
HEALTH

WARS



RACE MATHEWS



Australian
Fabians.

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Fabians.**



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Introduction

This pamphlet updates the health care debate and democratic socialist health care delivery policies of the Whitlam years, in the light of the “Strategies for Renewal” thinking currently being developed by the Australian Fabian Society, in association with Socialist Forum and Pluto Press Australia*.

The first of the pamphlet’s two parts provides a broad historic overview of the events which culminated in the passage of the Medibank Bills at the 1974 Joint Sitting of the House of Representatives and the Senate, and identifies links with more recent medico-political happenings. The Lyons, Curtin, Chifley and Menzies experiences are reviewed, and conclusions drawn from the successful use of delaying tactics by the medical unions. The way in which Whitlam developed the Alternative National Health Programme, which later became Medibank and, later again, Medicare, is examined, with special reference to the use of questions on notice and expert advice. Acknowledgment is made of the role of inquiries into voluntary health insurance by the Senate and Mr Justice Nimmo, in legitimising Whitlam’s critique and conclusions. The politicisation of the open health insurance funds is noted, as is the part played by the health care controversy in the overthrow of Gorton as Prime Minister and the downfall of the McMahon Government.

An attempt is made throughout to add further to the feeling of the times, as it has been conveyed already by Graham Freudenberg in *A Certain Grandeur* and Whitlam himself in *The Whitlam Government 1972-75*. There are also references throughout to the 1984-85 New South Wales medical specialists’ strike, as a salutary reminder of the excesses which must now be expected from some sections of the medical profession, and the extent to which the patient interest and professional ethics now figure for some as secondary to considerations of income, power and status.

The pamphlet’s second part reviews a number of current health policy options in the light of Whitlam’s commitment to a hospital-based health care delivery system, relates Medibank, as an exercise in policy development, to Labor’s current political position, and draws some conclusions about the importance of the ALP retaining a capacity for policy development independent of the Commonwealth and State bureaucracies at times when the Party is in government. The role of hospitals in achieving peer group review and practitioner accountability is analysed, as are the place of general practice in the hospital system, medical ethics, community health centres and the Victorian experience

* See Mathews J., *A Culture of Power: Rethinking Labor Movement Goals for the 1990s* and Altman D., *The Politics of Poetry: Reconstituting Social Democracy*, both Pluto Press, Sydney 1988.

of district health councils and a Health Services Commissioner with responsibility for consumer complaints.

The principles of democratisation and participation set out in the “Strategies for Renewal” documents are shown to apply to health care delivery arrangements as they do to all other aspects of community life. The need is identified for a framework which enables health care providers and consumers to relate to one another and plan together constructively, on a basis of mutual understanding and respect. It follows from all this that what is said will be attacked automatically by the New Right and other extremist groups within the medical profession as “doctor-bashing”. In this way the New Right always hides behind the overwhelming majority of doctors who reject medico-extremism and still take seriously their Hippocratic Oath. Groups which seek to deflect scrutiny and avoid accountability now resort routinely to the claim that they are being “bashed”. As some would say, it has replaced patriotism as the last refuge of scoundrels.

“A Bloody War”

The title “Health Wars” is not original. It stems from a threat by the New South Wales Branch of the Australian Medical Association (AMA) on 27 November 1987, that publication by the NSW Health Ministry of the names of doctors who over-charge patients would lead to “a bloody war”.

Concern about the level of doctors’ incomes and their cost to patients and the public purse has been highlighted by the Chairman of the Commonwealth Government National Prices Network, Mr George Gear, M.P. We are reminded thus that the more things change the more they stay the same. Medico-greed has been a major stumbling-block in Australia’s path to social reform as defined by parties of both the Left and Right, since 1937. Earlier still, in the 1920s, friendly society plans for low-cost medical care were frustrated. It is not turbulent priests who trouble modern rulers so much as avaricious physicians.

The “bloody war” with which the NSW branch of the AMA now threatens us has in reality been waged against the public interest by medico-unions, medico-politicians and medico-ideologues for half a century. This is comparable roughly with the combined length of the First World War, the Napoleonic Wars and the Wars of the Roses. As a nation, we have succeeded neither in curbing the rapacity of what is now the New Right within self-styled medico business, nor in ensuring that ordinary families have access to

medical care of a high standard, at a cost they – and the public purse – can afford. The conservative parties have, for all practical purposes, long since caved in to the stand-over tactics of organised New Right medico-banditry. The ALP and Medicare alone stand squarely between Australian households and overt, predatory medico-exploitation. We are indebted again to Mr Gear for some instructive examples. A list he provided on 27 November 1987, included minor plastic surgery charged for at \$225 or 163% above the schedule fee of \$138; and a coronary artery operation charged for at \$3,000 or 250% above the schedule fee of \$1,200. An anaesthetist was listed as charging \$125 for a procedure which carried a schedule fee of \$63, and a dermatologist as charging \$49 for a \$16.40 consultation.

It is consistent with these instances of medico-exaction that many in what once comprised the noblest and most caring of all professions now regard themselves simply as business people. The single-minded self-interest of medico-business stands out in contemporary Australia. No other organisation has attempted to impose its will upon government and the community with a ruthlessness comparable to that of the doctors' union, as organised until 1963 by the Federal Council of the British Medical Association; until 1968 by the Australian Medical Association; and subsequently on a divided basis by the AMA, the General Practitioners' Society, the Australian Council of Procedural Specialists and other groups further still to the loony Right. Fee increases introduced unilaterally by the AMA in October 1988, were designed, on the Association's own admission, to lift the annual income of the average G.P. by between 16% and 17%, from \$110,000 to \$156,000. Estimates prepared for the Commonwealth Minister for Health, Dr Neal Blewett, indicated that the real increase would be up to 30%, representing an additional \$600 million of taxpayers' money. The Federal President of the AMA, Dr Bryce Phillips, was quoted at the time as saying that the onus was on the Government to bring the Medicare schedule in line with that of the AMA.

Australian families mostly have general practitioners who they regard also as their valued personal friends. Sadly, this endangered species has less time than procedural specialists to participate in the wider world of medico-unionism and medico-politics. As a result, key medical union positions have fallen to New Right forces which are as irrational, incorrigible and insatiable as the Old Left of the ALP prior to the 1970 Federal Executive intervention, which cut the Gordian knot of the Left's Victorian hegemony, and ushered in the Whitlam ascendancy. There are jokes from some about a Painters and Doctors Union, but it is no joking matter. Medical unions have become as brutally obstructive and destructive as the BLF. Patients widely publicised in the media as having been denied medical treatment during the strike by procedural surgeons and other specialist medical practitioners in New South Wales in 1984-85 included a 21 year old car crash victim with broken legs and shattered vertebrae; a teenage girl car accident victim with a broken leg and pelvis; a four year old boy with a smashed elbow and a

seven year old with a compound fracture of the arm. The enormity of the ordeal to which the community found itself subjected was more profound by far than these high profile examples can begin to suggest.

NSW Specialists' Strike

The strike indicates the depths to which medico-bastardry can sink. Accounts of the experiences of one hundred and twenty-eight strike victim patients have been analysed by Professor Stuart J. Rees and Leonie Gibbons of the Department of Community Medicine at Sydney University, and assessed medically by Professor Charles Bridges-Webb and Dr Brian Driver of the same department*. Comments quoted in the study make grim reading. A wardsman from a public hospital summarised the availability of orthopaedic surgeons during the strike in the following terms:

You have got to be dying before they will come, and they will not take the word of anyone below registrar... Sometimes the orthopaedic surgeon will come, but the anaesthetist refuses to cooperate and the patient is left to cope as best he can. Some have died.

An intern in another public hospital commented in regard to the treatment of women with broken hips:

I'm disgusted at what I'm seeing. There have been several women in traction in this hospital. All we can do as doctors is find antibiotics to cure the infections they are getting. Almost all of them have developed pulmonary embolism. They lie here for weeks, in some cases months, trying to get treatment. There is no guarantee that the wounds that have developed will ever heal totally.

The niece of one elderly woman whose promised hip replacement was cancelled when the surgeons took their strike action observed:

* See Rees S.J. and Gibbons L. *A Brutal Game: Patients and the Doctors' Dispute*, Angus and Robertson, 1986.

... one cannot believe what is actually happening to people one knows and loves. Over the last six months I've watched my aunt grow older, more infirm, more frightened and more insecure because of the confusion, the uncertainty and her increased suffering. Her condition is such now that she has become virtually immobile and her confidence eroded. She is a prisoner in her own home.

According to a man diagnosed as having cancerous bladder warts and still waiting for surgery four months later:

I've had a mental breakdown because of the delays. They told me it was urgent, knew it was, it was bleeding. They cancelled the surgery. The doctor said that I could probably wait until the condition became desperate.

In the words of a woman who had been kept waiting for five months for an operation for the removal of cataracts, and feared she would become permanently blind:

Unless I can prove it's a dire emergency there's nothing much I can do. So I said to the general practitioner that I can hardly see anything, I'm frightened and I'm starting to panic, isn't that enough? He said he was sorry it wasn't enough.

Fifty-nine of the one hundred and twenty-eight patients studied by Rees and Gibbons were still being kept waiting for treatment by their doctors after months of delay, at the time the study was undertaken. These included five patients out of the thirty-seven who were classified by Bridges-Webb and Driver as requiring treatment within two days, together with four out of the sixteen whose treatment was required within two weeks and thirty-one out of the sixty where the requirement was treatment within two months. Treatment was similarly denied or deferred for seven out of the thirty patients classified by Bridges-Webb and Driver as severe and thirty-one out of the sixty patients whose conditions were assessed as moderate. Those who missed out altogether on treatment included one out of four patients with complications of pregnancy, two out of eight patients with cancer, four out of six with coronary heart disease and eleven out of twelve with prostatic and other genito-urinary conditions. As one of this latter group commented in his survey response:

You might have said my condition was non-urgent two years ago. Now I'm always in discomfort and you can't be far from a toilet at any time. It's distressing for me, it's distressing for my wife. It's a pain you wouldn't want when you're passing water.

