for the National Party members, unable, under the forms of the House, to submit a minority report, chose to have their objections published in the newspapers (Thorn, 1952: 156). Despite this conflict the Government again chose to press on and on 11 August, the day before the Social Security Bill was presented to Parliament, representatives of the BMA were summoned to Fraser's office to meet

with him and Nash (Hanson, 1980: 107; Lovell-Smith, 1966: 86). The doctors expected to be shown details of the Bill, but instead were consulted about some points of its intended administration. Jamieson and his colleagues protested that they were being shown the means of administration under a Bill, but not the Bill itself, and sought advice as to the content of the proposed legislation. Fraser reluctantly provided some general information, the nature of which caused the doctors to react with vehemence:

> "We were so convinced that a Universal General Practitioner Scheme was contrary to the interests of the country as a whole, that we could not do otherwise than oppose it to the utmost within our power. This was the expression actually used. We would oppose it, and we could not discuss matters of administration, remuneration and content of service which were secondary to the general principle of the scheme. We regretted that we had been forced into this position which we had done everything for two years to avoid." (Jamieson cited in Lovell-Smith, 1966: 86-7).

The doctors' feelings with regard to a universal general practitioner service and the withdrawal of their co-operation were confirmed in a letter from Jamieson to Fraser on 13 August 1938 (NZMJ, 1938: XXXVII, 202, 355; Hanson, 1980: 107; Lovell-Smith, 1966: 88). In effect however, this correspondence merely made official the situation which had existed since February.

The Social Security Bill was introduced to the House on 12 August 1938 with the Second Reading and debate commencing on 16 August (Hanson, 1980: 93). The Opposition were in a hapless situation for they were unable to attack the benefits themselves for fear of being considered uncaring, nor could they criticise the Government for having failed to keep its election promises. Although they did claim that social security would wreck the lodge movement, penalise thrift, and end in financial disaster the Opposition members' negative comments were not backed by attractive alternatives (Chapman, 1981: 344; Hanson, 1980: 94-7). Labour's overall response to actuarial criticisms was that the proposed scheme would stimulate the country's production sufficiently to pay for all benefits. Probably the biggest problem confronting the Opposition was the timing of the Bill's introduction to the House. A general election was due to be held in late 1938 and members of both main Parties were certainly aware of that when making their speeches to the Bill. Labour had chosen to delay the introduction of any social security provisions until after the election, thereby forcing National into a position where it had either to support the proposals or to

condemn them completely (Hanson, 1980: 97; Burdon, 1965: 238). Public opinion of the time made the latter option political suicide. To select the first option however would have lent credence to the Labour stand. Labour had National in a pre-election check-mate. In view of this predicament opposition to the Social Security Bill was unconvincing, with the overall result that the Social Security Act, which was passed in August 1938, remained very similar to the scheme outlined by Savage on national radio on 2 April (Burdon, 1965: 238).

The gratitude of the public for Labour's actions was amply expressed late the following month when the country went to the polls. Labour was returned to power with twice as many votes as its combined opposition (Wilkes and Shirley, 1984: 291; Chapman, 1981: 347).

Intransigence and Attrition: Doctors at Loggerheads with Government

One of Labour's first priorities during its second term in office was to implement the new Social Security legislation. Accordingly, Fraser sought an interview with the Hon. General Secretary of the BMA, Dr. P.P. Lynch, in order to recommence negotiations on the introduction of the general practitioner benefit (Lovell-Smith, 1966: 89). At this meeting Fraser stated that his personal preference was for a scheme such as that which the BMA had suggested, providing a complete free medical service for only a limited section of the population. However, such a scheme would now have to lie within the provisions of the Act. As a result, Fraser suggested that the Government could pay doctors on the basis of services rendered and requested Lynch to discuss this with his Association (Lovell-Smith, 1966: 89). The NHIC considered the matter promptly and Jamieson sent a reply to Fraser pointing out that such a fee-for-service scheme would be open to considerable abuse. Jamieson's memorandum suggested however that steps could be taken to prevent this, the most important being that patients should directly bear a proportion of the costs of treatment (Lovell-Smith, 1966: 91). Shortly afterwards, on 19 December, Dr. Lynch wrote to Fraser offering to re-open discussions and subsequently a meeting was arranged for 21 February in Nash's office. At this meeting it became obvious that the Government's conception of payment by attendance differed markedly from that of the BMA. Nash made clear that the Government would not consider any scheme which required the direct payment of a doctor by the patient (Lovell-Smith, 1966: 91). It was soon apparent that

progress along this track would prove fruitless so Fraser stated that he would temporarily abandon the matter of the general practitioner scheme and instead attempt to implement the maternity benefits (Hanson, 1980: 119). No doubt this move was prompted by a desire to avoid further protracted debates with the doctors by concentrating on a more limited and attainable goal and in the hope that the acceptance of one benefit might weaken the doctors' opposition to others (Hanson, 1980: 119). Politically this step was shrewd as considerable interest was being expressed in the maternity scheme and any refusal was likely to see the doctors publicly castigated for being stubborn and mercenary (Burdon, 1965: 248). Hence, early in March, the Government offered to establish contracts with licensees of private hospitals and maternity nurses in order to facilitate the free medical treatment and accommodation of mothers from the day of confinement until one fortnight thereafter. Within a short period of time, most but the doctors were under contract (Burdon, 1965: 248; Condliffe, 1959: 307).

Meanwhile, on 1 April 1939, the Social Security Act 1938 became operational (Blanc, 1949: 175). According to the Act free mental hospital, general hospital, maternity, and general practitioner benefits were available to the entire population (NZMJ, 1939: XXXVIII, 208, 403; Hanson, 1980: 119). Only the non controversial mental hospital benefits became immediately effective however. These simply transferred the costs of supporting mental patients from relatives to the taxpayer and did not alter existing methods of doctor payment, patient treatment, or hospital control (NZMJ, 1939: XXXVIII, 208, 403; Burdon, 1965: 248; Condliffe, 1959: 305). Free general hospital benefits followed shortly after on 1 July 1939 (Ward and Asher, 1984: 90; Lovell-Smith, 1966: 109). The introduction of this provision under the legislation met little interference from the medical profession. Staff who had once held honorary positions were now paid on a part-time stipendiary basis (Lovell-Smith, 1966: 109). This provided a most attractive solution for doctors who had in the past complained about honorary staff at hospitals being obliged to treat patients well able to pay for private treatment. Hospital Boards too would have been relieved. The Government however still did not have the assistance of the medical profession with regard to the remaining two benefits - free maternity care and a free general practitioner service. Although other agencies involved in providing maternity care in the community co-operated with the government when it sent out

cumbersome, administratively complex contracts during March, the doctors would not. The BMA was still grieved at not having been consulted about the legislation under which they were expected to work and continued to argue that the maternity scheme, like the general practitioner scheme, would adversely affect the doctor-patient relationship. As a result, only 25 percent of doctors signed the Government contracts (Condliffe, 1959: 305; Hanson, 1980: 119; Lovell-Smith, 1966: 94; Burdon, 1965: 245; Robb, 1940: 43). The Prime Minister did not take at all kindly to this further insubordination by the doctors and told them that if the BMA refused to co-operate he would be obliged to introduce a State Medical Service and would import some of the many foreign doctors desiring to settle in New Zealand to work it. This threat was substantiated by Fraser in the Dominion of 31 May 1939 (Lovell-Smith, 1966: 101 and 103). The medical profession was in a difficult situation for it was realised by Jamieson that acceptance of the Free Maternity Service would imply acceptance of the universal principle (NZMJ, 1939: XXXVIII, 205, 16) which could later be used to lever the country's doctors into working a free general practitioner service. In addition, corporate contract practice contravened the Constitution of the BMA (Lovell-Smith, 1966: 104). In view of the difficulty of the situation Jamieson sought the advice of G.G. Gibbes Watson, Counsel for the Association, who suggested a scheme which he thought might be an acceptable compromise to both parties and did not require the submission of the BMA on the principle of contract (Lovell-Smith, 1966: 104). Gibbes Watson proposed that:

> "(1) There should be paid from the Social Security Fund to every medical practitioner on proof of his attendance on any woman in a confinement, a sum already fixed, namely five pounds. (2) That this amount be accepted by the medical practitioner in full satisfaction for his professional services, provided that in the case of a specialist in obstetrics, he is entitled to charge such an amount as may be arranged between himself and the patient or her representatives." (NHIC cited in Lovell-Smith, 1966: 104-5).

On 6 July Gibbes Watson's scheme was presented to Fraser who happily accepted it and subsequently persuaded Cabinet that it represented the best solution under the circumstances (Lovell-Smith, 1966: 107-8). The new system required amendments to the Social Security Act. These were delayed somewhat by the outbreak of World War II but were eventually passed in September 1940. Although the doctors had accepted a contract basis for their services, Jamieson made it clear that there was no resemblance between maternity services and contracts and general

practitioner contracts. He summed it up thus:

> "Maternity is a specific thing, self-limited as to sex, period of life and duration. The responsibilities of the practitioner in regard to it, though wide and varied, are finite. It lends itself neither to simulation nor self-delusion beyond a certain time. In those respects it is altogether different from the rest of general practice. It was therefore possible to come to an arrangement regarding it, whilst it is quite impossible for the profession to accept for any predetermined sum, under predetermined conditions, the vast unlimited indeterminate sickness risk involved in general practitioner service." (Jamieson cited in Lovell-Smith, 1966: 108).

Whilst acceptance of the maternity benefit resolved the issue of universality, this having been a firm principle expressed in the Social Security Act, it did leave the question as to how the general practitioner benefits would be made operational. When the War broke out in September 1939 (Maclean, 1964: 31; Heggie, 1969: 36) the BMA assumed that implementation of the free general practitioner benefit would be postponed (Lovell-Smith, 1966: 110). However, on 28 February 1940 a letter from the Minister of Health requested the recommencement of discussions. The Government was under considerable pressure to begin operating its proposed social security benefits. The outbreak of War, the intransigence of the doctors and internal strife in the Labour Party had all hindered progress, and although members of the public had, for some two years, been paying a social security tax to cover the costs of a 'free' universal scheme they were still being forced to pay doctors' bills. Both the public and the politicians were anxious for action. In view of the situation faced by Government Fraser issued the doctors with an ultimatum:

> "I need hardly point out that the responsibilities upon Government to do all in their power to ensure that the full intentions of the legislature in relation to these benefits are given effect to...I propose to approach the Association again in this matter and intend to put forward specific proposals. I sincerely hope that the Association will see its way to enter into discussions and to co-operate in the making of arrangements for a General Practitioner Service." (Fraser cited in Lovell-Smith, 1966: 115).

Nothing was to come of this threat for shortly after it was made Michael Joseph Savage died and was replaced as Prime Minister by Fraser (Oliver, 1960: 199; Sutch, 1966: 246; Chapman, 1981: 349). The Health portfolio was not handed to McMillan who was promoted to Cabinet rank upon Savage's death, but instead to Hon. H.T. Armstrong, formerly Minister of Labour (Sutch, 1966: 246; Lovell-Smith, 1966:

39). Armstrong, like Fraser, was generally considered to be amiable, friendly, and a fine conciliator of disputes. It seems likely that these attributes brought him to the Health Ministry (Lovell-Smith, 1966: 118). In September, Armstrong met with delegates of the BMA and presented them with the Government's proposals for the universal free general practitioner service to be arranged on a capitation basis (Hanson, 1980: 120). These proposals differed very little from those temporarily retreated from by the Government in 1939 when it had chosen to proceed first with the maternity benefit. The BMA responded that it was not willing to support this scheme. Armstrong then confronted the Association with the proposition that if the doctors were not agreeable to a scheme which was acceptable to government, he would recommend to Caucus that the profession be regimented under the powers of the War Emergency Regulations (Lovell-Smith, 1966: 121). Armstrong abandoned this stand at his next meeting with the BMA and instead stated that if the Association took no acceptable action Parliament would proceed with a universal system, accepting those doctors who would co-operate and ignoring the remainder, or alternatively it would establish the system and strike from the medical register those doctors who would not comply with the Government's wishes (Lovell-Smith, 1966: 121-2). Although the BMA contemplated some retaliation to this threat, it eventually chose to do nothing and awaited the Government's next move with some anxiety (Lovell-Smith, 1966: 122-3). This came in December 1940 when the Finance Act No. 4, allowing for a medical benefits contract, was passed by Parliament. The result was that a contract was to be prepared which patients could present to the doctor of their choice. The doctor could, if he/she so desired, accept the contract and send his/her charges to the Social Security Department (Lovell-Smith, 1966: 123). The new regulations which were gazetted on 1 March 1941 offered doctors an annual capitation fee of 15s. for each patient on their books plus a mileage allowance payable at 2s. per patient per annum between three and twenty miles from the surgery. If accepted, the contract scheme would have significantly increased doctors' incomes (Lovell-Smith, 1966: 125; Ward and Asher, 1984: 91; Hanson, 1980: 121; French, 1977: 397). Despite this, the President of the BMA made clear the profession's stand on the same day as the new regulations were gazetted:

> "'The position is perfectly clear,' said Dr. Wilson. 'We shall have nothing to do with this Government national practitioner scheme.' 'What are you going to do about it? he was asked. 'Nothing at all,' Dr. Wilson replied. 'The Government has been

> told that its general practitioner service scheme cannot operate. It would be injurious to the nation's health. We are not going on strike,' Dr. Wilson added, 'but we do say we are not going to become a party to a scheme which would bring about mediocrity in the profession and would be deleterious to the public health.'
>
> 'We are not against the national insurance service. We are very much for it, but the Government has been advised of our requirements in that direction, and we cannot accept proposals which would be injurious to public health or deleterious to the high standard of medical practice in New Zealand.'" (Christchurch Press, 1 March 1941).

There was no compulsion for the doctors to sign the contracts and the BMA advised its members not to co-operate with the Government (French, 1977: 397). An editorial in the New Zealand Medical Journal made clear to doctors that the scheme was completely voluntary and advised them that their strength lay in the unity of their opposition. It added that under the new contract system members of New Zealand's medical profession would, in effect, become civil servants but without the status, amenities, protection or security of civil servants. Finally, the editor commented that those who had been sent contracts should bear in mind the facts that once liberties are surrendered they can never be retrieved and that all potential signatories should consider also the implications of their acquiescence to Government demands for other doctors, particularly those on overseas military service (NZMJ, 1941: XLI, 215, 1-2). Scarcely any of the nation's doctors signed the Government's contract (4).

In the meantime, the Hon. H.T. Armstrong relinquished his portfolio and was replaced as Minister of Health by the Rev. A.H. Nordmeyer who was gaining a reputation as a man who presented his left wing beliefs in a most forthright manner (Lovell-Smith, 1966: 124). It seems likely that the choice of replacement for Armstrong was based not only on Nordmeyer's belief in, and earlier work on, a free medical scheme, but also with consideration to the facts that a general election was due to be held late in 1941 and that the public was becoming increasingly agitated about the long promised introduction of all the provisions of the Social Security Act 1938. Nordmeyer was undoubtedly perceived as the man who could rapidly bring the BMA, peacefully or otherwise, around to the Government's way of thinking.

Public pressure for the free general practitioner scheme was evident, the Government had selected a tough new adversary for the BMA, doctors were increasingly aware that some form of health care scheme was

desirable. The NHIC was now subjected to attack from almost all sides. The mood of the time was captured by the miners of Dobson:

> "...upon a unanimous vote [at their bath house] it was decided not to work that day [4 March 1941] as a protest against the attitude of the British Medical Association, and to urge the Government to compel doctors to comply with the law as is done with other industrial organisations." (Christchurch Press, 4 March 1941).

Jamieson was confronted with grave problems in his maintenance of the profession's long-standing posture. The fact that he managed to retain the Association's firm stance under such circumstances is quite remarkable.

By April it was evident that the Government's efforts to gain contract service from the profession had failed so Nordmeyer began to threaten the doctors with coercive measures (Lovell-Smith, 1966: 126). He also stated publicly that some doctors were being intimidated by their leaders (Christchurch Star-Sun, 10 May 1941). These accusations were paralleled by invective from the doctors who claimed that, in certain areas, members of the profession were being threatened with Government actions to reduce the demand for their services through the employment of new doctors in their locality. Foreign doctors were apparently told that because they were enjoying the hospitality of the New Zealand Government, they must enter into Government service (Lovell-Smith, 1966: 127). Debate continued until July 1941 when the Rev. Nordmeyer announced that the Government soon intended to draw up further legislation on medical benefits. The BMA requested details of the new proposals. Whilst acceptance of the request would not have been without precedent the doctors' plea was denied, although Nash, acting as Prime Minister in Fraser's absence, asked the Association to meet with him in August to discuss the forthcoming legislation (Lovell-Smith, 1966: 132). At this meeting Nash made it clear to the doctors that the Government would agree to virtually anything to achieve the co-operation of the medical profession in implementing the Universal General Medical Practitioner Scheme immediately (Hanson, 1980: 121; Lovell-Smith, 1966: 132) and by the end of the meeting the doctors had been offered a set fee-for-service of 5s. at surgery, 6s. 6d. for home visits, and a travel payment of 1s. 3d. per mile (N.Z. Herald and Daily Southern Cross, 1 October 1941; Hanson, 1980: 121; Sutch, 1966: 246-7; Burdon, 1965: 249). This represented the first such offer by Government to the doctors and at the subsequent

meeting of the NHIC a resolution declaring the rescission of the BMA's plan for a medical service and approving acceptance of the Government's newly proposed scheme was passed by nine votes to five (Hanson, 1980: 121; Lovell-Smith, 1966: 134). At this stage then, compromise would appear to have been achieved. However, Jamieson was not happy with the situation and at the close of the meeting he gave notice of a motion to rescind, at a later meeting, that motion just passed. Jamieson had perhaps perceived that the Labour Party's position had weakened and he now sought to win the greatest possible gains. According to Lovell-Smith (1966: 133-4), Jamieson's stand was supported by the ordinary members of the profession and at a NHIC meeting on 17 September, the original motion supporting the Government was reversed. Jamieson had apparently considered the Association's acceptance of the Government's conditions a surrender and moved to change the decision. His ability to do so is perhaps a measure of his support and strength of influence over the profession at the time. With new resolve the Association met with Nordmeyer and again proposed that any system of payments should allow for some part of the consultation costs to be borne directly by the patient. The idea was strongly opposed and eventually the Government introduced a Social Security Amendment Bill, based on the principle of fee-for-service at fixed rates, to Parliament on 6 September 1941 (Hanson, 1980: 122; Lovell-Smith, 1966: 136-7). Following the Bill's introduction it went before a Public Health Committee of the House to which Jamieson and Gibbes Watson made representations. They argued that the Bill was a coercive measure against a professional body, that it denied rights and freedoms of personal arrangements, that it was unjust for it was being implemented whilst one-third of the nation's doctors were engaged in military activity and hence were unable to present their views, and, finally, that a flat fee did not cater for the exigencies of day-to-day general medical practice (Lovell-Smith, 1966: 137-8). These views, with some embellishments, were echoed in the country's newspapers:

> "The liberty of the individual has now been dealt a ... devastating blow. Personal arrangements between doctors and patients are prohibited. The principles of the Bill extend far beyond the provision of medical benefits. They form the first irrevocable step leading to the subjection of all people.
>
> While at least 30 percent of the profession are helping to take medical care to our boys overseas, their rights are being taken away from them behind their backs.
>
> In practice this free-for-all principle will simply overwhelm the

> already overworked home section of doctors...The tendency must be at least to shorten consultations, but the system might also induce the general practitioner to undertake work beyond his limitations." (Canterbury Division of the BMA cited in Christchurch Star-Sun, 8 August 1941).

All of the doctors' arguments met with "massive indifference" (Lovell-Smith, 1966: 138) and seem only to have strengthened the resolve of Government to have doctors abide by the legislation. The Public Health Committee recommended that a clause in the Act be altered in such a way that it was impossible for doctors to recover any fees from any patient (Hanson, 1980: 122; Lovell-Smith, 1966: 138).

A settlement was now being forced upon a medical profession which had not appeared willing to accept any form of service which did not suit its desires. The doctors' response was to make their position known to the public and on 14 September Jamieson wrote a letter to Fraser which he subsequently released to the press. In essence, Jamieson claimed that the socialisation of the medical profession represented a step towards the subjection to the State of all people in their vocation - something against which the country was fighting in the military arena. He also said that the medical profession desired that necessary medical services be available to all and that there was no need to encroach upon the individual rights of anyone in order to ensure that this was achieved (Jamieson cited in Lovell-Smith, 1966: 139-40). In addition to such emotive appeals to the press the Association decided to spend large sums of money on publicity campaigns. Interestingly, it was resolved by the Council of the BMA that advertising should not give the appearance of having emanated from the Association! (NZMJ, 1941: XL, 219, 317). The efforts of the medical profession seen to have made a considerable impression upon public opinion and an outcry against the Government arose in the press (Lovell-Smith, 1966: 140; Hanson, 1980: 122-3). The Council of the BMA also unanimously decided at an Extraordinary Meeting held on 17 September:

> "that the Social Security Amendment Bill, 1941, if passed by Parliament in its present form, should be disregarded by the Branch" (NZMJ, 1941: XL, 219, 317).

Jamieson was fully aware of the fact that the BMA would be breaking the law but considered that the risk would have to be taken. In order to ensure the strength of the Association he moved that the Council guarantee members of the profession backing in the stand against the Government, and that all doctors sign documents acknowledging their

support for, and allegiance to, the Association. The resolutions were passed (NZMJ, 1941: XL, 219, 317-8). In their co-operation with the national parent body Divisions were quick to respond. As early as 18 September the press carried news of the Canterbury Division's refusal to work under the terms of the Amendment Act! (Christchurch Star-Sun, 18 September 1941). Although the legislation had not been passed, the doctors were premeditating strike action.

