MEDICAL KNOWLEDGE, MEDICAL POWER

Doctors and health policy in Australia

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ABSTRACT OF THE THESIS

This research examines the influence of the medical profession on health policy in Australia. Case studies of policy struggles under Federal Labor governments since 1983 illustrate both the nature and scope of that influence, using sources which include transcripts of parliamentary debates and inquiries, government discussion papers and reviews, the profession's politico-industrial journals and media reports. The studies are informed by theoretical work in the areas of professionalisation, medical politics (including the role of the state), public policy, the sociology of scientific knowledge and the sociology of health and illness.

The central argument of this thesis is that neither of the two main types of conventional approach - by itself - can provide a wholly coherent or adequate analysis of "medical dominance" in Australia. Conventional functionalist approaches to "medical dominance" locate the source of influence in the high social utility of the science-based knowledge and skills over which the profession maintains exclusive control. In return for applying such knowledge under an altruistic code of ethics, the state grants the profession a high level of work autonomy, self-regulation and market protection.

"Power" approaches to medical dominance, on the other hand, locate the primary source of influence in the profession's capacities as a network of particularly successful and well-organised interest groups, able not only to mobilise resistance to specific policy proposals, but
also to apply structural leverage through its historical incorporation into the very mechanisms of the health policy process.

The first approach emphasises knowledge-based sources of influence and marginalises power-based sources, while the second approach emphasises interest group capacities to the marginalisation of knowledge-based sources. My general hypothesis is that the profession's policy influence is driven by both power and knowledge determinants, which are interdependent and mutually reinforcing. Neither can adequately account for "medical dominance" without the direct implication of the other. The profession's power aspects vary with the contingencies of interest group politics; but it is the degree to which contested health issues are broadly identified as medical problems requiring medical knowledge and expertise - epitomised by the notion of peer review and medical judgement as the delegitimisation of secular or non-medical knowledges - which equally determines the scope of health policy influence.

If the medical profession is to be made more publicly accountable, the term "peer" in peer review needs to be reconstituted to include not only medical representatives, but also representatives from a range of other health occupations, and from general community groups and interests. In this way, such representatives can 'get inside' medical knowledge, so that the judgements and decisions informed by that knowledge are subject not only to the localised scrutiny of fellow doctors, but also to the scrutiny of the broader political system within which health policy is made and implemented.
AUTHOR'S STATEMENT

I certify that this work does not incorporate without acknowledgement any material previously submitted for the award of any other degree or diploma in any university; and that to the best of my knowledge and belief it does not contain any material previously published or written by another person, except where due reference is made in the text of the thesis.

I give consent to this copy of my thesis, when deposited in the University Library, being made available for loan and photocopying.

Signed:......

Peter John Backhouse

Date..................
ACKNOWLEDGEMENTS

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By far the largest debt of thanks is due to Peggy McLean and Eleanor Backhouse. Peggy first introduced me to the rich potential of health as an area of research, theory and practice. Both encouraged, motivated and sometimes provoked me to fully explore the intellectual interiors of the project, without becoming estranged from the emotional and social relationships which lay outside it. Their support, trust and love, and their unerring sense of saneness, helped me keep the project in perspective, and mostly prevented an active interest from turning into an obsession. Their enormous efforts were sometimes repaid only by the material deprivations of postgraduate life, recurring adjustments to completion schedules, and the presence of a partner/parent who was often there, but not there. For all this, I express my profound apologies as well as my heartfelt appreciation.
LIST OF ABBREVIATIONS

ACPA  Association of Clinical Professors of Australia
AAS   Australian Association of Surgeons
ACHS  Australian Council on Hospital Services
ACOSS Australian Council of Social Service
ACP   Australian Council of Professions
ACTU  Australian Council of Trade Unions
ADF   Australian Doctors' Fund
AFCO  Australian Federation of Consumer Organisations
AFP   Australian Federal Police
AMA   Australian Medical Association
AMC   Australian Medical Council
APA   Approved Pathology Authority (organisations)
APF   Australian Pensioners' Federation
APP   Approved Pathology Practitioner (individuals)
ASOS  Australian Society of Orthopaedic Surgeons
AWE   Average Weekly Earnings
CHF   Consumers' Health Forum
CPI   Consumer Price Index
CPS   Council of Procedural Specialists
CS&HLA Community Services and Health Legislation Amendment Bill 1989
DPP   Director of Public Prosecutions
DRS   Doctors' Reform Society
DURC  Descriptor Utilisation Review Committee
EPAC  Economic Policy Advisory Council
FMP   Family Medicine Program (of the RACGP) - changed to RACGP Training Program from 1 July 1993.
FODS  Fraud and Overservicing Detection System
GAT   Geriatric Assessment Team
GPSA  General Practitioners' Society of Australia
HFA   Health Forum of Australia
HIC   Health Insurance Commission
HIC   Health Issues Centre
HP    Hospital Pathologist (Medicare benefit rate)
IPRO  Independent Peer Review Organisation
MBRC  Medical Benefits Review (Layton) Committee
MBAC  Medicare Benefits Advisory Committee
MBS   Medical Benefits Schedule
MBSRC Medical Benefits Schedule Revision Committee
MBSRC Medical Benefits Schedule Review Committee
MJA   Medical Journal of Australia
MPRC  Medicare Participation Review Committee
MPRC  Medicare Participation Review Committee
MRI   Magnetic Resonance Imaging
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<tr>
<th>Abbreviations</th>
<th>Medical Services Committee of Inquiry</th>
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<tr>
<td>MSCI</td>
<td>Medical Services Review Tribunal</td>
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<td>MSRT</td>
<td>National Association of General Practitioners of Australia</td>
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<td>NAGPA</td>
<td>National Association of Testing Authorities</td>
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<td>NATA</td>
<td>National Health and Medical Research Council</td>
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<td>NH&amp;MRC</td>
<td>National Office of Overseas Skills Recognition</td>
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<tr>
<td>NOOSR</td>
<td>Other Pathologist (Medicare benefit rate)</td>
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<tr>
<td>OP</td>
<td>Public Accounts Committee (Joint Committee of Public Accounts)</td>
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<td>PAC</td>
<td>Private Doctors of Australia</td>
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<td>PDA</td>
<td>Pathology Services Advisory Committee</td>
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<td>PMOA</td>
<td>Pathology Services Advisory Committee</td>
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<td>PSAC</td>
<td>Pathology Services Working Party</td>
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<tr>
<td>PDA</td>
<td>Private Doctors of Australia</td>
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<tr>
<td>RACGP</td>
<td>Royal Australian College of General Practitioners</td>
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<td>RACOG</td>
<td>Royal Australian College of Obstetricians and Gynaecologists</td>
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<td>RCS</td>
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<tr>
<td>RCPA</td>
<td>Royal College of Pathologists of Australasia</td>
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<tr>
<td>RDA</td>
<td>Rural Doctors' Association</td>
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<tr>
<td>RMO</td>
<td>Resident Medical Officer</td>
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<tr>
<td>SAHC</td>
<td>South Australian Health Commission</td>
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<tr>
<td>SP</td>
<td>Specialist Pathologist (Medicare benefit rate)</td>
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<tr>
<td>TPC</td>
<td>Trade Practices Commission</td>
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<tr>
<td>VHIAA</td>
<td>Voluntary Health Insurance Association of Australia</td>
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<tr>
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<td>Visiting Medical Officer</td>
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<tr>
<td>VR</td>
<td>Vocationally Registered</td>
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<td>WHO</td>
<td>World Health Organisation</td>
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CHAPTER ONE

MEDICAL DOMINANCE AND HEALTH POLICY
Introduction

This research seeks to provide an explanation for the high level of influence that the medical profession wields over health policy in Australia. Case studies over a range of health policy developments under the Hawke and Keating Labor governments are used to illustrate various aspects of such influence, and to analyse both its sources and its scope.

The main conclusion drawn from these studies is that medical influence on health policy cannot be solely attributed to the political strength of doctors as organised interest groups (epitomised by the lobbying activities of the Australian Medical Association [AMA]); nor can it be solely attributed to the high social utility of the specialist body of knowledge they exclusively control. To more fully account for its overall policy influence, and for its specific policy defeats as well as its successes, both the "power" and the "knowledge" aspects of medicine must be given comparable analytical consideration. Indeed, it is argued here that, in operation, these two aspects of medical influence are interdependent and mutually reinforcing, so that rather than viewing power and knowledge as discrete categories of influence, they are more usefully viewed as structurally enmeshed components of the same "irreducible dyad" of power-knowledge.¹

The active presence of both power and knowledge arms of influence in a policy conflict is very strongly associated with an outcome largely favourable to the general interests of the profession, such as in the

overservicing and GP fees studies of Chapters Four and Five. Conversely, where only one arm of influence is operating, the policy outcomes tend not to be entirely favourable to those interests. If, for example, the policy issues are not generally recognised as essentially medical in nature, requiring medical knowledge and expertise for their resolution, then the profession's formal political lobbying activities on their own may not be sufficient to fully protect medical interests against those of other contending lobby groups. Such a dilution of medical expertise through the formal presence within the policy process of bodies of knowledge from outside the realm of scientific medicine - so that doctors are not the sole recognised experts - occurs in the aged care and birthing cases of Chapter Six.

**Health as a policy problem**

As a policy area, health is notable for both the vagueness of its definition and objectives, and for the degree to which it impinges on other areas of public policy. Although health is a very significant issue for all individuals - more so, perhaps, for some than for others, and at some stages of life than at others - we have never as a society openly and systematically debated the issues around what good health is, how we should go about getting it, and what sort of minimum standard of health our policies should be based on. Moreover, we have not agreed on what being healthy actually consists of, even in the most general sense, apart from very vague, and essentially utopian, notions concerning a complete lack of illness or, in the view of the
World Health Organisation (WHO) a "state of complete physical, mental and social well-being".2

Accordingly, we have never been able to specify in any detail how we should go about getting the bulk of the population above such a minimum level of health, and what policies we need to implement to keep them there. Despite the widespread concerns in Britain about the low levels of fighting fitness amongst Boer War recruits, echoed in this country after World War I by the push to achieve national efficiency through improved public standards of physical health, no Australian government has ever laid out specific objectives or principles around which health policies could be organised. Like other policy areas, health policy in Australia has tended to be implemented with very little reference to clearly defined means and ends.

Despite such vagueness, health is inextricably linked to many other policy areas, sometimes as an effect and at others as a causal factor. How productive our labour force is, how receptive we are to education and training, and how strongly we are defended, depend at least in part on our physical and social health. At the same time, unemployment, poverty, inadequate housing, limited transport, environmental deterioration and low levels of education are all strongly associated with generally poor nutrition and health. There is a health component integral to virtually every public policy area. Yet it is only within the last decade that such mutual dependencies among

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policy areas have been widely recognised at the formal level, with the emergence in the mid-1980s of "healthy public policy" goals, and the recognition of the need for "intersectoral coordination" in policy development beyond the localised activities of government health departments.³

Health policy and party politics

Health policy in Australia is also notable for the high degree of political conflict that has been generated around it. Health is a big issue in Australia and, since World War II, has consistently occupied a position at or near the top ranks of the mainstream political agenda.⁴ For example, the medical profession launched two successful High Court actions against Labor government health proposals in the 1940s.⁵ Health reform was one of the main planks of the Menzies conservative governments' electoral platform throughout the 1950s and 1960s, and, through Medibank, was the lynchpin of Whitlam's 'back from the political wilderness' election strategy in 1972. The first

³ For example, the World Health Organisation's "Ottowa Charter for Health Promotion", in which participating nations agreed on the need for increased "intersectoral coordination" as a means towards more "healthy public policy", was developed in 1986. See Sax, S. (1990), Health Care Choices and the Public Purse, Sydney: Allen and Unwin, Chapters 1 and 3. In the same year, the Commonwealth Department of Health was restructured to become the Department of Health and Community Services, in clear recognition of the interdependence of the health and community services policy areas. Since then, the health portfolio has been restructured several times to include areas such as housing and local government.

⁴ Recently, health as a policy issue has also become very important in US elections, and was a key area of the 1993 election campaign. It is reported that whenever Clinton campaign staffers deviated from the target of highlighting George Bush's poor economic record, they were directed to a sign on the office wall, reading "The economy stupid (and health care too)", Australian, 3 February 1993:9.

⁵ The challenges, both against the Pharmaceutical Benefits Act, took place in 1944/45 and 1949. For more details of these events, see for example, Hunter, T. (1980), "Pressure Groups and the Australian Political Process: The Case of the Australian Medical Association", Journal of Commonwealth and Comparative Politics, Vol. XVIII, July, pp190-206.
Hawke government in 1983 came to power on the back of the Medicare health insurance system, both as an issue in its own right, and as the social policy cornerstone of the wages Accord it had negotiated with the Australian Council of Trade Unions (ACTU).

Health policy has been a crucial area in all Federal elections since then, perhaps most notably in 1990, when a $2.6 billion funding hole appeared in the Coalition's health strategy just weeks before polling day, and completely reversed its leading electoral position. Similarly, the high political significance of health policy is reflected in the direct interventions in the extensive negotiations around the 1984/85 NSW Doctors' Dispute by both the Premier of NSW and the Prime Minister (see Chapter Three). Prime Minister Hawke's intervention here is particularly notable, given his low-key, consensus style of leadership, his tendency to delegate responsibility, and his general reluctance to intrude into the policy areas of his senior ministers.

While the vagueness of its objectives and the breadth of its impact are quite conspicuous, health policy is not unique in these respects. For example, economic, social welfare, education and industrial relations policy all have rather broad formal objectives, such as less unemployment, higher income security, better training, and less industrial conflict. Similarly, many policy areas impact directly and

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indirectly on others, such as economic policy on social welfare and industrial relations policy, and education and environmental policy on economic policy.

Health policy and the medical profession

One feature which is generally more prominent in health policy than in other policy areas is the pervasiveness of its major client group. Other policy areas are certainly marked by active client groups which help to shape both policy content and the format of its implementation. Economists are very active in the development of economic policy, social workers in social policy, farmers in agricultural policy, and teachers in education policy. But no group or profession matches the level of overall policy influence wielded by the medical profession, and referred to as "professional dominance" in the British and US contexts⁸ and "medical dominance" in the Australian context.⁹ While many community, industrial and professional groups have different, often conflicting views on how to best get the economy moving, redress inequalities in material resources, make agriculture more productive, and train our workforce, the medical profession's views have unparalleled authority over the shape of health policy. More than most policy areas, we tend to leave large parts of health policy under the direct influence of one interest group - the medical

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profession - because there is widespread regard for doctors as experts in the field, and widespread trust in their altruistic intent.

Evan Willis argues that this "medical dominance" of health policy is the key feature of the production of health care in Australian society and the central analytical focus in explaining the social structure and organisation of health care. ¹⁰

In Willis's schema, the policy dominance of the medical profession derives from, and is expressed by, three different categories (or "levels") of occupational influence. These are the profession's autonomy over its own work, in that "[m]edicine is not subject to direction and evaluation by other health occupations"; its authority over the work of other health occupations, by direct supervision, or by indirect control through representation on their registration boards or through denying them formal recognition; and medical sovereignty, whereby the state customarily legitimates the activities of other health occupations only if the medical profession suggests its general approval or tolerance. ¹¹

As discussed in more detail in later chapters, the autonomy of doctors over their work is an integral part of the knowledge aspects of policy influence. It is crucial to understanding the sources and the scope of that influence, as well the means by which it might be subjected to more social democratic forms of control. The case studies in Chapters Three, Four and Five demonstrate that the highest and most pervasive expression of such autonomy is the medical peer review system. Under peer review, the work of doctors is, as Willis suggests,


effectively insulated from evaluation by "other health occupations" because it is so widely accepted that only the medically trained have the relevant expertise to assess medical work and medical decisions. This thesis shows that the significance of medical peer review extends beyond the exclusion of other health workers. Peer review also renders doctors' work immune to scrutiny by anyone outside the profession - including the consumers of medical services, and their political representatives in government, who largely underwrite the cost of medical practice through public funds.

As a means to help account for the unique position of doctors among policy client groups, this research also pays considerable attention to the medical authority type of influence. Such influence extends well beyond the occupational hierarchy within the health sector, and reflects the very esteemed position held by medicine in the wider community. It is not only an expression of the specific influence of doctors on health policy in Australia, but also of their more general authority over collective views on the social significance of health and illness, and of their relation to the body. To adopt Paul Starr's terminolgy, medical authority in this sense reflects the medical profession's high level of "cultural authority" within the Western industrialised world. This refers to the "probability that particular definitions of reality and judgements of meaning and value [in health] will prevail as valid and true".\footnote{Starr, P. (1982), The Social Transformation of American Medicine, New York: Basic Books, pp13-15.} Such a meaning is neatly encapsulated by Willis's suggestion that:
medicine is dominant in relations between the health sector and the wider society; doctors are institutionalised experts on all matters relating to health.\[^{13}\]

The notion of doctors as health experts is directly related to the distinctiveness of health policy as an area traditionally dominated by one client group, to the marginalisation or exclusion of all others. As we see in Chapter Two, Western societies since the Enlightenment have tended to privilege that specific type of knowledge which is based on rational scientific methodology and research. Almost by definition, such knowledge is impenetrable to the uninitiated lay person. As a specific, and very prominent, form of such knowledge, medicine implies objective, technical expertise applied to the task of staving off illness and incapacity.\[^{14}\] It is this science knowledge base of medicine, and the expertise derived from it, which helps to explain the medical profession’s extensive control over health policy.

As discussed in Chapter Two, the science of medicine in Western societies is very closely associated with the remarkable technological developments of the past two centuries, and the life-saving procedures and drugs generated by them. With such a strong record of achievement, medicine, more than any other school of knowledge, offers our society the promise of further technical solutions to both our current and future health problems. Moreover, such knowledge is esoteric, in that its form and content tend to be inaccessible to the layperson, and as such, quite isolated from his or her everyday life.


\[^{14}\] It is ironic that the widespread perception of medical knowledge as objective and technical is entirely undermined by medical practice in the clinic, which is often based more on individual experience and intuitive skills than on rational scientific knowledge. Practicing doctors, and indeed, medical texts, routinely view medicine as part science, part art. For more on this dualism within medicine, see Chapter Two.
and experience. It is in this sense, then, that it seems culturally appropriate to entrust considerable control over health policy to doctors, for they alone are trained in the science of medicine, and regularly practice its application in the clinic. Doctors are indeed, in our society, the "institutionalised experts on all matters relating to health."

In summary, the argument here is that it was the medical profession's adoption from the middle to late seventeenth century of a knowledge base with very strong and identifiable links to rational science - then emerging as the lingua franca of Western progressivism - which gave its organised lobbying activities the additional socio-political impetus needed to become an entrenched part of the state's health policy structures and processes.  

**Medical dominance and the health policy process**

A direct implication of this expert-driven policy is that political debates in the area of health tend to focus not on fundamental issues, but rather on secondary or ancillary issues. Thus in Australia, especially since World War II, health policy debates have centred on questions of how we finance existing medical health care services, rather than on what sort of services should be provided in the first place, which group of health workers can best provide them, and whether they should emphasise curative or preventive approaches. 