Treatment was received within twenty-four hours by five of the twenty-six trauma victims with conditions ranging from broken limbs and dislocated joints to multiple traffic accident injuries, but five were kept waiting for treatment for one to seven days, eight for eight days to a month, six for a month to a year and two for more than a year. Overall, the one hundred and twenty-eight patient sample included twenty-four who were classified by Bridges-Webb and Driver as having life-threatening conditions, and forty-three who had conditions which threatened them with permanent disabilities, but only twenty-six were treated within seven days, while one hundred and two experienced delays ranging from eight days to more than a year. Even profoundly conservative upward projections of the Rees-Gibbons data suggest strongly that the specialists' strike killed or crippled more Australians than any other peacetime disaster in our history. The specialists have the blood of the victims on their hands as surely as if they had attacked them openly with guns or knives.

It is appropriate that the last word on this whole disgraceful episode should come from a doctor whose views and humanity set him apart at the time from his striking colleagues. The abdication by the striking surgeons of their professional ethics and responsibility for preserving life and relieving suffering was described by Professor David Pennington in an open letter to the *Sydney Morning Herald* in November 1984, as "comparable to the action of terrorists taking hostages or threatening to blow up buildings unless policies are changed".

New Battlegrounds

Each year sees new battlegrounds staked out, new weapons tested and new banners raised. The NSW Branch of the AMA describes efforts to hold doctors' incomes and Medicare costs within reasonable limits as "fascist". It is the Branch's view that, in the event of the NSW Health Ministry proceeding with its plans to name publicly doctors who overcharge patients, "all Hell will break loose". In fact, as the Commonwealth Minister for Health, Dr Neal Blewett, told Parliament on 11 February 1986, medico-fraud and over-servicing by doctors has been costing the public purse annually up to \$200 million. The medical unions have for years flouted the government's fee-fixing procedures and recommended charges higher by far than the Medicare schedule. They now contemplate re-admission to the process, perhaps the better to debauch it from within. It would be more appropriate if the attention of our medico-rogues was turned

for once to putting their own house in order. As Dr Robert S. Myers observed in a seminal article for the American journal *Hospital* on 1 July 1957:

If the financial records of any hospital were audited as casually and as ineffectively as in the quality of its patient care, the Administrator and the Governing Board would probably land in goal. Or, barring such an unfortunate happening, the least they could hope for would be financial chaos, unpaid bills and a richly deserved reputation for incompetence.

Little has changed over the intervening thirty year period. The *Bulletin* reported on 1 December 1987 that doctors “allow 80 percent of terminal cancer patients to await death in undignified and unnecessary pain”. The Head of Melbourne’s Royal Southern Memorial Hospital Pain Control Centre, Dr Jerry Little, was quoted in the same article as attributing this grim statistic to “a mixture of ignorance, apathy and conservatism”. We should all be appalled that more attention by far is being given to maintaining and increasing doctors’ incomes than to implementing proper quality control measures and protecting patients against medico-ignorance and medico-incompetence.

Faced as we are yet again with massive medico-obduracy and medico-intransigence, it is appropriate to re-examine the Whitlam experience. Whitlam remains the only Australian political leader who has taken on the medical unions and won. The passage of the Medibank Bills through the Australian Parliament at the joint sitting on 7 August 1974 remains the only occasion on which the medico-politicians and medico-ideologues have experienced total defeat. Medibank remains the only instance of an Australian health scheme which successfully avoided medico-mutilation. It was destroyed instead – cynically and unscrupulously – by Malcolm Fraser, in the face of his 1975 election undertaking that “We will not dismantle Medibank”. The promise of its restoration was a major factor in the election of the Hawke Government. In order to understand Medibank’s success, it is necessary first to recall the long defeat of earlier efforts to establish health schemes in Australia, and Whitlam’s totally different approach. Whitlam’s emphasis on the role of hospitals in a National Health Scheme and the need for a National Hospital System remains as relevant today as when it was raised originally in his 1957 Chifley Memorial Lecture and his 1961 Curtin Memorial Lecture.

Lyons

A Nationalist Government in which Lyons was Prime Minister, R.G. Menzies was Attorney-General and Minister for Industry and R.G. Casey was Treasurer, launched the first of Australia's many enquiries into national health insurance and established our first health insurance scheme. The Controller of Insurance in the British Ministry of Health, Sir William Kinnear, came to Australia in 1937 at the invitation of Prime Minister Lyons to conduct the enquiry, and in 1938 the National Health and Pensions Act envisaged doctors, who were already providing care for friendly society members in return for per capita payments, accepting a similar arrangement for everybody with an annual income of not more than £385. When the medical union refused adamantly to co-operate with these arrangements, the Government established a Royal Commission "to enquire into matters pertaining to health insurance". The union in its turn established a National Health Insurance Emergency Fund and a Federal National Health Insurance Committee "to take legal advice, to levy money to cover expenses and to prepare a case for the Commission". On 28 October 1938, the lawyers and accountants representing this Committee before the Commission were wiped out in an air accident. On 29 December 1938, the Commissioner died, and with the coming of war in September 1939 the Act itself was abandoned. The medico-politicians had scored an initial victory over the public interest as interpreted by both Houses of Parliament, and learnt an important lesson about the uses of delay.

Curtin

Curtin's Labor Government passed the Pharmaceutical Benefits Act in 1944 in an attempt to provide free of charge medicines, materials and appliances listed in a Commonwealth Pharmaceutical Formulary, but this Act was challenged successfully in the High Court by the Victorian Attorney-General acting on behalf of the Medical Society of Victoria. In 1946 the Government won by referendum the right "to make laws with respect to the provision of maternity allowances, widows' pensions, child endowment, unemployment, pharmaceutical, sickness and hospital benefits, medical and dental services (but not so as to authorise any form of civil conscription), benefits to students and family allowances".

In 1947 a new Pharmaceutical Benefits Act was passed, but the medical union advised its members to return to the Department of Health the prescription forms and formulary supplied to them under this Act, and all but 155 of Australia's 8,000 doctors complied with this advice. In 1949 the Chifley Government amended the Act in an attempt to gain co-operation, but its amendments were struck down by what Whitlam described later as:

The remarkable decision of the High Court that it would be civil conscription to prohibit a doctor from prescribing medicines specified in a formulary otherwise than on a prescription form supplied by the Commonwealth, even though the prohibition did not apply when the patient requested the doctor not to write the prescription on the form.

The Government fell in December, and again delay had achieved its goal.

Chifley

Chifley's Government acquired authority through the National Health Services Act of 1948 to pay medical benefits at the rate of 50% of prescribed fees charged by participating doctors; employ on a salaried basis general practitioners for outback areas and specialist staff for hospital duties; establish hospitals, health centres and laboratories; make loans to the States for the construction, equipment and maintenance of hospitals; make payments to universities for research and for training courses in medicine, dentistry and related sciences; manufacture and supply medical and dental supplies, including spectacles and hearing aids; provide public education in the principles of dental hygiene and regular dental treatment for children; and compile and publish a list of medical and dental practitioners recognised as specialists and entitled to charge specialist fees. The provision of medical benefits was made a focus for opposition by the Federal Council of the British Medical Association. In the hope of meeting Association objections the Government amended the Act so doctors could limit their participation to specific professional services, and so fees could not be reduced without the Minister giving three months' notice in the *Gazette*. By the time this Act had been passed the 1949 election campaign had begun, and the responsibility for health care was about to pass into new hands.

Menzies

Professor Crisp notes in his biography of Chifley that:

From 1944, the B.M.A. Federal Council led a campaign of passive resistance, non-co-operation and delaying tactics against government proposals and against enacted law in the field of medical and health schemes which must have made many a militant trade unionist feel himself a tyro. Basically the Federal Council showed itself determined to fight every development wherein it could see – or believed it saw – the thin edge of any encroachment upon the individual doctor’s uninhibited professional freedom, as traditionally understood, or upon the profession’s rights of virtual syndicalist autonomy.

Although the health proposals of the Lyons, Curtin and Chifley Governments had been overcome by attrition, even the backwoodsmen of the medical union had grasped by 1950 that demands for a more equitable, economic and efficient delivery of health care could not be frustrated indefinitely. If the union did not want to have new arrangements imposed upon its members by external authorities, it would have to devise arrangements of its own. Preparations for such an eventuality had been under way since September 1941, when the report of Dr George Bell and Dr W.F. Simmons on contributory medical schemes was adopted as policy by the Federal Council of the B.M.A. By 1943 the Council had decided that it was in favour of “a health scheme which involved voluntary contribution unrelated to income level, free choice of doctor, a fee for service and a system of rebates embracing all services”, and this philosophy was given practical expression in 1945 when the Medical Benefits Fund (MBF) of Australia was established by doctors in New South Wales. It was extended in 1949 to replace the capitation arrangements under which medical care had been provided for the friendly society movement, and subsequently it became the basis of the health insurance system established by the Menzies Government under the National Health Act of 1953.

Whitlam

The apparent triumph over so-called socialist persecution was to be short-lived. The year in which the National Health Act reached the Statute Book was also the year in which Whitlam reached the Parliament. The extreme cynicism of using flat-rate, tax-deductible contributions to make health insurance more costly for poor than for rich families; the administrative extravagances of men to whom Whitlam would refer later as “the opulent bureaucrats of the great open health funds”; pointless increases in the number of benefit organisations; pointless piling-up of reserve finance; chronic inadequacy of coverage; and a chronic gap between benefits and fees would all turn out to be vulnerable to the painstakingly analytic Whitlam style of attack. In particular, the soaring Commonwealth cash commitment to health insurance would enable Whitlam to argue for a corresponding measure of Commonwealth control. As late as May 1973, the AMA itself would clinch this argument for its most dangerous critic by suggesting ingenuously that a 29% fee increase could cause no difficulties “as long as the Commonwealth accepts its responsibility to adjust medical benefits to match the new fees”.

The developing pattern of Whitlam’s interest in Liberal health insurance can be followed in questions he placed on the Notice Paper of the House of Representatives for successive Health Ministers annually from 1960 to 1972. On 30 August 1960, he asked the Minister:

- 1 How many claims were (a) accepted and (b) rejected by registered medical benefits funds during 1959?
- 2 What percentage of the cost of medical services for which claims were accepted was met by (a) the funds, (b) the Commonwealth and (c) Contributors?
- 3 What were the principle reasons for rejecting claims and what percentage of claims were rejected for each of these reasons?

and by 21 September 1967, he was asking:

- 1 What payments were made to registered medical benefits organisations by (a) their members and (b) the Commonwealth in 1966-67?