At this stage Fraser chose to assume control of negotiations and he arranged a meeting between Nash, Nordmeyer, representatives of the BMA, and himself on 23 September. At this meeting Fraser suggested to the BMA that a patient could present receipted doctors' accounts to the Social Security Department and obtain a refund of all or part of the costs of medical treatment (N.Z. Herald and Daily Southern Cross, 1 October 1941; Jamieson cited in Lovell-Smith, 1966: 142-3). This represented a marked change in Government attitude, for it required the patient to seek repayment from the Department where previous suggestions had revolved around doctors making approaches. Fraser's scheme also allowed doctors to charge a higher fee than the sum provided in compensation to patients by the Social Security Department (Hanson, 1980: 123). Although the doctors appeared to be happy with this proposal neither Nash nor Nordmeyer were. The feelings of these men appear to have been similar to those of many of their Cabinet colleagues for when Fraser put his suggestions to the Labour Ministers the reaction was acrimonious (Lovell-Smith, 1966: 146). Nevertheless, Fraser's viewpoint prevailed and the Social Security Amendment Bill was itself amended by an Order Paper brought down on 5 September. Three major changes to the earlier Bill were made. First, doctors were given the alternative of claiming fees directly from the patient instead of from the Social Security Fund, although in some cases patients were expected to apply for refunds from the Fund. Second, the restriction which would have prevented a doctor from accepting a payment from the patient in excess of the amount which could be claimed back from the Social Security Fund was removed. This point was to be the object of some debate later in the 1940s. Third, the rate for fee-for-service was raised from 5s. per surgery consultation and 6s. 6d. per visit to 7s. 6d. for attendance whether at home or surgery. Emergency attendances at night and on Sundays were payable at a rate of 12s. 6d. and additional fees could be claimed for time consuming attendances. Mileage could also be claimed at 1s 3d. per mile per journey except within urban areas (N.Z. Herald and Daily Southern Cross, 1 October

1941; Dunstall, 1981: 419; Ward and Asher, 1984: 91; Hanson, 1980: 123; Lovell-Smith, 1966: 147; Condliffe, 1959: 308). Whilst the first two changes were greater in terms of principle, it was the amendment to the fees payable which drew most criticism. The public, the politicians, and the doctors perceived it as a bribe, for the fee of 7s. 6d. was a most handsome offer. The N.Z. Herald and Daily Southern Cross was damning in its criticisms:

> "An attempt to sugar the pill for the doctors regardless of the added cost to the taxpayers is made in the latest amendments to the Social Security Amendment Bill...Under the new scale of fees, the Government has raised its bid to the doctors by 50 percent and more...This steep rise is absolutely unnecessary because at no time did the doctors object to the previous scale. Apparently, however, the Government takes the cynical view that money talks, and thinks to buy the doctors' compliance by a deeper plunge into people's purse." (N.Z. Herald and Daily Southern Cross, 1 October 1941).

When the General Medical Services Benefit was introduced the usual doctors fee was approximately 10s. 6d., so the new scheme left most patients with only about 3s. to pay (N.Z. Government, 1975: 48-9). Hanson (1980: 123) considers that it was quite likely that the increased fee of 7s. 6d. was included in order to clinch the deal with the doctors and that it was also to counter the removal of the clause which had forbidden a doctor from accepting any sum in addition to the prescribed fee:

> "By allowing for the payment of the generous sum, for those days, of 7s. 6d. per visit, Fraser and his colleagues must have hoped that for a time at least the doctors would not have to make extra charges." (Hanson, 1980: 124).

With the passage of the Social Security Amendment Act 1941 came the temporary end of the lengthy negotiations between doctors and government and the implementation of a general medical benefit. Although some members of the BMA were still opposed to the general provisions of the Act, it had been drafted in such a way that opposition would not lead to further refusals to work within its terms. The final stage of the Act was a distinct victory to the medical profession (Dominion, 6 December 1984: 1; Sutch, 1966: 248). The Government had compromised in order to get the scheme working (N.Z. Government, 1975: 48). Although medical care was universally available, as sought by Labour, its nature had been drastically altered by the doctors. The new system provided a buffer for doctors against

bad debts. It also raised the standing of doctors in the community by increasing demand for their already valuable services through the subsidisation of charges.

Losing the Lodges

Throughout the December 1940 to March 1941 period of negotiations between the BMA and the Government, friendly societies were concerned about the nature of their relationships with the medical profession. It was quite apparent to lodge members that if doctors accepted the Government's contract, their own medical schemes would become redundant, thereby weakening their overall strength. Whilst this situation existed, the friendly societies strived to preserve the nature of their relationships with doctors. By the end of April 1941, when it had become obvious to the Government that the BMA was not going to accept the capitation contract, the Minister of Health sought to subsidise the Lodges. Friendly societies considered this acceptable, much to the chagrin of the medical profession who saw that a subsidy would make Lodge benefits susceptible to Government control and would thereby indirectly affect the livelihoods of many doctors (NZMJ, 1941: XL, 217, 201-2; Lovell-Smith, 1966: 149-50). Accordingly, the Council of the BMA resolved that medical officers should terminate their contracts with any friendly society which agreed to accept the proposed subsidy from the Social Security Fund (NZMJ, 1941: XL, 217, 202). Divisional representatives of the BMA sent letters to lodges stating:

> "I have been asked by the chairman of the National Health Insurance Committee of the British Medical Association to notify all secretaries of local friendly societies as follows:- If the friendly societies accept subsidy from the Government's Social Security Fund they will endanger their existing arrangements for medical services. All doctors who undertake lodge practice have been advised by the Council of the British Medical Association (New Zealand branch) to terminate their present contracts or arrangements with the lodges if this Government subsidy is accepted by the lodges." (T.H. Pullar cited in Christchurch Star-Sun, 10 May 1941).

This action was very unpopular with the friendly societies who deplored the move and considered that the Association was:

> "taking a false and unnecessary step in [its] resistance to the Government's scheme for universal general practitioner service."

(NZMJ, 1941: XL, 217, 202).

Nevertheless, the relationship between the Lodge doctors and their respective societies was scarcely disturbed. In the wake of the Amendment Act of 1 November 1941 however it was apparent that Lodge contracts as they then existed would not be continued indefinitely. The BMA considered that it would be unfortunate if the medical schemes of the Lodges were to be abandoned and merged into the Social Security General Medical Benefit. It would be a loss to the community if the free social activities of the friendly societies were terminated and if the existing relationship between the Lodges and the medical profession was ended. Considering these points the Council of the Medical Association made an offer to the Societies to operate a scheme similar to that known as the Auckland Transport Workers No. 2 System (NZMJ, 1941: XL, 220, 405; Lovell-Smith, 1966: 150). The terms of this system allowed for a refund by the Lodge of an agreed scale of fees per item of service (Lovell-Smith, 1966: 150). Although this type of scheme was generally adopted the friendly societies of New Zealand were so weakened by conditions prevailing after the implementation of the Amendment Act that most suspended their medical benefit schemes.

This period then was one of considerable upheaval. Preceding years had seen the production of a health care system and attitudes to health care which were somewhat incompatible with one another. Although it was widely acknowledged that revision was necessary, the nature of that revision was the subject of considerable debate - particularly between organised labour and organised medicine. Conflict and compromise between representatives of these two major antagonists produced a system by which health care was available to most people, whilst the character of private medical practice was preserved. In view of the fact that medicine and labour were represented by elected spokesmen it is not surprising that the attitudes and characteristics of those individuals had considerable bearing on negotiations and outcomes. Dr. Jamieson personified and conditioned the intransigence of the doctors whilst Savage, McMillan, Nordmeyer, Fraser, and Armstrong represented the changing attitudes of labour in the face of fluctuating fortunes and circumstances. The overall result of negotiations was that general medical practice in New Zealand was allowed to continue on a fee-for-service basis. In the new milieu however, the State had become more involved in the provision of that service. Under the terms of the new contract between Government and doctors the State intervened to support a failing and progressively more uneconomic form of medical

combined to make private medical care, as it existed prior to c.1940, less accessible to almost people. A variety of interaction however saw the economic security of the medical profession maintained by a new set of relations which facilitated the expropriation of funds from the ill and the dependent. Activity within structural and conjunctural constraints conditioned this transformation. The Labour Party sought to create a State salaried service whilst the medical profession endeavoured to preserve private practice. Whilst the Social Security Act was of benefit to workers, it was also beneficial to New Zealand's doctors.

Despite their humanitarian zeal, the Labour Party had been driven - as the result of various pressures - to implement a mechanism which would facilitiate the strengthened perpetuation of the very system its members had once sought to eradicate. Whilst health care provisions prevailing after the passage of the Social Security Act were better for the working class, the contradictory character of the new system was also to permit doctors to enlarge their incomes, to facilitate the rechannelling of overaccumulated capital from other circuits into the tertiary circuit of capital, and to reproduce the labour class - at that class' own expense through the taxation system.

FOOTNOTES

1. For examples see NZMJ, 1934: XXXIII, 177, 257-68; NZMJ, 1934: XXXIII, 178, 354-65; NZMJ, 1935: XXXIV, 179, 7-14.

2. For a recent and detailed examination of the origins and character of the 'Kurow cure', see Natusch, 1984:42-6.

3. Dr. T.D.M. Stout was appointed by the Council of the BMA as one of the Association's representatives to appear before the NHIIC.

4. The Government claimed that 49 doctors would co-operate whilst the BMA stated that there were only 17 (Hanson, 1980: 121; Lovell-Smith, 1966: 125). French (1977: 397) asserts that 50 doctors signed the contract.

MORE

MONEY MATTERS

(c. 1942 – c. 1960).

6

CHAPTER 6

MORE MONEY MATTERS (c.1942-c.1960)

In this chapter consideration is given to the relationships which promoted the recommodification of medicine in the wake of Labour Government activity intended to make medical treatment 'free'. Despite a short spurt of expansion in the provision of health care services and benefits after the passage of its historic social security legislation, the Labour Government was ousted from power by a public keen to discard the regime which continued to impose restrictions more characteristic of wartime than of peacetime. In its last years of power however, Labour had succeeded in introducing a wide variety of health benefits which, in combination with various social pressures such as immigration and changing employment patterns, drew medical practice further into institutional domains and which consumed more and more State money. When National took political leadership in 1949 health care costs were escalating rapidly. In its efforts to place restraints on expenditure the new Government gradually assumed total control of public hospitals whilst at the same encouraging private hospitals, for the private organisations could provide beds which the community required, at less cost to the taxpayer than the equivalent numbers (1) of beds provided by the State. Private hospital expansion and subsidisation continued under the guidance of Hon. J. (later Sir John) Marshall, the Minister of Health, and upon the advice of a Consultative Committee on Health Reform. In the Hospitals Act 1957, private sector encouragement became a legal requirement of the Minister of Health. In effect, this period in which public and private hospitals came more firmly into the sphere of Government activity marked the placement of all hospital care in an arena in which a manipulation of the government apparatus could most successfully legitimate or preserve the patterns and levels of influence of those holding or seeking 'power' within the community.

A short time after the Social Security Amendment Act 1941, some doctors began encouraging a 'token' system of patient payment for medical services. The Government-BMA debate which ensued saw the establishment of the Medical Services Committee comprising doctors and government representatives to resolve the issue. Surprisingly, the recommendations made by the Committee for a 'Schedule' system gained both Labour government and BMA support and were incorporated into the

Social Security Amendment Act 1949. New relational characteristics saw doctors' wishes more readily conceded to than in previous years.

By the end of the 1950s then, 'private' medicine was being formally located as complementary to public sector services. In addition, Government-doctor relations saw the emergence of a mechanism which provided doctors with the potential to maximise incomes by use of taxpayers' money whilst maintaining professional sovereignty.

Labour's Gains and Losses

The Labour Party had always reproved the ungrateful and ungracious nature of repatriation following the Great War, and in the wake of the 1939-45 conflict its members sought to do all they could to provide returning servicemen with the best opportunities to recommence civilian life. To adequately achieve this it seemed necessary to the Government to institute new powers of control or to maintain those prevailing during the War to ensure that servicemen obtained jobs at adequate rates of pay; that farmland was available for settlement at reasonable prices; and that defenders of the realm were able to establish businesses, buy homes, or to complete a formal education (Oliver, 1960: 209-10; Chapman, 1981: 352). In the meantime the economy was booming and despite the return to New Zealand soil of thousands of servicemen there still existed a shortage of labour. The consequent struggle amongst employers for workers drove wages up, prices up, and sparked an inflationary spiral here which has been a characteristic of most Western economies since the War. Inflation was further fuelled by the high price of imports as they became available from war scarred industrial countries. Unpopularly high taxation was necessary to support the Government's broad based social security and repatriation schemes:

> "...taxes to finance welfare services, housing and school construction development programmes; taxes to pay for social security benefits which had to increase with prices; taxes to provide the subsidies which the government paid to producers to peg the prices of food." (Oliver, 1960: 210).

Whilst regulation and control had been acceptable during wartime, peace brought pressure for relaxation (Oliver, 1960: 211; Chapman, 1981: 352). The people of New Zealand sought the rewards they considered had been fairly earned during the recent conflict and a release from

regulation. The Labour Party however could not dismantle its ad hoc but cohesive system of controls during the 1940s for fear of disrupting the entire economy:

> "If Labour was still a party of change it stood surrounded and perhaps trapped by the changes it had made. If it was a social democratic party, then it was committed by democracy to the economic system which the overwhelming majority continued to prefer, however frequently they called for its social impact to be modified. Moreover New Zealanders had changed because of the war and the opportunities opened up by economic and social security. There was a drive to enjoy the peace, to take Labour's achievements for granted as the basis for getting on with private life." (Chapman, 1981: 354).

As the memories of war and restraint faded into the mists of glory and spartan pride the National Party became more popular. Whilst National intended to maintain social security in some form or other it claimed that it would both make the pound go further and give greater freedom to all (Sinclair, 1980: 287). In effect, the National Party was offering the voter much the same as advocated and implemented by Labour but with popular additions which Labour was philosophically, politically, and economically unable to provide. Labour's slide in popularity began early in the 1940s and despite efforts to stem the flow of voters towards National little could be done to fully prevent losses. Apparently in an effort to minimise the political implications of rural dissent in the more right wing rural areas Labour put an end, during 1945, to the 28 percent 'country quota' which gave that much extra representation to the rural population (Sinclair, 1980: 285-6; Sutch, 1966: 320; Chapman, 1981: 352-3). Under the new system electorates were worked out on the basis of the size of the voting age population. Inexorably however the 1940s saw National drawn closer and closer to political power and on 30 November 1949 it won with an election majority of twelve seats (Wilkes and Shirley, 1984: 292; Sinclair, 1980: 287; Sutch, 1966: 365; Oliver, 1960: 211 and 220; Chapman, 1981: 333). General trends indicate that people were happy with the Social Security legislation introduced by Labour and great advantage was taken of the wide and expanding variety of benefits which were available. The public were not so contented however with the regulation and taxation which were necessary to maintain these and other benefits. Although the National Party alternative eventually proved unrealistic, the promises to maintain the good aspects of Labour's legislation whilst dispensing with some of the less appealing elements obviously appealed to voters. These then were the general circumstances which led to public endorsement of free enterprise

policies, despite the advantages which had accrued to some people under a purportedly socialist government. In the specific field of health care, the period 1942-59 was initially marked by extensions to the health and security policies Labour had introduced during the late 1930s and early 1940s, but thereafter numerous forces fostered the re-emergence and development of what can loosely be termed free-enterprise medical care. The characteristics of the Social Security legislation had left legal and political scope for 'private' expansion. Although the Labour Government had more or less intended to uproot the tree of private enterprise in health care, pruning was all that had eventuated. In consequence, after an initial shock, and following a little tender loving care under the National Party, private medicine began to grow back with renewed vigour.

Growing Benefits - Growing Demands

In the first few years after the implementation of the Social Security Amendment Act the Labour Government extended both the health and welfare provisions of its legislation. In 1943 the rate of payment by Government to hospital boards rose from 6s. per patient per day to 9s.. This payment was regularly reviewed thereafter until a new method of funding was implemented (AJHR, 1944: H-31, 8; Department of Health, 1966: 15; N.Z. Government, 1975: 60). On 1 September of the same year Massage Benefits were introduced (AJHR, 1943: H-31, 5). These latter benefits served to strengthen the professional dominance of doctors over other helots of health, for the benefit was payable only if massage had been prescribed by a doctor. From September 1944, District Nursing and domestic assistance became available (AJHR, 1945: H-31, 9; Condliffe, 1959: 310). These represented the first steps towards inauguration under the Social Security Act of home help provision during the incapacity of mothers or in cases of hardship. 1944 also saw amendments made to the Outpatients Regulations in order to enable Hospital Boards to provide, as outpatient treatment, approved services afforded at some place other than a public hospital. The principal purpose underlying this was to allow Boards to make arrangements with recognised specialist surgeons to cater for cleft palate and hare lip operations (AJHR, 1945: H-31, 9). In 1946 a laboratory benefit was introduced, providing general practitioners and specialists with the facility to obtain tests outside the hospital laboratory service at no cost to their patients (N.Z. Board of Health,

1974: 10; Condliffe, 1959: 310). 1947 saw artificial aids such as limbs, contact lenses and hearing aids made available (AJHR, 1948: H-31, 36-7; Condliffe, 1959: 310). The type and nature of benefits were expanded. Growth also occurred in the scale and cost of benefits provided. Whilst this was stimulated to some degree by the fact that more people were availing themselves of medical services because of negligible or non-existent costs at the time of use (AJHR, 1944: H-31, 8; AJHR, 1945: H-31, 10; AJHR, 1946: H-31, 23; AJHR, 1948: H-31, 36; Recorder, 1945: 34; Condliffe, 1959: 312), expansion was also stimulated by natural increase and immigration which together drew population upwards at a rate of almost 2 percent per annum from 1945 until the 1960s (Dunstall, 1981: 400; Hawke, 1982: 177); general price inflation (Hawke, 1982: 169) which pushed up the cost of some benefits, particularly pharmaceuticals (AJHR, 1944: H-31, 8; AJHR, 1946: H-31, 23); and the demobilisation of many men following military service overseas (Condliffe, 1959: 96). More people were using increasingly expensive medical services. "A great majority of the population [were] receiving services which they were unable to afford in the past." (AJHR, 1947: H-31, 29). Unfortunately "these advantages [were] purchased only at a price." (AJHR, 1948: H-31, 36). The Government began to consider that expenditure on health services was becoming somewhat exorbitant and that the general population was abusing the privileges which had been gained so hard:

> "It seems to be forgotten by too many of our people that health services as organized in New Zealand are a form of insurance against sickness and ill health and that, whatever form or measure of service is demanded, it must inevitably be paid for, however indirect payment may be. All too frequently one hears the statement that so much tax is being paid and it behoves every one to get as much in return as possible." (AJHR, 1948: H-31, 36).

Although medical services were provided on a collective basis, much of the rest of the economy operated along capitalist lines. Under such conditions, with a prevailing capitalist consciousness, it is scarcely surprising that some members of the public sought to obtain 'value for money'. However, as has already been stated, growing pressure on Government funded health services was not purely a matter of greed.

Heightened demand was stimulated, in part, by changes in the composition of the workforce. Wartime conditions had required many women to serve in non-traditional roles in which some found a new satisfaction and sense of identity. Consequently, in the wake of the war, large numbers of women continued to seek paid employment. With

post-war demands for labour this wish could be fulfilled. As had occurred in the past however this type of employment shift had implications for New Zealand's social fabric. Women in paid employment were not in the same position to care for sick or injured family members as their predominantly home-bound predecessors. Instead of illness being treated in the home, increasing reliance came to be placed upon doctors and hospitals. This too was fostered by the expanding scope of medical practice which, by the late 1940s, was reaching into previously unconceived areas of personal and community health. Over time, the growing feelings that 'the doctor knows best' and that home health care was inadequate became ingrained in the public's consciousness. Social pressure was to both prevent the continued practice of previous forms of medical treatment and to enhance the position of professional and institutionalised medicine. The growing reliance on professional medical care which all of these movements promoted would eventually help to provide a core of demand which would persist even after Government intervention was redirected and de-emphasised.

The problem of escalating costs in the provision of health services was one which was to plague various Governments for many years to come. Attempts to dissociate the State from burgeoning expenditure were a feature of much of the subsequent reorganisation of the New Zealand health care system.

Pushing to Private Hospitals

Despite their nationalisation under the provisions of the Social Security Act hospitals were not co-ordinated into a national system (Condliffe, 1959: 310). In essence, the character of hospital administration remained as it had prior to 1938 with the only real difference being that hospitals were to provide patients with free treatment in return for a payment from government of 6s. per day (AJHR, 1952: H-31, 33; AJHR, 1944: H-31, 8; Department of Health, 1966: 15). This level of remuneration was readily accepted by Boards for 6s. was considerably more than the average sum collected from patients. It is intriguing to observe that although Government became the primary source of funds for hospital boards it permitted the continued local administration of hospital activities. It seems likely that it was necessary to maintain local administration in order to gain

the acquiescence of hospital boards to the concept of a universal free hospital service. The situation then was that whilst hospital boards were funded mainly by Government - with most of the remaining finance coming from rates - they retained a considerable degree of administrative autonomy. Government held little control over its own expenditure. In the wake of the Act the combination of the technological competence existent in public hospitals with the provision of free care saw a rush of people to public beds (Condliffe, 1959: 312; Recorder, 1945: 34). This trend was accentuated by the rapidly increasing population. Although most funds came from Government, rates still provided some of the money for hospitals, and the growing demand for hospital beds put a quite direct strain upon ratepayers' budgets. Without placing huge and unpopular demands on their ratepayers, hospital boards could not keep up with the demand for the hospital services which the Government had promised would be free. In consequence, government endeavoured to stabilise the hospital rate with the passage of the Finance Act (No. 2) 1946 which became effective on 1 April 1947 (Department of Health, 1966: 15; McKay, 1969: 19-20; N.Z. Government, 1975: 60; Condliffe, 1959: 312; Fraser, 1984: 63; Advisory Committee on Hospital Board Funding, 1980: 109).

