

Course Materials Database Cover Sheet

COMMONWEALTH OF AUSTRALIA
Copyright Regulations 1969
WARNING

This material has been reproduced and communicated to you by or on behalf of Queensland University of Technology pursuant to Part VB of the Copyright Act 1968 (the Act).

The material in this communication may be subject to copyright under the Act. Any further reproduction or communication of this material by you may be the subject of copyright protection under the Act.

Do not remove this notice.

This file is a digital version of printed copyright material. Due to the process used to create it, its accuracy cannot be guaranteed. Please refer to the original published version if you have any concerns about its accuracy.

Journal Article

Article Title : The attack on the welfare state

Author : Green , David

Journal Title : Australian Journal of Social Issues

Volume : 18

Issue : 3

Year : 1983

Page From : 157

Page To : 170

Isbn Or Issn : 0157-6321

This article was originally digitised for the following unit. Articles may be reused in future semesters in other units by different lecturers.

Unit code : HHB213

Unit title : SOCIAL POLICY PROCESSES

Lecturer's Name : Tomlinson, John

Faculty/School : School of Humanities and Human Services

Request ID : 45772

DIGITAL COPY MADE FOR QUEENSLAND UNIVERSITY OF TECHNOLOGY

under part VB of the Copyright Act 1968 reliance on:

S.135ZMB (insubstantial portions of a work), OR

S.135ZMC (article contained in a periodical), OR

S.135ZMD (literary, dramatic, musical and artistic works), OR

S.135ZME (certain illustrations in electronic form)

on 28-APR-04

David G. Green

The Attack on the Welfare State

In a recent review article Jones (1981) notes two characteristics displayed by many social scientists. On the one hand, they have supplied information showing that the welfare state has been ineffective, produced unintended results, and particularly that its beneficiaries have by no means always been the poor. On the other hand, they have often displayed considerable faith in the welfare state as an instrument of radical change and especially as a tool which can be used to bring about a more egalitarian redistribution of wealth and income. He concludes: 'One can support their aims to develop a better society but doubt whether the welfare state will be an important instrument'. (1981 p. 287).

There is a very powerful modern tendency to dismiss any such suggestion, and in particular any call for the curtailment of the power of government, as nothing more than a backlash against the welfare state by the rich and powerful. However, this contention not only fails to take account of the fact that over many years the welfare state has not produced the results expected of it. It also fails to take into consideration an argument recently advanced by a number of writers on both the right (Friedman 1980, Hayek 1960 and 1973-79, Nozick 1974) and the left (Encel 1975-80). They argue that the modern (welfare) state apparatus is inherently vulnerable to capture by key groups among the citizenry and that these groups have tended to use the machinery of government in their own favour, often at the expense of the poor.

Friedman is probably the best known exponent of the right-wing position. Friedman draws attention to the fact that the chief beneficiaries of many welfare programmes have been the middle classes and expresses this idea in the form of Director's Law (1980, p. 107) a principle formulated by Aaron Director and first published by Stigler (1970):

Public expenditures are made for the primary benefit of the middle class, and financed with taxes which are borne in considerable part by the poor and rich.

The law is based on the following reasoning. If a government has coercive powers which allow it to engage in actions, in particular the taking of resources, which could not be carried out with the voluntary agreement of the society's members, then any portion of the society which can secure control of the machinery of the state will employ this machinery to improve its own position. In present conditions the group best able to do this is the middle income group.

Encel, a left-wing social scientist, has shown how public expenditure in Australia increased sharply as a percentage of GNP in the early 1970s. Between 1972 and 1975 it rose from 25 per cent to 31 per cent. He contends that this was due largely to

David G. Green is a Research Fellow in the Urban Research Unit of the Research School of Social Sciences at the Australian National University, PO Box 4, Canberra City, ACT 2601.

pressures from the middle class (1975–80, p. 163). This view is shared by Jones who has argued that many of the programmes of the Labor government assisted the professionals who ran them but did little for the intended beneficiaries (1977, p. 80). However, according to Encel, many middle-class voters in Australia had second thoughts about the policies of the Whitlam Government when they saw their inflationary effects. Their change of allegiance contributed to Whitlam's defeat in 1975. For Encel this is one of the contradictions of modern capitalist societies:

The internal contradictions of neo-capitalism are such that no government, conservative or social-democratic, can resolve them. We may therefore expect fairly continuous alternation of governments in the capitalist democracies as they strive to cope with inflation, unemployment, resource problems and industrial trouble (1975–80, p. 166).

COMPULSION WITHOUT TERROR

In this paper the validity of these criticism of the welfare state are examined. It is obvious that although the left and right-wing positions share the view that governments have responded disproportionately to the interests of the middle class, they have little else in common. For a critic like Encel this fact is the result of a property inherent in neo-capitalism. And for a Friedman it is the result of too much intervention.