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Such a secondary policy focus provides compelling evidence for the medical dominance thesis, for it clearly demonstrates that the strong influence of the medical profession in our society persists over time, and is not essentially dependent on contingent political patronage. Since World War II, the basic structure of health care in Australia has been, with the exception of Labor's failed health nationalisation attempts in the late 1940s, treated as a given in all health policy schema, regardless of which political party is in government. Other features of the health system have been more subject to debate and party differences - especially the means by which to finance health and medical services.

After the War, Labor governments attempted to introduce a national health service on the British model, and were fiercely opposed by the combined forces of the conservative parties and the medical profession. The scheme was ultimately defeated through a High Court action by the profession against the government's proposals. During the next twenty years or so, conservative governments developed health policies centred on voluntary health insurance schemes - starting with the Page Scheme in the early 1950s - which were widely supported by the medical profession.17

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One of the main planks of Labor's successful 1972 election campaign was Medibank, a universal health insurance scheme which the Whitlam government implemented against vigorous opposition from the profession and the conservative parties, shortly before it lost office in late 1975. Its successor, Medicare, was introduced when Labor came back to power in 1983, and retained the universal features of Medibank. In between, the conservative Fraser governments gradually dismantled Medibank, and in effect reintroduced a voluntary health insurance scheme under the same name. Since 1983, the Coalition’s health policy, echoing that of the Fraser governments, has centred on a series of comprehensive reforms to Medicare which have much more in common with a voluntary than a universal health insurance scheme.

Looking at the development of health policy in this way, a distinct correlation can be seen between the types of Federal policies in place and the political persuasion of the party in government. There is also an identifiable pattern in the political relationships between the organised medical profession and the main political parties, with general support by the profession for Coalition health policies, and general antagonism towards Labor policies.

However, to distinguish these party policies wholly on the basis of the insurance system used to fund medical services is to overlook the more fundamental features shared by the health systems of both types of government. Under both Labor and conservative governments, doctors have been at the top of the health workforce hierarchy, with all other health groups subordinate to them. Similarly, the organisation of health services has been characterised by private
medical practice and fee-for-service remuneration,\textsuperscript{18} with the overwhelming emphasis on curative rather than preventive services.\textsuperscript{19} There have been no formal moves by either party to seriously challenge or reform these basic features, despite occasional posturing from both sides on the need for a more preventive focus. The major difference between Labor and conservative health policies in the area of medical services has tended to be over the question of how to pay for the existing structure of such services - through private insurance premiums or through the taxation system.

Associated with an expanded policy role for doctors is a reduced role for other groups in the wider community. The strong role of doctors limits the level of democracy within the development processes of health policy. The development of health policy is premised on the continued emphasis on curative medical services provided by doctors, so that the involvement of other non-medical groups or health workers is limited to the secondary issues around the funding and distribution of existing health care services. These groups are thereby preempted from direct involvement in the more fundamental policy issues over the content and organisation of those services.

\textsuperscript{18} Australia's longest-serving Federal health minister refers to fee-for-service remuneration for doctors' services as an "inescapable feature of the medical landscape in this country." Blewett, N. (1983), "What Medicare will mean to you", \textit{New Doctor}, No. 30 (December), pp5-7, at p7.

\textsuperscript{19} For example, while spending on health promotion and disease prevention has gradually increased over recent years. In 1988/89 it represented only 1.7\% of total recurrent health expenditure by governments. On the other hand, spending on hospitals, nursing homes and other institutions accounted for 53\% of total recurrent expenditure in the same year. Australian Institute of Health and Welfare (1992), \textit{Australia's Health 1992}, Canberra: AGPS, p93 and p344.
Medical peer review

In the context of this research, the primary marker for the medical dominance of health policy is the presence of both organised medical interest group activity and some form of medical peer review mechanism. As the case studies demonstrate, interest group activities by the profession - especially through the AMA - are almost always in evidence during significant health policy developments and conflicts; whereas the presence of peer review mechanisms, while very common, is relatively less constant. Where peer review is not present to reinforce and legitimate interest group activity, policy outcomes may not entirely protect medical interests.

The full impact of the medical profession's "power" activities is dependent on their interaction with the "knowledge" aspects of medical influence, which give credence and authority to those activities. What most distinctly marks knowledge-based influence within a particular policy conflict is the presence of a formally constituted medical peer review mechanism. Such a mechanism reflects a widespread presumption amongst the key policy players that the crucial issues involved are essentially medical in nature, rather than political or social, and that they are thereby dependent on the medical knowledge and expertise exclusively controlled by doctors for both their assessment and their resolution. In other words, medical peer review represents the formal subjection of identified areas of health policy to the exclusive control of doctors.

Both Labor and conservative parties, in government or in opposition, and most health ministers, have explicitly endorsed medical peer review as the primary organising principle for the scrutiny and
evaluation of medical service delivery. Indeed, beyond this bilateral support, medical peer review has been almost universally endorsed by all health policy players where the content of the issues at hand have been (usually implicitly) identified as essentially medical in nature. These include other health occupations, such as nurses and physiotherapists, Federal and State health agencies, individual health ministers, the minor political parties such as the Democrats and the National Party, alternative medical organisations such as the Doctors' Reform Society (DRS), parliamentary inquiries and Royal Commissions, and the various health consumer and community interest groups, such as the Consumers' Health Forum (CHF). Medical peer review has never been explicitly contested or seriously challenged in Australia as the primary means by which to assess and evaluate the clinical decisions of doctors. Indeed, it is widely regarded as the only technically and politically feasible means of such assessment.

The selection of the policy case studies from recent Labor governments is largely informed by this universal acceptance of medical peer review. For in view of the medical profession's traditional antagonism towards Labor health policies compared to those of conservative governments, and in view of Labor's traditional social democratic policy approaches, more policy emphasis on increasing the accountability of doctors can be expected under Labor governments than under conservative ones. The lobbying activities of the profession to maintain their high level of autonomy can be expected to fall on far less sympathetic ears under Labor than under the Coalition.

The evidence of the case studies strongly suggests that the effectiveness of recent Labor governments in making health policy in
general more responsive to social democratic values, and in making doctors in particular more accountable for their medical judgements, has been quite limited. This lends at least indirect support to my argument that the privileging of medical knowledge occurs across all political divisions, and that this has extended the policy influence of the medical profession well beyond that expected solely from its organised lobbying activities. In this way, this research can avoid limited party politics conclusions about medical dominance, whereby the policy fortunes of the medical profession are closely linked to the type of government in office. At the same time, it can more adequately account for the maintenance of medical dominance within an extended period of Labor Party rule.

Where a medical peer review mechanism is not present, the general presumption amongst the policy players is that the issues involved are not entirely medical in nature, but at least partly social or economic or political (or all three together), and so properly subject to control by a broader community of interests than the medical profession on its own. As noted above, such a situation occurs in the aged care and birthing studies in Chapter Six, where the preferences of the clients and the expertise of other health workers are given formal recognition in the selection of treatment modes, in addition to those of the medical providers.

**Making doctors more accountable**

The concept of medical dominance raises questions about what reforms might responsibly limit the influence of doctors on health policy, or at least make them more accountable for the decisions they
make which significantly impact on the final shape of such policy. One of the principal aims of Chapter Seven is to suggest what types of health policy reform could be expected to resolve these questions.

As noted in some of the case studies, the economic recession, and Labor's strategy of tightening social welfare spending, have recently increased calls from across the community to intensify the monitoring of medical practitioners in order to make them more accountable. These calls are largely informed by the significant proportion of private and public funds consumed by health spending in general, and by medical service provision in particular. Since the mid-1970s, total health expenditure has consistently accounted for about 7-8% of GDP in Australia, and currently amounts to over $30 billion annually, of which some 70% is government funded. Total medical services represent about 18% of total expenditure, or $5 billion annually.\textsuperscript{20} It is one of the great ironies of recent health policy developments that the general response to such calls has been to increase the level of peer review, or to streamline its procedures. In other words, where the self-regulation of doctors is seen to be lacking in some respect, the general political response has been to give them more self-regulation.\textsuperscript{21}

Such a routine and uncritical acceptance of the principle of medical peer review suggests that fundamental changes to the medical dominance of health policy, and the accountability of medical providers, may be a long time coming. For example, while the new Federal health minister, Senator Graham Richardson, has proposed a

\textsuperscript{20} Ibid., pp339-345.
\textsuperscript{21} For an example of such an approach, see Bates, E. and Linder-Pelz, S. (1996), \textit{Health Care Issues}, 2nd edition, Sydney: Allen and Unwin, Chapter 13, "Professional accountability".
significant tightening up of the monitoring of medical practice and the accountability of doctors, he has already explicitly endorsed medical peer review as the principal means of achieving it, and is concentrating his accountability reforms on incidental legal and procedural matters.\footnote{See, for example, Senator Richardson's \textit{News Release}, 8 September 1993, "Minister and AMA Move on Overservicing". He announces that the "central element" of revised procedures for dealing with medical overservicing is Professional Services Review Committees, "which will comprise the peers of the practitioner under review. They (alone) will provide the expertise to judge whether or not overservicing exists."}

In this present account, however, medical peer review is viewed as part of the problem rather than part of the solution. The proposals for reform in Chapter Seven focus on extending the scope of the term "peer" in peer review to include not only doctors, but also representatives of other wider community interests, such as government ministers, State and Federal health agencies, health administrators and economists, health and medical academics, sociologists and political scientists, nurses, social workers and other health workers, and consumer and patient groups. In this way, medical decisions, particularly those with significant cost and social policy implications, can be subjected to scrutiny and evaluation by a more broadly democratic political process than that offered by the existing doctor-only peer review mechanisms. It is suggested that under sustained exposure to such extended peer review, exclusive medical decisions, with significant social and economic impact, can become more like inclusive community decisions.

Such an extended or reconstituted peer review membership presumes that the non-medical - or 'lay' - representatives are capable of
understanding the scientific issues and the content of the medical decisions under review. Moreover, it implies that medical peer review involves something more than technicians assessing technical data, and that doctors can use the apparent neutrality of peer review to further their political interests. This may conflict with our everyday notions of medical science as a body of knowledge impenetrable to those without specialist training, and of the medical profession as an essentially altruistic group precluded from pursuing self-interest by a strict code of ethics.

However, such notions rest on the assumption that medical science consists of an integrated series of objective, universal facts which are free of contamination by and exist separately from political values and conflicting interests. Indeed, it might be asked, was not the development of Enlightenment rational science characterised by the elimination from our knowledge of Nature of any divine, superstitious or supernatural content? These notions also imply that doctors can collectively and completely separate their clinical work, where they apply their medical science knowledge, from their own professional and political interests.

The practical and theoretical difficulties imposed by such neutral conceptualisations of medical knowledge and the medical profession are the subject of Chapter Two. This chapter examines different theories about the professions as occupational groupings, and about the process of professionalisation. It concludes that conflict type approaches can more adequately account for the historical development of professions in relation to other occupations, and for
their political activities, than can those of the "attribute" school, which tend towards descriptive taxonomies rather than systematic analysis.

Chapter Two also considers some of the debates over the nature of scientific knowledge, including medical knowledge, and concludes that approaches emphasising the social construction of knowledge (knowledge as artefacts), though not without their problems, help to account for medical dominance more coherently than do those which assume the conceptual separation of science and society (knowledge as facts). This chapter also reviews much of the literature related to the crucial task of making viable connections between medical power (doctors as organised interest groups) and medical knowledge (doctors as experts in health). Such connections provide the basic structure of the theoretical framework within which the evidence from the policy studies of the later chapters can be analysed.

**Approaches to medical influence**

While there is a considerable body of work concerned with the policy influence of the medical profession in the United States and European health systems, that on the Australian system remains much less extensive. Recently, however, research in this area has been steadily increasing, stimulated perhaps by the renewed political prominence of health policy since the election of the Whitlam government in 1972 ended over two decades of continuous conservative government.

Some of these works focus on particular aspects of health policy in Australia, such as the political debates over health insurance or the development of the AMA as the medical profession's key industrial and
political lobby group. Others take a more expansive approach, and attempt to locate issues about health and health policy within a much broader social, economic and political context. There is a great deal of diversity within these works on both the conceptualisation of medical influence and its impact on the development of health policy. However, there are also some identifiable characteristic types of approach amongst these works. In this next section, some of these approaches are outlined as part of an overview of the general terrain within which this current research may be located.

*Medical influence as power driven*

This is by far the largest single category of works on the policy influence of the medical profession, and in Australia is typified by the works of Thelma Hunter and Sidney Sax. In both cases, the development of health policy is presented as the locus of outcomes of formal negotiations between (mainly) the organised medical profession and various state health agencies. Both embrace essentially pluralist conceptions of political power through the formal institutions and processes of parliamentary democracies. Thus the AMA is seen as an especially capable and well-resourced interest group, successively involved in lobbying the government through established channels in order to protect the general interests of the medical profession against unwelcome policy proposals. In this sense, the AMA is the embodiment of medical influence, and while its impressive record of policy successes is recognised, it is not necessarily regarded as an

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elite group which can completely dominate health policy to the exclusion of all other interests.\textsuperscript{24}

In this type of work, little or no recognition is given to policy influence arising from the profession's exclusive control over medical knowledge and expertise. The implication is that if another health interest group or profession were to develop a political lobbying capacity comparable to that of the AMA, then it would enjoy a proportionately larger share of the available policy influence. Such an approach is significantly limited by its inability to explain why, in so many different Western countries with so many different social, cultural and political contexts, it is only the medical interest groups which have such extensive policy influence; and why no other groups can mobilise to effectively challenge or displace them.

A notable variant of such pluralist approaches is Robert Alford's "structural interests" account of medical influence, originally developed for the US health system,\textsuperscript{25} but later adapted by Stephen Duckett and others to the Australian context.\textsuperscript{26} Alford contends that

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\textsuperscript{24} In her 1980 article on the AMA as a pressure group, Hunter explicitly acknowledges the difficulties the AMA presents for the pluralist perspective of political power, and the advantages presented by "some of the generalisations of elite theory". Indeed, after Klein in the British context, she invokes the thesis of professional dominance of health policy in Australia. However, while she notes that "It is tempting to conclude that...a potential elite has in practice become an actual elite", her later assessments (1984) of competing medical groups place the AMA back firmly within the category of pluralist interest group, albeit still a very powerful one. Hunter (1980), "Pressure groups and process..."; p201; Hunter (1984a), "Medical politics..."; Hunter (1984b), and "Politics of National Health...".


reforms to health policy, and also the barriers to such reforms, are the product of conflicts between three categories of "structural interests" in the US health system. The first is "professional monopoly", represented primarily by medical practitioners who are given exclusive legal sanction to provide prescribed diagnostic and therapeutic services. Alford argues that because the current organisation of health care protects their political and economic interests, the "professional monopolists" actively resist moves towards substantial health policy changes.

The second "structural interest" is "corporate rationalization", represented mainly by health administrators and bureaucrats working in the major health institutions, such as hospitals, health insurance companies and state health agencies. This group continually seeks to expand the borders of the policy territory under its control by implementing technical reforms to make the health system more efficient and effective, and by including more consumer and community groups in the processes of policy making. Alford argues that this is currently a "challenging" interest, pushing to reform health care against organised resistance by the "dominant" interest of "professional monopoly".

The third category is the "equal health advocates", who seek reforms to make health care services more accessible and equitable. Much weaker relative to the other two interests, Alford notes that this category is currently (1975) a "repressed" interest.27

Alford's schema has some general similarities to Richardson and Jordan's concept of the "policy community". Richardson and Jordan argue that Western industrialised nations have become "post-parliamentary democracies" because policy making is increasingly conducted within closed "policy communities", consisting of senior bureaucrats and various professional groups and policy experts. In the specific case of Australian health policy, the "policy community" would consist of medical organisations and colleges, health economists, health insurance companies, hospital administrators and senior representatives from State and Federal health agencies. Within this approach, "policy communities" not only minimise or deflect direct policy involvement by elected representatives, but they also shape policy by trying to maintain or extend the policy problems on which their careers and sphere of influence so heavily depend.

Both Alford's "structural interest" schema, and Richardson and Jordan's concept of "policy communities", provide very useful extensions of the pure pluralist approaches to policy influence. They explicitly recognise that individuals or groups beyond the formal parliamentary process can have a significant impact on both policy making and policy implementation. The policy impact of the medical profession is clearly greater than that suggested by the relative voting strength of its numbers. Indeed, it is also greater than that of any


comparable health interest group, such as the organised nursing profession or public sector health unions. However, the two schemes also share the same sort of limitations in accounting for medical influence.

Like the "policy community" approach, Alford's "structural interest" model is more descriptive than explanatory. It provides a useful taxonomy of the main health policy players, and assesses their relative strengths. However, it fails to explain why these interests came to be organised in this particular way, how their current relative positions might change over time, or how the medical profession maintains its dominant position against "challenging" interests. Similarly, both schema allow very little scope on the part of the government, political parties or the parliament to significantly influence the specific content or general direction of health policy. As such, they represent perhaps not so much an extension of pluralism, but rather a partial negation of it.

But in the context of this research, the most limiting aspect of Alford's and Richardson and Jordan's approach is its implicit assumption that the medical knowledge controlled by doctors, and the demand within the health sector for the skills based on such knowledge, is the principal determinant of medical dominance over health policy. No attempt is made either to explain the relative lack of influence of other groups of health workers holding comparable specialised knowledge and skills (such as psychologists, physiotherapists and medical scientists), or to account for the policy influence of the medical

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30. In this sense, Alford's use of the term "structural", implying analysts rather than description, is a little misleading.
profession's substantial capacities in its organised interest group lobbying activities. It is in this sense that accounts using this type of concept begin to shift from the "power" category of the pure pluralists, towards the "knowledge" category outlined below.

**Medical influence as knowledge driven**

In this type of approach, it is generally proposed that the therapeutic efficacy of the knowledge and skills of doctors, and their state-legitimated monopoly over their clinical application, is the primary source of medical influence over health policy. Thus, for example, Pensabene’s history of *The Rise of the Medical Practitioner in Victoria*\(^{31}\) suggests that as medical knowledge and practice in the late nineteenth century became increasingly based on systematic, rational science - particularly in the search for the modes of transmission of infectious diseases - the "control of this knowledge gave doctors a degree of power and influence unequalled in the past."\(^{32}\)

Such a view has considerable difficulties. For example, it implies that medical influence increased as science-based treatments became more effective. Yet, as Pensabene himself acknowledges,\(^{33}\) the "rise of the medical practitioner" began well before the new theoretical knowledge about infectious diseases was transformed into effective clinical treatments. Indeed, even when significant declines in mortality did occur, they were "largely coincidental", and had little direct connection to the new germ theory developments in medical science.\(^{34}\) Moreover,


32. *ibid.*, p33.

33. *ibid.*, pp42-43.
the argument here is largely a technological determinist one, in that knowledge is presumed to shape society, with no reverse flow.