> "The Finance Act 1946 pegged the rate of levy to 1/2d. per pound of rateable capital value in a hospital district, or an amount equal to one half of the net estimated expenditure of the Hospital Board, whichever was the lesser amount." (N.Z. Government, 1975: 60).

The effect of this legislation was to reduce the financial pressure on local ratepayers and to assure Hospital Boards of a minimum subsidy from Government of pound for pound with no fixed maximum (Condliffe, 1959: 312; N.Z. Government, 1975: 60; Department of Health, 1966: 15). This led to changed outlooks on the part of many hospital boards which could now build, purchase equipment, and employ staff to degrees which would not have been feasible under the previous rating system (Advisory Committee on Hospital Board Funding, 1980: 109; Department of Health, 1966: 15). A variety of interactions had created a public health milieu which encouraged the expansion and development of medical practice within the community. Even though hospital board contributions towards their own running increased because of land revaluation, expenditure by the boards - which was expanded, in part, by inflation - rose dramatically during the 1940s, thus placing an immense burden upon Government finances. As a proportion of levies and

Government subsidies, levies fell from 48.6 percent in 1940 to 21.7 percent in 1950 (N.Z. Government, 1975: 60). Accordingly, in an effort to seize control of public hospitals and thereby to gain greater ability to curtail the massive expenditure on hospitals the Government introduced the Hospital Amendment Act of 1951. Under this legislation hospital board levies were to be progressively phased out with the Department of Health assuming total financial control of public hospitals during the 1957-8 fiscal year (AJHR, 1955: H-31A, 5; Marshall, 1983: 183; Department of Health, 1966: 15; N.Z. Government, 1975: 60; Condliffe, 1959: 312; McKay, 1969: 20; Fraser, 1984: 63-4; Advisory Committee on Hospital Board Funding, 1980: 109). Paradoxically, in efforts to reduce its expenditure on public hospitals the Government had first to shoulder a greater burden of that expenditure. Other logic also underlay the move, for at much the same time as Government was progressing, perhaps unwillingly, towards almost complete control of public hospitals it was also beginning to offer greater encouragement to private hospitals. The tale of the private hospitals during the 1940s and 1950s is interesting, coloured as it is by mixed fortunes and beneficent Government action. It was never seriously contemplated by any New Zealand government that private hospital services here should be dismantled. Even the Labour Party's reforming zeal of the late 1930s did not extend to private hospitals. Indeed, the Social Security Act entitled the licensee, or any other legitimate claimant, of a private hospital to funds equivalent to those payable to public hospitals (i.e. 6s. per patient per day) by Government in respect of patient treatment. The Rev. Nordmeyer's 1938 Select Committee on National Health and Superannuation had considered that those people wishing to make use of the private sector should be quite free to do so (French, 1977: 411). In view of the Labour Party's attempted socialisation of medicine this attitude seems somewhat contradictory although three explanations can be perceived. First, the Labour Government may have considered that the abolition of private hospitals would alienate many potential supporters of the Social Security Act and probably felt that a free public hospital service, with its better resources, would gradually put an end to private hospitals anyway. Second, despite the emphasis on curative medicine of the 1930s' Social Security legislation Labour's attention had been directed at preventive medicine. Therefore, hospitals, with their curative role, escaped close scrutiny. The third, and related factor, is that the emerging status quo of duality may not have appeared to be problematic. Available evidence

suggests that the Government's actions with respect to private hospitals were to have perhaps unexpected consequences. In 1942 New Zealand had 321 private hospitals. Over the next twelve years these hospitals closed their doors at a rate of almost 15 per year leaving only 146 operational in 1954 (Department of Health, 1966: 20). Interestingly though, the same period saw the number of private beds available rise from 3025 to 3227 (Department of Health, 1966: 20). The average private hospital size had more than doubled from 9.4 beds to 22.1. Although lack of interest on the part of the nurses who ran many private hospitals and the enforcement of higher standards forced some, particularly small, hospitals to close (N.Z. Government, 1975: 52), government funding methods also had a considerable impact for such funds provided a guaranteed source of income to those hospitals which could attract patients and staff. In order to appeal to these two groups in the rapidly expanding field of medicine and to be able to compete with the public hospitals, private hospitals had to be sufficiently large and wealthy to enable them to justifiably purchase attractive, up-to-date equipment. It would also have helped to be established in a large, densely populated settlement in close proximity to a wealthy clientele. Although attitudes towards charity and free public service had changed markedly over the years, there still existed a body of feeling favouring private facilities as being socially and morally superior to those of the public sector. Accordingly, a market for private hospital services was still evident. Whilst the number and size of private hospitals altered, so too did the empirical relationship between public and private beds. In 1939 22 percent of the nation's hospital beds were privately provided. This figure had dropped to less than 15 percent in 1949 (AJHR, 1950: 38-9). By 1950 too the number of public hospital beds per 1000 of the population was declining (Bassett and Harris, 1978: 6) despite great increases in government expenditure on them. The costs involved in providing hospital beds were escalating and it became increasingly difficult for both public and private providers of facilities to keep pace, although they attempted to do so - at different rates. The newly elected National government, with its policies of free enterprise and deregulation, had to find some means to satisfy voters' demands for hospital treatment whilst restraining State expenditure in that area. A solution appeared to lie with private hospitals, for those which were economically viable at the time were providing services comparable, in some respects, with those available at public facilities. In line with National policy, Government support for private hospitals would provide

people with the 'freedom to choose' between public and private hospitals and would serve to increase the number of hospital beds at less expense to government than if they had been publicly provided. The reasons for the National Government's support of private hospitals are stated in the autobiography of the man who assumed the position of Minister of Health in 1951, J. (now Sir John) Marshall:

> "There were several reasons for keeping private hospitals, which appealed to me. First, they were private-enterprise ventures, and we stood for private enterprise. Secondly, private hospitals saved the State a very large amount of public funds in running costs. Thirdly, as private hospitals closed, the State had to meet the substantial capital cost of replacing that amount of hospital accommodation. Fourthly, private hospitals gave opportunities for those members of the medical profession who were not on the staff of public hospitals. Fifthly, where the private hospitals were available, people had a choice, if they could afford it, not to get better treatment (the public hospitals were often better equipped) but to have the attendance of their own doctor, more personal service, free visiting hours, and, on occasion, earlier admission for less urgent cases." (Marshall, 1983: 185).

When one recalls that the new National Government was simultaneously increasing its control over public hospitals some interesting motives are revealed. In assuming responsibility for hospital board finances Government was creating an environment in which it would be possible to reduce its expenditure on public hospitals with little effective complaint from ratepayers and hospital board members. Muzzling of discontent would also be effected by the existence, promotion, and growth of private facilities. The National Party could thus fulfil election promises to maintain social security services - even increasing the level of 'assistance' to them - whilst reducing Government expenditure and adhering to the Party's political philosophies. Just one year after its election to power National established a Committee of Inquiry to investigate the financing of private hospitals (French, 1977: 42; Department of Health, 1966: 13; Hay, 1984: 4; Board of Health, 1974: 11). On the basis of the Committee's recommendations a maintenance subsidy scheme was introduced to provide assistance to private hospitals on the basis of need (Hay, 1984: 4; MANZ, 1975: 42; French, 1977: 42; Department of Health, 1966: 13; N.Z. Government, 1975: 52; Fougere, 1984: 81; Board of Health, 1974: 11; Fraser, 1984: 63). These subsidies were increased in 1951 and 1953 (Board of Health 1974: 11). In October 1952 more public money was made available to private hospitals by means of a loans scheme to assist in the construction of building extensions; to

purchase equipment; for the purchase of existing hospitals; and for the building of new private hospitals. This scheme was extended two times, first in 1954 and again in 1956 to include suspensory loans (Hay, 1984: 4; Board of Health, 1974: 11). The effects of these schemes were described by the Minister in a memorandum to Cabinet on 18 October 1956:

> "The increase (sic) in benefits and the loan provisions have resulted in a much brighter outlook for this very important service...This in addition to saving a decadent and dissatisfied service and turning it into a happy satisfied and more efficient one, performs a very useful State function in providing one-seventh of our total hospital beds and are (sic) today adding beds at a greater rate than public hospitals." (Minister of Health cited in N.Z. Government, 1975: 53).

The policies were continued because:

> "If new private hospital beds are not established to help meet growing demands, the full responsibility of providing the beds devolves on the hospital board and the total cost has to be met eventually from Government funds. In addition to the eventual capital savings, the Government also saves a considerable part of the maintenance costs of the beds to the extent of some several hundreds of pounds per day per annum." (Cabinet Paper cited in N.Z. Government, 1975: 53).

The National Government continued its experiment with private medicine by establishing a Consultative Committee on Health Reform chaired by Mr. H.E. (later Sir Harold) Barrowclough (Department of Health, 1969: 16; Gilbert, 1969: 73; French, 1977: 413; N.Z. Government, 1975: 62; MANZ, 1975: 45; Bassett and Harris, 1978: 7). The terms of reference of the Barrowclough Committee required it to:

> "inquire into and report on matters affecting the administrative control of public hospital and other services provided by Hospital Boards, and, after taking evidence, to make recommendations to the Government for the reform of the present hospital system." (AJHR, 1954: H-31A, 39).

As part of this, the Committee was directed to investigate steps which could be taken to provide for the more effective and efficient control of expenditure (AJHR, 1955: H-31A, 25). In its report of 6 November 1953 (AJHR, 1955: H-31A) the Committee claimed that an important method by which maintenance expenditure could be limited lay in the encouragement of existing private hospitals. Private hospitals were considered to be of interest to the community in that they relieved the burden on public hospitals and improved the standard of medical care. The Committee believed that financial difficulties were forcing many

private hospitals to close, thereby increasing the pressure upon public hospitals. This saw the Government compelled to spend sizeable sums of money to provide the beds which had been lost in private hospitals:

> "Having regard to the fact that the capital costs of extra beds in public hospitals is something in the vicinity of 4000 pounds to 5000 pounds per bed, it is obviously bad business for the State to allow these private hospitals to go out of existence." (AJHR, 1955: H-31A, 30).

Furthermore, the cost to the Government of maintaining a patient in a private hospital was considerably less than if the patient was treated in a public hospital. The Committee went on to argue that because private patients paid at least as much in the way of taxes and social security charges as public patients they were entitled to receive considerably more from the public purse than was the case at the time:

> "It (sic) that were done, then private hospitals could, without fear of losing patients, raise their fees to such a figure as would enable them to conduct business on a sound financial basis. They could look ahead with reasonable confidence and keep their institutions in a modern and up to date condition. They would make proper and adequate allowance for depreciation and still receive a reasonable return on the capital invested. At the same time, notwithstanding the payment of a much more liberal subsidy, the State would be saved a considerable sum in the maintenance of each patient who elects to go into a private institution. It would also save the capital cost of replacing beds that are lost when a private hospital closes down." (AJHR, 1955: H-31A, 31).

Perhaps providing the basis of the comments made by Sir John Marshall, the Barrowclough Committee considered that private hospitals provided a useful workshop in which practitioners who were not on the staff of public hospitals could practise and keep current with their art. In this way private hospitals supposedly maintained and/or raised the standard of medical practice in the community (AJHR, 1955: H-31A, 31). It is difficult to comprehend however the means by which surgeons, for example, raised or maintained their levels of practice by performing the types of operation typically conducted in private hospitals (e.g. appendectomies, tonsillectomies) instead of the broader, more intricate type of procedures undertaken at public hospitals. In the wake of the Barrowclough Committee's Report the Minister of Health introduced a policy to the House in July 1954 which was to "give a new lease of life to private hospitals" (Marshall, 1983: 186). The new policy marked a number of significant changes in Government attitudes towards private hospitals. A direct patient subsidy of 18s. per day for medical hospitals, one pound one shilling for surgical hospitals,

and one pound ten shillings a day for maternity hospitals was to be paid. Low interest loans were also to be made available for innovations and new equipment, and suspensory loans were also established (Marshall, 1983: 186). Marshall's funding scheme and the principles it embodied were to serve the country through the following thirty years of predominantly National Party government.

A variety of processes had conditioned the character of the health care system such that exchange relations in medicine were resurfacing. Social security legislation had allowed the continued existence of private hospitals and, now, in response to new relationships, recommodification of one aspect of medical practice was occurring. The characteristics of the new system saw patient discrimination on the basis of wealth, not need, and the expansion of a State-supported, yet 'private' milieu in which doctors could practise and profit.

The Barrowclough Committee did more than simply advocate Government support for private hospitals. It also endeavoured to examine the whole future of the public hospital system with regard to demands that would be placed upon Government when hospital rating was eventually abolished. The Committee expressed its doubts as to whether the system of administrative control which was adequate when hospitals were funded primarily by rates would be satisfactory when hospitals were entirely Government financed (AJHR, 1954: H-31A, 5). In line with long established trends by which administrative control followed finance to its sources, the Consultative Committee went on to say that if Government was to provide funds it must assume greater responsibility for the quality and nature of the services to be provided. The Committee considered that this control might be achieved if legislation was passed to give the Minister of Health, as "the representative of the State" (AJHR, 1954: H-31A, 7) initial responsibility and authority over hospitals rather than leaving it with the Boards. In view of the fact that the Government had undertaken to provide free and adequate hospital services for the entire population it appeared to be the duty of the Minister to direct and control the provision of those resources. In order to achieve sound administration of this new system Barrowclough's Committee envisaged a pattern similar to that of the English National Health Service. The recommendation was that a three tier hierarchy of administration be established. This would comprise the Department of Health, which would oversee the national situation, five Regional Authorities to act as agents of the Minister of Health in

their respective regions, and hospital boards, which, at the hospital district scale, would serve as the agents of regional authorities. The regional authorities were intended to take an intermediary position in the apparently wide gap between hospital boards and the Department of Health, thereby facilitating more effective hospital management than was previously the case (AJHR, 1954: H-31A, 4-16). Despite strong opposition from hospital boards, whose members had taken great interest in the development of hospital services in the community and were reluctant to retire from the scene, the Committee also thought that for administrative ease within their proposed tripartite system and in order to make more economical use of equipment and services, the number of hospital boards in the country could be reduced from 37 to 23 (AJHR, 1954: H-31A, 16-8). The changes were primarily to affect smaller boards. Improved communications, different rates of relative growth, and more expensive medical technology engendered spatial and bureaucratic patterns which made small scale hospital boards less administratively acceptable within a general milieu characterised by growing government dominance. In turn, change would colour the perceptions of space held by doctors, nurses, patients, and hospital administrators. Hospital board areas of activity would be different, and patterns of hospital location and dominance would alter.

Strangely, despite the circumstances of the time, many of the recommendations of the Barrowclough Committee, including those directly affecting the spatial patterns of hospital board administration were not implemented. It is possible that the election to power of Labour in 1957 (Wilkes and Shirley, 1984: 292) had a part in this. Nevertheless, at least some of the Committee's suggestions found their way into the Hospitals Act of 1957. One reversed the policy of placing primarily on local hospital boards the responsibility for providing hospital services, replacing it with one under which the Minister of Health was charged with the duty (Department of Health, 1966: 16). This represented both a centralisation of authority and part of the Government's move to gain greater control of the hospitals it was to completely finance with the phasing out of the hospital rating system. Constraints on hospital board activities could now be better implemented and more tightly enforced. Formalisation was also given to the already existent encouragement by the Minister of Health of private hospitals. The Act sets out the duty of the Minister:

> "to encourage the provision and maintenance to such an extent as

> he considers necessary, of private hospitals..." (Hospitals Act cited in Malcolm, 1983f, 1).

Thus, with the passage of the Hospitals Act 1957 the Government had at last assumed almost complete control of public hospitals - something towards which it had inexorably moved for decades - and it had also assumed a position subject to political, economic and social vacillations, of importance in private hospitals. If so desired, the Government could now make up for inadequacies in the public sector by encouraging the superficially cheaper private sphere. The Act was a deliberate and reasoned step towards this capacity for interchange and marked the culmination of many years of apparently unrelated interactions and processes. There were, however, underlying trends. The capitalist system of the pre 1920s period had been shaken in 1929. The effects upon workers in New Zealand were profound. Various adjustments which served to restore the faith of workers in the system which ensured their continued reproduction and exploitation by capitalist classes occurred (e.g. social security legislation). In the wake of the Depression further readjustments occurred, these facilitating the most economically productive use of capital. This however was not achieved in such a way that workers became concerned at a loss of security. The compromise which evolved permitted security to be maintained whilst allowing political and economic flexibility in case of future fluctuations in capital. At any time funds could be diverted from the public sector to the private and vice versa.

Paying the Doctor. No Token Gestures?

Whilst rearrangements in the hospital system were occurring protracted wrangling between the Government and the doctors continued. With the passage of the Social Security Amendment Act in 1941 the rift between the BMA and the Government was only temporarily bridged. The scheme proved to be administratively expensive, costing the taxpayer up to 1s. 6d. for the processing of each refund claim sent from patients to the Department of Health (Lovell-Smith, 1966: 151). In some areas too, doctors commenced operating an informal 'Token System' under which doctors continued to charge their patients 10s. 6d. but did so by accepting only 3s. from the patient and claiming the balance of 7s. 6d. directly from the Social Security Fund (Lovell-Smith, 1966: 152; Hanson, 1980: 124). According to the BMA's own solicitor, Mr. G.G. Gibbes Watson, this practice was illegal under the provisions

of the Act in that such claims against the Fund made implicit representation to the Department of Health that the doctor had not received any payment from the patient. Dr. Jamieson expressed this view in the December 1941 issue of the N.Z. Medical Journal and was surprised when he subsequently received a letter from the Director-General of Health disputing Gibbes Watson's interpretation of the Act. Correspondence continued, with legal advice given to the BMA contradicting that given to the Department of Health (Lovell-Smith, 1966: 152-3). Against this backdrop of legal debate the number of doctors accepting 'token payments' continued to grow and the Department of Health urged doctors to claim directly from the Social Security Fund rather than have patients make the claim. The Department considered that this system would lower the administrative demands placed upon it. The BMA rejected the Department's proposal as it would be absolutely contrary to the attitude agreed upon after the passing of the Social Security Act and because of the problems the Association considered were likely to arise from the scheme. However, there were problems arising within the profession:

> "It is possible to sympathise with Jamieson and the other leaders of the profession in their intransigence in this matter, but it became increasingly obvious that they were, to a large extent, out of touch with the rank and file of general practitioners, who saw the Token system as a means of 'practising as before' and yet acceding to the wishes of the bulk of the community..." (Lovell-Smith, 1966: 154).

Although there was a stage when almost 60 percent of the country's general practitioners were working the 'Token System' (French, 1977: 399; Lovell-Smith, 1966: 156) it was possible under the existing legislation for doctors to be remunerated in any one of four different ways. They could work under a Refund system, under Capitation, under Direct Claim, and under Direct Claim plus a token payment from the patient (Lovell-Smith, 1966: 154). Some doctors informally assessed each patient's income and used whichever system appeared appropriate. Incomes soared - a growth accentuated by the late wartime shortage of doctors throughout the country. Jamieson was distressed with the situation, seeing it as an abuse of the system by both doctors and patients. He was not the only one to be perturbed. Specialists and salaried doctors now earned considerably less than general practitioners (Lovell-Smith, 1966: 154-6). Action had commenced however. Confusion and concern about the plight of doctors returning from overseas military service had led to the formation of a most important Committee of Council of the BMA on 7 May 1943. This was The

Medical Planning Committee (Lovell-Smith, 1966: 157). Comprising a more representative sample of the nation's medical profession than the NHIC it temporarily replaced and superceded, the new Committee met frequently over the ensuing three years and on 6 January 1946 it published a final report. This document was the BMA's blueprint for a unification of New Zealand's medical services and for planning and policy formulation (Lovell-Smith, 1966: 157-8). Amongst a host of conclusions, the Committee recommended that provision of all specialist and general medical services be mediated by one means of payment only - that being the Refund system. The ideas of the Committee were not well received by the remainder of the medical profession who first had the chance to offer criticism on 13 September 1944 when the draft final report was considered at a meeting of Council (Lovell-Smith, 1966: 158-71). After some debate, with various Divisions supporting each of the four systems of payment then being used, the meeting was faced with the choice of advocating either fee-for-service (i.e. direct claim by doctors from the government), towards which public opinion was slowly forcing doctors, or the Refund system. Only a stirring speech by Jamieson prevented the medical profession from adopting the direct claim system - a system which Jamieson believed would mean subordinating medical work and the doctor-patient relationship to the government (Lovell-Smith, 1966: 172). However, discontent remained amongst medical practitioners so a survey of opinion of all doctors in New Zealand was conducted. The results of this referendum strongly indicated that the BMA should re-open discussions with Government and that the general body of doctors was no longer in favour of Jamieson's policies. As a result, Jamieson, a bitter and disappointed man, chose not to seek re-election to the office of Chairman of Council in March 1945 (Lovell-Smith, 1966: 173). In accordance with the opinions indicated in the survey, the Association approached Government to ascertain the likely future direction of medical services in New Zealand and whether the Government would agree to the Refund system as the normal means of remuneration. The results of Government-BMA discussions were somewhat inconclusive as the Executive of the BMA failed to gain any clear indication of the Government's intentions towards medical services. There was evidence however that a State salaried service was being considered (Lovell-Smith, 1966: 173-7). With this knowledge the Final Report of The Medical Planning Committee was presented for confirmation at the first post-war annual general meeting of the BMA in February 1946. In general the profession was happy with the Report but debate arose from the third recommendation:

> "The Refund system should be adopted as the standard method in general practice, and fee for service continued. No extension of the capitation system should be attempted prior to demobilization." (Lovell-Smith, 1966: 178).