- 2 What payments of (a) organisation and (b) Commonwealth benefits were made to, or in respect of, their members by the organisations in 1966-67?
- 3 How many members (a) made payments to the organisations and (b) received payments from them in 1966-67?
- 4 For how many individual professional services were claims (a) accepted and (b) rejected by the organisations in 1966-67?
- 5 What percentage of the cost of the services for which claims were accepted was met by (a) the organisations, (b) the Commonwealth and (c) the members?
- 6 What were the principle reasons for rejecting claims and in what percentage of claims did each of these reasons apply?
- 7 What are the (a) reserves and (b) operating expenses of the organisations, and what percentage of members' contributions did the operating expense represent?
- 8 How many persons are employed by the organisations?

Similar questions were put down each year about the activities of hospital benefits organisations.

Whitlam's interest was given impetus by the behaviour of a handful of open fund administrators in whose hands control over most of the health insurance industry had become concentrated. The arbitrary manner in which these moguls interpreted the rules of their organisations had become a source of widespread contributor resentment, reflected in an increasing number of letters to Members of Parliament, and in particular to Whitlam himself. Early in the 1960's a spectacular falling-out took place between the joint directors of the monolithic MBF-HCF, Messrs J.F. Cade and R.J. Turner, and this dispute was pursued on both sides with a notable contempt for the interests of contributors. On 1 November 1963, the two funds went their separate ways to the accompaniment of a costly advertising campaign in which each sought to entice away contributors from the other. Turner's own membership became a matter of acrimonious dispute, with the HCF accusing the MBF of "hijacking" its executive director, and hinting darkly at the existence of many more victims. The scandal had scarcely died down when the HCF touched off a new controversy by buying Turner a \$40,000 executive aeroplane, ostensibly for use in supervising the organisation's extensive branch network. Whitlam

asked the Minister for Health on 10 May 1967: “Did the Hospital Contribution Fund of New South Wales seek his approval to acquire an aircraft? If not, why not?” and was told: “No. The Fund’s purchase of an aircraft was a matter concerning the internal administration of the fund and, as such did not require the approval of the Minister for Health.” The Senate Select Committee on Medical and Hospital Costs pointed out acidly that the operations of the HCF were “not obviously affected by the decision not to replace the aeroplane after its loss by accident”. Cade in his turn was put down when Turner gave evidence before the Committee on the outlay of contributors’ funds for political purposes in which the MBF had become deeply involved.

As far as back as 1957, Whitlam had complained in his Chifley Memorial Lecture “The Constitution Versus Labor” that: “The present constitutional position is quite unsatisfactory in that the Commonwealth has to pay more and more for the running of hospitals and still has no say in running them, patients are unable to afford medical and hospital treatment and the medical profession participate in any scheme only on its own terms.” His dissatisfaction prompted a major re-thinking of the ALP approach to health, which passed into policy at the Party’s Federal Conference in May 1959. Summarising this approach, Whitlam argued in his 1961 Curtin Memorial Lecture that:

While the constitutional position precludes the socialisation of doctors, it permits the socialisation of hospitals. The best way to achieve a proper National Health Service is to establish a National Hospital System. Quite apart from the economic advantages there is the great social advantage of providing both patients and doctors with an alternative to the present system. Patients would be free to consult the salaried staffs, doctors would be free to join them. Doctors and patients and communities are alike unable to provide an alternative. Only the Commonwealth can give them a choice. There is no sphere in which government initiative can be such a liberating force.

The advantages of the new proposals received further elaboration the same year in two Victorian Fabian Society pamphlets – *Reform in Medicine* and *A National Health Scheme for Labour* – written by another participant in the process of re-thinking, Whitlam’s future Minister for the Environment and Conservation, Dr Moss Cass. Whitlam, John Menadue and myself as his principal private secretaries, Cass and Mrs Ruth Inall of the Australian National University were to work together closely in developing arguments in favour of the policy and amassing the statistics and international comparisons with which to sustain them.

In debate on the National Health Bill in 1961, Whitlam pointed out that the motivation of Liberal health insurance was “not the desire to reduce the expenses of patients, but the desire to guarantee the fees of doctors”. In a major speech delivered

for the annual meeting of the Rochester and District War Memorial Hospital on 28 August 1964, he was able to quote Professor John Griffith of the Department of Hospital Administration at the University of New South Wales as estimating that whereas the cost of health services was £26 per capita in England, it was £A29 in Australia, and as saying: “We are spending one-third as much as they are in England and Wales on a less comprehensive service for a population which is not even one-quarter of theirs”. He was able to quote a leading dignitary of the British Medical Association, the editor of the *Lancet*, Sir Theodore Fox, as saying: “The grim thing about voluntary health insurance is the penalty so often exacted from people who chance their luck or never had any.” Debating estimates for the Department of Health on 1 October 1964, he drew attention to the fact that: “The overhead of the Taxation Branch represents 1% of its collections and that of the Department of Social Services represents 1.5% of its payments, whereas the overhead of the 200 hospital and medical benefit funds represents nearly 10% of their payments.” He concluded: “We should no longer condone such extravagance on the part of organisations which function only because governments have guaranteed them.”

It was not in the Parliament alone but also on every available public platform that Whitlam was driving home his indictment. He told the Biennial Meeting of the Federal Council of the Hospital Employees’ Federation on 28 November 1967, that:

Of the one hundred and nine hospital benefits organisations, twenty-seven have under 1,000 members, thirty between 1,000 and 5,000 members, twenty-two between 5,000 and 10,000 members and only two more than 500,000 members. Of the seventy-eight medical benefits organisations, six have under 1,000 members, twenty-seven between 1,000 and 5,000, seventeen between 5,000 and 10,000 members and again only two more than 500,000 members. This proliferation of funds leads to bloated bureaucracies and duplicated staff, buildings and equipment. The Hospitals Contribution Fund has purchased a \$40,000 aeroplane. Imagine the outcry if the Taxation Commissioner or the Director-General of Social Services or the Repatriation Commissioner purchased a plane.

He told the Annual Conference of the Health and Research Employees’ Association on 5 March 1968, that:

Under voluntary health insurance, contributors must bear a proportion of the cost of the health services they receive. This proportion must not be less than 10%, and in fact averages more than 30%. The more the service costs, the greater the gap tends to be between the amount the contributor pays and the amount he recoups as a benefit.

By now the latent indignation of the electorate had been aroused. Whitlam's attacks were attracting extensive coverage in the media and favourable editorial comment. Ministers might reiterate that Australia had "the best health scheme in the world" but increasingly their declarations failed to carry conviction. When J.G. Gorton became Prime Minister in January 1968, he promptly invited a committee headed by Mr Justice Nimmo to carry out an enquiry into health insurance, with the reservation that the committee should make recommendations only within "the context of a voluntary health insurance scheme". The emphasis given by this reservation to the government's want of confidence in its own philosophy provided yet another weapon for the Whitlam armoury. Within a year the committee's report confirmed that the case against Liberal insurance was well-based in every significant respect, and implied strongly that committee members would have come out in favour of making insurance obligatory if their terms of reference had allowed them to do so. Gorton reacted by nailing his colours to the voluntary principle and campaigning at the 1969 elections on a caricature of the committee's recommendations. This was a decision which turned out to be disastrous both for the government and for its doctor clients. "Five dollar operations" opened up a rift between specialist and general practitioner opinion. They brought about the establishment of the Society of General Practitioners and through it conferred upon the intemperate disciples of Ayn Rand and her Objectivist philosophy a status as spokesmen for the medical profession equal in the eyes of the public to that of the AMA.

Allies

While Whitlam and his Labor associates were developing their critique of Liberal and health insurance on the basis of international comparisons and replies by Ministers to questions on notice, a similar undertaking was being launched on the basis of exhaustive economic analysis by two research workers in the Institute of Applied Economic Research at Melbourne University. In 1965 the Institute had drawn John Deeble from his post as Deputy Manager of Melbourne's Peter MacCallum Clinic, and a year later it had taken Dick Scotton from the Commercial Banking Company of Sydney where he was employed as an economist. Pioneering studies were to be produced for the Institute by Deeble on "The Commercial Structure of the Pharmaceutical Industry" and "The Costs and Sources of Finance of Australian Health Services", by Scotton on "Voluntary Insurance and the Incidence of Hospital Costs" and "Voluntary Health

Insurance in Australia” and by Deeble and Scotton jointly on “Health Care under Voluntary Insurance”, “Compulsory Health Insurance for Australia” and “The Nimmo Report”. Early in 1967 both men were invited by Cass to his home for a meeting with Whitlam and Menadue at which the basis for an alliance was established. As the meeting was breaking up, Whitlam asked Deeble and Scotton if they had developed, in addition to their criticisms of Liberal insurances, ideas about the arrangements by which its place should be taken. He was told that they had ideas, but so far there was no system. In January 1969, a Joint Committee of the Victorian Council of Social Service and the Victorian Branch of the Australian Association of Social Workers brought down a report which argued strongly for making health insurance obligatory. By June, Deeble and Scotton had developed proposals for an obligatory insurance system, and in July these proposals provided the core of the definitive address on “The Alternative National Health Programme” delivered by Whitlam at Sydney’s Royal Prince Alfred Hospital and subsequently published by invitation in the *Medical Journal of Australia*. The proposals were later endorsed as “soundly based and based on solid assumptions” in evidence given to the Senate Select Committee on Medical and Hospital Costs by the Director of the Research Section of the Commonwealth Department of Health.

In the “Alternative National Health Programme” Whitlam focussed public attention for the first time on the finding by Deeble and Scotton that:

The average annual operating costs for the funds between 1953 and 1967 were 15.3% for medical benefits and 12.1% for hospital benefits. Comparable funds in Canada incur operating expenses of only 7.9%.

that:

Health insurance is ‘intrinsically expensive’ also because of the amounts which the funds accumulate as reserves. Australian health insurance funds currently assign to reserves about 10% of the contributions they receive each year. By June 1966 reserves totalled \$85,740,000. Economists estimated that these reserves exceeded real requirements by \$36,500,000 or 72.8%;

that:

Operating costs and additions to reserves together make up the proportion of subscriptions which the funds reside in for their own purposes. For Australian medical funds the figure is 24.9%; for Canadian medical funds, 15.1%;

that:

Under voluntary health insurance, 17% of Australians have no medical cover whatsoever and 15% have no hospital cover. The uninsured include many of those least able to afford to pay for medical or hospital services;

and that:

Costs fall most heavily on those members of the community least able to afford them. Contribution tables are fixed without regard to the contributor's ability to pay. Contributors with high incomes can offset the cost of health insurance and the uncovered medical and hospital expenses against tax deductions. Such deductions are of little or no value to those with incomes in the lower tax bracket.