For the purpose of the present paper I will therefore formulate a general contention which, I believe, could be accepted by each of these critics. In order that it may be readily tested I will put it in the form of a logical *if-then* proposition:

IF the following conditions prevail:

First, the potential for influencing governments is distributed unevenly amongst members of the society.

Second, all individuals are equally entitled to organise politically (that is, there are no government-imposed barriers such as exist in Poland today).

Third, the government attempts to achieve its goals by compulsion (largely by taking resources from its citizens to fund its programmes or by enacting legislation threatening punishment for non-compliance).

Fourth, the government is *not* willing to employ terroristic methods to achieve its goals (and therefore requires the willing co-operation of key individuals or groups to achieve its aims).

THEN the following result is likely:

individuals or groups whose co-operation is essential for the achievement of the government's aims will secure concessions from the government at the expense of others. These concessions will tend to be at the expense of those who are already poor in political and economic resources.

The theory of democracy now prevailing in the West is made up of an array of ideas about government. Among these is the idea that a governed people ought to be able to replace their government without bloodshed at regular and frequent intervals by means of elections based on a universal adult franchise. There is, too,

the notion that a governed people ought to be able to criticise the government without fear between elections. Minimally this requires right of access to official information, the right to free speech and rights of association. There is, finally, the principle which permits unlimited majority power. In other words, it is accepted that the state's means of compulsion are available to anyone who can command the support of a majority in parliament. It is also accepted that these means of compulsion may be put to any use. This is how George Bernard Shaw expressed the idea:

Fortunately, there is . . . fine impartiality about the policeman and the soldier, who are the cutting edge of the State power. They take their wages and obey their orders without asking questions . . . A House of Commons consisting of 660 gentlemen and ten workmen will order the soldier to take money from the people for the landlords. A House of Commons consisting of 660 workmen and ten gentlemen will probably, unless the 660 are fools, order the soldier to take money from the landlords for the people . . . The State, . . . will continue to be used against the people by the classes until it is used by the people against the classes with equal ability and equal resolution (Quoted in Coates 1975, p. 142).

I will refer to this kind of democracy as commandist democracy. It may be contrasted with an alternative libertarian theory. A libertarian theory of democracy has no difficulty in accepting the first two principles, namely, that it ought to be possible to replace governments by means of regular elections and that free criticism proceed between elections, but finds the permissibility of unlimited majority rule incompatible with individual freedom. A very different conception of majority rule is preferred. It is recognised that there will rarely be total unanimity on a subject, that in spite of this there needs to be some way of taking decisions, and that abiding by the decision of the majority is the most convenient device for doing so, but that there are great dangers in allowing a majority in Parliament to use the state's powers of compulsion to achieve *any* objective it desires. Libertarian democracy seeks, therefore, not to take over these means of compulsion for this or that faction or this or that purpose, but to deny the use of these means of coercion to all sectional interests.

Commandist democracy shares with authoritarian forms of government its unwillingness to put a fixed limit on the government's use of compulsion as a means of achieving its goals. It differs from authoritarianism in that, along with libertarian democracy, it is committed to pluralism. That is, it opposes the view that there ought to be a single party in control of government with the ability to deny opponents the right to organise politically. It also shares with libertarian democracy a hostility to a second facet of modern authoritarian regimes, their willingness to resort to terroristic modes of social control, arbitrary arrest and imprisonment: or actual or threatened violence against an opponent or his family: denying employment to opponents. Of course, authoritarian governments are not constantly using these methods against all potential opponents. But everyone living under an authoritarian regime knows that the use of such techniques is possible. In typical western democracies, governments have not usually used such methods: nor do the great majority of their peoples live in fear that they might do so.

Thus, what distinguishes the prevailing theory of democracy — commandist democracy — from libertarian democracy is its commitment to compulsion as the principal means of achieving its goals. It shares this commitment to compulsion with authoritarianism, but commandist democracy differs from authoritarianism in its rejection of terror as a means of social control. This fact is of significance because compulsion without terror is a mode of goal-achievement which appears to have an inherent bias in favour of certain interests. Originally this discriminatory use of government power was felt to be justified so long as it served only the interests of the poor. But the method of compulsion without terror appears to have an inbuilt tendency to serve the interests of groups other than the poor. A government which sets out to achieve an objective by this method relies upon securing a degree of co-operation from key groups of citizens. Often such co-operation must be sought from particular groups on their own terms. These groups will not necessarily be the most wealthy, for a government can very easily relieve such people of their resources. But, whilst dispossession can be accomplished fairly easily, a government can not compel its citizens to positively co-operate.

The use of terror also has its limits, but there is little doubt that a government able to threaten opponents with death, torture or unlimited imprisonment can secure compliance more readily than one which has no such means at its disposal.