After considerable discussion and several proposed amendments the BMA resolved to permit the Executive to negotiate with the Government upon the Token system. Jamieson and his followers were deeply disturbed at this move and several senior members of the profession subsequently withdrew from the BMA in protest (Lovell-Smith, 1966: 179-80).

Discussions with Rev. Nordmeyer commenced shortly afterwards. Nordmeyer expressed the Labour Party's dislike of the Refund system and noted that there existed considerable pressure within the Party to abolish Refund. He also told the Association's representatives that he intended to introduce legislation which would make Token practice illegal, put an end to Refund, and enforce a Direct Claim system of practice. Whilst the Minister's personal preference was for a salaried service, the Labour Party had decided that the fee for service (direct claim) system was best, provided that under its terms medical care would be entirely free to the patient (Lovell-Smith, 1966: 180). It was obvious at this stage that both sides had changed their attitudes. The time seemed right for alterations which to be made to the character of payment for general medical practice in New Zealand. Accordingly, the Executive of the BMA resolved in May 1946 to request Government to establish a committee comprising Government nominees and BMA representatives. Rev. Nordmeyer agreed, this marking a triumph for the Association which had for years endeavoured to convince the Labour Party that an 'expert' committee should be commissioned to conduct an inquiry into New Zealand's health services (Lovell-Smith, 1966: 181-9).

Scheduling a Change of View: The Medical Services Committee

The Medical Services Committee was set up in October 1947 under the chairmanship of Mr. T.P. (later Mr. Justice) Cleary and, in addition to Mr. Cleary, comprised three BMA representatives and three from government (N.Z. Government, 1975: 49; Lovell-Smith, 1966: 189; Royal Commission on Social Security, 1972:43; Hanson, 1980:124). The Committee was charged with examining the provisions of the Social Security Act 1938 affecting the services and administration of medical

practitioners and to advise of the alterations would be necessary to give effect to the Government's policy of providing general and specialist care free or substantially free of cost (N.Z. Government, 1975: 50). The composition of the Committee created some tension, but the elements of co-operation and concession existed amongst its members. The Committee produced a report with three main sections. The first section recommended the establishment of a variety of committees through which the medical profession could discipline its members for infringements of regulations and ethical principles. In part, this was to give doctors greater autonomy. Second, the report suggested that the prevailing scale of benefits could be improved with the introduction of Specialist Benefits. Third, it was considered that only one form of claiming from the Social Security Fund should exist - this being the Schedule system. To preserve the doctor-patient relationship claims on the Fund were to be made by doctors on their patient's behalf. The amount received by the doctor could be used in part or total payment of the consultation charge. The doctor could not collect any payment over and above the Social Security Fund refund until one month had elapsed from the presentation of a detailed account. During this period a patient could refer the account to a local investigation committee of the BMA if there appeared to be some inconsistency in charging (Lovell-Smith, 1966: 193-8; Condliffe, 1959, 309). The recommendations of the Cleary Committee were largely supported by the Minister of Health and the Council of the BMA and were subsequently incorporated in the Social Security Amendment Act 1949 which came into effect on 1 April 1950 (Hanson, 1980: 124; Condliffe, 1959: Lovell-Smith, 1966: 200). Specialist benefits were one omission from the Act however. Although a provisional scale of benefits had been drawn up for Government this came to nothing and because the 1949 successors of the Labour Party were both preoccupied with industrial unrest and committed to cheap government and minimal social service extension the idea was shelved until about 1963. Under the new Social Security Amendment Act doctors were able to charge their patients a sum over and above that received from the Social Security Fund and were also entitled to sue for non-payment of fees. The Act also provided for the disciplining of doctors by other members of the profession rather than by some lay body.

In effect, the death knell of the free general practitioner service envisaged by the 1938 Labour Government had been sounded. Doctors could charge patients for services rendered; characteristics of the

doctor-patient relationship of which so much had been made and misconstrued were preserved; doctors were provided with a government subsidy which effectively lowered the cost of their services to patients; and discipline with respect to overcharging and ethical matters was left in the hands of the profession. The situation which was produced with the enactment of the 1949 Amendment was to condition general medical practice in New Zealand for an indefinite period of time. New Zealand's doctors had conclusively won their crowns of professional sovereignty and self-determination.

The exploitation of ill-health for financial gain was allowed to continue and was even strengthened by the intervention of the State. It is evident that the doctor-patient relationship had been altered. The State still stood between the physician and his/her client - but in such a way that the financial rewards accruing to the doctor would be greater than ever before. In the context of the time this seemed politically and economically sound and members of the public were happy as the Government had provided a mechanism which could make the direct, immediate costs of a visit to the doctor less financially painful than might otherwise have been the case (the pain would come instead at taxation time!). State intervention had enhanced the capitalist character of general medical practice within New Zealand society in the face of pressures which could have destroyed the exchange character of that practice.

In the 1940s and 1950s the New Zealand government found it less and less politically desirable to meet the costs of burgeoning health care expenditure. Individual actions - getting value for money, women engaging in paid employment, moving to New Zealand, having a child - all pushed up the demand for health services in the community whilst the State was bound by legislation to provide for those mounting requirements. Continued and expanding growth was the forecast. Actions within Government and within the domain of the State altered the character of the health care system in ways such that investment in more 'productive' sectors of the economy would be facilitated and such that those with pecuniary interests in medical practice held their Government subsidy and were permitted to charge fees which the market would bear.

To save money the Government appears to have moved towards the obvious solutions. Private hospitals, being relatively cheaper than those of

the public sector, were encouraged and the nature of Government subsidy to general practitioner services was altered in such a way that State expenditure could be disconnected from inflation (although not from the possibility of conflict and other pressures to increase the subsidy). The Government contribution to general practice treatment could remain relatively stable whilst the 'token' payment made by patients to doctors would be subject to general upward 'economic' forces.

At the end of the 1950s there existed in New Zealand a weakening public hospital system. Government contributions, although increasing, were diminishing in effect. The resultant decline in availability of public hospital facilities conditioned the compensatory growth in stature of, and emphasis on, State subsidised private facilities. Within general medical practice, doctors' work was subsidised by a slowly adjusting Government contribution. Over time, as the subsidy dwindled as a proportion of doctors' total consultation charges, increasing emphasis was again placed upon the user pays principle.

FOOTNOTES:

1. Although provided at less cost, the private hospitals could rarely match the type and range of treatment available in public hospitals.

THE CHAINS OF CHOICE

(c. 1960 – c. 1985).

7

CHAPTER 7

THE CHAINS OF CHOICE (c.1960-c.1985)

This penultimate chapter brings the examination of the New Zealand health care system from the early 1960s to the present day. The beginning of the period saw the election of the National Party in November 1960, a 'free enterprise' party which was to hold the political reins for all but three of the following twenty years. Changing population and employment characteristics in tandem with other features of modern New Zealand society brought pressing demands upon the public health care system. Following overseas example, and instigated by a group of doctors, there came into existence, in 1960, a medical insurance society which, for small, regular contributions, provided people who sought to circumvent public sector inadequacies - expressed most clearly by lengthening waiting lists - the opportunity to receive assistance at private hospitals without the worry of having to pay a large account at a time of ill-health. The growth of Southern Cross medical insurance was also conditioned by the acceptance of medical insurance contributions as a tax deductible item; the amalgamation of social security tax into general tax; the beliefs and actions of Southern Cross' Chief Executive; and, not least, by Government decisions to cut hospital spending. Later, medical insurance growth was also stimulated by the decline of the G.M.S. as a proportion of general practitioners' fees. Under New Zealand's 'dual' system of hospital care medical insurance growth is considered to exacerbate some public sector inadequacies and to stimulate demand for private sector care. In effect, a variety of influences and interactions have pushed medicine further back into the domain of exchange. Private hospital growth was stimulated not only by hospital-insurance-patient interactions, but also by deliberate moves within government to save money on care of the aged. Instead of having the older members of society treated in publicly provided hospital beds emphasis for this growing group was placed upon private facilities. Not only have these private hospitals catering for geriatric needs enlarged, but private surgical hospitals have also expanded in response to real or perceived public sector inadequacies. Long-standing public-private relations in the arena of doctor employment are part of a situation where private sector demands for doctors' services are likely to lead to the decreasing availability of those services in the

public sector.

Private sector medical growth has facilitated the scheduling of some worker absences from employment for health reasons. Minimal disruption to worker exploitation is the result. This factor has prompted many employers to subsidise medical insurance subscriptions for their employees, although maintaining worker allegiance is another point of motivation. The trade union movement, following the initiative of the Distribution Unions' Group (D.U.G.), has also been obliged to enhance the commodification of medical practice. Appeals to Government to effect repairs to the ailing public health system proved fruitless and difficulties faced by many workers in availing themselves of primary medical treatment formed two of the prompts which saw the D.U.G. and other groups participating in medical insurance schemes. Voluntary unionism and the battle with employers for the 'hearts and minds' of workers also drove trade unions to private medicine. Interactions in a variety of arenas have driven virtually all advocates of socialised medical care to private enterprise.

It was evident during the Labour Party's brief three year reign which commenced in 1972 that the New Zealand health care system was in disarray. Plans for reorganisation were embodied in a White Paper so controversial that it did more to harden existing attitudes and relations than to 'resolve' problems. Subsequent similar reorganisational efforts by the National government yielded little result. However, in steps intended to correct deficiencies in hospital board funding mechanisms, National's Advisory Committee on Hospital Board Funding produced recommendations for a population based funding formula in a series of 'Blue Books'. Basing their arguments on the prevalence of private medical facilities already in existence, the Advisory Committee suggested that private hospital bed numbers be used to determine the amount of funding appropriate for public facilities in the same area. As law, this recommendation has made public hospital funding formally dependent upon private hospital growth/decline.

An interesting twist to the character of the provision of medical care in New Zealand arose, in part, from a series of interactions initiated by desires to amend Workers' Compensation legislation. The Accident Compensation Act 1972 provides for the State-funded treatment of accident-caused ill-health at public and private facilities. Charges made by doctors upon the State for patient treatment are vetted by the

Accident Compensation Commission. In the final analysis, the system introduced under accident compensation legislation appears to leave doctors at the mercy of the Commission in the determination of changes. In addition, although accident treatment is completely subsidised by the State, treatment for 'day-to-day' ill-health is largely the responsibility of the individual. This relationship seems likely to be a major conditioning factor in the foreseeable future of medical care in New Zealand.

Public Pressures

Over the period c.1960-c.1985, the place of New Zealand within the global capitalist system was readily distinguished for the economic fortunes of the New Zealand public changed with current events. The first half dozen years were ones of relative prosperity for New Zealanders but in 1967-8 the inflationary effects of the Vietnam War upon the United States economy flowed on to New Zealand (Sinclair, 1980: 312). This marked the commencement of a series of financial fluctuations which were to persist thereafter. Although the 1967-8 balance of payments crisis was the most serious faced in New Zealand since World War II unemployment never grew to more than one percent (Sinclair, 1980: 297). The next major crisis came in 1973 when the Organisation of Petroleum Exporting Countries chose to quadruple its prices for petroleum products (Hawke, 1981: 371; Sinclair, 1980: 312; Chapman, 1981: 368). With this, New Zealand's post-Korean War boom collapsed massively:

> "...there was the worst drop in New Zealand's terms of trade (that is, the relationship between the prices of exports and imports) since the depression of the thirties: from June 1973 to March 1974 there was a forty-six per cent decline. A large surplus in the balance of payments in 1973 had become a deficit of $1,300,000,000 by 1975 and continued near $1,000,000,000 in 1976 and 1977. The Labour Government tried to cope with the situation, not by old-fashioned deflationary policies but by overseas borrowing on a scale never known before. By 1975 the external public debt stood at $863,000,000." (Sinclair, 1980: 312).

1973-7 saw real incomes per capita fall by eleven percent, inflation spiral upward to nearly 18 percent in 1976, unemployment grow rapidly, and huge numbers of people - most notably the young and skilled - leave the country (Sinclair, 1980: 312-3). New Zealand's linkages with the global economic system saw the internal economy in a state of massive upset. Inflationary forces, enmeshed tightly with the upswing in

petroleum prices forced the Government to seek methods to save funds and restrict overseas spending. The administration which sought to curtail expenditure and 'tighten the belts' of the public was, apart from a three year interlude from 1972-5, that of the National Party, advocating as it did, free enterprise solutions to economic problems. The National Party had resumed political control of New Zealand after the general election of 26 November 1960 (Wilkes and Shirley, 1984: 293) and under its direction the idea of a universal health service as sought during the late 1930s and early 1940s became less and less a reality.

The expansion of the medical capabilities of hospitals over the two decades 1960-80 saw mounting demands for institutionalised medical care. Growth in demand was also stimulated by changes in the nature of modern society. The increasingly consumption concerned character of society and the incumbent necessity for working age people to engage in paid employment created an environment in which familial medical assistance became more impracticable than it had been in the past. Indeed, as part of societal change, attitudes altered to such an extent that home care was often frowned on. Another, but 'reverse' interaction stimulating formal health care demand can also be perceived. Because the State had assumed much of the responsibility for maintaining health standards within the community, many of those people who, in the past, might not have engaged in paid employment were now more free to do so. The onus upon women, in particular, to remain at home in case of the ill health or injury of a family member had largely been eliminated. Increasingly, people of twentieth century New Zealand had imbedded in their own consciousness an awareness of the fact that in times of serious illness, responsibility for medical treatment would be shared by the State. A diversity of influences-humanitarian, political, economic-over a long period of time, had facilitated the participation of more people in an economic system the survival of which depended upon constant expansion of workforce and demand. Whilst the demand for formal medical assistance increased, the cost of such care rose markedly. Throughout the period 1961-81, the prices of health service inputs increased at about 2 percent more than the overall rate of inflation (Smith, 1981: 61) and although Government expenditure on health care services increased from 4.7 percent of Gross Domestic Product in 1961 to 7 percent in 1981 (Barnett, 1984: 1) the increasing breadth of Government intervention in the health care arena (1) and changes in the population structure

and location meant that each health dollar was less effective than the same dollar spent in earlier years. The end of the post-war 'baby boom' in the late 1950s-early 1960s reduced the need for maternity and related services which, once established, proved politically and socially imprudent to shut down. Public opinion is not usually conducive to the closure of any facility of perceived community importance (e.g. debate arising from the possibility of closure of the Hunterville and Foxton Maternity Hospitals) and nor is it easy to relocate a resource such as a maternity hospital - even if its function-specific character can be adapted to new uses. Instead of having to cater for a young population, New Zealand's health care providers were finding that proportionately more of their patients were from amongst the old (N.Z. Department of Health, 1969: 51):

> "Countries with more than 7 percent of the population over 65 are classed as having an 'old population'... New Zealand with 8.9 percent over 65 falls into the older group..." (AJHR, 1979: E.10, 28).

In general, an old population tends to place a greater burden upon medical resources than a young one as illnesses and injuries amongst the elderly are usually more frequent and take longer to cure or heal than amongst the young. So, whilst the Government was politically obliged to maintain the facilities it had provided to cater for the baby boom, it also had to cater for demands now being placed upon it by the elderly.

Rapid changes were occurring in the distribution of New Zealand's population. The proportion of the population living in urban areas increased markedly (Table 7.1) and more people chose to live in larger settlements (Table 7.2). Although various pressures were placed upon the health facilities existent in all areas, those facilities in the larger settlements were obviously subjected to considerably greater demands than experienced in smaller towns (AJHR, 1962: H-31, 33; Fraser, 1978: 25). Indeed, all settlements, except those greater than 25000 people in size, experienced relative population decline over the period 1961-81 (Table 7.2). The consequence of this was that medical resources were not in the places they were most needed and expensive compensatory action was necessary.

TABLE 7.1: Rural and Urban (1) Populations as Percent of Total Population. (1956-1981)

Census	Urban Percent	Rural Percent
1956	74.94	25.06
1966	80.30	19.70
1971	82.64	17.36
1976	83.65	16.35
1981	83.59	16.41

NOTE: 1. Urban population defined as that of the 37 census defined urban areas plus that of all boroughs, town districts, communities, district communities, and townships with populations of 1000 or over.

Source: New Zealand Official Yearbook, 1984: 80.

TABLE 7.2: Distribution of Population by Size of Settlement Centres (1961-1981)

Population of Centre (City, Borough, Town District or Community)	Census			
	1961	1971	1976	1981
	Percentage of Population in those Centres			
1000-2499	3.0	2.4	2.4	2.8
2500-4999	7.2	5.0	4.7	5.0
5000-9999	9.6	8.8	7.4	6.9
10000-24999	15.0	12.8	12.5	11.9
25000+	32.5	44.6	50.4	51.0
TOTAL	67.3	73.6	77.4	77.6

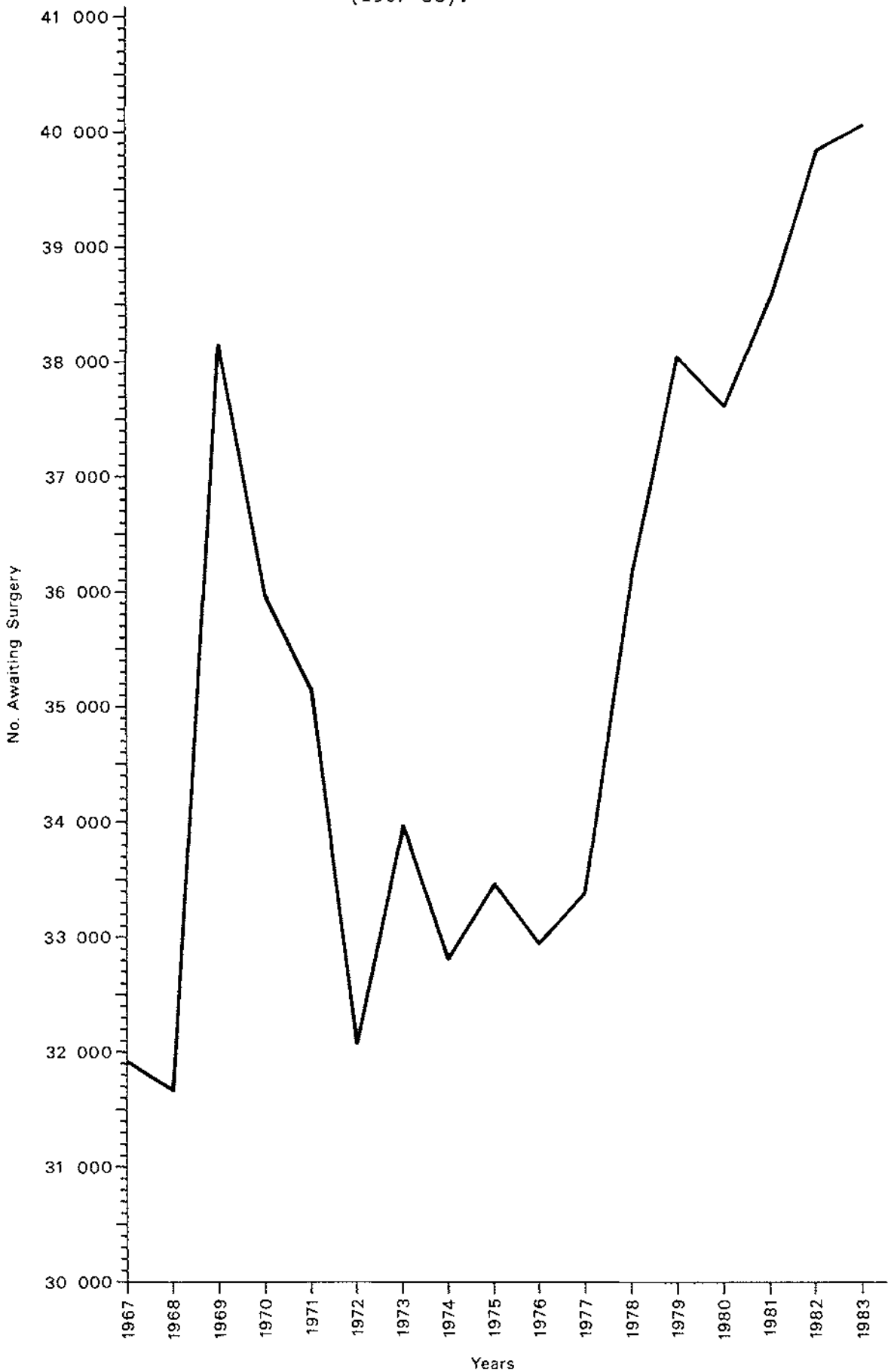
Source: New Zealand Official Yearbook, 1981: 81.

The conflict between a mobile, changing population and fixed buildings and other resources had become very apparent. The constructions which had evolved to facilitate the care of patients by medical staff were relatively intransigent fixtures in a world characterised by constant change. It was also difficult for the Government to remedy the problems it faced in providing facilities because of hospital board funding systems. The Hospitals and Charitable Institutions Act of 1885 had allowed hospital boards to seek financial contributions from local government authorities which, in turn, imposed a hospital rate. This method of rating had created inequalities between the more populous, wealthier rural boards and the poorer boards. Despite the introduction of central government subsidies after World War I and the eventual

assumption of complete hospital board financing by Government with the passage of the Hospitals Act 1957, major differences in board financing continued to exist (Barnett, 1984: 5-6; AJHR, 1980: E.10, 8-9). Undoubtedly for political expediency the autonomy of hospital boards had been preserved under the terms of the Hospitals Act 1957 (N.Z. Government, 1975: 64), so whilst Government had assumed complete responsibility for the funding of hospital boards, it had allowed itself virtually no scope to supervise the expenditure of that money. Hospital Boards remained locally elected bodies, but unlike other local bodies were able to spend money which they had no part in raising (Bassett and Harris, 1978: 8). Government funding to the Boards was based on each Board's own estimate of likely expenditure and, with no restriction upon them by having to provide part of their own finance, hospital board expenditure spending escalated (N.Z. Government, 1975: 65; Bassett and Harris, 1978: 8). Demands for funds could be justified on the basis of the size and type of facilities available for use - these being historical legacies reflecting earlier funding arrangements - rather than upon the actual demand for them. Accordingly, the new requirements for medical services by a shifting, ageing population could not be satisfactorily fulfilled, despite increased Government expenditure on health care. In fact, the situation which existed into the 1960s was one in which previous, formalised relations between the public, the hospital boards, and the Government continued to shape new formal relations between those agents. In the new societal context these formal relations were to prove inadequate means to facilitate the politically, economically, and socially acceptable provision of medical care facilities to individuals within the community.