He asserted on the basis of these criticisms that:

Australians want a health scheme that will provide proper service at a cost the community can afford to pay. They want a scheme which can cope with the demands of all forms of illness, injury or incapacity, regardless of their type, origin or duration.

He said that:

The Commonwealth Government could replace the existing system of voluntary health insurance with a system of universal insurance. This scheme would be administered by a Commonwealth Health Insurance Commission. The Commission would draw its revenue from a National Health Insurance Fund. The Fund would be financed by the following means: (a) a health insurance contribution, assessed and collected as a 1.25% surcharge on income tax; (b) a matching Commonwealth Government contribution, in part funded by withdrawing income tax concessions now granted for voluntary contributions to insurance funds; and (c) a levy on compulsory insurers equal to their present liability for medical and hospital care under third party insurance and workers' compensation insurance.

that:

Representatives of the Commonwealth Government, the Health Insurance Commission and the Australian Medical Association would negotiate a

schedule of benefits designed to cover 85% of current standard fees. Doctors in private practice would then have the option of (a) charging their customary fee to patients, who would then be entitled to recoup 85% of that fee from the Health Insurance Fund; or (b) billing the Fund regularly for the scheduled 85% in full settlement of their fees.

and that:

The Commonwealth Health Insurance Commission would provide hospital benefits at the level required to fully finance public treatment, without a means test, in public hospitals. Whether particular patients are accommodated in single-bed wards or multi-bed wards should be determined purely on medical grounds. The full public-bed benefit should, however, be available for those who choose private or intermediate bed care in either public or private hospitals, with voluntary insurance funds providing cover for the optional additional cost.

Backlash

In February 1969 “Comments by the Australian Medical Association on ‘The Alternate National Health Program’ Proposed by Mr E.G. Whitlam, QC, M.P.” were published officially by the Association under the title “Paying for Health Care”, as a pamphlet and as a supplement to the *AMA Gazette*. In April these comments were demolished effectively by Whitlam in the *Medical Journal of Australia*. Whitlam was able to show that some particularly pungent criticisms of Liberal health insurance attributed to him by the AMA in “Paying for Health Care” and condemned by the Association as “utterly unworthy” had been made in fact by Sir Theodore Fox. He was able to point to repeated, malicious mis-representations of the Labor proposals, to expose numerous errors of fact and to demonstrate that the assumptions on which the Association had based its arguments were in conflict with the experience not only of schemes overseas but of its own allies in the open health funds. In summing up his case against “Paying for Health Care” and its anonymous authors, Whitlam commented, “No member of a reputable profession would wish, I think, to be associated with so shoddy and careless a publication”, but slipshod research and

contempt for the truth turned out to be characteristic of the campaign conducted by the AMA, and subsequently by the AMA together with the Society of General Practitioners, in the years which followed.

The willingness of the AMA to seize any stick with which to beat the Alternative National Health Programme was exemplified by the way in which the Association used “Paying for Health Care” to attack the Programme’s provision that modest point of service charges should be imposed with a view to deterring unnecessary consultations. Whitlam had told his audience at the Royal Prince Alfred Hospital that: “Any risk of patients abusing ‘free’ general practitioner services or ‘free’ unreferral specialist services could be eliminated by imposing a scale of modest charges for these ‘patient-initiated’ services,” and Deeble and Seaton had proposed a scale of 50 to 80 cents for general practitioner consultations, \$1 to \$1.50 for general practitioner home visits and \$2 to \$2.50 for unreferral specialist attendances. The Association stigmatised these charges as “a slug”, argued that they would bear most heavily on the lower income groups and raised the possibility that “some doctors might regularly certify that the patient was unable to pay cash”, to the disadvantage of competitors. Whitlam replied that in foreshadowing the possibility of deterrent charges:

I intended no more than to recognise that the fear of over-utilisation is honestly held among great numbers of doctors, even if in my own view it is ill-based. If the profession as a whole is unappreciative of the proposal, or regards it as an excursion into unfair trade practices on my part, I am more than happy to forget the whole idea.

The abandonment of the charges was described as “a gracious gesture” by the Secretary-General of the AMA, Dr E.F. Thompson, in a letter published by the *Medical Journal* on 19 April 1968, but before long the Association was attacking the Programme’s lack of deterrents even more vehemently than originally it had attacked their inclusion. Few doctors would recall by 1973 that it was at the instigation of their own representatives the charges were dropped.

In answering the AMA over “Paying for Health Care”, Whitlam signalled to the Association that he would resist its plans for frustrating changes in the health insurance system. The AMA President, Sir Clarence Reiger, had launched “Paying for Health Care” on 6 February 1968, in the *AMA Gazette* with the thought that: “Doctors will undoubtedly be asked questions on this topic by patients and others in the coming months, and their answers will be influential. I hope the supplement will prove useful in providing some of the answers.” Whitlam replied in a warning against the use of surgeries as frontline trenches for a campaign to re-elect the Liberal Government:

I would be sorry to see practitioners who in good faith accept Sir Clarence's advice subsequently held up to public ridicule for having put into my mouth words which I have never spoken, and for lending their prestige to statements which are demonstrably false or inaccurate.

He recalled that "AMA authorities" had been quoted in the *Melbourne Age* on 28 October 1967 as revealing the existence of a "highly secret plan" to resist "nationalisation of doctors by a federal Labor government" which had been adopted at the first federal assembly of the AMA in Adelaide in 1962. He referred for the first time to a private report on anti-Labor activity commissioned from public relations consultants by the Blue Cross Association of open health funds and turned over to the Senate Select Committee on Medical and Hospital Costs by a dissident Association member. He quoted the report's recommendation that the Blue Cross Association should:

... launch a campaign from the combined resources of the Blue Cross Funds which, by the subtle persuasion of accepted public relations techniques, will convince the public that they have the best medical benefits scheme in the world, that any change to nationalised medicine would be for the worst and an interference with their personal welfare, that they would incur the danger of losing some of the freedom to choose whatever help they may need in matters affecting their own health and well-being.

The report also recommended that the Association should: "Set aside an adequate sum of money every year for a period of 5 years (probably about £10,000 a year)" to finance the campaign.

The Blue Cross Association implemented the advice of its consultants by setting up the Voluntary Health Insurance Council of Australia, comprising three representatives from the HBF and one each from the Hospital Benefits Association and the Mutual Hospital Association of South Australia. The existence of this organisation and its £100,000 slush-fund was a nagging source of concern to Labor strategists in both the 1969 and 1972 election campaigns. Discouraging individual benefit organisations from backing with contributors' money the political philosophies of their senior bureaucrats became a matter to which Whitlam himself gave close attention. In October 1968 a body describing itself as the Victorian Council of Health Benefit Organisations began distributing to contributors reprints of a series of newspaper articles on health insurance which omitted the article written by Whitlam. In April 1969 the Hospitals Contribution Fund of Australia established a political warfare section which it described euphemistically as "The Office of Health Care Finance" and commenced to publish tracts described by Whitlam as "costly apologies for voluntary health insurance".

Sensing that the next step would be a direct subvention from the bank accounts of the benefit organisations to the campaign chest of the Liberal Party, Whitlam issued a statement exposing the covert politicking of the industry and calling upon the Minister for Health, Dr Forbes, to protect contributors against mis-use of their money. In May he forced the Minister to give an undertaking that “Should any instance occur in the future where action publicly directed to purely political objectives is undertaken or financed by any registered benefit organisation, I will certainly see that appropriate action is taken.” While this undertaking did not lead to suppression of the Office of Health Care Finance, or act as a deterrent after the 1972 elections to the Medical Benefits Fund issuing anti-government car stickers and the Voluntary Health Insurance Association publishing at the expense of contributors a 21-page political tirade against the report of the Working Party on Health Insurance, it served in conjunction with Whitlam’s evident watchfulness to cover the industry as a whole during election periods and abort the more ambitious strategems to which militant managements had been giving thought. Turner himself found it expedient to tell the Senate Select Committee that: “We do not regard benefit organisations as having any right to participate in politics in any way. Accordingly we do not support the use of contributors’ money to that end.”

While the benefit organisations were flirting with the idea of political activism, developments of an ultimately more serious nature were occurring within the medical profession itself. In April 1968 a group of Sydney doctors had fallen out with the AMA over the imposition of fines for over-servicing pensioner patients, and established a breakaway organisation styling itself the General Practitioner’s Society in Australia. This new trade union became the instrument for an outflanking of orthodox conservatives on the Association’s Federal Council by the Birchers, Butlerites and Objectivists of the New Right. Distant memories of the Hippocratic Oath and its ethical implications had held back the conservatives from too overt an avarice, but such inhibitions were seen by the ideologues of the General Practitioners’ Society as irrelevant and even offensive. The President of the Society, Dr Peter Arnold, summarised their attitudes in Sydney on 24 September 1972, when he said that the public had no right to the services of general practitioners, that such services were “a luxury” and that, “We must be less concerned for the patient’s pocket”. Asked to amplify these remarks, he added, “I am a trader trading my services, trading my skills and trading my experience”. The Victorian Secretary of the Society, Dr Mervyn Jacobson, said in Melbourne on 26 March 1973, “We are a service industry and we are in limited supply. We certainly have our own destiny in our own hands.”