However, the most significant difficulty in the context of this research is the marginalisation of the medical profession's activities as organised interest groups. Pensabene details the profession's intense activity during this period in lobbying the state to formally legitimate its increasing hold on the occupational territory of health and illness against competing practitioners. From this and other accounts, it is clear that the profession lobbied very competently. Yet Pensabene accords these activities, mainly orchestrated through the AMA's organisational predecessor, the British Medical Association, no explicit recognition as an integral component of medical influence. The "rise of the medical practitioner" is attributed almost entirely to medicine's timely association with the rising star of scientific knowledge. For Pensabene, the crucial difference between the victorious medical profession and its vanquished rivals in nineteenth century Australia was the public’s perception that "the registered [medical] practitioner had a body of scientific medical knowledge, the alternative doctor lacked any sound theory of sickness and disease."\(^{35}\)

*Medical influence as system driven*

In works taking this sort of approach, the influence of the medical profession is seen as a direct product of the wider social and political economy context in which health-related practices are located. Evan Willis's *Medical Dominance* is the most notable of these in the

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Australian context.\textsuperscript{36} Willis identifies as the primary source of medical dominance the close historical ties between the skills of the medical profession and the needs of capital ("in particular financial and industrial capital"),\textsuperscript{37} mediated by the expanding role of the state in the transition from \textit{laissez-faire} to monopoly capitalism. Willis argues that the compatibility of medicine's scientific knowledge base with the reproduction of a class ordered politico-economic system, provided the medical profession with both extensive links to the dominant capital classes, and a strong case for government protection against competing health occupations.

Medical dominance then rests upon state patronage, achieved through medicine's role in reproducing the relations of production and seeking to maintain bourgeois ideological hegemony.\textsuperscript{38}

As we see further in the next chapter, there are considerable difficulties involved in expansive, system-wide explanations of medical influence, whether they are structural functionalist, neo-Weberian or neo-Marxist. While they more directly and fully acknowledge the impact of the broader social, political and economic context in the development of medical influence - unlike, for example, the pure pluralist interest group accounts - they are still unable to adequately account for why it is specifically the medical profession which can so comprehensively influence policy. Other professions and groups have comparable historical links with the dominant classes or the requirements of capital; or control knowledge which is highly functional to the general operations and coherence of society; or, in

\textsuperscript{36} Willis (1983), \textit{Op. cit.}

\textsuperscript{37} \textit{Ibid.}, p6.

\textsuperscript{38} \textit{Ibid.}, p204.
the case of neo-Weberian approaches, enjoy some degree of state sanctioned market monopoly through a process of social closure. Examples of such groups range from lawyers and motor mechanics to computer analysts and plumbers. However, none of these groups wield a level of policy influence in any policy field comparable to that of the medical profession in health policy.

Moreover, system-wide accounts cannot easily accommodate the policy influence generated by the specific organised lobbying activities of the medical profession, or for the qualitative differences in health systems among different countries with the same general type of politico-economic system. Nor can they easily explain contingent developments in health policy which stand opposed to general 'system requirements', such as state legitimation of other health occupations against medical interests, or the social provision of health care services which go beyond the needs of a labour force fit for wage labour work.

Medical influence as power-knowledge driven

The argument developed in this chapter has been that accounts of medical influence or medical dominance which emphasise the "power" aspects of the medical profession's formal lobbying activities are limited by their marginalisation (or exclusion) of the influence associated with doctors' exclusive control over scientific medical knowledge, and the expertise and authority in matters of health which is derived from it. Conversely, accounts which base medical influence over health policy on "knowledge" aspects tend to marginalise the "power" aspects of the profession associated with its organised interest
group activities in lobbying governments to develop health policies compatible with its general interests. I have also argued that system-wide accounts are too generalised in their scope to adequately account for the specific policy outcomes which directly contradict system requirements, however defined.

Reasserting medical knowledge
In 1983, Willis argued that conventional accounts of medical politics in Australia focus too much on technical determinist explanations for medical dominance which emphasise the profession's exclusive control over medical knowledge and technology. He made a strong case for setting occupational struggles over health policy in "the wider politico-economic context", claiming that "the role of medical knowledge... has been overstated".39 In this research, the role of medical knowledge in maintaining medical dominance is emphasised, especially where it is channeled through formal medical peer review mechanisms.

This is not to endorse technological determinism. Indeed, as discussed in more detail in the next chapter, I agree with Willis in arguing for the socially determined character of medical knowledge, rather than supporting the view of it as a collection of technical, apolitical and incontrovertible 'facts' about health. Rather, it is because I consider, against Willis, that recent accounts have tended to overstate the occupational control aspects of medical dominance to the detriment of the knowledge aspects. The mutually reinforcing nature of power and

39. Ibid., pp4-5.
knowledge remains central to the analysis; but in order to achieve this in the context of recent accounts, the relatively neglected role of medical knowledge and expertise has required additional attention. This account, then, is partly aimed at bringing medical knowledge back in to the centre of research activities about medical dominance over health policy.

In the next chapter, one of the main debates considered in regard to such knowledge aspects of medical influence relates to the widespread presumption that scientific knowledge, including medical knowledge, is essentially objective, technical and politically neutral in nature. A range of research has strongly suggested that this is not the case, and that medical knowledge which might appear neutral, is actually laden with the values and interests of the medical profession. The social constructionist approach is particularly useful here, because its departure point from conventional theories about knowledge is that all knowledge, including medical knowledge, is identified as essentially interpretive and social, and thereby infused with some of the values present in the socio-political context in which it is produced.

While there has been very little such research in Australia, some recent works in the US have identified the knowledge of medical science as politically loaded. For example, in Sylvia Tesh's study of the development of US public health policies, the knowledge informing the formal processes of defining and treating diseases is identified as a mix of fact and value, or science and ideology, so that "politics masquerades as science". She argues that public health debates can

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be made more democratic, and public health policies more effective, by making the "hidden arguments" about ideology and value which are embedded in that knowledge more open and explicit, and more directly subordinate to the political process.

While Tesh acknowledges the social construction of the scientific knowledge and expertise used to define disease and recommend treatment, she simultaneously implies that it is quite possible to separate out the political components from the factual, scientific components. In other words, she contends that a true, incontrovertible reality about each disease process does exist, located below several layers of obscuring socio-political matrices; and that to get to that reality, we simply need to remove those layers by making the values they contain more explicit. It is in this sense that Tesh's account is only partly constructionist, for a full constructionist approach does not recognise any core of facts or scientific data as entirely value-free.

The partial constructionist approach which characterises Tesh's analysis - and others\(^4\) - has significant implications for the usefulness of constructionism as a perspective through which to analyse health policy. In recognising the interpretive nature of knowledge, but presuming the existence of an ultimate, objective, scientific truth, waiting to be discovered under the layers of social

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41. For a analysis of US health policy which is similar in this regard, see Beauchamp, D.E. (1988), *The Health of the Republic: Epidemics, Medicine and Moralism as Challenges to Democracy*, Philadelphia: Temple University Press. Beauchamp, like Tesh, presumes that medical science can lead us to the incontrovertible truth, and focuses his concerns on the way in which science should be applied, especially in regard to developing public health policy which is adequately informed by "republican" values (like free speech, for example), rather than elitist or populist ones.
sediment, such approaches reinforce the notion of science as the means by which to reach that truth.

Whenever the subjective nature of scientific knowledge is made more explicit - as analyses like Tesh's consistently do - or whenever the failures and limitations of medical science are emphasised, science itself is not seen as the problem, but rather the way it is being applied. The widespread faith in the potential of rational science to solve social problems remains unshaken because, under the presumption of objective knowledge, such failures are reformulated as useful and even necessary steps along the linear path towards a single truth. Each step along the way is seen as a little less contaminated by obscuring social factors than the previous one. Fully constructionist approaches, on the other hand, acknowledge the value-laden, social nature of all 'truths', including those produced by even the most proper application of rational science.

The re-emphasising of the knowledge aspects of medical influence does not, however, mean the neglect of the power aspects, for the central argument of my thesis is that they are interdependent and mutually reinforcing. The political power aspects are considered through the perspective provided by Steven Lukes's "three dimensions" of power.42 This moves somewhat beyond the limited conceptions of power inherent in pluralist accounts ("first dimension"), and identifies the exercise of political power through "non-decisionmaking" or agenda-setting ("second dimension"), and, most importantly for this research, through the shaping of people's general

values and preferences to accommodate the interests of those wielding - or benefitting from - "third dimension" power.

Lukes considers the latter "the supreme and most insidious" type of power, because, unlike the other two types, there is no observable conflict by which to recognise its use. Such power is exercised without the subjects' conscious awareness. It is also the type of power which can most readily link power theory with social constructionist knowledge theory, forming an integrated framework within which to analyse the case studies. As discussed further in the final chapter, the widespread acceptance of medical knowledge and expertise as technical and politically neutral, permits doctors to insert political values supportive of medical interests into the formal policy process, whilst maintaining the appearance of non-partisan experts on health.

Both knowledge and power theories are operationalised in the case studies by assessing the ways in which medical peer review mechanisms act as a conduit for the flow of medical influence - both in the form of 'trusted' expertise, and in the more conventional form of political power. The approach taken here can thus make a useful addition to our understanding of the policy influence of the medical profession, because it analyses policy case studies in the Australian context through the social constructionist perspective on medical knowledge, while at the same time incorporating more conventional political science perspectives on the exercise and distribution of power.

43. ibid., p24.
The case studies

The first case study in Chapter Three examines one of the first attempts by the newly elected Hawke government to impose some sort of accountability controls on doctors' incomes under the new Medicare insurance scheme. In effect, the Section 17 proposals allowed the Federal health minister to place specific limits on the incomes which Visiting Medical Officers (VMOs) could earn from treating private patients in public hospitals, and imposed a set of fees to be paid by VMOs using public equipment and facilities to treat such patients.

The Penington inquiry established to quell widespread concerns about Section 17's implications for medical autonomy and the "unfettered powers" of the health minister, proposed a medical peer review mechanism as the means for monitoring VMO practices which went beyond the recommended income limits, and this was formally agreed to by the government. In other words, income excesses under Medicare by specialist VMOs were to be regulated by other VMOs.

However, what began as a relatively minor legislative accompaniment to Medicare eventually erupted into one of the Australia's longest and most intense conflicts between the state and the medical profession, the events of which are widely referred to as the NSW Doctors' Dispute. By the latter stages of the dispute, when the nature of the issues at stake had shifted from largely medical to wholly industrial, the medical profession's strategy changed from measured, formal negotiations with the government through the AMA, to militant industrial strike action by a group of breakaway NSW surgeons. A variety of contingent factors contributed to the profession gaining a
series of concessions from the government through such militancy, including the complete repeal of Section 17.

However, the social and political price paid by the profession for these concessions was extremely high. Accompanying the shift from formal negotiations to militant action was a qualitative change in the public perception of the profession. This moved from reasonable and highly esteemed health experts seeking to resolve a series of esoteric medical issues with the government, to aggressive and uncaring industrial zealots seeking to line their pockets at the expense of both their patients and the public purse. The AMA instigated a substantial public relations campaign in response to this widespread community backlash. The long-term continuation of this program is testimony to the profession's keen awareness of both the policy influence attached to its role as trusted health experts, and the threat to such influence posed by unchecked lobbying activities conducted in isolation from that role.

In the second case study in Chapter Four, the complex policy problems posed by medical fraud and overservicing are investigated. When a parliamentary inquiry in 1982 revealed widespread benefits abuse under Medicare of at least $100 million per year, equal to about half of the total national loss from burglaries and "conventional" property crimes at the time,\(^44\) the need for effective monitoring and prosecution of some doctors' billing practices became quite obvious and compelling.

However, the uncritical acceptance by all policy players of overservicing as essentially a matter of medical judgement, requiring medical knowledge to establish its occurrence, severely limited policy options in this regard. By accepting such a definition, direct evaluation of suspected overservicing can only be conducted by medical peer review, leaving it entirely within the hands of the medical profession, where the problem is produced in the first place. The government and other non-medical interests can only pursue procedural changes to such peer review mechanisms to make them work faster and more efficiently. However, non-medical interests in the community have no formal means by which to have a direct role in either the assessment of specific provider practices, or the development of acceptable standards of practice which establish the line between the provision of "medically necessary" services and overservicing.

The third case study in Chapter Five examines the introduction of a new fees system for GPs under Medicare. Under the system originally proposed by the AMA and the Royal Australian College of General Practitioners (RACGP), the current schedule of fees based on the length of time for a consultation was to be replaced by a schedule based on the medical content of a consultation. The higher the level of medical work value and complexity, the higher the fee, regardless of the time taken.

Concerned about the possible cost implications for Medicare, the Federal government rejected the scheme, and the AMA broke off formal negotiations. In response, the government took up negotiations with the RACGP as substitute political representative for the GP sector
of the profession. The two parties agreed on a compromise schedule which depended on both the time and the content of a consultation. The higher fees attached to this schedule were only available to GPs who agreed to register for a continuous program of post-graduate training and education.

While the profession was bitterly divided over the format of the new fees system, it was very strongly united against any form of monitoring of the system by non-medical personnel. Again, monitoring the use of the new fees system was to be conducted through a medical peer review mechanism. Any remaining government concerns about the cost implications of doctors abusing the fees system seemed to be satisfied by such a mechanism, as did any professional concerns about government intervention into clinical decisions. However, I argue that by defining the fee categorisation of GP consultations as a wholly medical issue, dependent exclusively on medical knowledge and expertise, the government has effectively conceded any direct form of cost control in this area.

The final case studies in Chapter Six are somewhat different from those of the preceding chapters, in that they examine two policy areas (aged care and birthing) into which consumers and other health occupations have recently made some significant, although not extensive, incursions into medical dominance. In birthing, this is indicated by the rise in the numbers of women choosing to give birth at home, or in a user-friendly birthing unit, supervised by publicly subsidised independent midwives, rather than by specialist obstetricians in a high technology hospital. In aged care, the incursion takes the form of non-medical health workers, such as nurses.
occupational therapists and social workers, taking formal control of the assessment process which directs the placement of clients into nursing home or hostel care, or which, in light of the client's preferences, keeps clients in their own homes, supported by a range of domiciliary care services.

I argue that the crucial factor here, which limits the medical profession's control over these areas, and which thereby distinguishes them from the policy areas of the other studies in this research, is the broad community's definition of birthing and aged care as social and cultural issues, as well as medical issues. Because they are not defined as exclusively medical issues, despite attempts by the profession to medicalise them (or, in the case of birthing, to remedicalise them), medical knowledge is not recognised as providing the only relevant expertise.

I argue that the fact that doctors are not recognised as the sole experts in birthing and aged care facilitates the state sanctioned application of other forms of knowledge and skills, such as those provided by nurses, social workers, midwives, and most significantly, the 'lay' clients themselves. There is simply no medical peer review mechanism here by which doctors can give further legitimation to their organised lobbying activities in these areas, and by which they can protect their professional interests under the guise of providing 'technical', non-partisan expertise. In this way, aged care and birthing are treated as broad health issues, the policies for which are properly shaped by the wider community through the political process, rather than left entirely in the hands of the medical profession.
All of these case studies provide strong supporting evidence for my central thesis that medical dominance in Australia cannot be adequately explained without an understanding of the mutually reinforcing nature of the "power" and the "knowledge" aspects of medicine within the arena of health. However, to reach such an understanding requires an evaluation of some of the various theoretical approaches to both power and knowledge in the context of medicine. It also requires an assessment of how some specific theoretical approaches might be combined, modified or elaborated in the analysis of the case study evidence to provide a coherent system of conceptual links between the two. These tasks form the main objective of the next chapter.
CHAPTER TWO

POWER, KNOWLEDGE AND THE MEDICAL PROFESSION
Introduction

As an area of philosophical and political inquiry, the relationship between knowledge and power has a long and often tumultuous history, with its modern forms developing through the scientific revolution of sixteenth and seventeenth century Europe, and consolidated by the Enlightenment focus on the liberating potential of reason and rationality, and its opposition to arbitrary forms of power and authority. The aim of this chapter is not to provide an historical overview of the development of this general area of inquiry. Rather, it is to examine some of its developments in the specific area of medical knowledge and expertise, and to lay the ground for relating these developments to the shaping of the particular health policies described in the case studies in Chapters Three, Four, Five and Six.

The first section examines the notion of scientific inquiry and its pivotal role in the development of medical knowledge in Western nations. The second section examines some possible means to link conceptualisations of power and knowledge within political theory, giving special attention to the potential of Lukes's "third dimension" of power as a useful vehicle. The third section examines some of the ways in which traditional medical sociology and the sociology of the professions, having incorporated the distinctly Western scientific approach to medicine, attempt to explicate the relations between medical power and medical knowledge. A fourth section marks the development of "Freidsonian" medical sociology as a significant point of departure from these traditional approaches towards a less rigid conceptualisation of medical knowledge. Here the expansion of medical knowledge, and its application in the field, is seen as a social
as well as a technical process. The final section considers the usefulness of 'post-Freidsonian' approaches to knowledge and power in medicine. Such approaches use a social constructionist perspective which exposes the content of medical knowledge, as well as its application, to critical scrutiny. It is argued that, in the context of the case studies which follow, this approach overcomes some of the explanatory limitations of previous approaches by countering their tendency to overemphasise "power" aspects to the exclusion or marginalisation of "knowledge" aspects in their accounts of health policy development in Australia.

**Western scientific medicine**

The modern era is characterised by the generation and expansion of knowledge based not on supernatural intercession, but on rational scientific principles. Under these principles, natural and social phenomena are subjected to series of controlled, reproducible experiments in order to develop sets of predictive laws and theories for their behaviour under a variety of conditions. What is referred to as Western scientific medicine is a specific form of this type of knowledge applied to the practical problem of maintaining health (or avoiding death). Through the methodology of scientific medicine, we seek to puzzle out the mechanisms of various diseases, illnesses and injuries, and to develop treatments to counter or subdue those mechanisms. With the development of scientific medicine, the human body ceased to be viewed as the mere vessel of a divinely controlled spirit subject to overarching theological laws, or as the passive channel for immutable natural processes. In its place emerged the view of the body as an organic machine, the individual parts of which can be subjected to an
array of observations, diagnostic tests and investigations in order to
determine the underlying pathology of various diseases and illnesses
according to an increasingly systematised discipline of scientific laws.

One of the crucial developments in this application of scientific
method to medicine was William Harvey's discovery of the blood
circulation system. In his Exercitatio Anatomica de Motu Cordis et
Sanguinis in Animalibus (1628), Harvey reached his conclusion on the
heart as the body's blood pump through a systematic series of clinical
observations, measurement and experiment. He developed a systemic
analogy through which the action of each organ was explained in
terms of the maintenance function it performed for the body as a
whole. The broad acceptance of Rene Descartes' Treatise of Man (1664)
both consolidated and reflected the shift in Europe towards the
application of the new scientific understanding of nature to the
subject of the human body:

I assume [man's] body to be but a statue, an earthen
machine, formed intentionally by God to be as much as
possible like us... We see clocks, artificial fountains, mills,
and similar machines which, though made only by man,
lack not the power to move, of themselves, in various
ways; and I think you will agree that the present machine
can have even more sorts of movements than I imagined
and more ingenuity than I have assigned, for our
suspicion is that it is created by God.1

This is the clockwork analogy that underlies Western medicine's
mechanistic view of the human body - and of life itself. One of its first
applications to the notion of disease was Thomas Sydenham's
identification in 1656 of specific disease categories through a series of
controlled and carefully recorded observations of individual cases.
This enabled a new distinction to be drawn between the condition

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itself and the person suffering from it, and has its parallel in physics in the Newtonian concept of cause and effect. It is perhaps most strikingly expressed in the strong emphasis in the biomedical sciences on vivisectional and anatomical pathology since the nineteenth century.