Shortcomings in hospital services became evident early in the 1960s. One of the more obvious indications of problems was the growing length of surgical waiting lists at public hospitals. Although no nationwide information on the actual length of waiting lists was collected until 1967 (per. comm., Mrs. Pat. Collie, National Health Statistics Centre, 11 January 1985) the problem perturbed many individual hospital boards long before this (AJHR, 1966: H-31, 51). Indeed, the nation's 1967 figure of 31928 people awaiting surgery (Figure 7.1) gives some indication of the extent of the problem which had developed during the preceding years.

FIGURE 7.1: Hospital Board Surgical Waiting Lists (1967-83).



Data sources: - N.Z. Department of Health, various years: Hospital Management Data

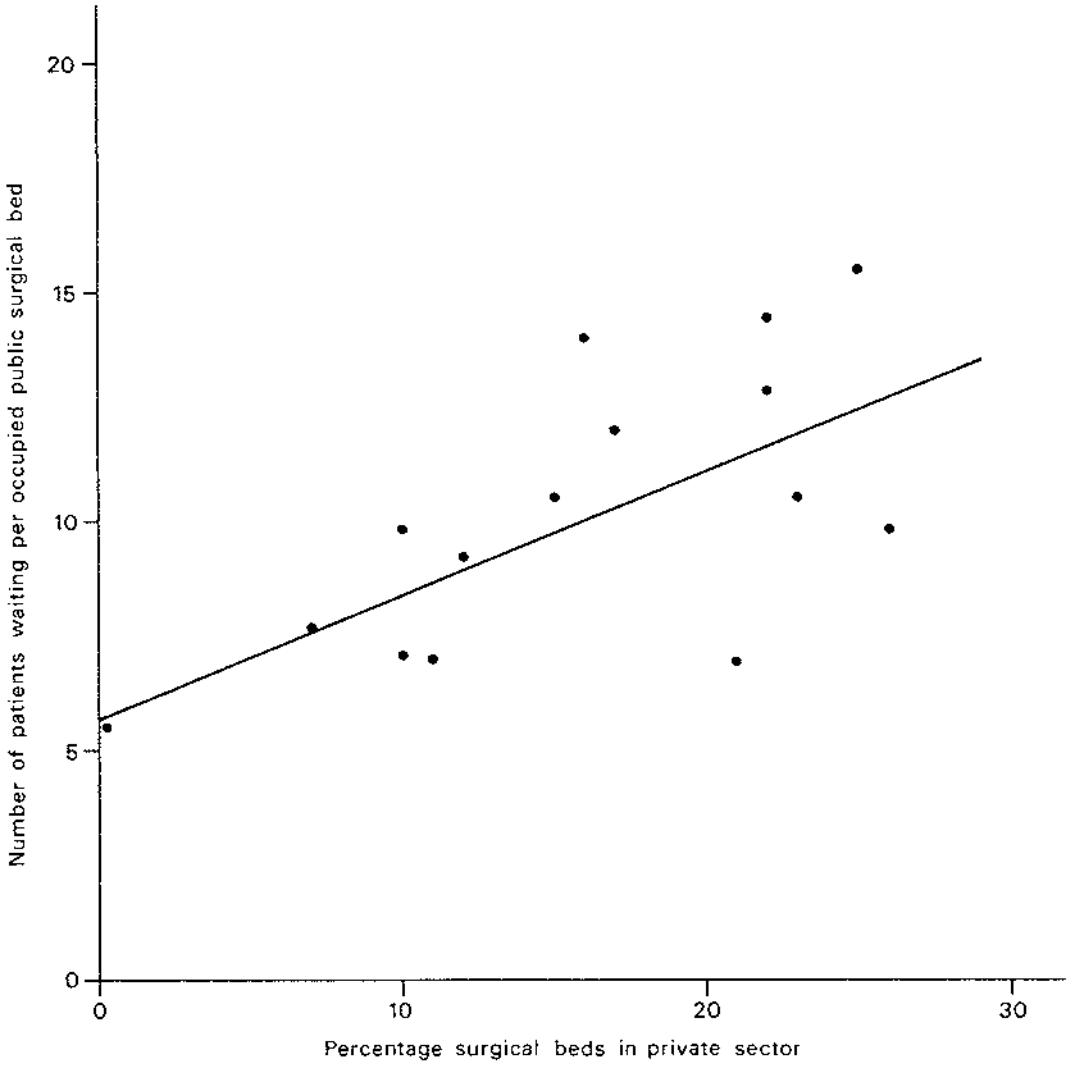
- Pers. communication, Mrs P. Collie, National Health Statistics Centre, 11 January 1985

Another of the factors which appears to have contributed to problems in the availability of public hospital facilities stemmed from the relationships between public and private hospitals as mediated by medical staff working part-time in both types of hospital. The apparent result of earlier debates over community hospitals and honorary appointments saw the system existent in New Zealand hospitals whereby doctors were permitted to practice part-time in a general hospital and part-time privately. As one might expect under such conditions most people would choose to concentrate most heavily, if not completely, upon that area of practice which provided the greatest potential income, and so, despite their humanitarian calling, the lure to many doctors of earning up to three or four times as much money by working in part-time practice (Rae, 1982: 21; Petterson, 1976: 8) was very strong (Davis, 1981: 135; Bassett and Harris, 1978: 9; Ward and Asher, 1984: 94). Under certain conditions this might have reduced public hospital waiting lists for surgery but, in fact, the scale and nature of private hospital facilities and the size of financial rewards for various types of surgery meant that doctors in private hospitals tended to concentrate most heavily upon "-ectomies" (hysterectomies, tonsillectomies, appendectomies, adenoidectomies, collectomies) (Rae, 1982: 18) rather than on the broad spectrum of surgical procedures (Petterson, 1976: 2-3). Doctors were spending less time engaged in major surgery in public hospitals. The consequence was that the length of, and accordingly the time spent on, surgical waiting lists progressively increased. This argument is more than adequately substantiated by the work of Wills (1983a) and by Figure 7.2. Where there is a high percentage of surgical beds in the private sector the length of waiting list for public surgical beds proves to be at least two times as long as is likely if no surgical beds are provided (Davis, 1981: 135).

Southern Cross Leads the Way

The consequence of the apparent decline in real public hospital bed availability was that many people were persuaded to opt for the no-wait private sector in order to avoid delays in attendance at public hospitals (Petterson, 1976: 5; Public Service Association, 1985a:9). Indeed, some have claimed that doctors employed part-time in public hospitals may encourage their patients to seek private hospital

FIGURE 7.2: Public Hospitals: Number of Patients Waiting Per Occupied Surgical Bed by Availability of Private Surgical Beds, 26 Health Districts (1978).



Source: Davis, 1981: 134

treatment (McKinlay cited in Ward and Asher, 1984: 94; Rae, 1982: 20; Malcolm, 1983f: 19-24). For many people however, gaining private hosptial care proved to be financially difficult and, had it not been for the actions of a number of surgeons and businessmen (Bassett and Harris, 1978: 9) at the end of the 1950s, private hospital growth would have been severely constrained by the inability of most people to pay the expensive costs of seeking attention in these establishments. In the late 1950s, upon the initiative of a Mr Don Carnachan (Ryan, 1976: 4), a group of medical entrepreneurs evaluated the wisdom of developing some type of co-operative medical insurance scheme to facilitate the payment of costs incurred by patients at private hospitals (Martin and Cullwick, 1983: 3). Aside from this 'humanitarian' reason there existed a number of others which are considered to have promoted the interest of these men in medical insurance. These were: the escalating costs involved in private sector hospitalisation; mounting surgical waiting lists at public hospitals; the growth of health insurance in Australia; and the desire to preserve the 'dual' system of health care, thereby allowing specialist practitioners to work concurrently in public and private hospitals whilst permitting patients to exercise some choice as to their doctor, hospital, and time of operation (Martin and Cullwick, 1983: 3). It seems likely too that continuing fears of progressive State expansion in the health services field may have partly motivated consideration of some form of insurance scheme. Doctors were concerned that financial stringency in the public health sector would lead to excessive impositions upon professional and other freedoms:

> "If the Government is paying the piper it is necessary for it to call the tune. It is a clear duty for it to run the services as economically and efficiently as it can. It must plan to avoid overlapping of services, to check over-visiting, to stop over-prescribing. Doctors, hospitals, specialists, medical machines and all other medical facilities must be carefully sited according to the needs of the population. In other words, a powerful and all-providing State must undertake full responsibility for the health of its citizens. This design...may be seen in Russia.... Doctors are assigned to areas of stipulated population size, and are refreshed by hospital work for three to four months every one or two years. They are paid by the State and have ordered and systematic lines of referral. There is little freedom of choice for either patient or doctor. It seems likely that if the State in New Zealand continues to pay the piper, the same tune will inevitably be called - note by note, and bar by bar." (NZMJ, 1960: LIX, 332, 211).

Freedom of a doctor to choose where and how to practice does not provide the basis of the best health service for all the people of a

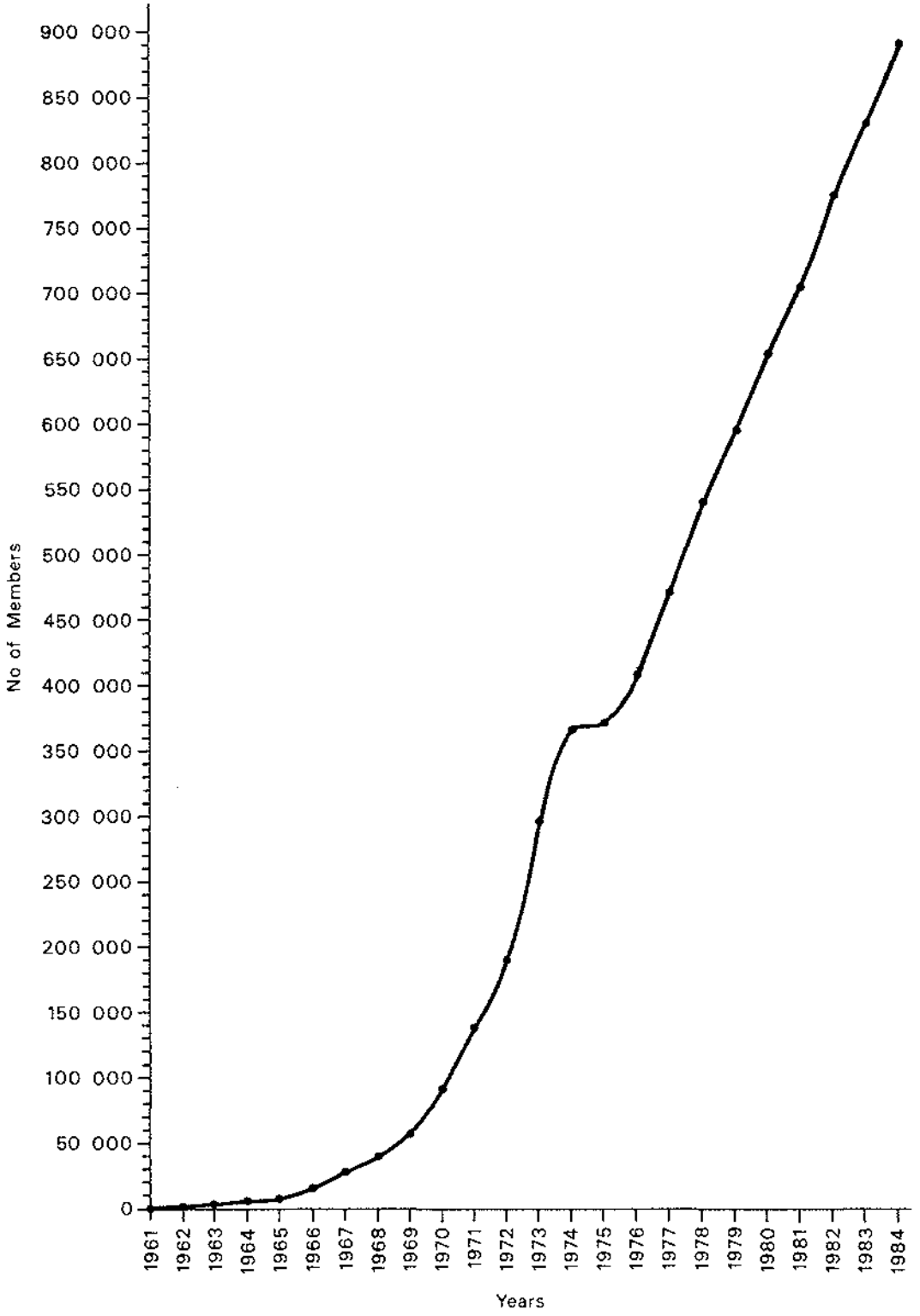
nation but, nevertheless, the concern amongst doctors regarding potential restrictions to their professional freedoms was indubitably a real and important reason for the desire to preserve private hospital practice. The argument that medical insurance was considered because it provides freedom of choice is less substantial. Although there are some grounds to the points that a patient may choose his/her hospital and time of operation, the argument that a patient is able to meaningfully choose his/her own doctor is absolute nonsense (Dr Ian Scott cited in Rae, 1982: 22; Malcolm cited in Rae, 1982: 22). What appears to have been the fundamental factor underlying the desire of Mr Carnachan and his associates to implement a health insurance scheme was the wish to preserve the 'dual system' which had evolved since the earliest days of this country's health care history. Stated very simply, the dual system allows those who can afford it to circumvent real or imagined difficulties in the public hospital sector whilst providing doctors with both a guaranteed income derived from public hospitals and the opportunity to earn vast sums of money in private practice:

> "One senior Auckland doctor agrees the growth of insurance companies has been 'doctor mediated'. 'I think it was a way of generating a more assured market for private surgery'." (Rae, 1982: 19).

Through the collective action of contributing regular payments, subscribers to medical insurance spread the financial burdens of private health care over a large number of people and over time, thereby surmounting one of the major barriers which prevents people from availing themselves of that type of medical assistance. The mutually effective interactions between public and private hospitals, in conjunction with broader social trends, were creating a growing demand for private, fee-for-service hospital care which was fundamentally limited by the ability of patients to pay for it. Some members of the medical profession could see that the potential for private sector growth existed, if a means could be found to exploit it. Contemporaneous moves in Australia towards insurance provided a solution which the founders of the Southern Cross Medical Care Society seized upon. Southern Cross was formally commenced at a meeting of 46 surgeons, a number of whom paid sizeable advance premiums to set the Society on its feet (Rae, 1982: 19; Public Service Association, 1985a: 4; Press cited in Public Service Association, 1985a: 4). Registered in 1961 under the Friendly Societies Act of 1909 (French, 1977: 424; Naessens, 1980: 16; Martin and Cullwick, 1983: 2) the

Society initially faced limited public appeal. Two advertisements in the Auckland Star during 1961 elicited some 500 mail replies, but only 10 confirmed customers (Martin and Cullwick, 1983b: 3-4; Rae, 1982: 18; Public Service Association, 1985a: 3). However, by the end of the year over 900 people had joined the scheme (See Figure 7.3). During the following years absolute growth was quite slow as Southern Cross contended with presenting a concept somewhat unfamiliar to a population which for some two decades had been accustomed to a predominantly State-mediated form of health service provision (Naessens, 1980: 16). Five years after its inception there was some concern with the Society about its limited progress and whether the idea of medical insurance was really an economic proposition in New Zealand (French, 1977: 424). At that time membership had reached about 15000 but was heavily skewed towards the upper end of the socio-economic scale (Fougere, pers. comm. 18 May 1984; French, 1977: 424). Nevertheless, demand for Southern Cross' 'product' gradually snowballed and by 1982 some 775924 people - or 24 percent of the country's population - were members. In the earlier years - until the mid 1970s - most of those who joined the Society did so because of perceived inadequacies in the public hospital system (Fougere, pers. comm. 18 May 1984; Fougere, 1974: 3; Malcolm, 1983a: 6; Wills, 1983: 3; N.Z. Government, 1975: 77; Public Service Association, 1985a: 6). A major element in the encouragement of that perception was the imposition of quite severe restrictions upon hospital board spending. In 1966 hospital boards throughout New Zealand were advised that because of the uncontrolled escalation of hospital board spending and the need to restrain overall Government expenditure, the total amount of funds made available from Vote Hospitals for the 1966-7 financial year had been set at a limit 2 percent less than total estimates submitted by the boards (N.Z. Government, 1975: 65-6). Little money was actually saved by the boards, so on 10 February 1967 the Prime Minister announced that expenditure in the 1967-8 year would be under much firmer control than in the past (Advisory Committee on Hospital Board Funding, 1980: 109-10; N.Z. Government, 1975: 66). In 1968 provisions for fixed allocations for maintenance grants were incorporated into the Hospitals Act (N.Z. Government, 1975: 66). (That same year surgical waiting lists skyrocketed [See Figure 7.1]). These actions marked the beginnning of the severe limitations upon hospital expenditure which partially conditioned the circumstances encouraging many people to purchase medical insurance.

FIGURE 7.3: Southern Cross Medical Care Society: Membership Growth (1961-84).



Data sources: - Martin and Cullwick, 1983: Appendix 1
- Southern Cross News, 1984: 3,2,2
- Southern Cross Annual Report 1984

Insurance growth was fostered to some degree by other factors. As from 1964, social security taxes were amalgamated with overall taxation instead of being a separate 7 1/2 percent levy on income (Naessens, 1980: 16). Although a minor psychological point, it seems possible that this administrative name-changing coloured attitudes towards the social welfare system. As taxpayers were no longer paying a labelled sum of money for the provision of health and welfare services a subtle hint of 'ownership' had disappeared. It seems feasible that this dissociation would have lessened some people's concerns for the fate of the public sector and have encouraged those who believed that one must pay for something for it to be worthwhile to seek an alternative form of health care. At much the same time as restrictions were being placed upon hospital boards, the National Government decreed in a 1967 Amendment to the Land and Income Tax Act that medical insurance premiums be considered a tax deductible item of personal expenditure (Holmes, 1976: 329; French, 1977: 413; Bassett and Harris, 1978: 9; Fougere, pers. comm. 18 May 1984). This is of considerable interest. Whilst curtailing expenditure upon public sector hospital care, the Government was encouraging those who could afford the luxury of private medical insurance - and for whom a tax deduction would likely be of most benefit - to purchase insurance. It would appear that the Government was endeavouring to muzzle the "voice" (2) of complaint about any eventual public sector shortcomings from the politically active and wealthy members of society by encouraging their "exit" to the private sector (Fougere, 1974). In 1982 the tax deductibility of medical insurance reportedly cost the Government $25 million - sufficient to make visits to general practitioners free to all children aged less than 16 years (McRaild, 1982).

The tremendous 'success' of Southern Cross and the health business in general has also been promoted by the enterprise and faith in private medical insurance of Peter A. Smith. Since he moved to Southern Cross from New Zealand Post Office Headquarters in the early 1970s Smith has seen the Society's membership increase by about 1500 percent (Wall, 1983: 37). Wall praises Peter Smith highly:

> "The fact the private hospitals didn't die is in no small measure due to the skills of one Peter Smith. It is doubtful that one Aucklander in a thousand knows his name, yet, when the history of New Zealand private enterprise is written (like The Book of Italian War Heroes, a slim volume) he will rate a chapter.
>
> Peter Smith...is the man who almost single handedly has returned

> New Zealand's ailing private hospitals to robust health." (Wall, 1983: 37).

Whilst Wall's outlook is constrained by a lack of awareness of the general circumstances which appear to have allowed Southern Cross to grow as rapidly as it has, her comments are probably justifiable to some degree. Peter Smith's capabilities in the medical insurance field are acknowledged by his one-time selection as President of the International Federation of Voluntary Health Service Funds and by his writing (Smith, P.A. 1982b) which exposes an unashamed confidence in contributory health schemes and private hospitals. Smith's belief in the system he supports has been described by the Secretary of the Distribution Unions Group as "almost even evangelical" (Rob. Campbell, pers. comm., 6 August 1984). It seems likely that Southern Cross' development - and, in probable consequence, that of both private hospitals and all medical insurance in New Zealand - would not have been quite so remarkable as it has been without Smith's dynamic contribution. Although the actions of individuals and the relationship between them and institutions created a milieu favouring the success of an idea such as medical insurance, it was necessary for some person or group of people to capably implement that idea. Without the initiative and activities of Peter Smith, Don Carnachan, and the group which formed Southern Cross, the course of New Zealand's medical history may have been different. Southern Cross grew at a hectic but steady rate and its success appears to have encouraged further development in the medical insurance field. In 1969 (3) the Manchester Unity Friendly Society extended its traditional concept of medical welfare benefits from members only to the general public (Anonymous, 1974: 11; French, 1977: 426). By 1972 Manchester Unity had contracts covering some 70000 individuals (Anonymous, 1974: 11; French, 1977: 426), this representing about one-third of Southern Cross' membership figures of the time. However, competition with the larger organisation and economically unsound group membership concessions forced Manchester Unity to cease providing medical insurance to the general public in 1973. Policy holders were advised that upon the expiry of their premium they could continue to be insured, but by Southern Cross, if they so desired (Anonymous, 1974: 11-2; French, 1977: 426). In the meantime, two somewhat more successful ventures had been commenced. In 1971 New Zealand Medicare Society and Group Health Co-operative Society were established (4) (Wall, 1983: 38 and 39; Bennett, 1983; Anonymous, 1974: 12; French, 1977: 426; Public Service Association, 1985a:3). By 1982 another two medical insurance organisations had been

set up - Medicaid, in that year, and Mutual Health Society in 1979 (Wall, 1983: 39; Public Service Association, 1985a:3). In 1983 the Druids' Friendly Society established 'Healthcare', available to the public through pharamacies (Public Service Association, 1985a:4). This scheme is narrower in scope than most other insurance schemes however. At the end of 1982, people in the medical insurance business claimed that 1.4 million people, or 43 percent of New Zealand's population, belonged to private medical insurance schemes, whilst Statistics Department figures showed 36 percent belonged to comprehensive private schemes (Rae, 1982: 18). At rates of growth then evident in the business it seems reasonable to assume that more than half of all New Zealanders are presently members of some type of private medical insurance scheme. In the space of just over twenty-one years medical insurance in New Zealand has achieved its age of majority.