The General Practitioners’ Society elected to rely for impact upon overstating its case to the point of falsification. Its policy of grabbing every available headline was summarised on 11 July 1973, by the General Secretary, Dr Duncan Yuille, who told reporters: “We have always tried to drop a bombshell every two months. We stepped

this up to once a fortnight and are now trying to drop one every week.” Inevitably in these circumstances a sacrifice was made not only of truth but of the elementary consistency upon which credibility depends. Dr Jacobson declared before publication of the Report of the Working Committee on Health Insurance that, “We talked with Government officials last week and the whole scheme is to nationalise doctors and provide a free medical service” and after publication, “Close study of the Report reveals it’s no less than an attempt at total nationalisation of medicine”, but the allegation was undercut by the fact that there were neither proposals in the Report nor powers under the Constitution for such a course of action. As early as February 1971 the then President of the Society, Dr D’Arcy Williams, asserted that: “Almost every baby born in Australia is now delivered by a specialist obstetrician”, but the AMA pointed out in December that G.P.’s had delivered 79% of the nation’s babies before the proclamation of the 1970 Health Act, and eighteen months later they were still delivering 72%.

Dr Arnold might have had more hope of being taken seriously over his statement that “Labor had no mandate to wreck a good health scheme” if he had not said earlier, “The Liberal scheme has plunged the daggers in the back of the practitioner, and Labor’s scheme is simply the act of knocking the nails into the coffin lid. We would not co-operate with either one.” Fearing for the professional veneer of medical unionism, the Secretary-General of the AMA, Dr E.S. Stuckey, stigmatised the Society in the *Medical Journal* as a “Judas team” and “a group determined to destroy loyalty”.

Headlines were not the only source of friction between the Association and the Society. In December 1972 the AMA attacked Society claims that general practitioners had been thrown into a catastrophic decline by Gorton’s amendments to the National Health Act with figures showing that between 1970 and 1972 the ratio of G.P.’s to population had actually improved from one for 1,935 to one for 1,901. Dr Yuille’s post-election declaration that Society members would never co-operate with the new government’s health programme was debunked as “premature” by the Federal President of the AMA, Dr J.G. Johnson, because the replacement of the existing benefit organisations with a single government health insurance commission was not contrary to the AMA policy and would not affect the individual doctor. In March 1973 a letter from the Society inviting specialists to register with it at an annual cost of \$20 was condemned by the Association as “blackmail”. In July the Association declined to sanction Society proposals that general practitioners should withdraw from the pensioner medical service and the repatriation medical scheme on the grounds that “The AMA has a contract with the Federal Government to provide the service and we have made no changes”. Unabashed, the Society provided its members with a model letter for pensioner patients in which it exploded allegations that “the present government hopes to bring about the nationalisation of doctors” was followed up by an equally unfounded claim that under the new programme, “I would not be permitted to provide you with the

attention I have been able to provide in the past” and the advice – misleading at least as far as repatriation patients were concerned – that “if you enrol in a medical benefit fund you will then be entitled to claim rebates which will enable me to treat you as an equal with all my private patients.” As Dr Jacobson had said on 22 March:

If necessary we would refuse to treat pensioner patients. This would be a drastic step we wouldn’t like taking but we will if need be. We would bring chaos into the repatriation field, pharmaceutical benefits, local hospital services and a host of other medical services in which we co-operate with the government. This would send the government departments into a chaotic mess in 24 hours.

Nimmo

On 25 March 1969, the Minister for Health, Dr Forbes, tabled the report of the Nimmo Committee in the House of Representatives and on 25 September the interim report of the Senate Select Committee on Medical and Hospital Costs was tabled in the Senate. Voluntary health insurance was condemned by Nimmo for having become complex to the point of incomprehensibility, charging contributions beyond the means of many members of the community, paying less in benefits than the cost of medical and hospital services, causing “serious and widespread hardship” through the application of “special account” regulations, appropriating too much of its contribution income for operating expenses and accumulating excessive reserves. Echoing most of these criticisms, the Senate Committee stigmatised the operations of the largest open funds in New South Wales and Victoria as “unsatisfactory and wasteful of contributors’ funds”. It singled out the use of contributions for political propaganda as “beyond the proper functions of health insurance organisations, and beyond the anticipated wishes of contributors.”

Whitlam noted with satisfaction that: “The report tabled by the Minister for Health bears out in every significant detail the criticisms of the national health scheme raised repeatedly by the Opposition over a period of years and as repeatedly rejected by the Government.”

The Deputy Director-General of Health confirmed for the Senate Committee that in the light of his Department’s experience nothing in the report was exaggerated. The *Canberra Times* concluded in an editorial representative of opinion among leader

writers, “the Report shows in a poor light the Commonwealth Government, State hospital authorities, the medical profession and health insurance organisations”. In order to do better the government “would have to battle the health organisations and the medical profession”. The advice turned out to be prophetic not only for the government to which it was addressed but for both its Liberal and Labor successors.

The Nimmo Report recommended free health insurance for families with three children and weekly incomes not exceeding \$42.80, insurance subsidised by two-thirds for those with not more than \$44.80 and insurance subsidised by a third for those with not more than \$46.80. The intention clearly underlying these figures was that contributions should not be paid by families with incomes below the poverty line established by Melbourne University’s Institute of Applied Economic Research, but instead the Government introduced what Whitlam called “a cut-down caricature” of the proposal, under which insurance was provided free for childless couples with up to \$9 above the poverty line, and denied larger families \$3 below it. Insuperable difficulties were encountered in identifying and enrolling families which met these narrow criteria, and the benefits of the scheme were never enjoyed by more than a quarter of the families which were entitled to them.

The Report recommended that the administration of health insurance should be transferred from the Commonwealth Department of Health to a five member National Health Insurance Commission, which would take responsibility for matters such as negotiating medical and hospital care for pensioners and low-income families, maintaining surveillance over benefit organisations and taking “appropriate disciplinary action in relation to any abuses of the health insurance scheme”. The Minister for Health announced in March 1970 that this recommendation had been accepted by the Government, but nothing had been done a year later when Gorton handed in his resignation, and the decision was reversed by McMahon. Entrusted again to the benign bureaucrats of the Health Department, the benefit organisations went forward to the 1972 elections as open to accusations of extravagance as they had been before the enquiries began.

The Government could afford to treat these recommendations casually because it saw them as peripheral. In the Government’s view, the weakness of the health scheme was not failure to provide cover for low-income groups or the extravagance of benefit organisations, but simply the gap between benefits and fees. If the gap could be narrowed, Whitlam would find it hard to retain an audience for his wider criticisms. It seemed from the submissions of the benefit organisations and the AMA to the Nimmo Committee and the Senate Committee that a way out had been found.

The HCF in particular had argued for months that if the fee most commonly charged for each medical service was known, most if not all doctors would conform to it, and the basis for an acceptable medical benefits table would be established. The AMA’s energetic private promotion of the common fee concept was expressed publicly by the

Association's Federal President, who said in evidence before the Senate Committee: "I think there is a case for fees being based on the usual common fee and the rebates being based on the usual common fee and the fees in excess of this should only be charged after due notification to the patient."

This view was accepted by both the Nimmo Committee and the Senate Committee in paragraphs which emphasised the impossibility of guaranteeing contributors a percentage return on their medical expenses in the absence of stable fees. The Committee recommended that action should be taken to establish a schedule of common fees charged by general practitioners and specialists for all types of medical services and that the schedule should be adjusted periodically on the basis of agreed economic indicators. The Senate Committee suggested that disputes about the establishment of common fees should be settled before an arbitration tribunal, and the Nimmo Committee proposed that payment of Commonwealth medical benefits should be made conditional upon doctors notifying patients in advance of any departure from the common fee. The Committees agreed that there should be no more than one medical benefit table, returning in the view of the Nimmo Committee all but \$1 of the common fee even for costly services such as surgery, and in the view of the Senate Committee 90% of that fee.

Fee

The most common fee was adopted by the Government as the basis for the "five dollar operation" promise on which Gorton campaigned at the 1969 elections, and for the amended National Health Act which was introduced the following year. "Five dollar operations" immediately became a source of confusion for the public, of frustration for general practitioners and of increased incomes for specialists. In May 1970 the Government rejected a proposal from the AMA that fees should be set by the Association on the basis of official economic indicators at meetings attended by government observers, and in June the Association in its turn rejected a government offer to negotiate fees at two-yearly intervals, with recourse to arbitration in the event of disagreement. At the same time it was becoming clear that in promoting common fees and negotiated fee settlements, the AMA had promised more than it was prepared to deliver.

Adherence to the common fee schedule fell in New South Wales in the case of surgery consultations from 76% for the March quarter of 1971 to 69% for the corresponding quarter of 1973, with a low of 49% for the June quarter of 1972. It fell

in the case of home visits from 68% to 29%, of initial specialist consultations from 73% to 64%, and of subsequent specialist consultation from 54% to 50%. Although the Government had set in motion a review of fees and benefits designed to bring into operation new schedules and tables by 1 July 1971, the AMA refused to wait until this review had been completed, and announced on 1 February that fees would rise in July by 15%. The Minister for Health, Dr Forbes, said the Government was “concerned” and could not accept the increases as reasonable. Gorton said the Government was “appalled”, and that in the absence of a negotiated settlement the increases must go to arbitration. Echoing Whitlam, he declared: “We do not believe any profession should be able to fix its fees at any level which appeals to it when it is supported by public money.”

There was wholehearted support for this stand both from the electorate and from the media. Leader writers were quick to contrast the tacit approval given by the Association in 1968 and 1969 to fees being fixed by negotiation, and its insistence in 1971 that they should be fixed by the profession alone. The Melbourne *Age* backed up Gorton in the view that: “As doctors derive a substantial part of their income from the Treasury, the Commonwealth has a right – indeed it has a duty – to exercise an influence over doctors’ fees? It was the view of the *Sydney Morning Herald* that: “As the Prime Minister says, no profession can be allowed to fix fees at any level it desires when it is supported by public money.” According to the *Australian*: “It is difficult to understand how doctors can imagine that a viable insurance system can be maintained when the group which is receiving all the payouts insists at the same time on being the sole authority on the question of their size”, while the *Canberra Times* concluded that: “The principle of unilateral increases advocated by the medical profession can only be rejected.”