During that century, the development of medical technologies such as the stethoscope (1816), the ophthalmoscope (1851), and X-rays (1895), allowed investigators to collect empirical data on the physiological effects of diseases directly from their ordered observations of the inner workings of the body. This process could be increasingly accomplished without having to rely on the reporting of sensory perceptions, thereby shifting medical attention away from the subject patient and towards the object condition. Such an approach to diagnosis embraces the conceptual antithesis to that of the Aristotelian humoral diagnosis which preceded it. It is also a marked deviation from the philosophical principles of the Hippocratic tradition, where the constitution of the person - rather than the condition itself - holds primacy.


The successful integration of 'germ theory', developed from the experimental work of Pasteur, Lister and Koch, is perhaps the epitome of the mechanistic approach to medicine and disease. It allowed medical science workers to focus almost exclusively on isolating specific pathogens as the direct causes of diseases, using Koch's postulates as the standardised criteria for establishing causation.\textsuperscript{6} When effective vaccines against a variety of disease pathogens were eventually developed on the basis of germ theory, diagnosis could be conducted in complete isolation from the subjective perceptions or feelings of the sufferer. Indeed, with the increasing use of X-rays, the film was developed and the diagnosis made in the complete physical absence of the patient.

In an influential analysis of this change in Western European medicine, Nicholas Jewson demarcates three stages in the process of incorporation of scientific method and theory within "medical cosmology".\textsuperscript{7} Each stage represents a socio-historically specific mode of production of medical knowledge. In the "Bedside Medicine" period from 1770 to the turn of the century, the "sick-man" was conceptualised as a total person, with no essential distinction presumed between his self-reported sensual, emotional and spiritual conditions and his physical conditions as observed by the attending doctor. Disease was defined by reference to "its external and subjective manifestations rather than its internal and hidden causes".\textsuperscript{8}


\textsuperscript{8} \textit{Ibid.}, p228.
all disease was presumed to be the result of some imbalance in the bodily system, the patient's own account of his or her condition was seen as a critical diagnostic tool.

In the "Hospital Medicine" period, when the centre of activity shifted from the domestic bedside to the large public hospitals, diagnosis was based on pathological anatomy, so that systematic observation and measurement of organic structures (signs) replaced the subjective reporting of the patient (symptoms). The medical perception of patients was transformed from independent individuals presenting with specific sets of conditions, to a cumulative series of cases which could be statistically recorded and classified within a growing taxonomy of diseases.

From "the middle decades of the 19th century", "Laboratory Medicine" represented Jewson's final stage towards the application of the theories and methodology of the natural sciences to the knowledge and practice of medicine. This is what Figlio refers to as the triumph of "mechanism", where the organism is seen as a set of separate parts, over "vitalism", where the organism is seen as an irreducible whole. Jewson argues that the discipline of physiology, utilising the principles of physics within research on living organisms, established the cell as the "fundamental unit of life", and diseases as specific configurations of inter-cellular processes. Clinical work focused on the use of cellular pathology tests on samples of body tissues and fluids to

9. The change in this period is analogous to the development of the "clinie" in the large hospital schools of Paris and Edinburgh in Michel Foucault's history (or "archaeology") of French medical knowledge. See Foucault, M. (1973), The Birth of the Clinic: An Archaeology of Medical Perception, (trans. by A.M. Sheridan), London: Tavistock, Chapter 4.

10. See Figlio (1977), "Historiography of Scientific Medicine...".
identify underlying disease processes. In this way, Jewson argues, "medical practice became an appendage to the laboratory", medical cosmology shifted from "person orientated" to "object orientated", and "the study of life [was] replaced by the study of organic matter".\(^{11}\)

There are some significant limitations imposed by Jewson's largely taxonomic approach. For example, it provides very little explanation of the actual mechanisms underlying this process of change in medical cosmology from one period to the next. The causes of these shifts in perceptions of the human body and the role of the patient are not explored. Moreover, there is no attempt to relate the perceptual shifts to the operation of social forces beyond the confines of medicine, such as the economy or the developing systems of political institutions. Jewson himself explicitly acknowledges such limitations.\(^{12}\) However, his work firmly establishes both the attachment of Western medicine to the natural sciences, and rational, quantitative methodology as the driving force of its cognitive basis.\(^{13}\)

Despite its broadly acknowledged advantages over the Galenic model, the bio-medical model of medicine, now as then, is problematic in its incorporation of the Cartesian separation of mind and body. Such a

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separation is strongly evident in both Harvey’s systemic analogy\textsuperscript{14} and Jewson’s categories of Hospital and Laboratory Medicine. On the one hand, its systematic and quantitative methodology provided quicker, more accurate diagnosis and pathology - although, as we see below, it did not immediately produce more effective treatments. On the other hand, the interdependence of mind and body is clearly demonstrable in everyday experience, as for example, when we decide (mind) to take a step or wave our hand (body), or when we physically shudder at the thought of something gruesome or disturbing.

Even within the confines of modern scientific medicine, this separation produces significant problems. For example, outcomes attributed to the placebo effect defy explanation in terms of pathology or physiology.\textsuperscript{15} Similarly, effective clinical outcomes are often produced by "non-scientific" therapies such as acupuncture, chiropractic and naturopathy. Indeed "alternative", holistic approaches to health, many of which have large numbers of clients testifying to their high levels of clinical effectiveness, can be distinguished from bio-medicine precisely because they reject the Cartesian duality of mind and body, and focus on the human being as an indivisible combination of both.\textsuperscript{16}

However despite these problems, the discourse of modern medicine remains rooted in rational, scientific knowledge derived from empirical

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observation and experiment. Explanations for this development tend to depend on a recurring set of determinants, but vary considerably in the weighting they give to particular elements. For example, some explanations (including neo-Marxist ones) give most prominence to the mutually supportive compatibility between the interests of the emerging bourgeoisie and the individualist ideology of a science of medicine based on germ theory. Within this school, Berliner for example, argues that:

[s]cientific medicine was not only similar to industrial production, it also validated capitalist production norms. Scientific medicine, therefore, tended to both legitimate and reflect the existing social order.

With germ theory as its cognitive centre, scientific medicine "helped to deflect responsibility for disease away from the [capitalist] social system and lodge it within the individual. Pathology was cellular, not social".  

Others emphasise the efficacy of treatments based on scientific theory - such as Lister's antiseptic techniques in surgery in the 1860s - as the principal source of medicine's legitimacy and of its ultimate endorsement by the state. In these approaches, which contain elements of technological determinism, the apparent link between

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such developments and the dramatic decline in mortality rates helped to secure the dominance and authority of medicine as a certified branch of the natural sciences.\textsuperscript{19} However, while there certainly was a significant decline in deaths from post-operative infections, the bulk of the decline in mortality rates during the latter half of the nineteenth century was in the area of infectious disease.

As the evidence from the historical epidemiology of McKeown and others strongly suggests, it was not so much the medical application of germ theory which produced this decline, but rather the series of extensive public health measures put in place in the preceding period, in the form of clean water supplies, sanitation and drainage, building regulations and occupational safety legislation.\textsuperscript{20} Indeed, at a statistical level, the developments in bacteriology had no effect on the general rates of success in treating infectious diseases in humans until the 1930s, with the exceptions of smallpox and diptheria.\textsuperscript{21}

This general argument suggests that, even though the bulk of effective treatments had yet to flow through from the experimental and theoretical work, such a strong association developed between the new scientific medicine and the rapidly declining mortality rates, that medicine's science-based legitimacy has persisted through to the

\textsuperscript{19} For example, Pensabene, T.S. (1980), \textit{The Rise of the Medical Practitioner in Victoria}, Research Monograph No. 2, Health Research Project, Canberra: ANU.


present. Berliner argues that the widespread support for scientific medicine was based on the achievements of science in areas outside medicine, so that

[j]t was a faith in science and what the word implied, much more than an implicit belief in this new mode of medicine that led to its public acceptance...If scientific medicine could not deliver, it could certainly promise.22

Similarly, Larson argues that the rational scientific basis on which modern medicine was developed gave the medical profession a level of occupational legitimacy denied its non-scientific rivals. She suggests that medicine’s science base

not only produces a more formalized language but also links a profession to the dominant system of cognitive legitimation. A scientific basis stamps the professional himself (sic) with the legitimacy of a general body of knowledge and a mode of cognition, the epistemological superiority of which is taken for granted in our society.23

In Foucault’s account, the development of medical discourses in the language of Western rational science, in itself constitutes the power of the medical profession. Technological developments facilitated the "clinical gaze" of medicine,24 and, as part of a wider apparatus of surveillance and control of the body, provided doctors with a crucial role in defining social reality and identifying deviance.25 Whatever the precise mechanisms involved, most accounts ultimately attribute the authority of medical knowledge to its general compatibility with the

22. Ibid., p36.


24. Foucault (1973), Birth of Clinic...

broader social paradigm of science, rationality and reason that has been the western world's dominant mode of thinking for the last three to four hundred years.26

Science, the state and social policy
The development of this "Age of Reason" and the dominant paradigm of rational science had considerable implications for role of the modern state. Under this paradigm, and as the state's activities and interventions expanded into more and more areas of social life, the state's policy responses became increasingly characterised by the search for "scientific" solutions which attempted to avoid the destructive clashes between competing values and groups in society.

In the general area of social policy, the implications of the "Age of Reason" for the operations of the modern state are most directly addressed in the work of Offe and Habermas.27 Although each gives it a different level of prominence within his theoretical schema, both argue that one of the main rationalisation strategies for western states has been the "scientization of politics". In order to cope with the organisational problems of increasing political demands and decreasing or fragmented state resources, liberal democratic governments have tended to encourage the "authoritative participation of scientific experts in the development and evaluation of political programmes".28

In this way, essentially social or political problems generating a large number of diverse, competing and often contradictory possible solutions, are reformulated as technical problems with one best solution. The technical status attached to such policy solutions makes them difficult to challenge except from within the same discipline, using the same technical terms and criteria. Moreover, difficult demands placed on the state can be postponed by diverting them to expert inquiries and assessments; or they can be disregarded or marginalised by defining them as scientifically unsound.\(^{29}\)

This view is a specific extension of Weber's concept of rationalisation, whereby instrumental rationality (ziekkrationalitat) increasingly underwrites power, authority and social policy, while socio-political action directed by shared values (wertrationalitat) correspondingly declines. Weber presaged Offe and Habermas in that his main misgiving about rationalism, as Hillier points out, is not so much that the ziekkrational form will dominate, but that "problems which are questions of value (wertrationalitat) become defined as technical questions (ziekkrationalitat)".\(^{30}\) The "scientization" argument also reflects Offe and Habermas's strong connections to the critical theory of the Frankfurt school, and in particular to Marcuse's conception of the essentially political character of the technical.\(^{31}\)

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Despite their views on its increasing incidence, neither Offe nor Habermas view the "scientization of politics" as a particularly effective state strategy for reducing the political conflict over social policy. Indeed Offe, for example, sees such conflict as "provoked and intensified" by these strategies, rather than reduced or modified by them.\textsuperscript{32} This view is readily supported by the history of social policy developments in capitalist states since World War II, and the continuing - even increasing - political discord over social and economic policy which characterises such states.

Offe contends that the "contradictions of the welfare state", arising from its coinciding and opposing functions of (capital) accumulation and (political) legitimation, undermine the state's capacity to perform such functions "simultaneously and successfully for any length of time".\textsuperscript{33} However, the continued political stability of the major capitalist states, despite "fiscal crises" flowing from persistently low economic growth and worsening recessionary indicators, demonstrates that Offe has underestimated the ability of the apparatus of the state to "muddle through" (in Lindblom's earlier phraseology\textsuperscript{34}) from crisis to crisis, evidently overcoming its contradictory functions. And as Held notes, Offe's argument also underestimates the capacity of state administrators to formulate and


\textsuperscript{34} Lindblom, C.E. (1959), "The science of muddling through", Public Administration Review, 19, 2, pp79-88.
actively pursue their own coherent political strategy despite their contradictory functions.  

Although the modern capitalist state has remained intact, the question of the effectiveness and long-term viability of its social policies remains open. This is particularly so in the case of health policy, where the relationship between increasing spending pressures and verifiable health improvements is at best tenuous, and the entrenchment of curative medical services as the cornerstone of health budgets has effectively precluded significant increases in longer term investment in preventive health services.

**Health policy and rational science**

It is argued in this chapter that health policy under the Hawke and Keating governments continues a long Western tradition of trying to find technical fixes for social problems, despite all of the problems and limitations that this involves. The experts that successive governments tend to rely on for policy advice, formulation, implementation and legitimation in the political minefield of health are very often members of the medical profession - whether in private practice or within state health bureaucracies. Even though Labor has made some limited attempts to reduce its reliance on medical advice in health - for example, by appointing non-medical Health Department heads, or by formally encouraging the policy participation of health consumer groups - there seems to have been little change in the political

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community's perception of a necessary link between science and state action in health. As some of the case studies illustrate, the radical or more holistic approaches to health and illness associated with such personnel are almost invariably pushed aside in favour of the traditional "medical model".

This is not simply the result of "false consciousness" on the part of the state, or a measure of its depleted autonomy in pursuing its own political strategy. As Douglas points out, there is a very strong and persistent public demand for such technical fixes to social problems. Such demand directly contributes to the maintenance the state's political reliance on technical fixes in formulating policy responses to health related issues. In this sense, the state's continued use of technical solutions in health both reflects and determines the political community's demand for them.

The expertise underlying this reliance is derived from the formal medical-scientific knowledge that forms part of the essential criteria for state-sanctioned membership of the profession. This is a distinctly rational, scientific approach to health policy, and both reflects and actively consolidates the "medical dominance" of the health system. In Willis's terms, the medical profession not only has autonomy over its own work and authority over the work of other health workers; it also has sovereignty over the relationship between health matters and society at large, so that doctors are the "institutionalised experts on all matters relating to health".  


In accepting this position on the relationship between health policy and rational science in general, and medical science in particular, I do not contend here that it is ideas alone which generate the material history of medicine and act as an index of the power of doctors. Nor do I contend, conversely, that the material history of medicine totally directs medical knowledge. In this context I follow Foucault in conceding that in many situations it is very difficult to completely separate the concepts of power and knowledge, because in practice each implies the other, is dependent on the other and shapes the other. Foucault suggests that we need to abandon the traditional notion of the objective, disinterested scholar studying aspects of knowledge and power as conceptualisations that are separate both from him/herself and from each other:

...we should abandon a whole tradition that allows us to imagine that knowledge can exist only where the power relations are suspended and that knowledge can develop only outside its injunctions, its demands and its interests. Perhaps we should abandon the belief that power makes mad and that, by the same token, the renunciation of power is one of the conditions of knowledge. We should admit rather that power produces knowledge (and not simply by encouraging it because it serves power or by applying it because it is useful); that power and knowledge directly imply one another; that there is no power relation without the correlative constitution of a field of knowledge, nor any knowledge that does not presuppose and constitute at the same time power relations.38

Because of this fundamental interdependence, we can often get no sense or understanding of one without reference to the other. Indeed Foucault often uses the term "power-knowledge" ("pouvoir-savoir") to

emphasise this fundamental unity, while Armstrong refers to it as the "irreducible dyad".

As Stephen Turner points out, there can be a danger in this approach of "simply collapsing the category of 'power' into the (suitably enlarged) category of 'knowledge'". If, he argues, we follow Foucault and extend the concept of power to include the actions and practices of science which transform our understanding of the world; if the changes produced by scientific inquiry to our view of the natural world also change the reality of both the natural world and our social world, so that those changes "structure the possible field of action of others", then we are left with little means by which to link the concept of power to the concept of political ends. Such a process of "depoliticizing power" not only extends the concept of power/knowledge so broadly as to be almost meaningless, but also sits very uncomfortably with the historical evidence of an organised, articulate medical profession, actively protecting its economic, industrial and ideological interests in negotiations over Federal and State health policy.

In the context of testing the links between the power and the knowledge of the medical profession in influencing health policy, the significance of this danger is considerable. However, a central argument of this thesis is not that the medical profession wields no power within the political system, but rather that its policy influence

39. Ibid.


42. Ibid., especially pp536-541.
does not reside only in its strength as an active interest group lobbying within that system. It is argued that such influence is also located in the medical profession's position as the sole legitimate holder of medical knowledge, with exclusive state-sanctioned rights to practice the treatments and therapies derived from such knowledge. Further, each dimension of this policy influence precisely expresses the other, so that in seeking to account for doctors' role in shaping health policy, it is unnecessarily limiting to examine their interest group activities without simultaneously examining the authority given to those activities by the status of doctors as the preeminent experts in matters of health.

Thus while I strongly support the interdependence of power and knowledge implied by Foucault's concept of "power/knowledge", the analysis of the case study materials is not essentially Foucauldian. The term power/knowledge is used in this research in a qualitatively different sense. Whereas Foucault's "power/knowledge" refers to the locus of power in the context of regimes of truth, normalising discourses, and historically distinctive constructions of the subject, the term is used here to refer to the expansion of standard political science and public policy conceptualisations of power to embrace policy influence over the state which derives from the medical profession's exclusive control over the knowledge and expertise of modern medicine. Accordingly, political power theories in this current work are to some extent articulated with theories on the social nature of knowledge - especially scientific knowledge. However, while the

underlying rationales may differ, the general consensus with Foucault that power and knowledge can never be meaningfully separated remains intact.

As discussed further below, in the modern development of empirical research and theorising in the area of medicine as a social phenomenon, there has been a tendency to emphasise the power aspects of medical influence to the exclusion - or marginalisation - of knowledge aspects. Within these perspectives, some Australian examples of which are outlined in the previous chapter, the medical profession is constructed as either an organised, pluralist interest group with an historically high level of political efficacy in its negotiations with the state; or as a crucial structural policy influence intrinsic to capitalism or advanced industrialisation, and so essentially beyond the direct control of the state and the political system. The contribution made by professional knowledge and expertise controlled by the profession tends to be either ignored or presumed negligible.

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Beyond interest group power

In order to more fully integrate the role of expertise into an explanation for the policy influence of the medical profession, we need a body of theory which can successfully link concepts of specialist knowledge to conventional concepts of political power. Marxist theory is not very satisfactory in this regard, because its central concept of power in Western societies, based on a hierarchy of classes within the structure of the capitalist system of production, is essentially about economic power, and does not readily lend itself to the notion of knowledge-based classes within that structure. Indeed, as we see in more detail below, much of the effort to apply Marxist theory to modern capitalist states is directed towards defining the class position of the growing numbers of middle-level and professional occupations — including the medical profession — who do not sit comfortably within either the capitalist class category or the working class category.