Whilst medical insurance growth in the 1960s was stimulated by perceived inadequacies in the public hospital sector, subsequent expansion has been driven to a considerable degree by the mounting costs faced by people visiting private medical practitioners (Christchurch Press, 17 July 1982; Christchurch Star, 10 February 1983; Fougere, pers. comm. 18 May 1984; Bassett, 1983: 5; Rae, 1982: 19; Shannon, 1978: 48-9). When first introduced under the terms of the Labour Government's social security legislation the General Medical Services Benefit (G.M.S.) of 7s. 6d. covered between three-quarters and all of a general practitioners consultation charge to a patient. The basic subsidy has been increased only once in its forty year history - that being in 1972 when it was raised to $1.25 (Beanland, 1983: Gordon, 1973: 4) following the recommendation of the Royal Commission on Social Security (Royal Commission of Inquiry, 1972: 413). At that time the increase took the standard G.M.S. to a level which represented approximately half of a general practitioner's fee. As a proportion of the total doctors fee the G.M.S. has declined and at its present rate represents less than 10 percent of the consultation charge sought by most doctors. Although it was made clear to the Royal Commission that the low level of the G.M.S. was preventing many people from obtaining necessary medical care, the decision not to restore it to 1941 levels (or to change it completely) appears to have been based upon the same arguments which preventd the introduction of a free medical service by the first Labour Government - denial of freedoms, reductions in medical standards, abuse of the system through overuse, and the high costs to the State of such a system (Royal Commission of

Inquiry, 1972: 406). The G.M.S. then has remained relatively constant, but in the meantime inflation has seen doctors' fees increase whilst against a backdrop of national economic insecurity the real incomes of New Zealanders fell by more than 11 percent between 1973 and 1977 (Sinclair, 1980: 313). The consequence has been that from the mid 1970s it has become very much more difficult for the ill and injured to purchase the services of a general practitioner. There has however been the option of medical insurance which, for those who can afford it and are not excluded from cover by age and illness criteria, has proved the cheapest method to pay for growing medical expenses. Nevertheless, it would appear that the availability of medical services to some sectors of the population has declined markedly. Between 1979 and 1982 New Zealand's general practitioners had 200 000 fewer visits each year (McRaild, 1982).

In spite of the dwindling number of visits to doctors and the relative decline in the G.M.S. as a proportion of usual general practitioners' consultation fees, there has been very little public complaint. This would appear to stem from the fact that private medical insurance has absorbed many of those people who, under a system in which insurance did not exist, might have the time, money, and political influence to voice effective complaint (Fougere, 1974). Lack of change to the G.M.S. seems also to be the likely result of national economic circumstances which have seen the Government endeavouring to curtail its expenditure overall (Ward and Asher, 1984: 96).

The commencement of operations by Southern Cross did not spark the redevelopment of private hospitals in New Zealand - it simply shaped a form of relationship between patient, doctor and hospital which facilitated the continuance and expansion of commodity relationships in one section of the health field. On an individual basis, many people were unable to afford private hospital and general practitioner care, but through the collective and contributory nature of insurance, it seems likely that more people than would otherwise have been the case could meet the costs of treatment. A mechanism was created then which gave doctors greater scope to practice in the private sector. The ensuing encouragement to patients to be treated outside the public system partly fostered the expansion of private hospitals. Whilst the Southern Cross Medical Care Society is itself a non-profit making organisation (Naessens, 1980: 16; Rae, 1982: 18; Wall, 1983: 38;

French, 1977: 424) the actions of its members have facilitated the re-expansion of private free-for-service medicine in New Zealand.

Private Persuasions

Private hospitals in New Zealand have grown over the past two or so decades. Although the actual number of hospitals in existence has only risen from 152 in 1958 to 170 in 1983. The number of beds available to the public has more than doubled, rising from 2565 in 1958 to 5676 in 1983. Quite obviously these figures imply that the average size of private hospitals has jumped considerably.

TABLE 7.3: Private Hospital Beds by Hospital Type (excluding psychiatric): 1962-83

	Year (Number of Licensed Beds)			
Type of Hospital	1962	1972	1983	Percent Change
Maternity	240	144	30	-88
Medical and Surgical	987	1071	1399	+42
Medical (with or without geriatric facilities)	991	1905	4124	+316
Medical and Children	249	303	--	--
Maternity, Medical and Surgical	457	464	102	-78
TOTAL	2924	3887	5655	--

Data Sources: Board of Health, 1974: 14;
New Zealand Official Yearbook, 1984: 175

Amidst these changes alterations also occurred in the nature of the services provided by private hospitals. Hospitals with a maternity component tended to decline markedly, whilst all others - and most notably those dealing in the provision of geriatric care - have shown

rates of increase (Table 7.3). This reshaping can be attributed partly to the changing structure of New Zealand's population during the period under survey. Dwindling demand for maternity services forced some 22 hospitals providing only this sort of care into closure between 1962 and 1983 (5). The reduction in maternity beds was also promoted by the provision of 'open' maternity wards at public hospitals (Board of Health, 1974: 14). These enable maternity patients to have their own choice of doctor during confinement and puerperium, thereby providing one of the purportedly attractive features of private hospital service (Board of Health, 1974: 14). Expansion of the geriatric sector has arisen from a changing population structure and new family relations in conjunction with Government moves to economise in the public hospital sector:

> "The major growth of private geriatric care began in the mid-1950's when hospital authorities recognised that many valuable acute beds were being occupied by long-stay patients who could be cared for at a much cheaper rate elsewhere. At that stage there was very little accommodation for the elderly in need of medical care. Liberal infusions of state capital support enabled private hospitals to cope with some of the growing demand for care of the aged." (Petterson, 1976: 4).

By the mid 1950s the National Government was obviously quite aware of the large sums of money it was being compelled to spend on public hospitals which were increasingly being filled by old people whose medical needs could more appropriately be catered for in less technologically advanced and expensive establishments (Petterson, 1976: 56(a)-(b)). The encouragement of enterprise which would require only subsidisation rather than complete financial backing would release public hospital beds for more serious medical and surgical problems. It served also to extricate the Government from what was obviously going to become a more pressing problem as New Zealand's population gradually grew older. This latter point has been confirmed in the Department of Health's Review of Hospital and Related Services in New Zealand (1969: 51). There was a deliberate Government move to direct geriatric patients to private sector facilities. The general nature of the arrangement which has been produced is one in which some private beds are rented by hospital boards which bear the entire costs of accommodating patients and provide treatment for them (Director, Division of Hospitals cited in Petterson, 1976: Appendix VIII). If such public-private contracts do not exist, hospital boards may pay for a patient's private care if there is no public bed available and the

patient passes a means test:

> "This test has of course been the subject of some considerable criticism, as unless the patient has extremely limited financial assets he often has to draw on savings to help bridge the gap between the cost of his care and his income. There is of course the geriatric patient benefit, but this has been insufficient to make up the difference between a pension and private hospital charges." (Petterson, 1976: 56(a)).

This system sees patients subdivided into two groups - those who must rely on means tested charity and those who do not. State subsidies have been provided and there exists a State 'safety net' for those who cannot avail themselves of private facilities. Indeed, transformations since the passage of Social Security Act 1938 have seen a change of emphasis from complete, collective care to collective assistance for those who find it difficult to help themselves. Interactions over the years have established the basis of a system which has led one section of the population into the private sector and has provided a strong and continuing incentive for that sector's growth. Despite the fact that in 1983 only about 25 percent of all private hospital beds were in establishments providing surgical facilities (Table 7.3) most debate in New Zealand over private hospitals has revolved around the outcomes of the relationships between such establishments and the individuals and institutions with which they are linked. The perceived advantages and disadvantages of private surgical hospitals co-existing with an essentially State provided health service are both numerous and, of late, well documented (6). Although the issue is of immense interest, it is not the role of this thesis to summarise the pros and cons of the existence of private surgical hospital facilities in the New Zealand health care system.

For various reasons, which have already been discussed, private surgical hospitals, like other private health establishments, were not dismantled under the provisions of the Social Security Act 1938 although their subsequent existence was of rather a tenuous nature. Nevertheless, a host of influences saw them grow back in an ever-changing relationship with public hospitals. The natures of the connections between public and private hospitals were larely created by staff who worked in both types of establishment. Private hospitals are simply places at which people sell their skills to the sick for a price. In an environment in which equally good, if not better, care is available elsewhere for no charge (at the point of use) in a socially acceptable establishment, there is virtually no scope for the private

sale of these skills. However, should deficiencies arise in the free system, some people will be willing to pay to overcome them, and given that the nature of the public-private relationship provides a context in which growing private business creates more public sector inadequacies (Fougere, 1974), it is evident that public sector weaknesses will be exacerbated. The point which differentiates private surgical hospitals from other private medical facilities in their relations with public hospitals is that the surgical hospitals provide an outlet for the sale of a large number of specialist services of which there is only a very limited supply. The more surgeons and other specialist medical practitioners who engage in private hospital work, the fewer are available to the public sector. The various forces which initiated private surgical hospital growth after the Social Security Act 1938 were supplemented by the actions of individual doctors within the context of the long-standing relationships between public and private hospitals. This, in turn, stimulated the growth of private medical insurance upon which private surgical hospitals are now so dependent for their survival.

"Hearts and Minds": Work, Unions and Insurance

Private surgical growth, in conjunction with that of medical insurance, has allowed workers to schedule their absences from employment for times when their services will be least required (Christchurch Press, 17 July 1982; Petterson, 1976: 5). This mechanism allows the maximum exploitation of workers whilst their health needs continue to be considered. Medical care is provided when the return from labour input is at levels lower than normally achieved. Whilst the initial production of this situation was not the result of deliberate actions but was instead the product of individual action within a tide of society and historical legacy, it has nevertheless proved to be in the interests of capital, and hence has motivated many employers to encourage their workers to join medical insurance schemes. This is not the only force driving employers to the doors of the insurance societies. Not only can more labour output be achieved via medical insurance but employer negotiated group discounts from insurance organisations can enhance the loyalty of staff to the body which employs them. Employers offer medical insurance schemes:

> "...to try and (sic) tie people into remaining employed with them.

> They take the long serving loyal staff and try to tie them in by offering fringe benefits which are sufficiently attractive to keep them there." (Rob. Campbell, pers. comm., 6 August 1984).

The power of these arguments is perhaps substantiated by the facts that 80 percent of Southern Cross Medical Care Society's business is in bulk group schemes (Naessens, 1980: 16) and that by late 1982 94 of the top 100 companies on the Stock Exchange held group policies with Southern Cross (Rae, 1982: 18). As medical insurance is a tax deductible item for employers (Rae, 1982: 18) it is clear that action mediated by the Government has had a distinct part to play in encouraging membership of health insurance schemes and has thereby facilitated the expropriation of maximum work output from a placid and predictable workforce. Government revenue foregone through the tax deductibility of employers' group schemes is inevitably gained from overall income and other tax (or alternatively fewer Government services are provided). Thus workers are, in fact, subsidising a system which ensures the continued exploitation of their time and creative efforts and binds them willingly to a position which curtails opportunities for occupational, social, and spatial mobility.

Surprisingly, the trend of employers to provide group discounted medical insurance has been followed by elements of the New Zealand union movement. In 1982 the Distribution Unions Group (7) (D.U.G.) comprising some 65 000 - 70 000 workers entered into a group health scheme with Mutual Health Society. (Rob. Campbell, (8) pers. comm., 6 August 1984; Christchurch Press, 6 October 1982). Although this move did not represent the first involvement of unions in private insurance the size and prominence of the D.U.G. soon saw its actions emulated by the Timberworkers' Union which went to Southern Cross and the Meatworkers' Union. The misnamed Engineers' Union is also considering the establishment of a scheme with Southern Cross (Rob. Campbell, pers. comm., 6 August 1984). The single biggest motivating factor behind the D.U.G.'s move was the high cost to people of visiting a general practitioner (Rob. Campbell, pers. comm., 6 August 1984). (It was considered by the leaders of the D.U.G. that the public hospital sector was not in the poor condition which many people perceived it to be and that public hospital facilities were always available to those who needed them). A number of other important factors prompted the D.U.G. to obtain discounted medical insurance for its members (Rob. Campbell, pers. comm., 6 August 1984). The first of these was the humanitarian desire to ensure that all union members

and their families had access to medical care when and where it was needed. The remaining reasons were "not purely altruistic by any stretch of the imagination" (Rob. Campbell, pers. comm., 6 August 1984). The introduction of voluntary unionism by the National Government in 1984 was "not a complete shock to the system" (Rob. Campbell, pers. comm., 6 August 1984) and the D.U.G. hoped that the provision of an extra service to its members would assist the Group's survival and expansion under the new laws. This was important to the D.U.G. for the group is the only one of its type in New Zealand and its existence and political impetus is dependent upon the number of workers it represents. In other words, the power of the D.U.G. in relationships with bodies such as the Government is largely dependent upon the choice by individuals to join the group. If many people join the D.U.G. its standing in negotiations with Government and other organisations increases. The nature of the relations between the D.U.G. and other bodies can, in part, shape the relations between worker and employer, worker and Government, worker and worker.... It is obviously important for the D.U.G. to encourage membership. Another reason cited by Rob. Campbell for his Group's entrance to the field of health insurance is summed up in his phrase that "it is part of the battle for the hearts and minds of the workers" (pers. comm., 6 August 1984). Just as employers seek the loyalty of workers so too does the union movement. It is all very well to have large membership numbers, but tenacity of membership is also required. In cases of industrial conflict large numbers of faithful unionists are more likely to be victorious than a small and/or unmotivated group. The "battle" to which Campbell refers has taken a very real form. When the D.U.G.'s scheme was initiated, the Employers' Federation sent out circulars to all of its members urging them not to show any sign of interest in the scheme nor to offer any kind of facility which might aid in its implementation (Rob. Campbell, pers. comm., 6 August 1984). This campaign has continued. Some individual companies have reacted in such an extreme fashion that legal action has had to be considered by the D.U.G.. Others have confronted their staff with what is virtually a Hobson's choice: "...you can join the union scheme if you want to pay, but we'll pay if you join ours" (Rob. Campbell, pers. comm., 6 August 1984). It is most unlikely that such actions on the part of employers stem from humanitarian motives! The D.U.G. did not see medical insurance as a first line of defence against problems of obtaining medical care for union members. Along with the Federation of Labour it made representations to Government seeking restoration of the decaying

social security system. Lack of success in this area compelled the Group to seek solutions to their problems elsewhere and, after considering the implementation of their own scheme, the Group's members chose to entrust themselves to the care of an existing insurance society. Mutual Health was selected over the largest operator in the field, Southern Cross Medical Care Society. The reasons for this were twofold. First, the size of Southern Cross meant that the D.U.G. would be "a small fish in a very big pond..." (Rob. Campbell, pers. comm., 6 August 1984). Second, Southern Cross already operated many schemes for employers in the distribution industries and was unwilling to undercut the terms of those schemes for the D.U.G. (Rob. Campbell, pers. comm. 6 August 1984). The D.U.G.'s decisions to implement some form of medical insurance scheme and to obtain the assistance of a private insurer were not greeted with equanimity by other elements of the union movement:

> "...we got a fair bit of a kicking around at the next F.O.L. Conference from people that (sic) didn't like the idea of unions getting involved in medical insurance. ...Everyone did a bit of a workout on us about what a pack of rotters we were forming a medical insurance scheme." (Rob. Campbell, pers. comm., 6 August 1984).

The major argument against the D.U.G.'s actions was that the union movement was committed to the support of the public health system and its members did not like to see any activity which might contribute to the decay of that system. Cynically, there also existed an element within the Federation of Labour which was jealous and/or generally suspicious of the D.U.G.'s undertaking (Rob. Campbell, pers.comm., 6 August 1984). Despite their criticisms, two of the unions most opposed to the Distribution Group's move soon began schemes for their own members! It seems likely that the D.U.G.'s initiative and defence of its actions, in tandem with the general natures of union legislation and social conditions, prompted other unions to follow in the Group's footsteps, thereby promoting the growth of medical insurance throughout New Zealand. Rob. Campbell is aware of the potential consequences of the D.U.G.'s actions but, perhaps unrealistically, contends that union decisions to negotiate medical insurance schemes will not alter patterns of insurance growth:

> "Obviously our scheme, as part of the total, has that potential. I don't think in fact that the existence of our scheme or other union schemes is increasing the total number of people who have or would have had medical insurance. I think all it is doing is

> altering where it is. In other words, I think that there are very few people who have been persuaded to take out medical insurance, as such, by the fact that there was a union scheme. Medical insurance was growing anyway.... I think that our intervention into it, which is only a small part of the market...is simply taking some of the market which otherwise would have gone in that direction. If I thought that we were significantly adding to privatisation I would be more concerned about it. I just don't think that we are." (Rob. Campbell, pers. comm., 6 August 1984).

Campbell does admit however that some people might have their resistance to the purchase of insurance lowered by the fact that some schemes are provided through unions (pers. comm., 6 August 1984) supposedly antagonistic to private enterprise. This confession probably belies a movement which will be larger than Rob. Campbell cares to acknowledge. The D.U.G.'s scheme is part of a broader course of events which is seeing medical insurance increasingly considered to be the fundamental medium permitting New Zealand citizens to gain access to medical care. That growth is facilitating the existence and expansion of 'private' medical practice in the community and the weakening of State mediated provision. Looking back over the D.U.G.'s situation it is evident that a series of individual actions arising from diverse motivating influences have gradually led to a situation in which private enterprise has been progressively condoned and fostered. Arising from growing differences between the G.M.S. and individual patients' payments - the result of relations over many years - concern developed within the labour movement about the ability of workers to avail themselves of primary medical care. The ensuing interactions between unionists and a Government subjected to severe financial difficulties and constrained by an election mandate advocating 'freedom of choice', yielded no desirable result. In consequence, the D.U.G., representing the interests of a multitude of workers, entered into overt relationships with the providers of medical insurance. The results of those relations will (have) flowed on to members of the D.U.G.. Other relations saw the eventual acceptance of the notion of privately discounted group insurance schemes by much of the the trade union movement. It is clear from this example that a series of linked and diverse relationships are facilitating major change within our society.

White and Blue: Efforts to Reorganise

By the early 1970s it had become evident that New Zealand's health care

system was in a state of disarray and during 1972 electioneering the Labour Government effectively campaigned on the run down condition of the nation's health services. Following election success on 25 November 1972 (Wilkes and Shirley, 1984: 293) the new Minister of Health, Tom McGuigan, introduced a White Paper in 1975 entitled A Health Service For New Zealand (French, 1977: 414-5). The Government had diagnosed the faults in the health care system as stemming from its fragmentation (N.Z. Government, 1975: 8 and 75; Fougere, 1984: 83) and in the White Paper presented a timetabled blueprint for reform and integration of preventive and curative medical services (Ward and Asher, 1984: 98). The proposals contained within A Health Service For New Zealand were based upon the principle that health is a right and accordingly should not be dependent upon one's personal economic circumstances (N.Z. Government, 1975: 83 and 84; French, 1977: 415). The White Paper expressed particular concerns with the problems faced at public hospitals (Bassett and Harris, 1978: 16) and by the health service in general, although it did lend some consideration to issues concerning primary health care and the natures of doctor-patient-State relations (French, 1977: 415; Bassett and Harris, 1978: 17).

Although the White Paper contained many meritorious proposals, its full frontal attack upon New Zealand's medical services served to antagonise all who benefit from the existing system, especially doctors, smaller hospital boards, the private sector, and voluntary agencies (Fougere, pers. comm. 18 May 1984; Fougere, 1984: 83). One of the major arguments centred on the suggested relacement of the subsidised fee-for-service system of payment for general practitioners with a contractual arrangement between doctors and proposed Regional Health Authorities (Ward and Asher, 1984: 98). Overall, A Health Service For New Zealand served to unite all of the possible opponents of State intervention and to divide all of its supporters, thereby giving the general public the impression that private interests were both dominant and useful in the health service (Fougere, pers comm., 18 May 1984). The White Paper was doomed to failure, and along with the Labour Government was thrown out at the general election of 29 November 1975 (Wilkes and Shirley 1984: 293). Despite the demise of the White Paper the newly elected National Government set up the Special Advisory Committee on Health Services Organisation (SACHSO), the proposals of which resembled those introduced by McGuigan (N.Z. Government, 1975; Cooper and Shannon, 1978: 141; Bassett, 1984:2). Area Health Boards were to be set up on a regional basis and were to be given overall

responsibility for planning and co-ordination of medical services (Ward and Asher, 1984: 98; Brooks, 1978: 71). Unlike the Labour Government before it, National chose to establish regional pilot schemes to test SACHSO proposals in Northland in 1978 and Wellington in 1979 rather than endeavouring to implement any proposal on a nationwide basis. These pilot schemes however represent only shadow reorganisations existing beside but not replacing existing administrative arrangements (Ward and Asher, 1984: 99). Although the experiments were reportedly successful (Ward and Asher, 1984: 99) the National Government had committed itself to no further action before 1984 when it too was unseated from political power.