Emboldened by the unanimity of public opinion, Gorton told representatives of the AMA at a meeting in Canberra on 12 February that, unless the Association backed down on its increases, fees in excess of the common fee schedule would be declared ineligible for Commonwealth medical benefits and doctors charging them would be obliged to practice outside the medical benefits scheme. He pointed out, as the Minister for Health had done already at an earlier meeting, that whereas the number of medical services performed in the December quarter of 1970 represented an increase of only 3.8%, their cost represented an increase of 25.5%. The increases for which the Association was now asking would add at least \$32 million to the nation’s health bill. Questioned in the House on 16 February, he declared that: “A participating doctors scheme is obviously a course which is open in this field in order to see that neither the patients nor the taxpayer is mulcted too heavily by people choosing their own special levels”. The AMA recoiled in the face of resolute opposition from so unexpected a quarter. The President of the New South Wales Branch, Dr E.S.A. Meyers, complained: “Doctors are not rogues, as we are being painted. I don’t think any profession could have a worse image than we are branded at the moment, and it is completely and absolutely unjustified”, but the Federal

President, Dr R.H. Macdonald, announced that the increases would be submitted to a plebiscite of Association members.

Within a matter of days events had made irrelevant this act of abasement. In March Gorton was replaced as Prime Minister by McMahon, who told the Association that he was prepared to approve an increase in fees if it was limited to general practitioners. Dr Macdonald suggested that this proposal should be submitted to a Federal Assembly of the Association called for the purpose, where to nobody's surprise it was endorsed. In announcing that on 1 July there would be an increase of 15% in the cost of general practitioner consultations, the new Minister for Health, Senator Ivor Greenwood, affirmed that: "The Government relies on medical practitioners adhering to the same voluntarily, and on the advice and encouragement given by the AMA for the charging of the same fee." Gorton, like Lyons, Curtin and Chifley before him, had run out of time in his endeavour to subordinate the interests of the medical unions to those of the community.

McMahon believed that by throwing a bone to the most vocal section of medical opinion he had defused the fees issue until after the 1972 elections and saved himself the embarrassment of fighting the health issue simultaneously on two fronts. He was disabused in February 1972 when the New South Wales Branch of the General Practitioners' Society urged its members to lift their fees by up to 100%. In the face of tacit support from the AMA for the Society's initiative, McMahon's initial reaction that "We are not prepared to let them get away with it" was supplanted by the decision to appoint Mr Justice Kerr as arbitrator on the fees charged in New South Wales for surgery consultations and home visits. Labor's Shadow Minister for Health and Social Welfare, Mr W.G. Hayden, condemned this move as "a hopeless, useless exercise unless it confronts and overcomes the problem of non-adherence to the common fee concept by medical practitioners on a national basis", and the General Practitioners' Society challenged its constitutional propriety, but in May fee increases of 20 cents for consultations and 40 cents for visits were proposed by Mr Justice Moore, who had replaced Kerr midway through the enquiry, and accepted by the Government at a cost to the taxpayer of \$6 million.

Medibank

The opinion polls showed consistently that Whitlam had won majority support for the Alternative National Health Programme. In September 1972 the AMA made an abortive attempt to mobilise its members in the Liberal interest, but the effect, if any, was swamped by the rising tide of public disillusionment with McMahon and his ministers. Attempts by Liberal candidates such as Mr Ian Wilson to enlist support individually from local doctors were exposed and savaged in an open letter written on behalf of the General Practitioners' Society by Yuille. After victory in December 1972, Whitlam as Prime Minister and Hayden as Minister for Social Security lost no time in setting up the Working Party on Health Insurance in which Deeble served as chairman and Scotton as a member. The Working Party laid down in May the measures that would be needed in order to give practical effect to the Alternative Programme, and Hayden announced, subject to Cabinet approval, that these measures would come into force on 1 July 1974. Medibank, conceived in 1967 at the home of Moss Cass, was about to be born.

There had never been any doubt that Australia would have a proper national health scheme. The economic inanities and social inequities of voluntary health insurance served to defer but not deny the establishment of arrangements under which health care of a high standard could be delivered at prices determined by the individual consumer's capacity to pay. It remained for a leader of Whitlam's calibre to painstakingly replace the electorate's intuitive distrust of the insurance system with a rejection based on argument and facts. It remained for the medical unions and the medico-politicians to outweigh with their rhetoric, greed and arrogance the goodwill and respect earned by working doctors at their patients' beds.

However, the war was not over. The two enabling pieces of legislation for Medibank were the Health Insurance Commission Bill 1973, which established a statutory authority to administer the Medibank program and the Health Insurance Bill 1973, which authorised payment of medical benefits and the negotiation of hospital agreements with the States. Medibank followed closely the analysis that Whitlam had made of every detail in the controversy for almost a decade. Its philosophy was that governments had a responsibility to provide health services, if not entirely free of cost to the individual at least free of the burden of major cost. It did not mean the "nationalisation of public health" (which had been dropped from the ALP platform at the 1965 Federal Conference), although in the disinformation campaign that followed the introduction of the bills to Parliament the claim was often made. All Australian residents were to be given free public hospital treatment and medical benefits totalling

at least 85 % of the cost of doctor and hospital services, with the maximum gap between the scheduled fee and the benefit for every single service set at \$5.00. Patients were to have a free choice of available doctor and hospital services.

The two Medibank bills were twice rejected by the Senate and were two of the six bills upon which a double dissolution was obtained for the elections of 2 May 1974. The Medibank legislation was passed by the joint sitting of Parliament but the Senate later rejected additional bills which would have substantially funded the scheme by imposing a 1.35 % levy on taxable incomes. It was therefore decided to finance the scheme from general revenue and Medibank's introduction was further delayed. The non-Labor State Governments stalled on the negotiation of hospital agreements. Medibank did not commence until 1 September 1975. Within a few months it was being dismantled by the Fraser Government.

Policy Development

Whitlam's foray into Labor's health war was characteristic of his approach to policy development.

First, he had to be convinced that the issue was "relevant". This meant, among other things, being politically sensible. Much has been said about the reforming zeal of the Whitlam era, and rightly so, but it was not the zeal of an ideological zealot, as far as Whitlam was concerned. It was the zeal of the leader of a great political party who wanted a programme he could put with confidence to the people. Whitlam was convinced about the relevance of a national health scheme from the beginning and believes now that Labor's health policy was a major factor in the strong electoral performance in 1969, the victory in 1972, and the crucial survival in 1974. He has noted Fraser's broken 1975 election promise not to dismantle Medibank, and its part in the ultimate downfall of the Fraser Government. He was critical of Labor's "apologetic" version of Medibank in the 1980 elections and notes that Hawke won in 1983 with a promise to restore Medibank. Similarly, the parliamentary process was supremely "relevant" to Whitlam. It was of the highest significance to him that the health battles outside Parliament should not be allowed to affect the process by which elections were won, office gained, legislation prepared, debated and, finally, enacted. Not least, the issue had to be relevant also to what might loosely be called history. Whitlam has a clear sense of the evolution of society and its current direction. He was the most modern of Australian Prime Ministers

and, in some ways, still is: nothing excited him more than the prospect of bringing Australia up to date. In the case of health, and many other social services, Whitlam was acutely aware that Australia had fallen behind Western Europe and Canada.

Second, Whitlam's policies mostly stemmed from central axioms, which he called his "insights". A pack of system cards was carried around in his jacket pocket, so that "insights" could be jotted down as they occurred to him. It was a Whitlam health "insight" that – in words already quoted from his 1961 Curtin Memorial Lecture – "The best way to achieve a proper National Health Service is to establish a National Hospital System." The creation of a National Hospital System is an objective from which he has never deviated. The National Hospital System-based National Health Scheme differed thus from Medibank, which was always intended as a medium-term, transitional institution. Whitlam always believed that people would more easily be able to embrace doctors based and backed by hospitals if they had first become accustomed to consultations without fees. As demand for the superior hospital system product increased, so Medibank would be able to wither away.

Third, Whitlam attached over-riding importance to research, and insisted that policies should be justified in depth with facts. As has been noted already, his chosen mechanism for gaining information was the parliamentary question on notice, which he elevated to an art form. No parliamentarian anywhere has used questions on notice more extensively or to better effect. In this way, he was able to place on record facts which otherwise would not have been available publicly, in a form which carried unchallengeable ministerial authority. Copies of the daily edition of Hansard were indexed painstakingly in his handwriting with the page numbers and headings of ministers' answers, and accompanied him everywhere in large suitcases. When he began his investigation of the health issue, it is doubtful if Liberal ministers appreciated the use to which their replies to his long and carefully-categorised question would be put, but the strategy was always clear in his mind.

Fourth, Whitlam instinctively and unceasingly sought expert advice. It may be that the habit stemmed from growing up in a public service family. The responsibilities of his principal private secretary included identifying sources of advice on the policy issues to which he attached priority. Networks within universities and colleges of advanced education were established, through which steady flows of original thinking could be maintained. Feature articles were torn in strips from the *Age*, the *Financial Review*, the *Canberra Times*, and the *Sydney Morning Herald* during motel breakfasts and early morning flights, so that their authors could be contacted and their minds picked. As "convertible literary material" was to a writer such as Evelyn Waugh, so "convertible policy material" was to Whitlam. His appetite for ideas was catholic and voracious. The most prolific provider was Professor Ronald Henderson's Institute of Applied Economic and Social Research at Melbourne University, which has since given the Cain Government its leading economic advisor and Head of the Department of Management

and Budget, Dr Peter Sheehan. Such ideas as survived the test of Whitlam's rigorous political and intellectual scrutiny were incorporated subsequently in the speeches with which he dominated Parliament and fired the imaginations of audiences throughout Australia. Whitlam's philosophy of life was summarised memorably by the murdered Senator Robert F. Kennedy, when he said "Some see things as they are and say 'Why?' I dream things that never were and say 'Why not?'" Australians are accustomed to having their votes sought through their purses and pockets. Whitlam alone has addressed himself uncompromisingly to their consciences and intellects.

Fifth and finally, Whitlam realised from the start that in order for policies to be accepted by the electorate they had first to be understood. Medibank was explained constantly from 1967 to 1969, and again from 1969 to 1972, in Parliament and wherever public platforms or media attention were obtainable. Fraser mistakenly supposed that Australians would accept his demolition of Medibank because it had been serving them for only two months prior to his Remembrance Day Coup and the premature 1975 election. The real strength of Medibank stems from the fact that it was explained to us more thoroughly by far than any other policy proposal in our experience or history.