To sum up: the contention being tested is not that 'government failure' may be attributed to too much government *per se*, nor that it is the automatic result of some in-built contradiction of neo-capitalism, but rather that the failure results from using an unsatisfactory *method* of government intervention: compulsion without terror. Such compulsion is unsatisfactory because it favours key groups. But it favours them, not because of their wealth, but because they can deny a government the co-operation without which it cannot succeed.

I will test this theory by examining two aspects of Australian social protection against ill health.

THE AUSTRALIAN NATIONAL HEALTH SCHEME

The Labor Governments of 1941–49 set out to establish an Australian national health scheme. In this paper I will only consider two aspects of the Labor plan: the proposed pharmaceutical benefit and their proposals for government-run primary medical care.

The Pharmaceutical *Benefit* Scheme

Towards the end of 1943 the government announced its intention to introduce a scheme to provide free medicines. It was to cover medicines and appliances listed in the Commonwealth Pharmaceutical Formulary where they were prescribed by a doctor on a government form and dispensed by an approved chemist. Participation was voluntary. In March 1944 the Pharmaceutical Benefits Act was passed, but the BMA (which became the AMA in January 1962) refused to co-operate. At the May meeting of the Federal Council of the BMA it was resolved:

That the Federal Council will not be a party to the . . . Pharmaceutical Benefits Act, which it considers to be almost entirely without merit (*Medical Journal of Australia (MJA)* 15 July 1944, p. 71).

In a statement setting out their reasons for opposing the Act the Federal Council declared that the main issue at stake was the freedom of the profession to prescribe for their patients as they thought fit (p. 72). A similar point had been made in the profession's initial response to the government scheme in January 1944. The BMA had wanted the scheme to be extended to medicines outside the Formulary. And it had called for control of the scheme to pass to a statutory body on which the medical profession was to be 'adequately represented' (*MJA*, 1944, vol 1, p. 231).

In September 1944 the Federal Council resolved that members should 'be advised NOT to co-operate with the Government in the use of the formulary o[r] the prescribed forms' (*MJA*, 1944, vol 2, p. 466; 1947, vol 2, p. 308). Implementation of the legislation was postponed, and it had still not been put into effect in November 1945, when the High Court considered the case brought by the Attorney-General of Victoria at the behest of members of the Medical Society of Victoria. The Court found that the Commonwealth had exceeded its Constitutional powers because the Act interfered with the State's own legislative powers and therefore with the public rights of Victoria's citizens (Hunter 1965, p. 419).

In 1947 the government renewed its efforts to introduce a pharmaceutical benefit scheme. A new Minister for Health, Senator McKenna, promised the BMA that all penalties for wrongful prescription would be removed from the Act and that doctors would form a majority on the proposed Formulary Committee. In June 1947 a new Act was passed, but the BMA again refused co-operation. The Act came into operation in June 1948 but only 155 doctors out of around 8,000 were willing to participate in the scheme (Commonwealth Parliamentary Debates, House of Representatives, vol 2, 1953, p. 160). In the end Labor lost office at the end of 1949 and the scheme was never fully implemented.

However a similar scheme was put into effect by the Liberal Country Party Government which won office in December 1949. It came into operation in September 1950 and provided for a smaller list of drugs than the Labor scheme. It was confined to costly life-saving and disease-preventing drugs. (Kewley 1973, p. 346). It was fully supported by the BMA, who in 1947 had suggested a similar scheme (*MJA*, 1947, vol 2, p. 308). As the price of their co-operation they had been allowed to play a decisive role in determining which drugs were to be supplied 'free'. They were also granted majority membership on the Pharmaceutical Benefits Advisory Committee, a body appointed to keep the list under review. It comprised nine (initially seven) members, six of whom were doctors chosen by the Minister from a panel of nine nominated by the BMA. (Kewley 1973, p. 347; Hunter 1963, p. 39 n. 10). In July 1951 the scheme was extended to provide, also free of charge, a wider range of medicines to pensioners using the pensioner medical service.

These arrangements — introduced under regulations authorised by the National Health Service Act 1948–49 — were consolidated in the 1953 National Health Act. This new legislation also improved upon the original scheme, notably by increasing the number of drugs available.

Medical Benefit

During the early 1940s the medical profession was divided over the method of

paying for medical care. In September 1941 the Federal Council adopted as its official policy a scheme published as 'A General Medical Service for Australia' (Joint Parliamentary Committee on Social Services (JCSS) 1943, Appendix C). Private practice was to be retained and everyone earning less than 416 pounds a year would be required to contribute to an insurance scheme covering medical care on a capitation basis. The scheme was to be controlled by a statutory committee on which doctors were to be represented. A counter scheme was submitted to the Federal Council by a sub-committee of the Victorian BMA. But this was rejected by the Federal Council. In November 1941 the National Health and Medical Research Council published its 'Outlines of a Possible Scheme for a Salaried Medical Service' (Hunter 1966, p. 317; JCSS 1943, Appendix B). Under this plan medical care was to be provided free at the time of use and would be funded out of general taxation. Private practice was to be allowed to continue. The scheme was to be administered by regional medical officers responsible to the Commonwealth Department of Health.