The 1975-84 National Government also engaged in other activities to reorganise health care arrangements. These moves were prompted by problems which had arisen nearly two decades before. It had become evident by the early 1950s that there existed marked discrepancies in the type and quality of services offered by different hospital boards throughout the country. These discrepancies, which stemmed essentially from allocative mechanisms and the relative wealth of hospital board districts were seen to be a problem of note (AJHR, 1980: E.10, 8) and consideration of the situation led to alterations in the funding mechanisms under Sections 88 and 89 of the Hospitals Act 1957. Although the Act amended these arrangements, its provisions hindered the implementation of major changes effecting the availability of medical services. In 1967 the Department of Health began using a new formula to determine hospital board funding allocations. According to this formula the major determinant of finance provision was the previous year's expenditure by each board, although funds were also adjusted to allow for price and wage increases, the construction of new buildings, and general growth (AJHR, 1980: E.10, 9). However, the fundamental principle of determining funding requirements on the basis of previous expenditure did not provide an encouraging backdrop for the redistribution of resources in line with shifts in population structure and location. This problem provided some of the encouragement which led the Minister of Health to establish an Advisory Committee on Hospital Board Funding in December 1979 (AJHR, 1981: E.10, 40; Ward and Asher, 1984: 99; Barnett, 1984: 7-8; N.Z. Department of Health, 1984: 1). The principal recommendation of this Committee was that a "population based formula should be used to allocate funds to hospital boards" (Advisory Committee on Hospital Board Funding, 1980: 10). The formula suggested by the Committee was not based solely upon crude

geographic population, but used:

> "...weightings for age, sex, mortality ratios and fertility ratios to calculate requirements for hospital services. It also includes adjustments for such factors as patient flow between Boards and into the private sector, costs involved in teaching medical students and the costs of running long term care institutions for the mentally handicapped." (Ward and Asher, 1984: 99).

The report was well received (AJHR, 1980: E.10, 40) and in February 1981 the Minister of Health requested the Advisory Committee to further investigate the population funding formula (AJHR, 1982: E.10, 35). The subsequent findings were published in July 1981 as the Blue Book: the Supplement to the Report "The Equitable Distribution of Funding to Hospital Boards" (Advisory Committee on Hospital Board Funding, 1981). Shortly afterwards the Minister of Health met chairmen and other senior executives of the country's hospital boards to discuss the Supplementary Report, and although some issues required further investigation (AJHR, 1982: E.10, 35) the formula seemed suitable for implementation. It was eventually announced in December 1982 by the Minister of Health that the new population based funding mechanism would be effective from 1 April 1983 (AJHR, 1983: E. 10, 36; Wright, 1984: 8). Under the new formula for funding hospital boards formal consideration is given to the presence and scale of private hospital activity in each hospital board area. The Advisory Committee on Hospital Board Funding had argued in its initial report that the amount of money allocated to a hospital board should be reduced by a sum proportionate to the number of bed days board patients spend in the private sector (Advisory Committee on Hospital Board Funding, 1980: 21). This approach was considered to be:

> "...the most equitable in that the bed days a board resident utilises in the private sector are days that his board of residence does not have to provide." (Advisory Committee on Hospital Board Funding, 1980: 21).

The funding formula which was adopted incorporated the Committee's recommended allowances for private hospitals. Although no limitations were placed upon the extent of private hospital growth a mechanism was employed which made the level of funding to, and, accordingly the development of, public hospitals dependent upon private sector expansion (Public Service Association, 1985b: 5). If private hospital boards in one hospital area grow, the public hospitals in that area receive less Government funding than they would otherwise. The nature of this relationship was confirmed by Hon. G.F. Gair as Minister of

Health whilst addressing the 1981 Annual Conference of the Private Hospitals Association:

> "I want to make it quite clear that no hospital board will be given authority to build extra public hospital beds where a surplus of suitable private beds exists unless exceptional circumstances prevail." (Gair cited in N.Z. Private Hospitals Association, 1981: 3).

Whilst the formula takes account of the fact that public and private hospitals do not cater for the same types of medical care (Advisory Committee on Hospital Board Funding, 1980: 178-9) it still confirms the mechanism which could eventually see public hospitals in New Zealand confined to providing only those services which are unattractive to the private sector. All remaining hospital treatment would necessarily be sought from private hospitals on a user-pays principle. On the basis of the information presented above it would appear that the Advisory Committee on Hospital Board Funding was the fundamental initiator of a public-private relationship which could lead to the steady demise of public sector medicine. In fact however, the Committee's recommendations were grounded upon national circumstances which had been created through individual actions:

> "The existence of [the private] sector cannot be ignored in New Zealand where, for example: (i) it provides about 24 percent of the available non-obstetric/non-psychiatric hospital beds; (ii) it incurs some 46 percent of the total public expenditure on laboratory tests; and (iii) it incurs about 14 percent of the public expenditure on radiological examinations. A significant state subsidised 'private' sector does exist and it is a national resource which is complementary to the public sector therefore it must be recognised in any funding of hospital boards on a population basis." (Advisory Committee on Hospital Board Funding, 1980: 20).

In order to avoid the perceived shortcomings of public sector medical care many individuals had opted to seek treatment in private hospitals. That very action, emulated by thousands of others, had fostered the growth of private hospitals to such an extent that their growth was used to justify the implementation of formal measures to reduce government funding for public hospitals. As a result of these moves medical care in New Zealand may increasingly be made available on the basis of one's ability to pay for treatment, rather than on the severity of one's illness. This is likely to become increasingly the case as more people are driven to the private sector by the foreseeable deterioration of public hospitals under the conditions fostered by the new population-based formula.

There exists a further implication of the 'equitable' funding formula. In times of economic prosperity it is likely that private medical practice will flourish, thereby reducing the extent of government funding for private hospitals. Economic hardship however will probably drive many people to seek medical refuge in the public sector. Given the nature of medical resources it would be highly unlikely, if not impossible, for public hospitals to respond quickly enough to cater for such fluctuating demands. The obvious consequence is that in times of depression there would exist a group of people who could not afford private hospital care, and for whom the shrunken public sector could not provide sufficient facilities.

Compensating for Labour

The Accident Compensation Act 1972 was drafted on the basis of the recommendations of the Report of a Royal Commission for Personal Injury published in 1977 (Hanson, 1980: 139; Ison, 1980: 13). Set up in 1964 by the National Government, and chaired by the Hon. Mr Justice Woodhouse (later the Rt. Hon. Sir Owen Woodhouse), this Commission was to propose improvements to the mechanism which allowed compensation to be paid to the victims of workplace accidents (Ison, 1980: 17; Hanson, 1980: 139). The main instigator of the Commission's establishment was the Minister of Labour, T.P. Shand. Along with many legal practitioners Shand was dissatisfied with existing Workers' Compensation legislation, under which, fault on the part of an employer had to be substantiated by a court of law before anything more than a limited amount of compensation would be paid. There also existed problems with the Motor Vehicle Insurance (Third Party Risks) Act which required the proof of some person's fault before any compensation would be provided (Hanson, 1980: 139).

The Woodhouse Report covered more ground than was intended and for reasons of "wisdom, logic and justice" (Woodhouse Report cited in Hanson, 1980: 140; Accident Compensation Commission, 1976: 6) considered compensation for all manner of accidental injury:

> "In essence, the commission recommended that worker's compensation and common-law proceedings be abolished, and that instead

> statutory compensation and/or earnings related benefits be paid out to all persons injured in all types of accidents no matter who was at fault." (Hanson, 1980: 140).

Whilst the Accident Compensation Act did not incorporate all of the recommendations of the Woodhouse Commission it did implement many of them, with others being added by the Labour Government in 1973 (Dunstall, 1981: 422; Hanson, 1980: 140; Accident Compensation Commission, 1976: 7). Basically, from funds acquired through a levy upon all employers, self-employed people and motor vehicle owners, plus some supplementary Government finance, New Zealanders injured by accident are entitled to lump sum and/or weekly compensation and free medical treatment for their ailment (Hanson, 1980: 140; Sandford, 1974: 7). Although the financial compensation elements of the Act preserve inequality by maintaining continuity of income (Dunstall, 1981: 422), the three points arising from this legislation which are most germane to this thesis are those regarding the provision of free medical treatment to the victims of accidents.

First, the Accident Compensation Act entitles the victims of accidents to free medical care from public or private services whilst those people whose health afflictions are the result of 'natural causes' are entitled only to free public care under the provisions of Social Security legislation. Although both the Labour and National Parties have acknowledged the absurdity of the situation and "moves have been made to consider the extension of the accident compensation scheme on to a broader base" (Hanson, 1980: 142) nothing has yet been done to rectify the problem. It would appear that the accident-disease quandary arose because the scope of the Woodhouse Commission's inquiry was very limited, and although an extension to that was made by the Commission's members, further extensions may have been considered imprudent in terms of both politics and the physical scale of the investigation. Second, some doctors expressed concern about the free provision of medical services, which included their own. The doctors' worries focussed on their perennial fears of nationalisation of the medical profession and the disturbance of the doctor-patient relationship. However, despite the fact that elements of the Accident Compensation Act 1972 were to alter the doctor-patient relationship in much the same way as was intended under the Labour Party's original vision of the Social Security Act, the 1972 Act met only minimal protest. Some indication of the reason behind this underlies the following description of Accident Compensation Commission

(A.C.C.)-doctor relations by K.L. Sandford, foundation chairman of the A.C.C.:

> "Some doctors have...expressed the view that the charging of medical fees to the Commission may endanger the traditional doctor-patient relationship and be a step towards nationalisation of medicine. The Commission has failed to see the validity of that view. It will not interfere in the clinical management of a patient's case by his doctor. Nor will it interfere with what a doctor chooses to charge for his services. TH (sic) Commission's only involvement is in paying to a doctor or dentist such an amount in respect of his fee as it considers it is reasonable for it pay. For obvious reasons it is hoped that the views of the doctor on what he should charge, and the views of the Commission on what it should pay, should coincide. But in the course of a number of amicable and constructive discussions with representatives of the medical profession, there has been worked out a satisfactory system for dealing with any disagreement in views. We do not now see this as presenting any substantial problem. There will be isolated occasions, as there have been already, when it seems to the Commission that a doctor or dentist is regarding the advent of Accident Compensation as a new opening to riches. This is no real difficulty." (Sandford, 1974: 9-10).

Although the Social Security Act 1938 and the Accident Compensation Act 1972 were both to change the relationship between doctor and patient in such a way that no financial transaction betwen the two individuals was necessary, the responses of the medical profession to the two Acts were vastly dissimilar. This would appear to have arisen primarily from a fundamental difference between the two Acts. Under the Social Security Act the fee received by a doctor for his/her services was to be quite overtly determined by the State, whilst under the Accident Compensation Act, the size of the fee is essentially set by each medical practitioner. An interesting point to note about the accident compensation situation to which the doctors have agreed is that it seems to rule out the validity of any future arguments about the need for some financial transaction between doctor and patient in order to preserve the unique character of their interaction. If circumstances ever permit the elimination of the disease-accident dilemma, as created by the Accident Compensation Act, in such a way that free health care is to be provided to all, New Zealand's doctors, who appear to have relinquished their right to use the argument which proved most successful during the conflict with the post-Depression Labour Government, may be philosophically unable to support their own stand. To attribute only pecuniary motives to the different reactions of the medical profession to the Accident Compensation Act and the Social Security Act is perhaps unjust for there was surely one other major influence upon the decisions. The medical profession of the late 1930s

and early 1940s was led by a doctor whose belief in the sanctity of the doctor-patient relationship was matched only by his abilities to lead and persuade. New Zealand's doctors of the early 1970s did not possess a leader of the same character, and accordingly the profession's dealings with the State were of a completely different nature and outcome. Individuals representing the interests of the State were obviously different too. Third, although the A.C.C. may pay for the costs of private hospital care incurred by an accident victim, such treatment is generally regarded as unnecessary since free care is available at public hospitals. Accordingly, the A.C.C. does not generally pay for private hospital costs (Ison, 1980: 116). Other private services are paid for however and this may partly account for the growth of private laboratories and other similar facilities since the 1970s.

The steady, relative withdrawal of the State from the health care arena since World War II became most marked from the early 1960s and an alternative means has been found to facilitate individual patient payment for the more heavily emphasised private treatment of illness. This alternative has taken the shape of medical insurance which, whilst providing the 'freedom to choose' between public and private facilities, has also conditioned the nature of those facilities. The recommodification of medicine since the 1940s sees New Zealanders in a milieu in which one is virtually bound to hold health insurance in order to avoid the growing costs of medical treatment and to circumvent apparent inadequacies in the public system. Even prior to the introduction of the 'equitable' funding formula the move to private weakened the already ailing public sector but now the situation is exacerbated. Even labour movement efforts to surmount health care difficulties have ended with the movement's substantial and growing contribution to the firm replacement of exchange relations in the sphere of medicine.

Although the character of accident compensation legislation has also strengthened the position of private medical enterprise in New Zealand, the accident-illness dilemma fostered by that legislation and the new dominance by the Compensation Commission over the financial aspects of the doctor-patient relationship may introduce interesting elements to any future conflict over personal payment for medical services.

FOOTNOTES

1. Some idea of the expanding levels of government activity in the health care arena can be gained from a perusal of the contents of the Department of Health Annual Reports of 1960 and 1980 (AJHR, 1960: H-31 and AJHR, 1980: E.10).

2. For detailed consideration of the concepts of exit and voice see Fougere, G. 1974: Exit, Voice, and the Decay of the Welfare State Provision of Hospital Care. M.A. Thesis (Political Science), University of Canterbury.

3. French (1977: 426) states that Manchester Unity's extension to benefits occurred in 1967.

4. Bennett (1983) states that New Zealand Medicare was formed in 1970.

5. There existed 27 private maternity hospitals in 1962 (Board of Health, 1974: 14). By 1983 there were only 5 (New Zealand Official Yearbook, 1984: 175).

6. See Equitas, 1964; Fougere, 1974; NZMJ, 1974: LXXIX, 510, 747; MANZ, 1975; Petterson, 1976; French, 1977; Fougere, 1977; Fougere, 1978; Fougere, 1981; Davis, 1981; Rae, 1982; Smith, P.A., 1982b; Christchurch Press, 17 July 1982; Christchurch Press, 12 September 1983; Malcolm, 1983f; Wall, 1983; Barnett, 1984; Ward and Asher, 1984; Public Service Association, 1985a; Public Service Association, 1985b).

7. The D.U.G. provides administrative, research, and advocacy services to a group of unions essentially involved in the distribution of goods (Rob. Campbell, pers. comm., 6 August 1984).

8. Rob. Campbell is the Secretary of the D.U.G.

TERMINUS.

8

CHAPTER 8

TERMINUS

This thesis represents probably the most complete single documentation of New Zealand's health care history. It is not however a narrative of that history. Instead, it presents a relational view of processes underlying one aspect of a changing society. Efforts have been made to investigate, articulate and explain the place and mutually conditioning characteristics of medicine within indigenous, but distinctly, capitalist processes of production and consumption. The adequate performance of those tasks necessitated an initial investigation which provided an awareness of overall characteristics of health care provision and use in New Zealand and which allowed the subsequent identification of emerging structures. From this realist viewpoint it became apparent that health care activity in New Zealand has been a constitutive and constituted part of capitalist social relations and that inquiry ought to be directed at understanding the place of events and the actual in the reproduction of those relations.

It has also been possible to see that despite the intentions of various individuals and organisations, their actions and interactions have contributed to the constitution of outcomes which may never have been anticipated. Indeed:

> "people, in their conscious activity, for the most part, unconsciously reproduce (and occasionally transform) the structures governing their substantive activities of production. Thus people do not marry to reproduce the nuclear family or work to sustain the capitalist economy. Yet it is nevertheless the unintended consequence (and inexorable result) of, as it is also a necessary condition for, their activity." (Bhaskar cited in Williams, 1981:36).

Interpretations of reality, and activity intended to achieve certain ends within that perceived context, have been, and are, constrained by a lack of awareness of the broader pattern of relations of which both are a part. In New Zealand, actions at various conjunctures to solve health care problems and conflicts arising from changing social patterns and rigid organisational frameworks have simply proved ameliorative. Solutions are but resolutions.

Discussion at the actual and empirical levels was organised to illustrate and give greater understanding of processes characterising health care in this country. The sometimes lengthy scrutiny of empirical details was intended to provide greater insight to the actual operation of various processes by individuals. This must be distinguished from the theoretical elaboration of processes, the contingent but necessary manifestations of which represent the observable events, infrastructure and personnel of health care. In presenting each chapter care was taken to explain developments theoretically and to account for actualised events. Much discussion in each chapter covered issues in which people were making decisions in keeping with processes and where the results of decisions bore upon later interpretation and action by knowledgeable agents. However, the understanding of the processes articulated with respect to health care is a theoretical exercise and it is only in the domain of theory that a more complete understanding of processes can be obtained.

In this final chapter a synopsis of the principal relational transformations linked with health care provision and consumption is presented. It is hoped that by highlighting major changes in the structures of relationship that a condensed framework will be available for other researchers.

Synopsis:

In the earliest days of New Zealand settlement health care provision and consumption was organised along laissez-faire lines. Doctors were 'free' to treat people who were 'free' to become patients. Fundamentally however, many people requiring medical attention were unable to gain care because they could not afford it. Although this social predicament was addressed early, it has remained, in different guises, at the heart of changes in New Zealand's health care services.

One of the first responses to payment problems was the formation of friendly societies, these allowing the support of doctors and defining a path for money and capital circulation. The Government, under the largely humanitarian initiative of Governor Grey, established health care facilities for the indigenous which facilitated the integration of the Maori population into the newly transplated capitalist system. These same services were provided for the poor, and rooting their

compassionate arguments in the consequences of the depression of the 1880s, two agents, Atkinson and Grabham, prompted the allocation of more State funds to health care services. The actions of these men facilitated the co-existence of public and private interests in the same milieu, and under pressures derived from an ageing, urbanising population, labour influences upon political attitudes, and new medical technology, the State mediated sector expanded in importance. In the meantime, there became established a recognised medical profession. Initiated by Dr. Charles Hastings, the British Medical Association was set up in England to further medical knowledge and to engender camaraderie amongst doctors. By the time it had expanded to New Zealand the Association's pursuit of the goals of knowledge and unity was fostering a standardisation of practice and professional control of economic activity within medicine. Technology, specialisation and medical eduction also contributed to these same outcomes. By the end of the nineteenth century the medical profession, as such, was established and was in a position to exert considerable control over the production of health care. A major plague scare prompted political action to reorganise public health administration. Whilst the legislative outcome brought more effective prevention of environmental circumstances likely to produce ill-health, it also served as the basis for co-ordinating demands expressed through the State. As of about 1900 then, the arrangements for the production and consumption of medicine had become firmly linked in ways which were to condition subsequent doctor-patient-State relations.

In the first three or so decades of the twentieth century pressures for the decommodification of health care were evident, as were 'defensive' moves by those desiring to maintain exchange relations (e.g. doctors' efforts to deny the well-to-do the benefits of honorary practice; pay wards). Chapters 3 and 4 comprise thorough examinations of these relations. Members of the working class became conscious of more aspects of their place in capitalist relations and amalgamated for strength. Unification, expressed through an active political party, gave this group more power in conflict over health care issues. At much the same time, fears that private hospitals were not as 'safe' as possible saw calls for their licensing and regulation. The subsequent private sector decline in conjunction with growing public sector attractiveness brought increased demands upon the State mediated service.

Experiences during and after WWI contributed to changing conceptions of the place of public health care in the community. In an economic flush, conditioned by wartime demands for New Zealand's products, and for compassionate reasons, dependants of men 'defending the realm' were entitled to free medical treatment, as were injured returned servicemen. Arguably these moves lured young men into a conflict which served the long term interests of capital, for through the large-scale destruction of material possessions characteristic of wartime, opportunities for profit are created and recreated. Nevertheless, wartime 'demands' seem likely to have enhanced the place of free, public care in the community.

Growing doctors' charges encouraged many people to join friendly societies which provided a capitation system of medical care. This movement, in conjunction with organisational ties and changing technology brought a curtailment of medical 'freedoms' and prompted the BMA to take the issue of doctor-lodge relations to the Government. Here, suggestions of a State medical service to be run along lodge lines arose. Moves towards greater State intervention were also fostered by the poor public health response to the 1918 influenza pandemic. This encouraged reorganisation and broadening of Government concerns.

The political body which had arisen from the labour movement grew in stature and by the 1930s was on the verge of election victory with promises - reflecting and conditioning social trends - to introduce a national, free medical service. These promises were not the only reasons for Labour's success. The Party's rise was conditioned by changing settlement patterns, the consequences of the Great Depression, and the voting patterns of farmers who sought to end several years of financial frustrations. The Labour Party embodied one series of moves towards the decommodification of medical practice in New Zealand. A second contemporaneous series of moves proved to serve the same end despite the intentins of actors to maintain the commodity character of medicine. Many doctors found that they were treating, free of charge, at public hospitals, patients who could afford private care. Ensuing conflicts between hospital boards which, for political reasons, were obliged to accept all patients, and doctors, saw the 'closure' of many hospitals to honorary practitioners. The result was seen by doctors, hospital boards and the Department of Health to be detrimental to medical standards. Endeavours were made to find mutually acceptable

solutions and although some general accord was reached over the proposal that pay-wards be introduced, this suggestion proved unsuccessful. By the 1930s members of the medical profession, whose incomes were being seriously eroded, were drawn to seriously investigate the implementation of some large-scale insurance scheme which would facilitate patient payment for medical services.

Thus, interactions from c.1900-c.1930 drew diverse groups seeking to provide or use medical care towards a national health 'insurance' scheme. The stimuli and the aims differed, but the general direction of movement proved to be the same.