Taking all five points together makes plain their provenance. Whitlam has epitomised throughout his career the Fabian approach to politics and policy development, his enduring lesson for the Labor Movement that the process of equipping ourselves with contemporary policies relevant to current political opportunities and challenges is necessarily on-going. The access to public service policy advice which Labor governments enjoy currently must never embolden us to neglect our own inescapable responsibility for policy development, or allow policy development mechanisms such as those of the ALP and the Australian Fabian Society to fall into disrepair. Whitlam is also unabashed in his acceptance of the inevitability of gradualness. His success in enabling Labor to emerge victorious from its health wars recalls the summary of the tactics of the Roman general Fabius Cunctator by the early Fabians: "For the right moment you must wait, as Fabius did, most patiently, when warring against Hannibal, though many censured his delays; but when the time comes you must strike hard as Fabius did, or your waiting will be vain and fruitless." Each new piece of work he undertook started from the principles of social justice and equality which have given his career its whole motivation and purpose. Facts and advice were gathered painstakingly and meticulously analysed, so that administrative options emerged and could be tested. Once the final form of a proposal had been settled, it was fought for with all the formidable force of his intellect and eloquence. "Research, analyse, educate, agitate and organise" – the strategy of the Fabian Society from its inception – are his watchwords. Adopting his approach now enables us to identify plainly some key components for a second generation health policy agenda.

Doctors' Incomes

Figures from Medicare featured in the *Sydney Morning Herald* on 12 November 1987, show that in the last financial year 11% of surgeons and 8% of physicians earned more than \$300,000 in fees charged for those services attracting Medicare benefits. Even allowing that these are gross figures, from which must be deducted tax and the cost of running a practice, they represent large sums of money. As the chairman of the Government's National Prices Network, Mr George Gear, M.P., has pointed out, even without including income from other sources than Medicare, such as treatment of Veterans' Affairs patients, workers' compensation and third party patients, doctors averaged incomes of \$168,000 gross last year.

Whatever figure the public likes to put on the annual value of a doctor to the community, the figures make a mockery of claims by the New Right that doctors are inadequately rewarded by Medicare schedule fees. It cannot be expected that the average Australian family, facing wage constraints and an uncertain economic climate, will accept with understanding and sympathy the grossly selfish claims which are advanced on the doctors' behalf. The basis on which the New Right of the profession have once again taken their stand is likely to be as unpalatable to the Australian people in the future as it has been in the past. If doctors think they have a right to charge what the market will bear, that they are in the business of making money like any other small business, they will be brought up sharp by the realities of what a national health care system is meant to do. It is meant to provide every Australian with medical care at a cost they – and the community – can afford. It is not meant to provide doctors with public funds to test the principles of the free market, as some so arrogantly assume to be their right.

Medico-business itself might be poorly served if medico-avarice and medico-abuse were to bring Medicare financially to its knees. It does not follow that such a misfortune would result automatically in a reversion to private health insurance on either the Gorton or Menzies models. Nor does it follow that the overwhelming majority of the New Right's fellow practitioners would in any way welcome the demise of Medicare as an institution which has put more money in their pockets than ever was there before. On the contrary, if the Hawke Government were ever to add Medicare to its privatisation list, the first to protest would be doctors. Orthopaedic surgeons and pathologists would be fighting one another in the streets for "Save Medicare" placards, and the New Right ideologues would be pilloried for the overthrow of medico-affluence they would be seen to have brought about.

Hospitals

Labor, for its part, would be enabled to move forward again, towards Whitlam's vision of a hospital-based health care delivery system. It has always been Whitlam's view that hospitals are not only the most cost-effective means of health care service delivery, but also the only way in which service quality can be effectively monitored and maintained.

The Rees-Gibbons study of the 1984-85 NSW specialists' strike elicited some instructive comments on this point, from patients who had the opportunity to draw comparisons between public and private hospital care. In the words of one such patient:

The treatment that I received was almost Dickensian by comparison with the public hospital I had been in. There was only one nurse admitting all the patients to be operated on that day, the wards appeared to be unclean, the lady in the next bed was undergoing an exploratory operation for cancer and no-one from the hospital bothered to counsel her.

As matters seemed to a second patient:

In the private hospital I was in agony, the anaesthetist behaved like a tow-truck operator. I was terribly sick for three days after surgery, and they kept pitching me different tales why.

According to a third:

After the first operation there were a series of doctors who came in to say "good morning" but there was never any examination. The specialist wasn't interested once he did the surgery. He never came to see me again.

Further steps now need to be taken towards high standards of medico-quality control and – correspondingly – good medical practice. However, Shaw's great aphorism that "All professions are conspiracies against the laity" remains as true today as when he voiced it for the first time in his play *The Doctor's Dilemma*. Accordingly, even the best possible system of medical self regulation is no substitute for the wider, independent and free-standing medico-accountability arrangements which the shameful spectacle of the NSW specialists' strike has reminded us are urgently required.

Complaints Authority

There is a need for – at the least – a statutory health complaints authority, on the model adopted recently by Victoria, in every Australian Territory and State. Eight health complaints objectives or guiding principles underlie Victoria’s Health Services (Conciliation and Review) Act 1987. They are (i) quality health care, given as promptly as circumstances permit; (ii) considerate health care; (iii) respect for the privacy and dignity of persons being given health care; (iv) adequate information on services given or treatment available; (v) participation in decision-making affecting individual health care; (vi) an environment of informed choice in accepting or refusing treatment or participation in education or research; (vii) reasonable access to information in personal health care records, except information which is expressly prohibited by law from being disclosed or information contained in personal notes by a person giving health care; and (viii) confidentiality of personal health records.

These objectives in turn reflect the Act’s assumption that “identifying the persistent causes of people’s complaints can tell our health institutions and carers what works and doesn’t work in the health system, and where quality controls need to be improved”. The Act provides for appointment of a Health Services Commissioner to receive, mediate, conciliate and investigate complaints made by health service users against health service providers, together with a Health Services Review Council which overviews the operations of the health complaints system – including the work of the Commissioner – on behalf of the Minister for Health, and, with the Minister’s approval, refers matters to the Commissioner for investigation. Support for the Commissioner and the Council comes from enquiry officers, investigators, conciliators and a registrar. Providers who can be the subject of complaints include individual practitioners such as doctors, dentists, psychologists, therapists and chiropractors, along with institutions such as public and private hospitals, nursing homes, special accommodation houses, psychiatric clinics, ambulance services, pharmacies and community health centres.

Provision is made for a period of up to twenty-eight days in which the Commissioner is required to determine whether a complaint should be rejected, accepted or referred to another authority such as the appropriate professional registration board. It is expected that most of the complaints accepted by the Commissioner will be resolved by negotiation and conciliation, but an immediate formal investigation can be authorised. Alternatively, a formal investigation can follow where conciliation has broken down. A complaint upheld after formal investigation normally results in the issue of a notice requiring remedy or redress from the provider. Failure to respond to a notice from the Commissioner within

forty-five days can lead to the offender being reported publicly to parliament. The Act is seen to create in this way “a means by which people’s questions, uncertainties and grievances can be addressed promptly in a supportive, collaborative and non-adversarial way”.

Integration

Thinking about hospitals and the accountability issue reminds us how much more effectively our health care delivery arrangements would function if our general practitioners were integrated closely with the hospital system. It was always Whitlam’s view that general practitioners should be associate members of the staffs of their local hospitals. As Sir Theodore Fox, has noted: “... to take care of patients as their personal doctor demands the continuous exercise of well-informed judgement; and for acquiring and maintaining such judgement no other form of postgraduate education can compare with frequent discussion of cases with colleagues”. As Whitlam saw it, hospitals would also provide their general practitioner associates with access to a full range of ancillary services, such as physiotherapists, speech pathologists, occupational therapists and visiting nurses. Patients who required more sophisticated investigation or intensive treatment than was available in the general practitioner’s surgery could be admitted to a local hospital under his personal care, and he would be able to visit them there both on his own and in company with the hospital’s salaried medical staff. The ideal situation is one where the care given to a patient in hospital is the subject of discussion on a day-to-day basis between a general practitioner who has a long-standing familiarity with every aspect of the patient’s condition and circumstances and the specialist hospital staff who necessarily come to their association with him as strangers. It may well be that the obvious advantages for general practitioners and hospital staff working together on this co-operative basis would result over time in the establishment of a salaried general practitioner service. It would be helpful for similar reasons if the private consulting rooms of non-salaried specialist staff were to be located in the public hospitals where so great a part of their work is done, and not in separate premises so far apart as to cause inconvenience to their patients and themselves.

It is in no way integral to the Whitlam vision of a hospital-based health care delivery system that hospitals need necessarily be the monolithic, bureaucratic institutions with which currently most Australians are familiar. There is room in hospitals for the application of many of the mechanisms for improving productivity and enhancing work satisfaction which enlightened management and workforce co-

operation has implemented in the manufacturing industries of Sweden and other countries comparable with our own. It may well be that many of the services which hospitals currently provide for themselves on an in-house basis could be better organised as industrial or service co-operatives on the Mondragon or Bologna models, where industrial democracy and high productivity support one another, and the workers own their jobs. It is vital that issues of this character should occupy a high priority in a second generation Labor health policy agenda.

Information

There is a further need to upgrade the access which ordinary Australians are able to obtain to accurate, comprehensive and readily intelligible health care delivery information. It emerges clearly from the Rees-Gibbons study of the NSW specialists' strike that the least likely source of reliable advice about health care systems and arrangements was the medical profession itself. Comments received in response to the survey bear grim witness to the systematic use of misinformation by the striking specialists in order variously to brainwash, frighten, fob-off or rip-off their hapless and helpless patients. The President of the NSW Branch of the AMA, Dr Bruce Shepherd, can be thanked for a classic example. Asked on television why an injured Wollongong miner was taken from hospital to hospital as a result of the refusal of a succession of surgeons to operate on his crushed fingers, he replied "In England, I can tell you, it would take even longer to treat this man." In a second incident, an orthopaedic surgeon who, prior to the strike, had told a twenty-four year old motor accident victim that further surgery on her injured leg was "imperative", subsequently kept her waiting through a variety of subterfuges until the ligament had shrunk and her use of the leg was permanently impaired. A third incident involved the discomfiture of a surgeon who excused himself from performing a knee operation, on the grounds that the necessary prosthesis was not available at the public hospital and could not be paid for privately, only to have his story contradicted by the Medical Superintendent and exposed as "only an excuse to avoid doing surgery on an old age pensioner".