The Federal Council submitted these schemes to the state branches for discussion. In March 1943 they reviewed the response. No state branch supported the proposal for a salaried profession. A new statement was issued 'The Principles which should Govern a General Medical Service in Australia'. This document came down strongly in support of a voluntary insurance scheme (JCSS 1943, Appendix D).

Shortly after this, in July 1943, the Parliamentary Joint Committee on Social Security published its Sixth Interim Report. It proposed a salaried medical service to be introduced on a part-time basis. Private practice was to be retained, but administration was to be in government hands.

In December 1943 the JCSS met representatives of the BMA and the National Health and Medical Research Council. This conference agreed to the establishment of experimental group clinics in each state, staffed by part-time salaried doctors. A Medical Planning Committee was established to prepare a detailed scheme. Its report, published in March 1944, was approved by the Federal Council of the BMA. (JCSS 1944, Appendix A, p. 40). It proposed that, in respect of professional matters, doctors should control the scheme, but that 'administrative and economic' matters were to be administered by a committee on which doctors were merely to have 'adequate representation'. However this scheme was not implemented.

By July 1947 the Labor Government had been returned to power determined to introduce a national health scheme. In that month the BMA met Senator McKenna. The Federal Council reasserted its previous policy: it would only accept payment on a fee-for-service basis. In August the profession launched its own voluntary insurance scheme in New South Wales, the Medical Benefits Fund. A similar scheme had been operating in Victoria since 1945. At that time the Bankers' Health Society, formerly open only to bank employees, opened its membership to the general public.

In November 1948 the National Health Service Bill was presented to Parliament. It was largely an 'enabling act' which gave the minister wide powers to establish a national health scheme by regulation. Considerable concessions had been made to

the BMA. There was still provision for clinics in country centres and urban areas with doctors paid on a sessional basis, and for a salaried medical service in remote areas. But the scheme envisaged that the majority of medical care would be supplied by doctors paid on a fee-for-service basis. The government would pay 50 per cent of an agreed, scheduled, fee.

Notwithstanding these concessions, at a special meeting of the Federal Council in December, the BMA rejected the plan. Further co-operation was refused unless it was agreed that, *inter alia*, the scheme could be administered by a body on which doctors formed a majority and that it employed the procedure of the existing voluntary funds (a refund to patients and not a direct government payment to doctors).

Partly in response to the BMA's objections, the government introduced some amendments in October 1949. Its power to make regulations was also extended. The legislation was approved but before further progress was made the government lost power in December.

The new Liberal-Country Party Government was also pledged to introduce a comprehensive national health scheme, a scheme was outlined by the Minister, Sir Earl Page, in May 1950 (Kewley 1973, p. 345). His scheme was introduced with BMA approval by means of regulations authorised by the Labor Government's Act of 1948-49. The medical benefit scheme provided a subsidy for voluntary health insurance. Each contributor took out insurance of his own choosing and obtained medical care from a doctor of his choice. He paid the fee and obtained a refund from his insurance organisation, which also paid him the government subsidy (Kewley 1973, p. 360). The maximum amount of subsidy was laid down in schedules to the Act. The scheme became operational on 1 July, 1953. In April 1954 the regulations were repealed and incorporated into Parts III and VI of the 1953 National Health Act (Kewley 1973, p. 359).

During the 1960s voluntary health insurance came under criticism. One of the criticisms was that insurance benefits covered too low a proportion of a patient's costs. In 1964 the Menzies Government had increased the Commonwealth benefit to reduce the gap between fees and benefits. In March 1968 a revised benefits schedule came into operation (Kewley 1973, p. 514). It resulted from the work of a committee on which the Australian Medical Association (no longer the BMA) and the Department of Health were represented.