The Labour Party achieved election success in 1935 and following the leadership of two principal agents, Dr. D.G. McMillan and Rev. A.H. Nordmeyer, commenced work on plans for a nationwide medical care scheme. McMillan and Nordmeyer strongly favoured a taxation funded scheme which would ensure that medical attention was available free at the time of use. These ideas met the approval of the Labour Party. McMillan's scheme would have brought the production and consumption of medicine completely within the domain of the State. With this, doctors led by the remarkable J.P.S. Jamieson, were unhappy. There followed a protracted and sometimes vitriolic battle, the character of which was conditioned both by principles, personalities and structural possibilities. The period of most active debate lasted from c.1935-1942 and in Chapter 5 detailed investigation of this conflict is conducted. Whilst doctors and Government representatives wrestled over matters such as independence, professional rights, the doctor-patient relationship, money, freedom of practice, and freedom of choice, the outcomes of those debates had considerable implications for the 'real' domain of social activity. The struggle between doctors and government is perceived as the product and the producer of efforts to rechannel overaccumulated capital, the existence of which was demonstrated by the Great Depression. Debate centred on the form that 'switch' should take. The compromise legislation which emerged from debate at the level of the 'actual' temporarily satisfied the doctors and kept the Labour government in favour with the voting public while consolidating the position of the State in many spheres of human activity. Legislation also confirmed the decommodification of some medical relationships and formalised the rechannelling of capital from one circuit to another. Of these consequences doctors and government representatives were unaware. It is only through theoretically

informed analysis that they become evident. The antagonists of the time sought only to pursue specific interests within the context they perceived and the constraints they experienced.

During the 1940s the fees sought by doctors increased and many practitioners commenced operating the 'token' system of payment. In part, members of the medical profession were driven to the token system by the desire to maintain the relative value of their incomes in an environment marked by post-war inflation. Conflict over the token system arose between doctors and Government and, despite internal disputes within the BMA, a solution was eventually achieved. The character of the compromise was such that doctors were permitted to charge patients virtually any amount on top of that received from the Social Security fund. In later years this 'solution' has allowed Government subsidisation of general practitioner services to dwindle as a proportion of doctors' fees. In effect, doctor-Government relations, of that time, in conjunction with subsequent patterns of activity, facilitated the recommodification of one aspect of medical practice. Another aspect, hospital care, was also moved back towards the market place. Mounting burdens upon Government finance by demands for hospital services were perceived as undesirable by the National Government. In their efforts to save money without making potentially unpopular cuts to hospital services, National members placed increasing emphasis upon private hospital services whilst reducing funding to public hospitals. Subsequently, there emerged inadequacies in the public sector, these being expressed most obviously by growing waiting lists. In response to this and in the desire to ease patient payment for private services and facilities, a group of medical entrepreneurs followed an Australian example and established Southern Cross Medical Care Society in 1960. Although non-profit making organisations, Southern Cross and those which have emulated it, have contributed to the overall recommodification of medical practice in New Zealand by facilitating payment for private services in a context where private sector growth is achieved at public sector expense (staff and money). Insurance also serves to stifle pressure for a more humane provision of health care and facilitates the minimal disruption of worker exploitation for health reasons.

Some members of the union movement became concerned about the problems workers were facing in gaining access to doctors' services and hence sought to remedy this problem. Efforts to restore State activity to

1940's levels proved unsuccessful so the unions opted for the solution which offered the greatest apparent rewards to both workers and their representative organisations. Surmounting philosophical barriers, unions commenced formal relations with insurance organisations through which special insurance membership conditions were negotiated. Despite an awareness of the consequences of insurance activity, a 'conspiracy' of relations had driven unions to support an organisational form which serves to recommodify medicine and which therefore counters long-standing worker interests.

By the 1970s rising costs, organisational disarray and other motivating influences had driven Government members to give serious consideration to a reorganisation of the country's health care services. Initial efforts by the Labour Government met a hostile private sector and eventually proved unsuccessful. Subsequent attempts by National Governments yielded a system of health care organisation which seems to express distinct private sector influences. Most notably the implementation of an 'equitable' hospital board funding formula has produced a mechanism which makes public sector hospital funding dependent upon private sector activity. Although the new funding formula emerged as a response to specific 'superficial' problems and the intention in implementing it appears to have been to introduce a 'fairer' system of allocating finance to hospital boards, its characteristics also facilitate the recommodification of medicine. Overall, in view of recent Government cutbacks in hospital expenditure and the growth of medical insurance, the future holds considerable promise for those who can profit from medicine as a commodity.

Thus, interactions over recent years have fostered the return of general practice and hospital medicine to the private sector. However, activity in the specific field of accident compensation has apparently run contrary to overall trends. Perceptions of inadequacies in worker compensation legislation had encouraged the reconsideration of pertinent laws. The Commission established to 'rectify' the problems resolved that for reasons of "wisdom, logic and justice" (Accident Compensation Commission, 1976:6) earnings related benefits should be paid to all accident victims and that the injured should be entitled to free medical treatment. The 1972 Accident Compensation legislation which resulted has strengthened the private sector but it seems also to have brought once 'hallowed' aspects of the doctor-patient relationship under the wing of the State. Whilst the equitable funding formula

would appear to be a means by which recommodification can occur (and perhaps decommodification in other circumstances), the Accident Compensation Act has contributed to the decommodification of medical practice. Perhaps subsequent analyses will place the Accident Compensation enigma more clearly within trends in the transformation of exchange relations in medicine.

Relations with Capital:

There has been a broad sweep from purely commodity relations towards the relatively decommodified provision of medical services and back again. The character of relations has changed. State intervention, in conjunction with many other interactions, has had profound implications for both the production and consumption of medical care. Intervention has not only served the ends of labour by facilitating the collective provision of services which, under pure 'market' forces, would not be available to all, but has also served opposing ends by providing an opportunity for the rechannelling of overaccumulated capital and by ensuring the reproduction of a healthy and happy workforce. At times activity mediated by the State has also enhanced the profitability of medicine e.g. the existence of the GMS allows doctors to receive more from patients than otherwise would be likely. State intervention in some spheres has meant that many people have been able to more fully participate in a variety of production and consumption processes. However, as collective action mediated by the State has been withdrawn, and some medical relations have resumed a place in the market, the ability to return to previous patterns of medical provision has largely been eliminated. Professional dominance, specialisation and new levels of 'socially necessary' technology have prevented much of a reversal to earlier relational forms. In addition, many people have become so embedded in 'new' processes of production and consumption that a return to such relations is unlikely.

Analysis of interactions in the health care arena has made evident the place of medical activity within capitalist processes. In response to a host of influences commodified medical practice was gradually drawn into more of our day-to-day relationships, displacing previous forms of interaction. Although labour struggle in the expanding domain of the State brought moves towards decommodification, the character of the relations between antagonists prevented complete decommodification and

medicine subsequently moved back towards exchange.

The producers of medicine have had little choice but to push the relationships of which they are a part to 'limits of capital'. These limits have then been partly transcended in order to maintain the profitability of medicine, to hold medical practice within the domain of exchange relations and to legitimate those relations, to facilitate patient use of health care services, and to ensure reproduction of the workforce. The tale of the New Zealand medical care system then is one of the constant search for new areas of profit within ever-changing relational constraints.

New Zealand's health care system has been shaped by and has shaped the real structures which exist independently of our day-to-day knowledge of them. Although motivated in their actions by many and various personal, institutional and organisational relationships, those who have conditioned the nature of medical enterprise have been operating within constraints produced by socially determined structures. Actions within those structures have both reinforced and transformed structural characteristics and effects. In order to adequately comprehend changes in health care consumption and production processes it has been necesary to consider the actual nature of the relationships between all of the agents - some of whom, like Jamieson, Fraser, Nash, McMillan, Campbell, have been more influential than others - and mediating institutions considered here to have had some bearing upon transformations in those mutually affective spheres of our society. This has necessitated an extended, but rewarding, analysis.

The Nature of the Change:

Throughout the thesis change in the nature of health care has been examined. However, this has not involved the analysis of change by comparing superficial appearances at various points in time. Instead, having made clear a particular conception of society, the scale, character and explanation of change are assessed in terms of their constant 'becoming'. Static views of society - conditioned by and conditioning data availability - have been replaced here by a view embodying the notion that phenomena are related and that together the relations form a structured whole. To comprehend courses of action it is necessary to examine the relations between ideas and action, to

understand how options came to be, to see what information was available to those who made decisions. Whilst this allows one to see the social world in its unified totality it is also necessary to comprehend who gains or loses from a course of action, for this brings us to an understanding of how (health) institutions and structures are involved in mutually conditioning relationships with specific groups (Eyles and Woods, 1983:244-6). In the course of this analysis efforts have been made to deal with all of these issues, although various constraints prevented the deep investigation of many specific relations. In dealing further with matters of the relations between ideas and action subsequent works might profitably deal with, for example, questions pertaining to the movement of trade unions towards support for medical insurance; the place of allopathic medicine as the dominant form of medical practice in New Zealand and the connected emphasis upon preventive care; the greater popularity of medical insurance in Tauranga and Auckland than in Westland and on the East Coast; the meanings associated with the word 'equitable' in the recently adopted hospital funding formula; and the transformations which have seen the humanitarian goals of the medical profession produce pecuniary rewards for doctors. On the other hand, there remain numerous questions about the gains and losses stemming from particular paths of action: how did the Social Security Act 1938 contribute to changes in the production and consumption of commodities in New Zealand society; why was the Accident Compensation Act so readily accepted by members of the medical profession at the time; what is the long-term place of medical insurance in our society. Whilst a separation of issues has been indicated here, the two dimensions of inquiry should not be set apart. For example, in the consideration of the meanings associated with the word 'equitable' one is obliged to investigate the patterns and rewards which have arisen from the definitions of that word. Similarly, an examination of the place of the Accident Compensation Act would be incomplete without an understanding of the Act's origins and consequences.

Support or suppression of interests is conditioned by sets of ideas. The actual implementation of ideas, and hence the nature and pace of change, is influenced by the character of social relations through which those ideas are mediated (Eyles and Woods, 1983:246). Although our life paths are steered within a hegemony, they are certainly not confined to, for example, "production only in its present form" (Le Heron, 1984:57. Emphasis added). Historical evidence, including that

from this thesis, illustrates that change in our world and our world views may emerge from the different experiences and demands of various groups within society.

What Now?

This thesis was written within and around an explicit theory of process. Accepting that the analysis of change could not be value free, a theoretical base from which the actual and empirical were evaluated was articulated. Examination revealed tendencies both towards and away from the commodification of medical practice. However, constraints upon this piece of work rendered it impossible to carefully examine the place of many aspects of medical and related activity within these tendencies. Although there is scope for others, further investigations might profitably be conducted along the following lines.

Some of the demands upon health care relations of soldiers returning from WWI have been investigated herein. Whilst it is presumed that many returned serviceman had only limited funds to support their medical care and that they fostered new health care provision initiatives, the details warrant further inquiry. What was the extent of the soldiers' problems? How did their constrained consumption affect the production and distribution of health care? That is, how were barriers to their consumption overcome? It would also be intriguing to more fully assess the repercussions of the demands made by soldiers and the ensuing arrangements upon health care provision for other sectors of the community. Were there demands by government workers for free care if incapacitated due to workplace accidents and illnesses? How many wives and dependants of servicemen used the free care to which they were entitled? How long did that entitlement last?

Aspects of the expansion in the domain of medical practice and the costs of that practice are seen as areas warranting investigation. Technological change in medicine has taken the art further into people's lives and has brought growing requirements for specialisation of staff, new equipment, and expanded building stocks. Hospitals have become immense and expensive as has the scope of medical practice. This has had to be paid for. How much have the costs of medical care risen in 'real' terms? Can the main sources of cost increases be

isolated? When were the periods of greatest increase? What efforts were made to ensure that the ill could meet growing costs? Who produces and sells medical goods and where are those companies based? To what extent do cost increases in health care appear to have been derived from overseas and have New Zealand producers and consumers been obliged to enter new health care relations as a result of those price changes? These latter questions obviously lead one to a consideration of the framework of medicine and its incumbent technology within the place of global capitalist relations.

The Accident Compensation Act appears to be a guaranteed payment scheme for doctors and other producers of medical care resources - acceptable so long as doctor - Accident Compensation Commission relations remain cordial. Has the Accident Compensation Act affected doctors' incomes? Is there evidence of a disproportionate increase in claims under the provisions of the Act? Are there any doctor-A.C.C. tensions over payment? Do there appear to be similar trends elsewhere away from 'personal responsibility' and towards schemes of State-mediated payment for illness or injury? That is, is the Accident Compensation Act part of a wider scheme of relations?

A broad investigation of events over the period c.1940-c.1960 could prove illustrative. This period appears to have been subjected to very little scrutiny, perhaps being overshadowed by the tumultuous years during which the Social Security Act was negotiated and drafted. The years about the middle of this century were ones of considerable change, and the necessarily brief examination of relations of that time conducted herein may prove to have been misguided and misleading. Why, for example, were private hospitals not drawn completely within the domain of the State under the provisions of the Social Security Act? Who used these hospitals and why did they do so when free public care was available? What was the professional composition of the Barrowclough Committee and why did the National Government choose to implement those recommendations which it did? Why did the Labour Government establish the Medical Services Committee after years of reluctance to do so? Why has the G.M.S. been increased so infrequently? The answers to questions such as these might provide further insights to moves back towards the private sector in the wake of the Social Security Act.

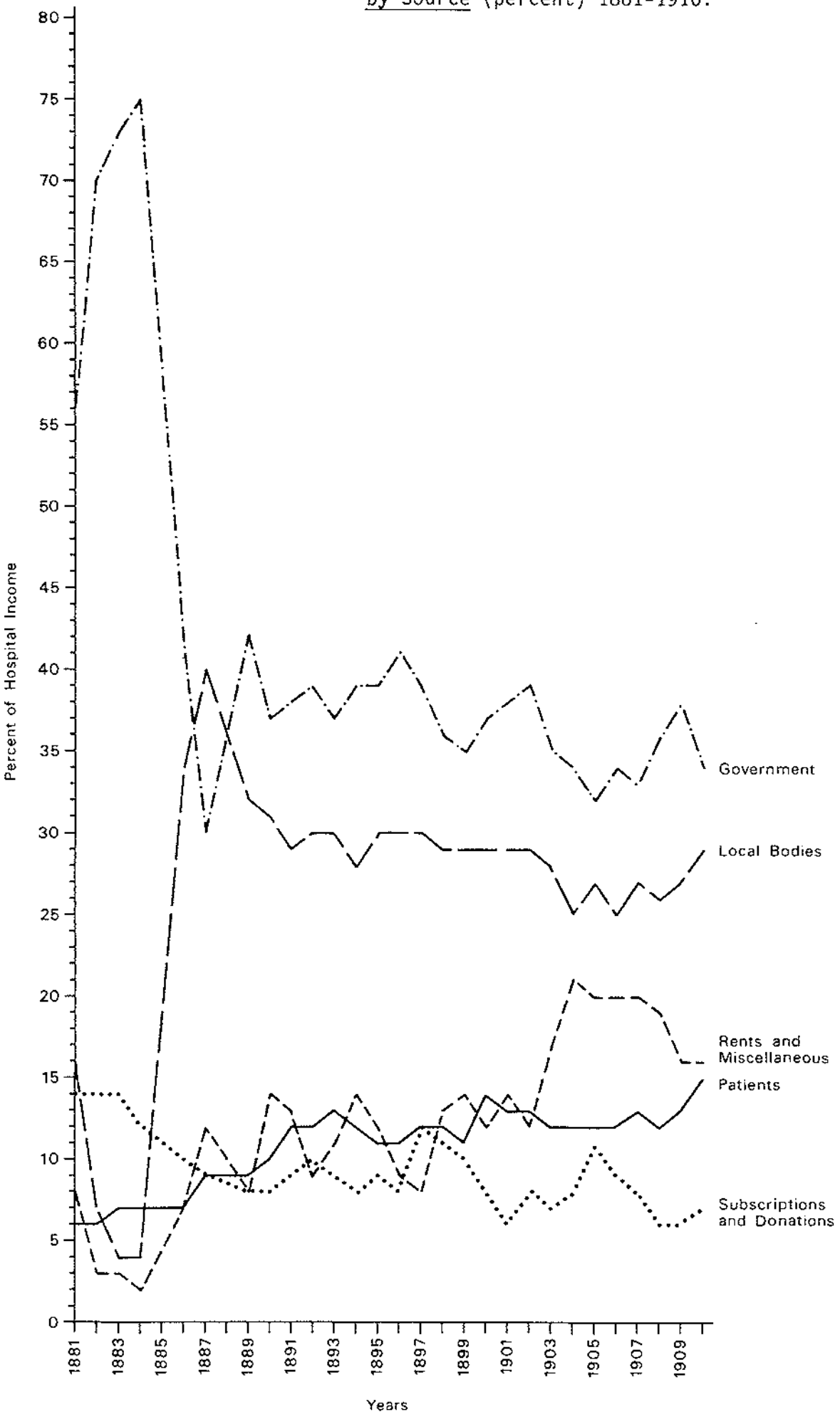
Investigations by geographers and other social scientists along these

and other lines will assist future interpretations of the social world. They will not allow prediction. They may facilitate 'revolution'. Indeed, that is the best for which one can hope.

"So long as we regard a tree as an obvious thing, naturally and reasonably created for a giraffe to eat, we cannot properly wonder at it. It is when we consider it as a prodigious wave of the living soil sprawling up to the skies...that we take off our hats..." (Chesterton, 1936:126-7).

APPENDICES, ARCHIVES AND BIBLIOGRAPHY.

APPENDIX ONE: New Zealand Hospital Income by Source (percent) 1881-1910.



Adapted from data in A.J.H.R. 1881-1911

APPENDIX TWO: PRINCIPLES PRODUCED BY BMA, HEALTH DEPARTMENT AND HOSPITAL BOARDS' ASSOCIATION FOR THE REGULATION OF HOSPITAL ADMISSIONS

"(1) That all members of the community requiring treatment in hospital be eligible for admission to public hosptials.

"(2) That patients in public hospitals who need, because of the nature of their illness, accommodation other than in the larger wards shall be provided for by an adequate number of one- to four-bedded wards.

"(3) That patients voluntarily availing themselves of such special accommodation shall pay the full cost of maintenance, including overhead expenses, provided that no distinction is made in the case of patients unable to pay.

"(4) That the medical attendance on patients be in the hands of a visiting staff, with the assistance of a requisite number of resident medical officers.

"(5) That each Hospital Board must determine the number of the visiting staff, but it be recommended that in arriving at a decision the Board shall, consistent with the convenience and smooth running of the institution, appoint as many of the medical practitioners residing in the district as possible.

"(6) Subject to the approval of the Board, that the right of attending their own patients admitted under resolution (3) be extended to all practitioners except such as may for special reasons be deemed unsuitable.

"(7) That in making appointments to the visiting staff and in determining the suitability or otherwise of practitioners for the privilege of attendance on patients the Hospital Board should be guided by the advice of a special consultative body, or, in the case of the smaller hospital districts, by the advice of the

Director-General of Health.

"(8) That such special consultative body comprise the consulting staff, if any, of the hospital, or in other cases should comprise the senior members of the medical profession of the district, selected by the Hospital Board with the approval of the Director-General.

"(9) Patients unable to pay the ordinary hospital fees shall be attended by the visiting medical staff in an honorary capacity.

"(10) Patients entering the hospital able to pay for medical attendance in addition to maintenance fees shall make their own terms with their medical attendant, who will be responsible for collection of his fees."

Source: New Zealand Government, 1975:41.

LIST OF NEW ZEALAND NATIONAL ARCHIVES CONSULTED (Categorised by Subject)

Throughout the thesis archives have been referred to by the following alphanumeric codes which are also their National Archive Library reference numbers.

File Title	National Archives Reference
Soldiers:	
Records - Soldiers Undergoing Hospital Treatment. Instructions re Custody of etc.	AD1: 23 128
Hospital Boards - General - Arrangements with Hospital Boards re Soldiers	H1: 54 33
Arrangements re Soldiers 1918-22	H1: B.19 54/33
Arrangements re Soldiers 1922-36	H1: 22525 54/33
Friendly Societies:	
Friendly Societies - General 1907-17	H1: B.107 149/-
Friendly Societies - General 1918-26	H1: B.107 149
Friendly Societies - General 1926-35	H1: 149

Medical Associations and Doctors:

Medical Associations - General 1921-36	H1:	150	13445
British Medical Association. Meetings, Conferences 1959-68	H1:	170/2	2350 33573
State Medical Services (Medical Practitioners)	H1:	170/3	

National Health Insurance:

National Health Insurance 1936-7	H1:	B.23	54/88/1
National Health Insurance - Clippings 1936-7	H1:	B.23	54/88/1

Charitable Aid:

Assistance to Applicants for Charitable Aid 1915-8	H1:	B.19	54.32
Hospital Boards - General - Assistance to Applicants for Charitable Aid	H1:	54	32

Social Security:

Social Security - General 1938	H1:	B.129	206
Social Security - General	H1:	B.129	206

1938-40				
Social Security - General 1939-42	H1:	12127	206	
Social Security - General	H1:	27525	206	
Social Security - Newspaper Cuttings 1937-41	H1:	11659	206/5	
Social Security - Newspaper Cuttings 1941-50	H1:	22603	206/5	
Social Security - Newspaper Cuttings 1950-71	H1:	40792	206/5	
Social Security: Medical Benefits - General 1938-9	H1:	B.129	207	
Social Security: Medical Benefits - General 1939-40	H1:	B.129	207	
Social Security: Medical Benefits - General 1940-1	H1:	11568	207	
Social Security Hospital Benefits - Benefits in Licensed Private Hospitals 1956-65	H1:	2051	30787	209/4

Private Hospitals:

Hospital Benefits - Private Hospitals 1940-50	H2:	23170	209/4/2	
Private Hospitals 1934-53	H2:	24600	6/6/609	
Private Hospitals 1942-6	H2:	22461	6/30	
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