Pluralist conceptions of power are also of limited use in this regard, for no fundamental distinction is made between the political power of one interest group and that of other interest groups. While it can acknowledge different levels of resources and success between interest groups in acting politically to protect their interests, pluralism explicitly rejects the notion of any one group dominating over time because of some extra-political resource — such as knowledge or expertise. Under the pluralist perspective, political power is, over time, distributed more or less equitably amongst all interest groups, with no tendency towards cumulative power concentrations. This perspective opposes the very notion of "medical dominance", and contains no means by which to link medical knowledge to the historically high
levels of policy influence enjoyed by the medical profession in Australia and other Western nations.

Weberian theory offers some hope here, because it explicitly acknowledges expertise as a component of power and market control within the general process of bureaucratic rationalisation in Western societies. For example, "[b]ureaucratic administration means fundamentally the exercise of control on the basis of knowledge...technical knowledge, by itself, is sufficient to ensure it a position of extraordinary power." However, as we see below, Weberian theory provides no guidelines for adequately explaining how some groups with one form of expertise gain market control, while others with different forms of expertise do not. Moreover, the organisation of the medical profession is often inconsistent with the criteria for Weber's ideal-type of rational bureaucratic administration, especially those relating to remuneration, promotion and discipline.

Three dimensional power
A very useful method of linking power and knowledge is provided by Steven Lukes's concept of the three "dimensions" of power. His "first dimension" of power embraces the pluralist interest group approach outlined above, and involves:


46. Ibid., pp333-334.

a focus on *behaviour* in the making of *decisions* on *issues* over which there is an observable *conflict of (subjective) interests*, seen as express policy preferences, revealed by political participation.48

The locus of "first dimension" power is traced by the decisions emerging from the open process of conflict resolution through the formal institutions of the political system. This makes the gathering of empirical evidence to establish the presence of this type of power quite straightforward. The classic research using this approach is Robert Dahl's 1961 study, in which he finds that the distribution of political power in the town of New Haven in the areas of education policy, urban development and political nominations is widely diffused, with different identifiable groups and actors active in each area, and little evidence of overlapping membership or elite concentrations of power.49

Lukes's "second dimension" of power embraces Bachrach and Baratz's notion of "nondecision making", and represents a significant revision of the pluralist approach. Unlike "first dimension" power, "second dimension" power is evident during overt or covert conflicts between political actors involving actual issues or potential issues. It is not dependent on the presence of open, observable conflict, and is exercised where there is a "mobilisation of bias" within the institutional decision-making structure. Such a systematic bias is reflected in the operation of a covert, informal alternative agenda which consistently excludes some issues from the political process, and restricts the formal political agenda to "comparatively innocuous" issues which do not fundamentally threaten the *status quo*.50


Bachrach and Baratz are suggesting that to get a more complete picture of the operation and distribution of power, we need to examine not only what happens (as the pluralists do through decisions on "key issues" and the observed behaviour of officials and politicians), but also what does not happen.

The major difficulty with trying to empirically establish the occurrence of "nondecision making" forms of power, as Polsby points out, lies in the presence of alternative, equally viable explanations for the same policy outcome or decision. An issue may not be on the formal agenda because of deliberate, routine collusion between interested parties against the interests of other groups, in which case a form of "nondecision making" has occurred. On the other hand, it may not be on the agenda because there is a genuine, broad-based consensus on that particular issue rather than a conspiracy of silence, "in which case nondecision-making is impossible".

However, Bachrach and Baratz argue that their thesis can be empirically tested by looking for actors or groups with covert grievances about the issue under study which are not given recognition within the formal negotiation process. Where none can be identified, there is assumed to be a genuine consensus on the issue, rather than a "nondecision" form of power at work.


Very strong empirical support for Bachrach and Baratz's nondecision thesis emerged from Matthew Crenson's comparative study of air pollution policies in two adjacent steel towns in the State of Indiana.\textsuperscript{53} Whereas East Chicago enacted pollution control laws in 1949, such laws were effectively resisted in Gary until 1962. Crenson attributes the difference to the relatively high prominence of the US Steel Company within Gary's economy, which, through the mechanism of "anticipated reactions" (for example, that the corporation might decide to move its operations elsewhere), effectively precluded the issue of air pollution from entering the community's formal political agenda for at least a further decade.

Lukes's "third dimension" of power involves the shaping of people's needs or preferences when there is neither overt nor covert conflict present. Here the actors subject to the "third dimension" of power share an implicit value consensus with those wielding power, and have no active perception of their interests being compromised through decisions made under that consensus. "A exercises power over B when A affects B in a manner contrary to B's interests."\textsuperscript{54} Lukes suggests that such "latent conflict" would become explicit only if B were to become aware of his or her "real" or "objective interests" (as opposed to "subjective interests"). The actors who wield power in this conceptualisation are not necessarily those who make the formal decisions, but rather those who directly benefit most from the outcomes of such decisions. Precisely because preferences are shaped so that there is no observable conflict, the scope of this type of power


\textsuperscript{54} Bachrach, P. and Baratz, M.S. (1970), \textit{Power and Poverty}..., p27.
extends well beyond that of the other two, and is for Lukes the "supreme and most insidious" type of power.\textsuperscript{55}

There are two main limitations to this concept of power. First, because it is not tracked by observable actions and decisions, but rather by the distribution of benefits amongst political actors - that is, "who benefits?" rather than "who decides?" - there is some difficulty in precisely identifying who is exercising power. The broad interpretations that can be applied to the assessment of the overall balance of benefits means that this dimension of power is not very amenable to direct empirical evidence.

The second problem, related to the first, is contained within Lukes's notion of "interests". It is presumed here that political actors are aware of their "subjective" interests, but are incapable of recognising their "real" interests. The researcher or observer, on the other hand, can recognise both. The act of the researcher identifying what A's or B's interests are, or what promotes or compromises those interests, is inherently normative. As Lukes acknowledges, "the notion of 'interests' is an irreducibly evaluative notion".\textsuperscript{56} Lukes suggests that we can more accurately identify peoples' interests by considering the counterfactual: in a given situation where it is contended that "third dimension" power is in operation, what would people prefer, given adequate information and given the choice?\textsuperscript{57} If the answer is qualitatively different from existing arrangements, then this lends

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\textsuperscript{55} \textit{Ibid.}, pp24-25.

\textsuperscript{56} \textit{Ibid.}, p34.

\textsuperscript{57} \textit{Ibid.}, p34 (fn. 2), and p46.
support to the "third dimension" power thesis. If the answer tends more towards arrangements which are already in place, then the thesis is unsupported by the counterfactual. However, given that the scope of "third dimension" power is dependent on the size of the gap between the actor's "real" and "subjective" interests, significant difficulties remain in accurately measuring the extent of this type of power.

Despite these empirical limitations, we can usefully apply Lukes's concept of the third dimension of power to link medical knowledge to the policy influence of the medical profession. If as a society we tend to accept the primacy of medical knowledge in health policy - as the notion of "medical dominance" and the structure of health budgets suggest - and if in doing so it can be shown that our "subjective" interests are preserved while our "real" interests are compromised and those of the medical profession are enhanced, then we can safely conclude that at least part of the profession's influence is tied to this knowledge-based "third dimension" of power.

As illustrated in the case study chapters - most explicitly in the pathology study of Chapter Four - one of the "rules of the game" tacitly accepted by all policy players, is that any assessment of what are seen to be medical decisions or judgements must be implemented through peer review mechanisms. Under such mechanisms, only medically qualified people are seen as having the knowledge and expertise necessary to make such assessments; and as a corollary, people with lay or non-medical knowledges are not competent or entitled to scrutinise medical judgements. The case studies also reveal that peer review mechanisms tend to consolidate, or even extend, the scope of
doctors' occupational autonomy and self-regulation, while simultaneously limiting the effectiveness of policy reforms aimed at constraining health expenditures through higher levels of public accountability. The privileging of medical knowledge imposes limitations on the range of remedies seen by political actors as possible or appropriate, and compromises the "real interests" of the public to the direct benefit of the medical profession.

As Lukes acknowledges in a later work, these limitations on the perception of actors are part of the economic, cultural and political structure of the society in which the actors exist. As such, they are not examples of actors or groups consciously exercising a particular type of power. Rather, they are part of an institutionalised power, expressed not in the specific actions of individuals or groups, but in the form of an inbuilt bias in the distribution of resources and priorities towards one set of interests and against others.\textsuperscript{58} The argument throughout this thesis is that such a systematic bias towards medical interests in Australia is based on the medical profession's exclusive bearing of a body of knowledge and expertise which is widely and uncritically accepted as technical and universal, rather than interpretive and laden with political values disguised as impartial medical judgements.

Medical sociology and the sociology of the professions

Most of the work directly concerned with the nature of medicine and the social influence of the medical profession has tended to fall within the sub-disciplines of medical sociology and the sociology of the professions. While the former is more directly concerned with assessing the social structure of medicine, the latter developed as a specialism of the wider branch of the sociology of occupations and work. However, that part of the sociology of the professions specifically relating to the medical profession is intrinsic to both the empirical research and the theoretical bases of medical sociology; for, as Freidson points out, and as the case studies that follow illustrate, "the most important single element in the social structure of medical care is the medical profession itself". 59

In much of the literature on medical sociology and professionalisation, power and knowledge are treated as independent phenomena or separate realms. In attempting to explain the disproportionate influence of the medical profession in the field of health, this literature has tended towards one of two schools. The "attributes" school - or the "taxonomic approach" as Klegon refers to it 60 - distinguishes professions from other occupations by reference to a set of essential characteristics, first systematised by Carr-Saunders and Wilson in their seminal 1933 study of the British professions, 61 and then further


developed by US writers such as E. Greenwood, B. Barber, H.L. Wilenski, Talcott Parsons and W.J. Goode.\textsuperscript{62} These essential characteristics generally include a specialised body of theoretical knowledge gained through a prescribed university course, and a set of ethics which orients professional practice towards altruism and service rather than profits and self-advancement.

As Johnson points out, there are two distinct variants within this school - based on the "trait" model and the "functionalist" model.\textsuperscript{63} The first simply attempts to develop a list of core attributes that serves to distinguish the professions from other occupations. The second, more systematic variant attempts to limit core attributes to those which perform a specific function within the social system or within the relationships between professionals and clients. Here the influence and prestige of the professions - and the market monopoly they enjoy - are formulated as a Durkheimian trade-off for the social integration functions performed by them. Talcott Parsons for example, contends that the community service ideal of the professions helps to stabilise free enterprise societies fragmented by competition and individual self-interest.\textsuperscript{64}

\begin{flushright}
\end{flushright}


The "occupational control" or "conflict" school developed in the US and Britain from the late 1960s as a critical response to the "attributes" and functionalist accounts of professionalisation. According to Bryan Turner, this approach was first evident in the work of Everett C. Hughes, and was later developed most notably by Eliot Freidson (US) and Terry Johnson (UK). The proponents of this school are critical of the "attributes" school at two levels. First, they argue that the definition of essential professional attributes remains problematic. Not only is there limited consensus on which attributes are essential (and therefore which occupations can be usefully demarcated as professions), there are also considerable difficulties in precisely specifying the empirical criteria for those attributes. For example, as Freidson points out, Goode's "attributes" schema identifies one of the "core characteristics" as "a prolonged specialized training in a body of abstract knowledge". Any attempt to finely delimit the terms "prolonged", "specialized" and "abstract" must, argues Freidson, ultimately result in some occupations generally accepted as professions being omitted (such as law, by merit of the "abstract" term); and others generally rejected as professions being included (such as some areas of nursing, by merit of all three terms).


The "occupational control" school also suggests that the lists of professional attributes are often directly derived not from empirical evidence, but from the professions' own assessments of themselves. As a result, they tend to incorporate rhetorical and ideological components which require political analysis rather than uncritical acceptance.68 As Larson points out, "these ideal-typical constructions [of the "attributes" school] do not tell us what a profession is, but only what it pretends to be".69

Second, the "occupational control" proponents reject the notion of profession as an occupation placed somewhere along a spectrum, at one end of which is an ideal structure. Rather than analysing a static structure, this school concentrates on the underlying process. The dynamics of professionalisation in developing a knowledge base and gaining a legitimate market monopoly - a process involving occupational selection, control and exclusion mechanisms - can reveal the social and political influence of professional occupations and their relationship to various elite groupings. The focus here is on the strategies used to map out an exclusive, state-sanctioned occupational territory and to maintain autonomy over work within the division of labour. In this approach, unlike that of the "attributes" school, the interests of the professions and their clients do not necessarily converge. Indeed, given the social distance created by the


dependence of clients on the skills of the professional, their interests are more likely to diverge.

In these characterisations of the "attributes" and "occupational control" approaches to the professions, knowledge and power, as noted above, are treated largely as independent factors. Turner, for example, contends that

[In the first position, knowledge is the dominant criterion and occupational power is irrelevant. In the second position, occupational dominance is central and a systematic body of knowledge is irrelevant.]

However, the separation may not be as complete as Turner suggests, for there are significant areas of conceptual overlap between the two schools. For example, while the "attributes" school lays claim to the code of ethics as a core distinguishing feature of the profession, it can be equally argued that such a code forms a critical part of the profession's occupational strategy. A code of ethics, and the general motivation of altruism it implies, underpins an occupation's claim to autonomy over its work, free from regulation and supervision by 'outsiders'. However, it also acts as a mechanism of disciplinary control over its members to reduce and manage internal conflicts. This helps the profession to project a consistently strong image of solidarity and determination, and can bring material advantages to the profession by strengthening the power of its bargaining position in negotiations with, say, government agencies over accreditation arrangements.

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Similarly, the abstract, theoretical component of the training criterion which the "attributes" school emphasises can equally be regarded as part of the professionalisation strategy which is at the centre of the "occupational control" school's approach. As Freidson contends,

the reasons for inventing courses in theory in the training schools of ambitious occupations are utterly transparent, the popularity of courses in theory in professional schools is notoriously low, and the actual work of professional practitioners is far more often concrete than abstract.71

By implication, Larson agrees with Freidson on this point, and argues that

[c]ognitive rationality cannot be formally treated as an isolated attribute of profession, for it never appears in pure form; it is always embodied in the institutions for professional training, selection, and control and is often evident in the midst of political struggle.72

In other words, the rationality so consistently espoused by the professions occurs as both an attribute and a political resource. Indeed, Larson goes further, and suggests that the "visible characteristics" of professions should always be considered from two perspectives: "first, as structural elements of the general form of the professional project [i.e. professionalisation], and second, as specific resource elements, whose variable import is defined by different historical matrices".73

Also common to both schools is the problem of accurately defining the concept of profession. While the "occupational control" school's shift to a focus on process has certainly opened up the field to wider theoretical analysis, even Johnson concedes that the problem of

73. Ibid., p208.
definition remains.\textsuperscript{74} In his work, Freidson partly resolves the problem by reference to the historically and geographically contingent nature of the concept of profession. He points to the qualitative variations which exist across different periods and between different cultures and regions, in particular between continental Europe and the US and the UK, and between eastern and western Europe.\textsuperscript{75}

Accepting Becker's assessment of the phenomenon of profession as a "folk concept", Freidson suggests that current, official, localised definitions provide the best surrogate measure, providing a high level of socio-historical legitimacy. For his context, Freidson uses the classification system of the US Bureau of Census to demarcate professional occupations, noting that it is something of a "frail vessel" with limited scope for generalisation beyond the US.\textsuperscript{76} For our more specific purposes here, the category of profession is a little less frail, for in its "folk concept" form, as an Australian Bureau of Statistics (ABS) labour market classification, and in virtually all Australian, British, European and US accounts, the occupation of medicine is securely recognised as a profession.\textsuperscript{77}

\begin{itemize}
\item\textsuperscript{74} Johnson (1972), \textit{Professions and Power...}, p31.
\item\textsuperscript{76} Freidson (1986), \textit{Professional Powers...}, p37.
\item\textsuperscript{77} Larson's account perhaps qualifies this claim with her view that the medical profession is historically exceptional in its degree of autonomy and resistance to incorporation within bureaucratic structures. For Larson, engineering is the model profession, while medicine is essentially atypical of the category. Larson (1977), \textit{Op. cit.}
\end{itemize}
Neo-Weberian approaches

In their attempts to locate the nature and power of the professions within a theoretical framework, writers in the "occupational control" school have, like sociologists in general, tended towards two main groupings: neo-Weberian and neo-Marxist. The neo-Weberians generally view professionalisation strategies as specific applied instances of Weber's concept of social closure, whereby groups attempt to control the market for their product or services by restricting group membership on the basis of selective criteria, thereby limiting competition and maximising per capita returns. Thus Parry and Parry, for example, define professionalism as

a strategy for controlling an occupation in which colleagues set up a system of self-government and restrict recruitment through the control of education, training and the process of qualification. Thus professionalism provides a means whereby a degree of monopoly with respect to the provision of particular types of services in the market place can be obtained.78

Freidson directly acknowledges the role of Weberian concepts and theory in his work,79 including the process of rationalisation, rational-legal authority and the tensions between professionals and bureaucratic organisational structures. His arguments locating the essence of professional power in state-sanctioned autonomy over the content and terms of work are not explicitly formulated in terms of Weber's concept of social closure, but are certainly fully consistent with it. Indeed, it is precisely these characteristics of the medical profession which establish and maintain its monopoly control over


79. For example, Freidson (1986), Professional Powers..., p3.
what Freidson refers to as the "medical marketplace". In a later work, Freidson explicitly uses the term social closure, albeit without direct reference to Weber, to help delineate his specific criteria for the "professional category".

Other writers are at least partly Weberian in approach. Larson, for example, defines the "professional project" in terms of historically specific attempts by individual occupations to control markets and gain status. However, her argument that professions fulfil an important ideological function in bourgeois capitalism - appearing as a demonstration of equal opportunity while simultaneously legitimating structural inequality - and her notion of the proletarianisation of professionals within bureaucratic corporate structures, involve concepts which belong more to a neo-Marxist than to a neo-Weberian approach.

Terry Johnson also sits a little uncomfortably in the neo-Weberian school. In his earlier work, he conceptualises professionalism as one of three possible processes by which an occupation achieves control over its market, involving producers effectively defining the needs of their clients and the conditions under which services are provided.

80. Freidson (1970a), Profession of Medicine..., pp304-305.


83. See also Larson, M.S. (1980), "Proletarianization and educated labor", Theory and Society, 9.1:131-175; Larson, M.S. (1979), "Professionalism: Rise and Fall", International Journal of Health Services, 9.4:607-627. Further to this ambivalence in Larson's approach to the professions, Murphy suggests that she has made a "Marxian translation of her implicitly Weberian analysis", this being an instance of a wider trend of the 1970s in which "there were many neo-Weberians masquerading as neo-Marxists". Murphy, R. (1990), "Proletarianization or bureaucratization: the fall of the professional?", in R.Torstendahl and M.Burrage (1990), Op. cit., pp71-96, at p90.
(The other two modes of occupational control are "patronage" and "mediation"). While making no explicit mention of Weber in this context, his argument is congruent with Weberian theory and the concept of social closure. However in his later work, Johnson criticises Weberian approaches for their failure to explain how specific occupations gain control of their market and become part of a new middle class. Similarly, he locates the weakness of his earlier work in its lack of "an adequate theory of class relations" that would allow the conceptualisation of the conditions necessary for each of his categories of occupational control to emerge.\textsuperscript{85} While he is careful to separate Weberian approaches to the professions from Weber's own work - indeed he gladly adapts Weber's concept of heteronomy to his "mediation" form of occupational control\textsuperscript{86} - his later emphasis on a class based analysis of professional power places him more firmly within the neo-Marxist school.\textsuperscript{87}

**Neo-Marxist approaches**

While the neo-Weberian approaches to the professions stress market control, neo-Marxist approaches focus on the relations of production under modern monopoly capitalism. Here the emphasis in the sociology of the professions is on the attempt to satisfactorily position

\textsuperscript{84} Johnson (1972), Op. cit.