At about this time there were two important official inquiries. The Nimmo Committee reported in March 1969 and the Senate Select Committee on hospital and Medical Costs presented its final report in June 1970 (Kewley 1973, p. 391). The Nimmo Committee and the Senate Select Committee both recommended a formula based on the 'most common fee' then being charged. This concept had been accepted by the AMA in May 1969 (Kewley 1973, p. 510). In March 1970 the Minister announced a new government plan. The Gorton scheme linked Commonwealth and fund benefits to a schedule of common fees charged by doctors. The AMA established common fee list and contributors were required to pay 80 cents of the common fee for a consultation at a doctor's surgery and \$1.20 for a home visit. The figure increased for more costly services up to a maximum of

\$5.00. There was considerable public debate about the level of fees sought by the AMA. In March the *Sydney Morning Herald* commented:

The public may be excused for thinking that the Federal Government's medical benefits scheme was aimed at helping them meet the high cost of sickness. The medical profession clearly sees it in another light. To them it is a doctor's benefit scheme. After a long public debate on the inadequacies of the present health insurance scheme. Mr Gorton's Government was returned 10 Canberra last year on a promise that the scheme would be vastly improved. The Government has played its part by pouring out an extra \$32.5 million in subsidies which will find their way to the doctors. The public *has* played its role uncomplainingly by agreeing to pay higher insurance rates. But the doctors are not prepared to play their part (Kewley 1973, p. 511).

The scheme was implemented in July 1970. The Government agreed that there would be two-yearly reviews of fees with the first review to take effect from July 1971.

In February 1971 the AMA unilaterally announced fee increases to be imposed from July 1971. The average proposed increase varied from 7 to 20 per cent (Kewley 1973, p. 519). The Minister, A.J. Forbes, accused the AMA of **Jumping the gun**. The Government was also concerned about increases which had taken place anyway. From the Final quarter of 1969 to the last quarter of 1970 the average charge per service had increased by 20.9 per cent. The chief beneficiaries had been the medical specialists.

Gorton attacked the AMA. He said that he was 'appalled' at the 'great increases' that were proposed, and warned that his government would fight them with every means at its disposal. He did not believe that 'any profession should be able to fix their fees at any level which appeals to them when they are supported by public money' (Kewley 1973, p. 520). The government entered into discussions with the AMA and as a result of the government's intervention the fee increase proposed for July 1971 was reduced (Kewley 1973, p. 521). There were further amendments to the scheme in April 1971 following recommendations from the Medical Benefits Schedule Advisory Committee (Kewley 1973, p. 522).

WHO BENEFITTED?

In the case of the pharmaceutical benefit scheme obviously citizens in need of more-costly medicines benefitted in that their requirements were met free of charge at the time of use. However, this could have been accomplished in more than **one** way. And perhaps without other already-powerful groups exacting such a high-price, a price which had anyway to be paid by taxpaying beneficiaries of the scheme.

The doctors gained a great deal from the scheme. By refusing to co-operate, except on their own terms, they enhanced their control of the distribution of medicines. The doctors also secured considerable control over other aspects of the national health scheme. Although members of the Australian medical profession have appeared at times to be implacably opposed to all government intervention, in practice they have been quite willing to co-operate with governments as long as the

government conceded doctors effective control. They accomplished such control in a variety of ways.

The legislation requires that a great many senior positions in government are occupied by medical practitioners. Part I. Section 5 of the Act stipulates that a

person is not eligible to be appointed as Director-General unless he is a legally qualified medical practitioner of not less than 10 years standing (Hunter 1969, p. 256; Hunter 1963, pp. 35-6).

The State Directors and the Federal Director-General have always been doctors. Senior positions in the Department of Health have also typically been held by doctors (Hunter, 1969, pp. 252-3).

The fact that doctors hold influential positions in the committees set up under the national health legislation has already been referred to. The Pharmaceutical Benefits Advisory Committee is two-thirds doctors. They are also directly represented on the Commonwealth Health Insurance Council. In addition many of the nominees of the medical benefits organisations are also doctors, The National Health Act of 1953 also provided for the establishment of medical and pharmaceutical benefit committees in each State. They were to consider possible breaches in the supply of pharmaceutical benefits. Breaches concerning doctors were to be investigated by a committee made up of the Commonwealth Director of Health within the particular State and four doctors nominated by the State branch of the BMA (Kewley 1973, p. 349).

There are also regular meetings between the Director-General and the AMA. Once a year the Federal Council invites the Minister and departmental officials to attend Federal Council meetings. Additional meetings are also usually held between the AMA's Federal Executive and Department of Health officials. Officially no decisions are reached at these meetings. But as Dr A.M. Murray, a past president of the AMA, commented on the meeting:

We would all regard it as a mere waste of time if we did not think that a frank exchange of views did not at times influence or modify a proposed course of action. We look upon this meeting as a sounding board and a very useful opportunity for letting each other know what the other is thinking, and not infrequently this information has very definitely influenced the approach to a question (Hunter 1969, p. 254).

The Liberal-Country Party scheme of 1953 had been wholeheartedly supported by the BMA. This is not surprising since it was virtually identical with their scheme. They had achieved a public subsidy of their incomes and freedom from lay control in the form of either the friendly societies or the government.