Patients also expressed frustration and anger frequently about the way the striking specialists pressured them to accept private hospital care on the grounds that it would provide "first class quality" or "freedom of choice" when the patients themselves believed that the opposite was the case, and wanted to be treated under Medicare in the public hospitals which had their confidence. As one patient reported in his survey response:

You couldn't say I had much choice but what I did have depended on money. The doctor said "You've got two alternatives; you can stay on crutches for the rest of your life or pay". They didn't give a damn what happened to their patients, so long as they got their money.

Another saw himself as having been placed in a situation where "It wasn't much of a choice. The treatment in the private hospital was shabby and yet they wanted these enormous sums of money." A third commented that:

Choice is nothing if all they do is put pressure on you. They tried every trick to get me into a private hospital. The only ones who are doing the choosing are the doctors and they are deciding who they are going to treat.

One final incident should be recalled. A seventy year old woman was prevailed upon by her surgeon to sell her piano so that he could operate on her in a private hospital. When the proceeds of the sale ran out two days after the operation she was promptly removed to the casualty department of a public hospital. What she had to say about her unhappy experiences aptly summarises the conclusions of the wider community about the striking specialists and much of the medical profession in general: "You bastards blackmailed me."

Much of the medico-manipulation in which the striking specialists engaged at the expense of their patients could be avoided in normal times if more strenuous efforts were made to bring about a better public understanding of how Medicare and the public hospital systems of the various Territories and States actually work, along with higher standards of medico-morality. Once again, it is helpful to examine the Victorian experience. The Victorian Health Ministry issues detailed monthly reports on hospital waiting lists, which are regularly the subject of comprehensive analysis and explanation. While the problems experienced by the hospitals in the aftermath of the Victorian nurses' strike have still not been completely overcome, they are now much better understood and accepted. What goes on in medical schools and how medical school entrants are selected also calls for examination. One young woman asked by Rees and Gibbons "Do you have any idea how to achieve the principle of accountability to patients?" Answered succinctly "The major issue is who educates these goons?" In fact the moral myopia of the striking NSW specialists is less surprising or ominous than the virtual absence of any outcry against their actions from those sections of the profession which remained on the job. Plainly, great numbers of doctors who were not involved directly in the strike either shared the inability of the strikers to understand that what was happening was ethically outrageous, felt insufficiently strongly about the ethical issue to make themselves heard or allowed themselves to be covered into silence. The fact that this wider abdication of professional responsibility could occur suggests strongly that a moral vacuum has been

allowed to develop at the heart of our medical education system. A recent study by Dr Margaret Schapiro of Queensland University discloses that medical students become less interested in patient care and more concerned with status and financial rewards as their training progresses. According to Dr Schapiro: “During the training stages the results show that the group became less motivated to help others and more concerned about the profession and their personal goals and interests rather than about patients and the community in general.”

The extent to which the rot has spread has a significance which reaches outside the medical profession into other key areas of the health care delivery system. It may well be that the nurses’ strike would never have taken place if it had not been legitimatised in the eyes of those involved by the NSW precedent. The consequence is that the well-being and even the survival of patients has now become fair game for interest groups whose whole concern is to maximise the incomes and career prospects of their members. It should be made a condition of government funding for any medical school that its students are required to undergo a stringent course of instruction in the ethical obligations of their chosen profession.

Empowerment

The expanding network of community health centres and Victoria’s new District Health Councils also have key roles to play. Victoria has been building its network of District Health Councils since 1986. So far eleven of the projected forty-three Councils have been established. Each Council represents an area incorporating around 100,000 people. Its membership is open to users and providers of local health services, together with representatives of the area’s municipalities. There is a seventeen-member Committee of Management, with a paid Executive Officer. The functions of the Councils are to (i) listen first hand to consumers’ experiences, identify the health needs of the district and work with other local groups to establish local priorities; (ii) bring health and other agencies together to work on the issues; (iii) develop local projects in areas such as health services and program development, health planning and health promotion; (iv) engage in on-going discussion with the State Government, local councils and health service providers about how services should be developed; (v) inform the community about health-related matters; and (vi) make recommendations to Regional Directors of Health as to how to distribute resources more fairly.

In this way the Councils are able to improve local understanding of health issues, extend opportunities for local participation in decision-making about health care and make the health system more accountable to the community. Examples of projects completed successfully by District Health Councils included local consultations about the content of regional health plans; surveys of the health service needs of small country towns; development of proposals for improved specialist services such as psychiatric services in remote areas, public dental health services and integrated palliative care services for people with terminal illnesses; and the compilation of information packages for consumers of health care services such as local service directories and advice leaflets for older people about protecting their health, obtaining health services and remaining independent. Community Health Centres and the District Health Councils are major contributions to the empowerment of health services consumers, and the strengthening of the community's defences against medico-exploitation and medico-abuse. It may well turn out over time that the establishment of Medibank by Bill Hayden as Minister for Social Security in the Whitlam Government was less significant than the introduction of Community Health Centres by Doug Everingham as Whitlam's Minister for Health, and District Health Councils by John Cain's Health Minister, David White.

Conclusion

The conclusion which follows from matters discussed in this pamphlet is plain. The medical profession has for too long been allowed to remain in a sort of rogue elephant isolation from the community to which it properly belongs. The reasons for this unhappy and deeply counter-productive state of affairs include the air of mystery with which medical science has always been able to enshroud itself, the social pedestal to which traditionally the community has elevated its doctors and the success with which a facade of professional ethics associated in the public mind with the Hippocratic Oath has been exploited to camouflage the profession's otherwise narrow and unrelenting pursuit of its economic self-interest. Additionally, the fragmented nature of medical practice and the physical isolation of most doctors from one another have played into the hands of a militant conservative minority within the profession – currently exemplified by its New Right – allowing them to hold captive the decent and humane majority of doctors who otherwise would reject outright their profoundly ideological agendas and thuggish industrial practices. While Medibank and Medicare have effectively shielded most

Australians against the worst excesses of medico-rapacity, it has been at the cost of enriching elements of the profession in excess of their most avaricious expectations, while at the same time leaving the profession's New Right – who so often are the same group of people – with their capacity to inflict harm on the community unimpaired.

The sort of “socialisation” which making good these deficits requires is not one of taking the practice of medicine into public ownership, as the “wolf” “crying New Right so monotonously proclaims, but rather of breaking in the profession to an acceptance of the procedures for public accountability to which so far it has offered resolute resistance, and involving its members individually in planning, consultation and public information processes in which broad community participation and the public interest are paramount.

The effect for many would be to break down what are now inappropriately insular professional perspectives, in favour of a genuinely informed regard for patient welfare and the limitations of the public purse. A national hospital system on the model proposed by Whitlam, Community Health Centres such as those advocated by Cass and introduced by Everingham, Victoria's District Health Councils, the Victorian Health Services (Conciliation and Review) Act and a new approach to medical education and medical school entrant selection are all key elements in bringing about this major re-orientation of doctors' attitudes and health care delivery arrangements. A further benefit would be the emergence of a more effective resistance from within the profession itself to outrages of the sort which New South Wales suffered at the hands of the procedural specialists in 1984-85. The need to strengthen Medicare's defences against further episodes of medico-subversion cries out for the attention of the ALP, and all those who have at heart Labor's democratic socialist “light on the hill”.

Postscript

Every action Whitlam took was motivated by his indomitable and unswerving determination to bring into being an effective, efficient, equitable and affordable health care system from which all Australians would be able to benefit. It remains for a new generation of democratic socialist and social democrat policy analysts and implementers to take up again the work in which he was interrupted so tragically by Malcolm Fraser's Remembrance Day Coup, and see that what he envisaged is brought finally to completion, on the foundations which he so firmly set in place.

About the Australian Fabian Society

A great tradition

The Fabian tradition is one of achieving social progress through research and education. Edward Pease, Frank Podmore and Hubert Bland began it in London in 1884, and were joined shortly afterwards by Bernard Shaw and Sidney Webb. Other prominent Fabians included Beatrice Webb, Edith Nesbitt, Margaret Cole, G.D.H. Cole and H.G. Wells. Generations of Fabians have placed its stamp on every facet of British and Australian society. Gough Whitlam adopted the Fabian approach from the day he entered Parliament, and the seminal 1972 Whitlam policy speech was a drawing together of the threads of twenty years of systematic Fabian planning and research.

The Fabians in Australia

Australia had its first Fabian Society as early as 1891, and 1947 saw the establishment of the Victorian Fabian Society, which became the Australian Fabian Society in 1984. The Australian Fabian Society, with more than 1000 members drawn from every State and Territory, is the largest Fabian body ever to exist outside Britain itself.

Famous Fabians

Arthur Calwell was always proud to call himself a Fabian, and the tradition has been carried on through Bill Hayden, Bob Hawke, John Cain, John Bannon, Bob Carr and Neville Wran. The present Leader of the British Labour Party, Neil Kinnock, is a Fabian, as were before him, Michael Foot, Harold Wilson, Hugh Gaitskell and Clement Attlee.

Aims and goals

The Society has no policy beyond that implied in a general commitment to democratic socialism, and issues its publications as the opinions of their authors and not of the organisation. It does not admit members of parties other than the ALP. The aim is to promote education and discussion on policies designed to further the goal of democratic socialism. In carrying out this aim, the Society publishes books such as *Policies for Progress*, *Look Here*, *Towards A New Australia*, and *The Whitlam Phenomenon* and pamphlets such as Whitman's *Labor and the Constitution*, Hayden's *The Implications of Democratic Socialism* and Hawke's *Principles in Practice: The First Two Years*, together with a periodical – Fabian Newsletter. It also holds dinners, conferences and public forums.

Further reading

Historical information about the Fabian Society is available through your local library in books such as *The First Fabians* by Norman Mackenzie, *The Story of Fabian Socialism* by Margaret Cole, *This Little Band of Prophets* by Ann Freemantle and *Educate, Agitate, Organise* by Patricia Pugh.

Why you should join the Fabians

If you believe that reason, education and ideas should play a larger part in Australian politics, if you care about the quality of the society we live in and the direction it is taking and if you share the ethic of democratic socialism, the Australian Fabian Society would like to number you among its members. Membership brings: Invitations to forums, the annual lecture series and weekend conferences conducted by the Society, regular copies of the Society bulletin, *Fabian Newsletter* and free copies of Society pamphlets and other publications.

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