\textsuperscript{85} Johnson (1977a), "Professions in Class Structure...", pp:105-106.

\textsuperscript{86} Ibid., pp:109-110, fn:12.

professional occupations within the class structure: do the functions they perform and the interests they represent within a capitalist liberal democracy most accurately identify them with the working class, with the capitalist class or with a new, intermediate class? The difficulty of accommodating them wholly within either the working class or the capitalist class has produced several attempts to place them in a new intermediate class.

Barbara and John Ehrenreich for example, frustrated at traditional Marxist patterns of condemning class-ambiguous groups to the residual class of petty bourgeoisie - or in the case of Poulantzas, the "new petty bourgeoisie" - formulated the "Professional-Managerial Class (PMC)" as a solution to the theoretical difficulty. This class is comprised of professional, technical and managerial workers, and is distinguished from the old middle class category for tradespeople, farmers and the self-employed by its antagonism to both capital and labour. Members of the PMC "do not own the means of production and [their] major function in the social division of labor may be described broadly as the reproduction of capitalist culture and capitalist class relations".

Other efforts in this regard have attempted to place professionals in both worker and capitalist classes. Erik Wright, for example, developed the concept of "contradictory class locations", whereby professionals could be located "simultaneously in two classes and


thus share basic class interests with both of these classes". However, Wright is careful to emphasise the clear distinction in Marxist theory between occupation and class. An occupation is a position "defined within the technical relations of production", and so is a category, while class is "defined by the social relations of production", and so is a relationship. Class location can be determined therefore "only in terms of their social relationship to capitalists, not in terms of the technical content of their laboring activity". Thus for Wright, medical practitioners could be located in any of a number of different class positions, depending on their specific conditions of employment. Reworking his example based on the carpenter, "worker-doctors" are employed on salaries, and lack "significant control over their labor process"; "petty bourgeois doctors" are self-employed and sell medical services directly to consumers; and "manager-doctors" are salaried workers who "control the labor of other [doctors] within production".

Finally, other neo-Marxist writers have attempted to synthesise both of these strategies. Carchedi, for example, draws the essential line of class division between those whose work performs the "global function of capital" and those whose work performs the "function of the collective worker". The "new middle class" comprises those who "while not owning the means of production, perform the global function of capital". However, adding a new twist to similar accounts, Carchedi argues that "by far the most important part" of this class consists of


91. Wright (1980), "Class and Occupation...", pp177-178. Interestingly, although he argues that class and occupation "occupy basically different theoretical spaces", Wright then proceeds to empirically quantify "the distributions of occupations within class categories and the distributions of classes within occupational categories" in the US. Ibid., p186.
those who simultaneously perform "both the global function of capital and the function of the collective worker".  \(^92\)

Part of Johnson's later work attempts to explicitly apply Carchedi's analysis and categories to the medical profession. Professionalism, the mode of occupational control exerted by doctors, becomes possible only where

core work activities fulfil the global function of capital with respect to control and surveillance [of the working class], including the specific function of the reproduction of labour power. The professionalism of medicine - those institutions sustaining its autonomy - is directly related to its monopolisation of 'official' definitions of illness and health. The doctor's certificate defines and legitimates the withdrawal of labour.  \(^93\)

Johnson argues that as the state has taken a central coordinating role in the reproduction of labour power under monopoly capitalism, the medical profession has been able to successfully develop its professionalism strategy of control and autonomy - for example in its command over definitions of illness and health - precisely to the extent that this strategy is congruent with the capital requirement of the reproduction of a stable, healthy workforce.

Thus for Johnson, as for the majority of neo-Marxist writers - whatever their solution to the ambiguous class location(s) of professionals - the ultimate source of the medical profession's prestige and power is not to be found in its cognitive knowledge base, nor in its activities as an organised interest group seeking state-sanctioned

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\(^{93}\) Johnson (1977a), "Professions in Class Structure...", p.106.
market monopoly, but rather in its implicit dependence on the interests of capital. Just as the extent and the restrictions or benefits of the alliance are not agreed on, neo-Marxist projections as to the future development of the medical profession also show considerable variation. For those who would locate the profession within the working class or within a new class antagonistic to the interests of capital, doctors will be increasingly subject to the processes of deskilling and proletarianisation. For those who would locate the profession within the capital class, or in a separate class with interests compatible with those of capital, the position of doctors will remain securely linked to the system of hegemonic domination under the capitalist mode of production, and would only be threatened under a change towards a fully developed socialist mode of production.

This is generally analogous to the position of the neo-Marxist medical sociologists, epitomised in the work of Vicente Navarro. The central difference here is that, for Navarro, the class position of the medical profession is not so much a problematic to be explored as a pre-given

94. Johnson (1977b), "What is to be known? the structural determination of social class", Economy and Society, (May), 6, 2: 194-233.

assumption. Whatever the details of the relationships between doctors and other classes, the whole complex of medicine is subsumed within the logic of capitalism. Medicine is formulated as part of the superstructure determined by the economic base, and as such is ultimately shaped and directed by that base rather than by any of its own internal dynamics, organisation or influences.96

In the political economy approach characterising this neo-Marxist position, the patterns of illness and death are directly related to the nature of capitalist production. The drive for profits and the exploitation of waged labour produce conditions of work that result in class-based patterns of illness and death, so that the needs of capital are directly opposed to the health needs of the population.97 The underlying need for a healthy workforce is mostly satisfied through the activities of the state in providing or underwriting health and welfare services, into which medicine is necessarily co-opted.

However, despite these differences of emphasis, the neo-Marxists eventually converge on the position that "in the last instance" it is the structure of economic relations that determines the role of the medical profession. The agency of doctors themselves - in their professional organisation, knowledge and practice - is made clearly subordinate to that overarching structure. Through the case studies that follow, I seek to temper this formulation by providing empirical evidence suggesting not only that doctors' interests and those of capital can


97. For an Australian account in this style, see Taylor, R. (1979), Medicine Out of Control, Melbourne: Sun Books.
diverge, but also - in the case of the pathology reforms - that they can be mutually opposed. Moreover, these case studies suggest that the practice of medicine, and the health policies which frame that practice, are located within a capitalist economy but are not always ultimately dependent on the economic structure or the requirements of capital. Rather, they can be more determined by the agency of doctors as active interest groups, combined with their exclusive control of science-based medical knowledge and expertise.

Medical knowledge and indetermination

One concept that has often been deployed to help account for the interdependence of knowledge and power in medicine is that of indetermination. First developed in an influential paper by Jamous and Peloille,98 indetermination refers to those aspects of a profession's body of knowledge which are not amenable to standardisation and codification. These are referred to as the "virtualities" of the profession.

In the case of medicine, these represent the informal and non-systematic knowledges developed by individual doctors' extensive (usually) clinical experience with a wide variety of patients and conditions. These experience-derived knowledges form part of the profession's claim to a monopoly on the expertise needed for medical judgement. They are the intuitive skills which constitute the 'art' or 'mystique' of medicine, in which essentially personal and interpretive

assessments of individual cases as unique combinations of signs and symptoms predominate. In tandem with the more systematic science-based expertise, they form one of the "symbols of legitimacy" of medicine.\textsuperscript{99}

Jamous and Peloille's concept of technicality refers to the other parts of a body of knowledge "that can be mastered and communicated in the form of rules".\textsuperscript{100} These parts can be systematised and codified, and reduced to a set of universal, transmissable procedures and formulae, making them thereby vulnerable to administrative rationalisation. Jamous and Peloille argue that those professions in which the ratio of indetermination (I) to technicality (T) is greater than unity (that is, where I/T is greater than one) have the capacity to resist the processes of bureaucratic rationalisation threatening to impinge on their autonomy and authority. The indetermination ratio is in effect a measure of the capacity of a profession to control its expertise and maintain its autonomy.

Jamous and Peloille use the indetermination ratio to account for the medical profession's ability to resist external intervention and evaluation in the French university-hospital system. They argue that in this process, the profession is subject to two contradictory tendencies. On the one hand, the profession is required to formalise its knowledge into a systematic, scientific body in order to satisfy the dominant paradigm of (Parson's) "cognitive rationality", and the demands of the credentialing system. On the other hand, it is this very

\begin{itemize}
\item \textsuperscript{99} Johnson refers to these aspects of medical knowledge as the "structure of uncertainty". Johnson (1972), \textit{Professions and Power}.
\item \textsuperscript{100} Jamous and Peloille (1970), \textit{Op. cit.}, p112.
\end{itemize}
process which makes the profession's knowledge vulnerable to codification, and thereby to incursions into the profession's autonomy by external bureaucratic authority. In defence against such incursions, the indeterminate nature of its expertise is emphasised by the profession, in the form of ideologically based arguments and appeals to values outside the bounds of scientific rationality.

As Bryan Turner illustrates with the case of pharmacology, there can be a paradox in applying the indeterminacy ratio, in that one of the barriers to "successful professionalisation might be the presence of a knowledge base which is too systematic and coherent". The knowledge base of pharmacology is characterised as "too precise and systematic" to allow room for a significant level of professional judgement. He argues that the more successful professions have followed the general strategy of developing a "valid knowledge which allows for indefinite elaboration through interpretation".  

Indetermination, as seen in the pathology case study in Chapter Four, is a useful concept with which to explore the relations between power and knowledge in medicine, primarily because it seeks to elucidate their basic interdependence rather than treat them as separate domains. However, there are some problems with this concept which significantly limit its explanatory force. First, while Jamous and Peloilie indicate that the level of indeterminacy varies historically within the same profession, we have no guidelines by which to determine those specific conditions promoting or hindering the

development of indeterminacy. Is it, for example, simply the specific content of medical knowledge, and the health issues to which it is applied at the time, which enhances or reduces indeterminacy? Is it the historically contingent interest group power of the profession which can shape policy issues so that indeterminacy is at higher or lower levels? Or do particular configurations of elements within the structure of the health system, or the wider political system, variously influence the level of indeterminacy? Jamous and Peloille provide few clues as to how the concept of indetermination can be operationalised.

Second, the notion of neutral, technical knowledge is problematic, as the Frankfurt School pointed out, and as is discussed in more detail in the final section of this chapter. The point here is that in this schema, those parts of professional knowledge used in occupational strategies (or in the professionalisation process) are artificially restricted to those of an obviously social or ideological (that is, "indeterminate") character. There is no allowance for the possibility of knowledge labelled 'technical' to share such properties.

The third difficulty flows directly from the second. The separation of 'technical' knowledge from interpretive knowledge - the 'science' of medicine from the 'art' of medicine - is not only arbitrary, but also cannot allow for changes in the content of medical knowledge over time. The clinical practice of medicine often provides the empirical support for developments in the theory of medical science, while the latter, in turn, often engender changes to clinical practices. The processes involved in the interpenetration of theory and practice are central to the development of medical knowledge, and cannot be arbitrarily assigned to separate realms.
"Freidsonian" medical sociology

One of the central debates within medical sociology, since its development as a recognised sub-discipline after World War II, involves the differing - and in some ways opposing - notions of sociology in medicine and sociology of medicine.\textsuperscript{103} The former refers to the study of medicine from inside the discipline, where the fundamental concepts and categories of medicine are accepted as given, and the focus of activity is the delineation of social factors impeding or assisting its practice in the field. Sociology of medicine looks at medicine from outside the discipline, and rather than taking as given its knowledge and practices, regards them as valid subjects of sociological analysis in themselves.

Thus for example, many of the research projects in medical sociology in the 1950s and 1960s were aimed at pinning down social factors (such as class) which seemed to play a significant role in the onset of various categories of disease, and as such were largely exercises in social epidemiology.\textsuperscript{104} This is the sociology in medicine that characterised the early development of medical sociology in Britain, where researchers were often located within departments of medicine rather than separate departments of sociology.\textsuperscript{105} The turning point in

\textsuperscript{103} While the debate emerged in the 1940s, the terms sociology in medicine and sociology of medicine, and the distinction between them, were first formulated by Robert Straus in a 1957 article: "The Nature and Status of Medical Sociology", \textit{American Sociological Review}, 22 (April), p203, cited in Freidson (1970b), \textit{Professional Dominance...}, p41, 58.

the shift to the sociology of medicine approach arguably came with the publication of Freidson's *Profession of Medicine* in 1970. Here the analysis of illness and disease as the institutionalised products of professional interests and power relations "liberate[d] medical sociology from the confines of medically-defined categories".

In the context of this thesis, the distinguishing feature of Freidson's work is its analysis of both illness and disease as social constructions. Previous work in this area had tended to treat illness as subjective and socially based - for example, as a behavioural response, or as a labelling process to create a form of deviance. Disease, on the other hand, was accepted as an objective category - a biological reality. However, as Freidson's subtitle - *A Study of the Sociology of Applied Knowledge* - suggests, the knowledge base of the science of medicine, including its categories of disease, can be analysed as a product of the organised interests and power of the medical profession; so that "medical knowledge and procedures are themselves a function of the social character of medicine".

For example, he castigates some sociologists' approach to illness as deviance for their implication that

> there is some special sanctity to biological conceptions of illness that rules them out of sociology's purview. But that sanctity is not necessarily given by the scientifically "hard" qualities of medical knowledge and treatment.

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105. Although see Graham Scambler's case that there was a considerable amount of sociology in and of medicine in both the UK and the US during this period. Scambler, G. "Introduction". In G. Scambler (1987), Sociological Theory.... p2.

106. Freidson (1970a), *Profession of Medicine*....


Rather, it represents human agreement and consensus. Disease is put into a special category by [these] sociologists because they mistake extensive social consensus for facts independent of consensus.\textsuperscript{109}

This is generally congruent with Kuhn's notion of scientific paradigms, those metatheoretical models and normative background views implicitly developed within scientific communities through the consensual processes built into the practice of "normal science".\textsuperscript{110} However, Freidson seems to take the argument beyond Kuhn, and questions the very notion of a universal, trans-historical "fact" standing independent of its social context. Acknowledging that the level of consensus on the signs and symptoms of many illnesses is very high in modern medicine, he reiterates that such consensus:

\begin{quote}
does not make it any the less a social construction. In the case of physical illness, consensus is so extensive and taken for granted that we are inclined to impute to it a reality independent of our agreement.\textsuperscript{111}
\end{quote}

Similarly, he invokes the tradition of the sociology of knowledge (\textit{Wissensorzioologie}) expounded by Berger and Luckmann in \textit{The Social Construction of Reality},\textsuperscript{112} and contends that the conceptualisation of illness as a form of biological deviance is "essentially abstract and programmatic":

\begin{quote}
While we may subscribe to it as a measure of faith, we cannot rely upon it as our sole guide for analysis without wholly ignoring the interpretive character of social reality.\textsuperscript{113}
\end{quote}

\begin{footnotesize}
\begin{itemize}
\item \textsuperscript{109} Ibid., p214.
\item \textsuperscript{111} Freidson [1970a], \textit{Profession of Medicine...}, pp214-215, emphasis added.
\item \textsuperscript{113} Freidson [1970a], \textit{Profession of Medicine...}, pp206-208.
\end{itemize}
\end{footnotesize}
While Freidson certainly suggests taking this approach to the disease categories of medical and scientific knowledge, it is my contention that he is somewhat tentative and equivocal about it, and does little to develop it more fully as a base concept within his analysis of the power of the medical profession in the health services arena.\textsuperscript{114} I take this position on three main grounds. First, most of his discussion of the social aspects of medical categories is framed in terms of illness rather than disease, and of the variations in meanings attached to - and the management of - the same physical signs in changing social and historical circumstances. Second, it focuses on the problems facing the "everyday clinical practitioner" in making unambiguous diagnoses based on under- or over-representative selections of cases, and incomplete, inaccurate and sometimes morally censored, information from lay patients. Here the problem becomes the actual evidence available to the practitioner and the unreliability of the data derived from such evidence as to the incidence and seriousness of particular disease categories.\textsuperscript{115} As Freidson himself points out:

These comments [on the social construction of illness] have been designed more to point out than to actually grapple with the problem of the nature of the evidence available to the practitioner that in turn is responsible for shaping his concepts of illness.\textsuperscript{116}

\textsuperscript{114} Although to put Freidson's approach here in perspective, he makes it clear, in his later work, that he is "concerned more with an analytical description [of the professions' formal politico-legal institutions] than with creating a theory". Freidson (1986), Professional Powers..., page xii.

\textsuperscript{115} Freidson (1970a), Profession of Medicine..., Chapter 12.

\textsuperscript{116} Ibid., p275.
Finally, there are many passages where Freidson seems to take a position quite different - even opposite - from that indicated by the extracts above. For example, he notes that:

[w]hile illness as a biophysical state exists independently of human knowledge and evaluation, illness as a social state is *created and shaped by* human knowledge and evaluation.117

Similarly, he explicitly makes a qualitative distinction between illness as an inherently value-laden label for social deviance and "neutral scientific concepts like that of 'virus' or 'molecule'"118 - directly contradicting his notion, noted above, of biological categories as the product of "human consensus".

Freidson's general position here is that illness as physical deviance has been, and continues to be, mixed up with illness as social deviance. There is, more or less, a separation between illness and disease, but in medicine the more certain, consensual, less social base of scientific knowledge has tended to become conflated with the less certain, consensual, more socially determined aspects involved in the labelling of illness.

Because the biophysical status of medical signs [as distinct from symptoms] is confused with the moral and social status of the meaning of illness, no serious question is raised about medicine, as it is routinely raised in the courts, concerning the social and moral danger of labeling (or diagnosing) mistakenly. Medicine's concern is largely (though not without exceptions) with the biophysical consequences of diagnosis and treatment - whether they are accurate or efficacious. Its concern is not with the social consequences.119


For Freidson then, the social and professional influences on the construction of medical categories do not represent an intractable problem. He sees the solution to the problem lying in the "increasing sophistication of medical investigation and procedures, which begin to remove some of the practice of subjectivity from the frailly human hands of the physicians". In other words, the way to solidify the ambiguous categories of disease in medical science is simply to apply more science - to apply more rigidly the recognised and systematic procedures of scientific methodology.

By implication then, Freidson mostly conceptualises the cognitive base of medicine as a body of knowledge lying obscured beneath layered matrices of socially determined categories and practices. The "real" knowledge of medicine, forming the basis of medical expertise, is to be found by lifting back those matrices to reveal a solid core of objective facts free from social influences.

In a later work on the professions - Professional Powers - Freidson still gives considerable prominence to the connections between knowledge and professional power. Again the subtitle indicates his approach: A Study of the Institutionalization of Formal Knowledge. Here he views the social and legally-sanctioned institutions of medicine - or of any other professional discipline - as the essential link mediating between between professional knowledge and professional power. Accordingly, he sets out to identify the contemporary institutional mechanisms through which knowledge is transformed into power in

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120. Ibid., p277.

the US, such as the credentialing bodies, the courts, the legislative arrangements for professional employees and the professional associations.