At the end of the last century the friendly societies had employed around forty per cent of Australia's doctors (Bruck, 1896). They continued to do so until after the Second World War. Indeed, as late as the early 1950s contract practice was still thriving. In July 1950 the Minister for Health, Sir Earl Page, estimated that fifteen major friendly societies covered 600,000 families for medical benefit. This figure excludes those in hospital funds, in industry-related schemes, and in local medical clubs (*The Oddfellow*, 25 July 1950, p. 11). As A.J. Eade, the Federal President of the Friendly Societies of Australia, estimated this meant that about two million

individuals were covered for primary medical care by the friendly societies. This represented about a quarter of the Australian population (*The Oddfellow*, October–November 1950, p. 5). Under the terms of a model agreement approved jointly by the BMA and the friendly societies, each family paid the doctor an annual capitation fee, usually paid quarterly. The annual capitation fee varied from state to state. In New South Wales it was 39 shillings in the metropolitan area and 48 shillings in country areas. This covered the friendly society member and all dependants for all consultations with the doctor during the year. The system's two most obvious advantages were that it encouraged preventive medicine and made medical care available to those who could not afford the normal doctor's fee.

Until the end of the 1940s the BMA's Federal Council supported the continuation of contract practice, but during 1950 the BMA unilaterally ended its model agreement with the friendly societies. In New South Wales the contract system was terminated on 31 March 1951. This seems to have been principally the result of their determination to maintain a united front against the government. And the profession chose to unite around the fee-for-service principle, a principle which had by no means been unanimously accepted by doctors at the beginning of the war.

It is quite possible that this might not have come about had it not been for the government's intervention. The final decision to abandon contract practice in New South Wales was taken after a plebiscite of BMA members held on 21 September 1950. It is very difficult to gauge what may have influenced the minds of doctors, but we can guess from the arguments that were advanced during the campaign prior to voting. All doctors in New South Wales received a circular from the 'Federation of Local Associations — Affiliated with the New South Wales Branch, BMA'. This document circulated by the chairman and secretary of the Association says:

You are reminded that the policy of the Federal Council, of other State Branches of the British Medical Association, and of this Federation, is that in a National Health Service the profession should accept payment solely on a Fee for Service basis. You are warned that should the profession in this State decide to continue a Friendly Society practice on a Capitation Fee basis . . . the Health Service policy of the Association will almost certainly be defeated. *Should we at this late stage endorse a capitation rate Friendly Society service, which would be easy to administer, if put on a national basis, we cannot expect any Government to grant our request for a Fee for Service system which will be so much more difficult to administer.* It is therefore the opinion of this Federation that all practitioners should terminate the current Common Form of Agreement before a National Health Scheme is introduced (*The Oddfellow*, 25 September 1950, p. 5 emphasis added).

Friendly society contract practice had the advantage of being very simple to administer. The lodge secretary collected the members' quarterly contributions and paid the doctor. The doctor therefore received a regular cash income and was spared the trouble of sending bills to patients. But if the views of the doctors quoted above were at all influential, it may be that the very simplicity of contract practice led to its downfall. Today, ironically, such schemes — usually referred to as pre-paid group practices or health maintenance organisations — are being looked upon with a new enthusiasm (Somers 1971).

One of the results of the abandonment of contract practice was the removal of a means of lay control of the medical profession. The model agreement between doctors and the societies had provided a procedure by which patients could complain about their doctors and thereby keep them on their toes. With the new system this disappeared.

A second advantage of the friendly society system had been that, as consumer organisations, the friendly societies had a strong interest in preventing unreasonable increases in the incomes of the medical profession. At the end of the nineteenth century, for example, doctors were complaining about 'sweating' by the friendly societies. In this regard, government have proved to be far less effective representatives of the consumer than the friendly societies. The fact that doctors have been able to secure such a high level of control over their own incomes has not only meant that they have grown more wealthy. The introduction of the national health scheme also led to the removal of the principal constraint affecting the supply of doctors: the tendency for their incomes to fall where there were more doctors than the demand for medical services necessitated. Since the inception of government subsidisation (with the compulsion this implies) under the national health scheme the existence of too many doctors has not led to a fall in the price of their services. As a result, the supply of medical practitioners has increased considerably. This has been one of the principal factors contributing to the growth of over-servicing and unnecessary surgery.

In recent years concern has mounted about the extent of over-servicing and outright fraud carried out by doctors. The AMA began discussing over-servicing with the government in 1977 but little improvement had been accomplished by early 1982. According to the Minister for Health, Mr MacKellar, fraud and over-servicing together cost the taxpayer about \$100 million a year. And a report produced jointly by the Attorney-General and the Department of Health in October 1981 placed nearly ten per cent of Australia's doctors under suspicion. The report estimated that

there are of the order of 2,500 doctors who require further investigation of whom around 900 would be high priority (*Financial Review*, 8 February 1982).