In his conceptual schema, Freidson includes several types of knowledge that are borne by professionals. For example, "formal", "pure", or "abstract" medical knowledge is located in university textbooks on medicine, and is "produced and advanced by academics and researchers". On the other hand, "applied" medical knowledge is located in the field of practice, be it the private clinic, the hospital or the health bureaucracy. Elaborating on a theme of his earlier work, he argues that these two types of medical knowledge are fundamentally different.122 The former is transformed into the latter as it is routed through and incorporated by the various institutions identified above. This is the process he refers to as the "institutionalization of formal knowledge", and it forms the basic mechanism for the translation of knowledge into power.

...the actual substance of the knowledge that is ultimately involved in influencing human activities is different from the formal knowledge that is asserted by academics and other authorities whose words are preserved in the documents that are so frequently relied on by historians and other documentary analysts. Down at the level of everyday human experience...formal knowledge is transformed and modified by the activities of those participating in its use. Thus the paradox that, while the institutionalization of knowledge is a prerequisite for the possibility of its connection to power, institutionalization itself requires the transformation of knowledge by those who employ it.123

122. For example, in Profession of Medicine, Freidson sets out the task of the concluding chapters as showing that "...the practice, exercise, or application of expertise is analytically distinct from expertise or knowledge itself." Freidson (1970a), Profession of Medicine..., p337 (original emphasis).

123. Freidson (1986), Professional Powers..., page xii.
For Freidson, the process of transformation occurs at two levels. First, it occurs in the selection of the knowledge to be applied from the competing theories, schools, opinions and ideas that constitute the discipline's body of formal knowledge. Given these internal differences, the professional worker's application of formal knowledge to a particular task necessarily involves abstract decisions over which school of thought to follow. Second, transformation occurs in the selection of knowledge according to the type of task to which the professional seeks to apply it. For example, the practitioner in the clinic will use bits of the formal knowledge that are different from those employed by the administrator in the government agency or professional organisation and the "teacher-researcher" in the university or laboratory.\textsuperscript{124}

While Freidson explicitly dismisses the notion of knowledge as "some fixed set of ideas or propositions organised into a discipline that is then employed mechanically by its agents",\textsuperscript{125} he implies just such a notion in his "institutionalization" process. In this process, despite the suggestion inherent in his use of the term "transformed", there is no allowance for a change in the actual substance of the formal knowledge stemming from its practical application. Rather, the process Freidson describes is one of selective application of a pre-existing body of knowledge. The major implication here is that while different parts of the knowledge may be used in different work settings, there is no scope in this formulation for the substance of the

\textsuperscript{124} Ibid., Chapter 10.

\textsuperscript{125} Ibid., p217.
knowledge itself to undergo change as a result of that use. As firmly evidenced by the enormous differences between the corpus of eighteenth century medical knowledge and that of the twentieth century, the development of the formal knowledge used by the medical profession is both non-linear and socially based, and as such is subject to considerable - even fundamental - change over time, place and cultural context.

This problem with Freidson's notion of the "institutionalization of formal knowledge" arises from his conceptualisation of formal knowledge itself. This he defines as:

specialized knowledge that is developed and sustained in institutions of higher education, organized into disciplines, and subject to a process of rationalization...[It] may be found empirically by examining the literature produced by its creators and custodians - the professions' teachers and researchers, who are usually located in universities.\textsuperscript{126}

On his own admission a somewhat "crude and mechanical" definition - aimed as it is towards situating knowledge within concrete institutions\textsuperscript{127} - such a view of the formal knowledge base of professionals remains unnecessarily closed, static and ahistorical. As with the distinction we saw above between technical and indeterminate knowledge, it arbitrarily excludes the substantive changes to that knowledge feeding back from its application in the field, as practice interacts with theory, and as each is modified in the light of developments in the other. In treating formal knowledge and applied knowledge as separate, autonomous domains - in effect completely separating theory and practice - this conceptualisation also excludes the historical influences on its actual content arising from

\textsuperscript{126} ibid., pp225-226.

\textsuperscript{127} ibid., p226.
the wider social, political and economic context in which it is both produced and applied.

The limitations of Freidson's concept of formal, scientific knowledge are reflected in the reforms he suggests for the organisation of medical care in the US and, by implication, in the UK and Australia. His principal concern is the tendency for the medical profession's autonomy over the content of its (formal) knowledge to extend to autonomy over its application in the field. While he views the former as the rightful domain of the profession, the latter is located in a wider social or moral domain, in which the profession is "but one of a number of publics", which include patients, the government and various lay interests.\textsuperscript{128}

The health policy reforms by which Freidson proposes to rein in that autonomy include recruiting professionals from a wide variety of backgrounds; including more socially oriented, "non-medical" subjects in medical school curricula; increasing interaction between medical practitioners and academics; expanding peer review mechanisms; greater integration of other health professionals; and a generally closer scrutiny of the "modes of applying or practicing expertise".\textsuperscript{129}

While these could all be regarded as worthwhile reforms in themselves - and indeed several have been since been implemented in the US health system - they are largely aimed at encouraging the medical

\textsuperscript{128} Freidson (1970a), \textit{Profession of Medicine}..., p345.

\textsuperscript{129} Ibid., pp372-375. See also the final chapter of Freidson (1970b), \textit{Professional Dominance}..., for similar recommendations.
profession to become "more responsive to its clientele."\textsuperscript{130} What they are explicitly not directed at is exposing the core content of the profession's formal knowledge to lay scrutiny. This is especially evident in Freidson's call for more peer review mechanisms. As further discussed in some of the case study chapters ahead, "peer review" implies more than the improvement of quality assurance in medical services. It also implies an even greater level of control by the medical profession over both the terms and the content of its work - which is one of the major factors contributing to the lack of responsiveness to clients identified by Freidson in the first place. High levels of occupational autonomy and state-sponsored self-regulation help to insulate the profession both from the immediate market pressure to satisfy customers, and from the wider social pressure to be accountable to the state on behalf of the public. Moreover, as illustrated by the extensive remodelling of the health system currently being developed by the Clinton administration, the reforms suggested by Freidson seem to have done little to halt the deterioration of US medicine in its ability to adequately service the basic health needs of the population at large.

For Freidson then, the "basic concepts or theoretical assumptions" of medical knowledge, such as "the etiological notion of disease, today largely based on the germ theory", constitute "a truly esoteric aspect of knowledge in the evaluation of which laymen seem to find no important place".\textsuperscript{131} In other words, by accepting as given the formal knowledge base of the medical profession, and the autonomy over the

\textsuperscript{130} Freidson (1970a), \textit{Profession of Medicine}..., p352.

\textsuperscript{131} Ibid., p340-343.
content of its work that flows from such knowledge. Freidson's reforms are necessarily limited to restraining the profession's autonomy over the terms of its work. A central argument of this thesis - and it is an argument towards which much of the empirical evidence in the case studies is largely directed - is that more sweeping social democratic reforms to the health care system are only possible if the profession's core of formal knowledge itself is subject to external, non-medical scrutiny. Thus if we want health policies to embody ideals such as equity, access and democracy beyond the improvement of doctor-patient relations, then we need to make the medical profession more accountable to a wider public than only its own member bodies, and more accountable for both the content and the terms of its work.

"Post-Freidsonian" medical sociology

As seen above, there are certainly some areas of conceptual and empirical overlap between the "attributes" school and the "occupational control" school, and between the various notions of knowledge and power, in the arena of medicine. However, to the extent that they can be treated separately, there is much more emphasis on power than on knowledge in both the sociology of professions and the sociology of medicine. This is arguably a part of the general swing away from US-based functionalism in social sciences after World War II, when concerns over problems of social stability and coherence stemming from the upheavals of war gave way to critical assessments of the nature and general direction of "the system" within the socio-economic security of the "long boom". The core social problems shifted away from how disparate social groups and forces can be integrated, including the cohesive role of professional knowledge and ethics.
towards how the patterns of the distribution of wealth, status and power can be made more equitable. In this latter phase, professions were more inclined to be analysed in terms of their links to power elites, rather than the potential integration functions of their specialist knowledge and skills.

Freidson, for example, is quite explicit on this point. He argues that the process of professionalisation is "essentially political and social rather than technical in character - a process in which power and persuasive rhetoric are of greater importance than the objective character of [medical] knowledge, training and work". In Freidson's argument, the nature of professional knowledge, and its institutionalisation as medical expertise, is clearly subordinate to the political and ideological strategies of action aimed at maintaining autonomy over the terms and content of its work.

The distinguishing feature of sociology in medicine is its uncritical acceptance of medical knowledge and practice, while the sociology of medicine accepts medical knowledge as given, but critiques medical practice. In what I refer to - after Bury as "post-Freidsonian" medical sociology, neither medical knowledge nor medical practice is accepted as an unproblematic given. Rather, both are viewed as suitable - and indeed central - objects of political and sociological inquiry in the general area of medicine.

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132. ibid., p79.

Much of the intellectual stimulus for this approach came from the shift from the 1960s 'sociology of science' theory and research to that of the 'sociology of scientific knowledge'. The former 'weak' program was organised around Merton's notion that while the analysis of scientists as a social group was possible, the analysis of the content of scientific knowledge was not. Thus there was a distinct line drawn between scientific knowledge and politics, and social factors were explored only as impediments or distractions to the natural progress of 'normal' science. The so-called 'strong' program of the sociology of scientific knowledge\textsuperscript{134} emerged in the wake of historical and philosophical studies of the work of scientists and the development of scientific knowledge, most notably Kuhn's rewriting of the history of science in his \textit{The Structure of Scientific Revolutions}.\textsuperscript{135}

The first significant expression of this approach within medical sociology occurred with the publication of Wright and Treacher's collection, \textit{The Problem of Medical Knowledge: Examining the Social Construction of Medicine}, in 1982.\textsuperscript{136} Although the contributors were by no means united in their theoretical concepts and assumptions, or in the political implications of their arguments, their common bond was "the desire to test the limits of the view that medicine is socially constituted: that medical knowledge is the child of social forces."\textsuperscript{137}

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\textit{\textsuperscript{134} See Bloor, D. (1976), \textit{Knowledge and Social Imagery}, London: Routledge and Kegan Paul.}
\textit{\textsuperscript{135} Bartley, M. [1990], "Do we need a strong programme in medical sociology?", \textit{Sociology of Health and Illness}, 12.4:371-390. For an overview of the 'strong' program, and some of the recent debates within it, see Woolgar, S. (1988), \textit{Science: The Very Idea}, Chichester: Ellis Horwood, and London: Tavistock, Chapter 3.}
\textit{\textsuperscript{136} Wright and Treacher (1982), \textit{Op. cit.}}
\textit{\textsuperscript{137} \textit{Ibid.}, p.2.}
\end{flushleft}
This approach is what Wright and Treacher refer to as "social constructionism".

Medical knowledge here is not seen as the objective product of the application of neutral, scientific principles and disinterested endeavour. Rather, medical knowledge - like its application in the field - is shaped by the complex array of interests, influences, institutions and values pervading the social context of its production. Just as Freidson and Johnson developed a more critical analysis of the practices of professionals - beyond the image of disinterested altruism projected by their political organisations - social contractionism seeks to subject the body of knowledge underlying medical claims to autonomy and expertise to a more intense, critical scrutiny. In addition to Freidson's questioning of the application of medical knowledge, social contractionism calls into question its very creation and content.

In their introductory chapter, Wright and Treacher contend that there are four assumptions underlying traditional approaches to medical sociology and the history of medicine. First, medical knowledge is not problematic - it is self-evident. As for Freidson, it is to be found in medical textbooks and journals, from which the history of medicine is directly derived. Second, medical knowledge is scientific and effective, providing it with the "privileged epistemological status" of science.

[If science was the accurate reading of Nature's book with eyes undistorted by social interest or cultural prejudice, medicine was the benevolent application of some of what was found there.

Third, diseases are recognised simply as biological facts, parts of a universal and unquestioned reality. Under this assumption, they are
treated as "natural objects which existed prior to and independently of their isolation or designation by doctors". Fourth, medical knowledge and society are self-evidently two "independent and autonomous domains", so that 'pure' knowledge can be distinguished by a total absence of any social contaminants.  

Social constructionism, in effect, seeks to remove the technical status attached to medical knowledge, and to reveal its social, political and ideological foundations. That is, it seeks to highlight the power aspects of medical knowledge. This does not mean that medical knowledge becomes unscientific because of its social roots. It means, rather, that both science and medical knowledge have such social roots. The essential claim here is that all knowledge, including medical knowledge, is not innocent. Thus social constructionism does not tend towards emphasising either power or knowledge in its analysis. Rather, it provides the means for demonstrating their fundamental interdependence. Where a body of knowledge is accepted as technical, and so free of political content and intent, the claims to autonomy by the bearers of that knowledge remain, by definition, unquestioned. Conversely, where knowledge is not presumed to be technical, as in a social constructionist approach, the political intent residing within such claims is exposed to closer scrutiny.

The advantage of social constructionism over traditional approaches to medical sociology is that it provides a conceptual framework for investigating the processes involved in the so-called "medicalisation" of health. This refers not only to the incorporation of new areas of social
life and experience into the medical domain, but also to those existing areas in which medical knowledge has traditionally provided the basis for the dominant, recognised expertise. That is, the social constructionist approach can help us to explain, or can provide a vehicle through which to explore, the socio-historical circumstances in which specific areas of experience are established as the preserve of medical knowledge and judgement, and how the line between what is medical and what is not is maintained or shifted over time and place.

An illustration of the type of questions raised by the social constructionist approach to medical sociology is provided by the notions of signs and symptoms. Conventional medical sociology would regard signs as given biological realities, and symptoms as self-reported, subjective assessments containing some socially determined components. A full diagnosis might take into account both signs and symptoms, but would rely in the last instance on the biologically established signs as the decisive source of data. In the event of signs contradicting symptoms, the latter are given primacy. Social constructionism on the other hand, would regard both signs and symptoms as socially constituted, and therefore subject both to sociological inquiry and analysis. Thus for example, why are the self-reported symptoms of migraine and 'executive stress' accepted as the basis of diagnosis, while those for Repetition Strain Injury (RSI) are not so readily accepted, and in many cases, are rejected outright?\(^{139}\) Is such discrimination based on different positions along class, interest

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or occupational lines, which remain hidden behind the guise of technical neutrality?

The large number of parties involved in the RSI dispute, including workers, doctors, medical researchers, social workers, legal advocates, insurance companies, employers, unions and government health and welfare agencies, clearly have different, often opposing, interests, and seek to define the problem of RSI in terms most favourable (or least unfavourable) to those interests. A large part of this process is centred on the development of widely accepted, scientifically verifiable medical signs as the means for decisively establishing whether or not particular claimants have the condition (or indeed whether or not the condition really exists at all). That is, what symptoms make the best signs? Ironically, they will tend to be those symptoms consensually accepted as the most removed from the direct interests of the very parties responsible for their production.  

Social constructionism, in recognising the possibility of social determinants of medicine's cognitive base, opens the way for research which can establish links between specific pieces of medical knowledge and specific social factors or groups. This type of research attempts to associate the development of accepted medical knowledge and practices in a particular period with broad social changes, or with particular social groups (such as health professionals), or class interests (such as capital), or social policy (such as health policy)


which actively shape that knowledge or benefit most from it taking particular forms.\textsuperscript{142} This represents a significant, even qualitative improvement over conventional approaches to medical sociology, where social variables tend to be applied to specific areas within what are essentially medically defined fields of epidemiology and public health.

While social constructionism represents a promising attempt to expand the boundaries of medical sociology and medical politics beyond those developed with medical knowledge as a self-evident given, considerable theoretical and empirical difficulties remain. In a trenchant critique, Bury points to three main difficulties which can significantly limit, or even undermine, the usefulness of this approach in the present context.\textsuperscript{143} These are in many instances interdependent, but can be usefully distinguished here as coherence, scope, and relativism.

Bury contends that there is so much diversity within the social constructionist school that its intellectual coherence is undermined by contradiction and its political stance by confusion. He provides ample evidence from the work of various social constructionists to support


his argument that the school encompasses many different, and sometimes opposing, ideological and theoretical positions. As an example, he cites Wright and Treacher's use of the work of Cochrane as evidence of the inefficacy of modern scientific medicine. Because Cochrane sees the solution to such inefficacy lying in a more rigorous application of scientific methods (especially through the use of random control trials), Bury views this as a direct contradiction of social constructionism's essentially anti-scientific position. Similarly he notes that other writers in the group adopt "Kuhn's anti-rationalist account of science" to support this same position, despite Kuhn's generally conservative and pro-science stance.\footnote{144}

However, as argued further below, social constructionism is neither anti-scientific nor anti-medicine. It can readily acknowledge the achievements of medicine in curing diseases and alleviating suffering. But it also notes the paradox that while medicine seems to be legitimated largely through its scientific effectiveness, it is often afforded high levels of credibility and acceptance before its efficacy has been scientifically established. Cochrane's work on the largely unevaluated nature of many of modern medicine's most common treatments, procedures and therapies clearly demonstrates this paradox,\footnote{145} as does Melvin Konner's more recent work in the area, discussed in the final chapter.\footnote{146}

\footnote{144}{Bury (1986), "Social constructionism...", pp160-161.}


\footnote{146}{See Konner, M. (1993), \textit{The Trouble with Medicine}, Sydney: ABC Enterprises, Chapter 5.}
The practice of committing significant health resources to new therapies and technologies which have not been systematically assessed for effectiveness has continued since Cochrane's pioneering work of the early 1970s. In the case study on pathology reforms in Chapter Four, the government attempted to constrain the upward cost spiral of diagnostic services. One of the factors contributing to that continuing spiral was the expanding use of magnetic resonance imaging (MRI) technology. Despite capital costs of about $3 million each, and operating costs of about $800 per scan. 147 MRI facilities were installed in five capital cities before the completion of a systematic evaluation of their contribution to health outcomes. 148 Sometimes the knowledge and practice of medicine maintains this credibility even after its efficacy has been seriously questioned, as in the use of ultrasonic foetal heart monitoring technology. 149 This in no way diminishes or ignores medicine's achievements, but it does question the neutrality of the content of medical knowledge.

Moreover, social constructionism is not unusual in the social sciences for adopting an array of theoretical concepts, perspectives and methodologies with different or competing political implications. Bury's views seem at times quite congruent with those of Wright and Treacher. Bury contends that social constructionist approaches tend to rest on "a loose amalgam of arguments", and that they constitute "a loose trend in social thought". 150 Wright and Treacher contend that

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they have "tended to be rather heterogeneous and diffuse", and that they contain "differences of emphasis, occasionally even basic disagreements". While these views do not seem very far removed from each other, their critical intent is entirely different. The former is structured as an accusation implying a seriously damaged intellectual credibility, while the latter is an open acknowledgement of internal diversity. As such, Bury's point about incoherence makes no contribution to an argument for abandoning social constructionism, and amounts to little more than a difference of opinion or emphasis.