The AMA did not dispute this claim. Dr Lionel Wilson, the president of the AMA, estimated in February 1982 that about 900 of Australia's doctors were involved in 'gross abuse' of the health insurance system (*Canberra Times*, 4 February 1982). And according to a spokesman for the Australian Federal Police about twenty detectives were involved in the full-time investigation of such frauds. The 'Medifraud Squad', as it had become unofficially known, had been active for a number of years and 'was always busy' (*Canberra Times*, 6 February 1982).

By comparison, the friendly societies' capitation system had the obvious advantage that it removed the temptation to over-serve a patient, as this doctor's remarks testify:

I think that the doctor's general knowledge of his lodge patient is greater than that which he has of a private patient. The lodge doctor does not hesitate to go into the kitchen and learn from that angle . . . The doctor knows more of the psychology of the lodge household than he does of that of a private patient.

and he can therefore be of more help in the treatment of those conditions which are psychogenic in origin. *One does not hesitate to see a 'difficult case' in a lodge patient as frequently as one wishes; but if the same attitude is taken to a private patient there will probably be a charge of over-visiting.* If patients are encouraged to consult one early in their sickness, very often more serious complications can be avoided (Erichsen 1940, p. 211 emphasis added).

Other groups to benefit from the scheme were the drug companies and the pharmacists. The pharmacists were largely satisfied although they objected to the relatively greater control granted by the Act to the doctors. Under Section 99 of the National Health Act the Minister 'may after consultation with the Federal Pharmaceutical Guild of Australia' determine rates of payment and the conditions of supply of pharmaceutical benefits. Under this section the Minister's decision was final. In the case of the doctors, however, the position was different. Under Section 32 the Minister 'may . . . enter into an *agreement*' with the medical profession. The chemists have consistently pressed for Section 99 to be amended to give them the same standing as the doctors (Hunter 1969, p. 256).

Like the doctors the pharmacists also occupy some official positions in government. The Assistant Director-General and the Assistant Directors of the Pharmaceutical Services Branches are pharmacists. Pharmacists also hold positions on official committees. There are two on the PBAC, and the Pharmaceutical Services Committees of Inquiry are entirely composed of pharmacists (Hunter 1969, p. 255).

Drug manufacturers have also benefitted greatly. Their main complaint has only been that the government subsidy does not extend to *all* pharmaceutical goods (Hunter 1963, p. 36). There has been continuing concern about the prices charged by drug manufacturers. In 1963 some MPs criticised the 'huge yield from drugs by foreign companies' and called for a Royal Commission. In September of that year Menzies commented that the government was taking 'a very lively interest' in the cost of drugs, adding:

We are well aware of the existing situation, something will have to be done about it (Kewley 1973, p. 352).

In May 1964 the Minister for Health announced significant reductions in the prices of drugs. The expected full-year savings were calculated at 2.7 million pounds.

The manufacturers have not been the only beneficiaries in financial terms. Wholesale and retail suppliers' mark-ups amount to 51 per cent of the cost of drugs. By 1961 retail chemists were being paid three shillings for dispensing medicines and five shillings and sixpence for made-up prescriptions. This was in addition to the one-third mark-up on the wholesale price (Kewley 1973, p. 353).

Another unintended result of the pharmaceutical benefit scheme was that it reinforced the market position of the commercial chemists at the expense of those organisations supplying medicines on the mutual aid principle. As in the case of medical advice, friendly society members paid a low annual capitation fee which entitled the member and all dependents to any drugs prescribed by a doctor during the year, whatever their actual cost. By 1948 there were 165 friendly society

dispensaries or pharmacies with a total membership of 360,000. With their dependents, this meant that over a million individuals were obtaining their medicinal requirements through the societies (Eade 1948, pp. 44-5). At this time friendly society membership was expanding. Haines (1976) argues that if the growth of friendly society membership had continued 'it could have threatened the eclipse of private pharmaceutical practice'. He took the view that their growth would have continued had it not been for the national health scheme of the early 1950s under which a large range of drugs were supplied 'free' (Haines 1976, p. 239).

The friendly society dispensaries were committed to the supply of the best quality medicines at the cheapest attainable price. They were non-profit making. That there was, by comparison with commercial suppliers, a real difference in the commitment of the friendly societies to serving their customers, is demonstrated by this example. In October 1936 the Pharmaceutical Service Guild of New South Wales asked for friendly society support for a campaign to resist the plans of *Boots* — a large British company operating a chain of chemists shops — to open a series of retail outlets in Australia. The Guild claimed to have prevented a similar move in New Zealand. Their argument was that *Boots* would put out of business not only some chemists, but also the friendly society dispensaries and pharmacies. They offered the societies inducements to join them in lobbying the government. They were offered representation on the Guild's branch committee, and recognition of their right to trade openly with non-members, as long as they observed the Guilds pricing system in trading with non-members (Haines 1976, p. 238). A committee of friendly society representatives reported to the Friendly Societies Association of New South Wales:

That by supporting the Guild we have their promise of support in certain concessions that would be of material advantages to Friendly Societies and, providing same can be put into effect, we have, . . . something to gain therefrom, and nothing to lose . . .

That it is very problematic what effect the operations of 'Boots' would have on our Dispensaries and Pharmacies by the cut-rate system of dispensing — we certainly will not gain anything . . .

Nevertheless they argued that:

If our members can obtain their requirements cheaper elsewhere than at our dispensaries, it is only natural to expect them to trade elsewhere.

The committee recommended that the friendly societies did not join forces with the Guild, and the Friendly Societies Association adopted their recommendation. The societies, then, never lost their paramount commitment to their members, even where this might be at the cost of friendly society services (Friendly Societies Association, NSW Branch 1936).

THE IMPLICATIONS

To what extent does the theory propounded above find support from this account of the results achieved by government-imposed social protection in Britain and Australia? The poor have certainly benefitted to some extent. But I contend that this could have been accomplished by other methods. The chosen method —

compulsion without terror — has proved vulnerable to manipulation by key groups. The doctors, the pharmacists and the drug companies have all reaped considerable financial and other benefits from the government scheme. The most serious unintended effect was the severe weakening of the mutual aid movement. The conclusion I draw is that the use of this method of government intervention is an inherently unsatisfactory means of accomplishing social improvements. We can provide for our needs, including the needs of those who are poor, not only without using terror but also without compulsion. Australia's friendly societies have shown how.

ACKNOWLEDGEMENT

I am grateful to Larry Cromwell for his comments on an early draft of this paper,

REFERENCES

- Bruck, L. (1896), *The Sweating of the Medical Profession by the Friendly Societies in Australia*, Sydney: L. Bruck.
- Coates, D. (1975), *The Labor Party and the 'struggle for Socialism*, London: Cambridge University Press.
- Eade, A.J. (1948), *Friendly Societies and Social Services in Australia and Other Countries*. A report by the Grand Secretary to the Manchester Unity Independent Order of Oddfellows in New South Wales. Sydney: Manchester Unity Independent Order of Oddfellows.
- Erichsen, M. (1940). 'An Address', *Medical Journal of Australia*, II, p. 211.
- Encel, S. (1975–80) 'Capitalism, the Middle Classes and the Welfare State' in E.L. Wheelright and K. Buckley (eds) *Essays in the Political Economy of Australian Capitalism* (4 vols) Sydney: Australia and New Zealand Book, 3.
- Friendly Societies Association, NSW Branch (1930), *Minutes*, (October).
- Friedman, M. and R. (1980), *Free to Choose*, Melbourne: Macmillan.
- Haines, G. (1976), *Grains and Threepenn'orths of Pharmacy: Pharmacy in NSW 1788-1976*, Melbourne: Lowden.
- Hayek, F.A. (1960), *The Constitution of Liberty*, London: Routledge and Kegan Paul.
- Hayek, F.A. (1973–79), *Law, Legislation and Liberty* (3 vols) London: Routledge and Kegan Paul.
- Hunter, T. (1963), 'Some Thoughts on the Pharmaceutical Benefits Scheme'. *Australian Journal of Social Issues*, 1, (4), Spring.
- Hunter, T. (1965), 'Pharmaceutical Benefits Legislation, 1944–50', *Economic Record*, 41.
- Hunter, T. (1966), 'Planning National Health Policy in Australia, 1941–45', *Public Administration*, 44.
- Hunter, T. (1969) *The Politics of National Health*, Unpublished PhD Thesis, Australian National University, Canberra.
- JCSS (1943) Parliamentary Joint Committee on Social Security, *Sixth Interim Report*.
- JCSS (1944) *Eighth Interim Report*, March.
- Jones, M. A. (1977), 'Social Policy' in A.F. Davies, S. Encel and M.J. Berry (eds), *Australian Society*, 3rd ed, Melbourne: Longman Cheshire.
- Jones, M. A. (1981), 'Attacking the Welfare State', *Politics*, XVI(2).
- Kewley, T.H. (1973), *Social Security in Australia 1900-1972*, (2nd ed.) Sydney: Sydney University Press.
- Nozick, R. (1974), *Anarchy, State and Utopia*. Oxford: Blackwell.
- Somers, A. R. (ed.) (1971), *The Kaiser-Permanente Medical Care Program. A Symposium*. New York: The Commonwealth Fund.
- Stigler, G.J. (1970), 'Director's Law of Public Income Redistribution', *Journal of Law and Economics*, 13, (April).