The second area of difficulty identified by Bury lies in the scope of the social constructionist perspective. He contends that it is often claimed or implied to be so wide as to generate totalising statements about the "hold which contemporary medicine has over contemporary experience". He cites as examples Figlio's contention that medicine's representation of diseases as "natural" phenomena can lead to a "reification" of medical categories; and Armstrong's argument, following Foucault, that the modern clinic is part of a wider mechanism for surveillance and control over whole populations. Such views, he says, are not accompanied by supporting empirical evidence, and are so abstract in nature that "the possibility of refutation is avoided".

I have some sympathy with this criticism. In attempting to make sense of the complex relations between medical knowledge and power, there


153. Ibid., pp157-159.
can indeed be a tendency to overstate the extent and significance of medicine's social impact. This has been especially evident in discussions on the notion of medicalisation, which, like professionalisation, sometimes seems destined to encompass entire populations.\textsuperscript{154} However, as Bury himself points out, the totalising statements that can be generated only occur when the argument is "at its furthest point".\textsuperscript{155} Moreover, the existence of a gap between theory and evidence does not necessarily mean that the theory itself is essentially flawed. As with his coherence criticism, Bury seems to be confusing the relative newness and underdevelopment of an emerging perspective with a crucial, inherent weakness.

Arguably the most important of Bury's concerns with social constructionism lies with its inherent potential towards relativism. The core proposition of social constructionism - that the knowledge of (medical) science is not neutral, but rather social in character - must also apply equally to its own knowledge and premises. If medical knowledge and categories are not part of an independent reality, but are context dependent (by time, place and socio-political structure), then so too must be those flowing from the social constructionist approach. Because there are no universal, independent criteria against which to judge one approach against another, social constructionism cannot be directly evaluated or verified. Bury

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\textsuperscript{155} Bury (1986), "Social constructionism...", p159.
\end{footnotes}
contends that this pushes constructionism towards the "abyss of relativism, into which all arguments concerning the conventional character of knowledge, and the constitution of objects through the methods of their enquiry, threaten to fall".\textsuperscript{156}

For Bury, one implication of this tendency is that medical categories become "dispensible", so that medical knowledge can not be instrumental knowledge. Thus, for example, social constructionist versions of the categories of 'asthma' or 'cancer' can not be usefully applied in medical practice because their meanings are both value-laden and context-variable. Bury argues that this view of knowledge as fabrication does not change the real impact that such categories - "believed not to be fabrications" - have in social life, and so ignores both their "organising role" and their social legitimacy.\textsuperscript{157}

Bury's identification of the potential for relativism within social constructionist approaches to medicine, and its implications for the 'real world' instrumentality of medical knowledge, certainly provide useful notes of caution about the limits of new forms of analysis. However, they do not, as Bury implies, entirely negate or crucially compromise the insights provided by social constructionism. Under this approach, medical knowledge can still produce tangible benefits in identifying disease mechanisms and alleviating suffering, without losing its dependency on context. In this sense, asthma and cancer are real illnesses producing real suffering in real people; but the medical knowledge we have of them is neither stable nor universal.

\textsuperscript{156} Ibid., p152.

\textsuperscript{157} Ibid., p156.
Rather, it is the product of a specific form of institutionalised cultural and social practice - called medicine - which "observes, codifies and understands these sufferings, both within its technically-organised communities and as part of society at large".158

Moreover, in a significant extension of Wright and Treacher's conceptualisation, Woolgar points out that the relativism argument about the social construction of science amounts to "ontological gerrymandering", in that its assumptions and claims are themselves equally susceptible to relativism. He argues that its proponents remain locked into an "objectivist ontology" by failing to recognise the "ideology of representation". This refers to the range of values and practices derived from the presupposition that "objects (meanings, motives, things) underlie or pre-exist the surface signs (documents, appearances) which give rise to them", and forms the foundation of both scientific knowledge, and the sociology of scientific knowledge (SSK) which criticises it. Thus, rather than "dismantling representation per se, [these proponents] are merely in the business of substituting sociological, literary and philosophical representations for the representations of science". Woolgar suggests that we need to develop a more reflexive approach to what we tend to take for granted about representation, in order to take the social constructionist perspective of SSK beyond "the repeated application of the relativist-constructivist formula".159


Thus, rather than limiting the knowledge we have of 'asthma' and 'cancer' to that contained within the medical domain - as useful as they can be there - social constructionism acknowledges the validity of other types of knowledge about these categories, such as secular, cultural or experiential knowledge, or indeed, the knowledges of other professional groups. The important point here is that all of these knowledges, and especially medical knowledge, are shaped by the social reality in which they are located, and that none of them is intrinsically neutral or technical - that is, outside that social reality. Similarly, as Short urges, all of these knowledges "can and should be" exposed to social evaluation. Social constructionism departs from more traditional analyses of medicine in that it recognises more than one valid set of criteria for such an evaluation, be they rational scientific, religious, spiritual, political or cultural.160

All forms of knowledge, then, encompassing both medical knowledge and that derived from social constructionist analyses, can be subjected to sociological investigation. As Nicolson and McLaughlin argue, it is difficult to see how or why "the beliefs of doctors or medical scientists are valid exceptions, since the esoteric judgements of medical scientists depend upon models and social conventions and carry direct credibility only to those who have passed through quite specific forms of training and socialisation."161

160. This section is partly drawn from Short, S.D. (1989), "In Defence of Social Constructionism: A Reply to Bury", paper presented to the Annual Conference of the Australian Sociological Association, La Trobe University, Melbourne, (December).

Newtonian physics, with its simple cause-and-effect laws, no longer has a monopoly on making sense of the nature of motion and matter in the universe. The new particle physics developed by Einstein and Bohr describes a qualitatively different universe, based on more complex relational concepts of reality.162 This higher level of analysis has its parallel in the post-Freidsonian medical sociology that uses social constructionism as a framework in which to study the interrelatedness of professional knowledge and power. However, like the relationship between particle physics and Newtonian physics, it is not so much a replacement of as a complement to conventional medical sociology. The social constructionist approach does not negate all preceding analyses of medicine, but it does remind us of the changing and context-dependent nature of both scientific theories and medical knowledge, and thereby of the need to avoid its uncritical acceptance as essentially asocial or apolitical.

**Conclusion: social constructionism and health policy**

The value of social constructionism is directly dependent on its usefulness in performing the specific tasks to which it is applied. In this research project, one of the major tasks is to illustrate the interdependence of power and knowledge through a series of case studies on the role of the medical profession in shaping health policy under recent Labor governments. Both medical expertise and occupational control strategies are established as core, interpenetrating determinants of the policy outcomes. The value of social constructionism in this context is as a perspective which

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extends the scope of potential reforms to the health care system from those dealing only with the terms of medical work to those dealing also with the content of that work; from those driven by cost-containment and efficiency to those more directly based on the values of equity, access and democratic decision making. It is precisely these values which underlie Labor's overwhelming electoral mandate in 1983 for the restructuring of health financing through the Medicare scheme.

Under the formal objectives of cost constraint and efficiency, the Hawke and Keating governments - like the Whitlam government - have attempted to introduce reforms with potential to counter the medical dominance of health policy. The reforms would expose the profession to limited competition from other health occupations and consumer groups, and subject it to levels of cost constraint, accountability and regulation commonly applied to professionals working in other social policy areas, such as welfare and education. Many government efforts in this regard have been limited or significantly modified by the profession's robust organisational base for mobilising social and political resistance against potential erosion of its perceived interests. As an occupational lobby group, and as an historically entrenched part of the health policy process, the medical profession has an impressive record of developing effective political strategies to preserve its work autonomy and territory.

Most of these strategies are, however, underpinned by the knowledge and expertise of medical science borne by the profession. The government's prevailing tendency to "scientize" the maelstrom of health policy issues - to seek objective, technical solutions to essentially social and political problems - directly contradicts its
attempts at the social democratic reform of health policy: for these technical solutions ultimately depend on medical expertise as their major source of legitimation and authority. As the case studies illustrate, the more governments seek to head off political conflict over health issues with technical strategies, the greater the scope for the medical profession to strengthen its autonomy and self-regulation through peer review mechanisms based on medical judgement and expertise. Rather than constraining the dominance of the medical profession, as originally intended, policies based on "scientization" of health issues tend to produce the opposite outcome of effectively consolidating it.

The preeminence of medical expertise in health policy is based on conceptualisations of Western medical science as the sole source of incontrovertible, universal truths about the human body, disease and health. Such conceptualisations deny the social, political, cultural and economic context in which such truths are produced and applied, and imply that reality is always fundamentally bound to a single valid interpretation. Medical science here is reduced to a process of "discovering" naturally occurring phenomena related to the body and reading the attached labels.

However, a social or cultural version of reality is inherently of equal validity as a medical version. There is no intrinsic necessity for competent assessments of medical practices to be the sole moral and technical preserve of doctors and medical scientists. Just as lay juries are deemed capable of making valid assessments of forensic science evidence, despite the complex and specialist nature of that evidence,
so too can non-medical people make legitimate judgements on what may seem like predominantly medical issues.

The next three chapters provide case studies of how our tendency to defer to medical knowledge as the ultimate authority in matters of health both reflects and consolidates the medical dominance of health policy in Australia. These chapters focus on health matters which are widely accepted as being medical in nature, and so primarily dependent on medical knowledge for their effective management. These matters include the relative work-value of different types of GP services, the fees for specialist procedures in hospitals, and the clinical necessity of particular pathology tests. In order to make the health policy process more open, accountable, broad-based and democratic, we need to assess medical practice and policy not just through the narrow "clinical gaze" of the doctor's medical expertise, but also through the wider social gaze of non-medical types of knowledge and experience.

In the next chapter, however, we find that the new Hawke government, in concert with all other interested parties in the dispute over the Section 17 legislation, is extremely reluctant to even consider subjecting the work practices of visiting hospital specialists to such community based assessments, despite the repeated emphasis in Labor's election campaign on Medicare's significance for social justice and equity, and despite the large potential cost savings involved. Instead, we find a wholly unreflective validation of peer review as the sole legitimate principle by which to evaluate the practices of visiting specialists in NSW's public hospitals. As a direct result of this, Hawke's first attempt at constraining health expenditures through a
more thorough scrutiny of medical practices was notably limited in its effectiveness.
CHAPTER THREE

SECTION 17 AND THE NSW DOCTORS' DISPUTE
Introduction

On paper, the amendments to Section 17 of the (Commonwealth) Health Insurance Act 1973, proposed by Health Minister Blewett in 1983, are quite unremarkable. While there was an enormous amount of political controversy over the major principles of the new Labor government's Medicare scheme, the Section 17 provisions initially received very little attention - in both parliamentary debates and in the wider public debates monitored by the media. They represented nothing more than a legislative mechanism necessary to give administrative effect to a marginal component of the scheme.

However, within the historical context of Australian health policy developments in general, and the relations between the medical profession and (State and Federal) Labor governments in particular, Section 17 can be more readily recognised as a potential source of intense political conflict. Indeed the amendments were ultimately to trigger one of the most extensive and acrimonious disputes in Australian medical politics. Although other issues eventually took centre stage, it is very doubtful that the intense escalation of conflict in the health policy events of 1983 to 1985 - collectively referred to as the New South Wales Doctors' Dispute - would have taken place in the absence of the Section 17 proposals.1

The purpose of this chapter is to examine the events and outcomes of the dispute in order to assess the relative impacts of medical

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1. Bernie McKay argues that "a confrontation of some sort" would have occurred even without the Section 17 proposals, "although it may have been much less traumatic". McKay, B.V. (1986), "A Participant's Account of the New South Wales Doctors' Dispute", Community Health Studies, 10, 2:220-231, at p221.
knowledge and expertise on the one hand, and interest group power on the other. This case study is somewhat different from those in subsequent chapters, in that the various issues at the centre of the dispute can be separated - analytically, at least - into two distinct categories. The issues at stake in the initial Section 17 phase of the dispute were largely medico-political in nature, while those in the later phase, when the focus of conflict shifted from the national level to the State level, were very much more industrial in nature.

The argument developed in this chapter is that the medical profession maintained its policy dominance through the Section 17 phase because its influence as a well-resourced interest group, and that derived from its structural position as the sole legitimate source of medical expertise, could both be simultaneously drawn on in its negotiations with the government and its health agencies. In the NSW phase, however, where industrial rather than medical issues were predominant, medical expertise was neither relevant nor requested, so that the profession was left to negotiate with the state armed only with its capacities as an organised political interest group. As a result, while it arguably gained some generous industrial concessions from the government, the profession did so at an unprecedented cost - both to its status as the foremost legitimate source of impartial expertise in health, and to its future capacity to control the direction and content of health policy in Australia.

**The Section 17 amendments**

The Section 17 amendments were needed to accommodate a difference in the benefits structure between Medicare and the previous
Medibank scheme. Both schemes retained the principle of private practice in public hospitals for both salaried and visiting specialists (the latter also known as visiting medical officers, or VMOs). However unlike its predecessor, Medicare provided for medical benefits to be paid for diagnostic services for private patients in public hospitals. This feature was designed to avoid a repeat of the exodus of pathologists and radiologists from public hospitals which occurred under Medibank. In an effort to contain the possible cost implications for this new feature of Medicare, Dr. Blewett laid out in the amendments the terms and conditions under which the Federal government would pay benefits for such diagnostic services.

The main conditions were that the fees charged for these diagnostic services be at or below the level set in the independently arbitrated Medical Benefits Schedule (MBS), and that specialists using public hospital facilities for private patients enter into written contracts with the hospitals setting out the terms and conditions of such arrangements. The individual terms of the contracts had to be approved by the Federal Minister, but all would be subject to a national scale of facility charges for the use of public hospital equipment and/or support staff, administered by the hospital (rather than by the service providers themselves) for an approved administrative charge. In addition, all hospital specialists would be subject to uniform income limits for providing such services. Full-time salaried specialists were limited to 25% above salary after deductions for facilities charges, while the limit for non-salaried visiting specialists was to be negotiated between the Federal and State Health Ministers.
In an economic climate characterised by severe fiscal restraint and ever-increasing health budget blowouts (especially in the high-cost hospital sector), both Coalition and Labor State governments were quite sympathetic to the general principle of imposing some kind of controls on specialists' incomes and service levels for private practice in their public hospitals. Because diagnostic services for private patients represented such a clear case of private gain largely through the use of expensive public resources (particularly X-ray machines and pathology laboratories), the State governments were even more sympathetic towards controls on these services in particular.

Indeed, at the first Health Ministers' Conference convened by Dr. Blewett in July 1983, all the States agreed to the Federal government imposing such controls through the amendments to Section 17 outlined above. As the Federal government has little formal control over the volume of such services performed by specialists in public hospitals, it is not surprising that its efforts at cost control focussed on the level of fees payable for them under Medicare.

The amendments were introduced into parliament on 6 September 1983, and given assent on 4 October. In their final form, the amendments provided for the designation of particular diagnostic services by regulation and the contractual conditions under which they were provided through guidelines formulated by the Minister and then gazetted. In effect, the amendments gave the Federal Minister of Health ultimate legislative authority over the types of diagnostic services eligible for Medicare benefits and the conditions for their

delivery for private practice in public hospitals. This feature of the amendments, giving to the Minister what many in the medical profession saw as "unfettered power" over private practice in public hospitals, is later played a key role in determining the extent and direction of the dispute.

The Medibank experience

In order to better understand the apparent failure of both State and Federal governments to foresee the medical profession's vigorous opposition to the Section 17 proposals - and indeed the reasons for that opposition - it is necessary to consider some of the contingent political issues shaping the decisions and responses of both parties at the time.

The first of these is the outcomes arising from the implementation of the Medibank health insurance scheme ten years prior to the Section 17 dispute. The decision to make Medicare benefits payable for diagnostic services to private patients in public hospitals was directly linked to the experiences of the Whitlam government with its Medibank scheme. Because medical benefits were not payable for such services under that scheme, significant numbers of salaried pathologists and radiologists were leaving the public hospital sector by 1974. The inclusion of private diagnostic services under Medicare was a conscious attempt to prevent the recurrence of the specialists'
exodus under Medibank, while the amendments were aimed at controlling the income generated by these new services.4

The Medicare promise

The second feature of the political environment of the Section 17 dispute concerns the new Medicare scheme. The implementation of a universal health insurance scheme, financed by an income-based tax levy and providing free public hospital care, was a key plank in the ALP's policy platform for more than a year before the 1983 elections.5 Included in the policy was a commitment to implement the scheme within twelve months of assuming office. This commitment was consistently emphasised in Labor's election campaign.

While the organising principles of Medicare were well established by the time Labor took office in March 1983, most of the substantive details and administrative arrangements needed for its implementation remained to be negotiated. These arrangements necessarily involved extended and complex consultative processes with each State health minister, a myriad of State and Federal health and welfare agencies, organised medical groups, the Royal Colleges, private hospitals and the health insurance funds. The administrative process was further complicated by a matrix of political issues, each one of which was a source of potential conflict and delay, and as such required intensive negotiations towards a sustainable consensus.

The Federal government was required to negotiate the terms and conditions of a separate five-year Medicare funding agreement with each State. While the Federal government, as the principal health funder, ultimately had the strongest bargaining position, a recalcitrant State could, in the meantime, greatly hinder the negotiating process. In this sense, the largest source of potential resistance for the Federal government was the non-Labor States with strong ideological objections on the collectivist principles underlying the Medicare scheme.

Almost inevitably, negotiations with the strongly conservative Queensland government of Joh Bjelke-Petersen were far more protracted, complex and acrimonious than those with the other States. Indeed, Queensland was the last State to sign the Medicare agreement, and only conceded some months after Medicare was operating throughout the rest of the country. In the end, Mr. Bjelke-Petersen's resistance brought significant financial concessions to Queensland through the direct intervention of Prime Minister Hawke.

Moreover, the legislation necessary for Medicare involved amendments to at least five Commonwealth Acts, and had to go through draft, debate and committee stages in parliament before the scheme could be fully implemented in February 1984. During this period, Labor did not control the Senate, with the balance of power being held by the Australian Democrats. While the Democrats were generally sympathetic to the aims of Medicare, some horse-trading, compromises and delays in the passage of the legislation were almost inevitable. Once the legislation was passed, there remained the
organisational tasks associated with establishing the physical network of Medicare agencies - including office space and equipment, staff recruitment and training, and information systems - and the administrative procedures needed to make them operational.

The electoral imperative to have all of these processes and arrangements in place within twelve months imposed on the government and its health agencies a very tightly packed implementation schedule. This further complicated the awkward "settling-in" period when a new government seeks to implement its high-priority policies and at the same time establish working relations with the public service agencies involved in that implementation. The latter was a substantial task for the newly elected Labor members, whose party had been in opposition for the previous seven years under Fraser, and, apart from three whirlwind years under Whitlam, for 23 years before that. The new government had very limited collective ministerial experience to draw on in order to forge working relations with executive officers of departments and other bureaucratic agencies.

Yet another layer of complexity in the process of establishing Medicare was imposed by the need for the new government to establish workable relations with the State governments, so that the level of mutual Federal-State cooperation essential to many policy areas could be achieved.7 Nowhere is such cooperation a more critical policy


7. While the development of good relations with the States was certainly aided by the fact that a majority of four of them were under Labor governments when Hawke took office (NSW, SA, WA and Victoria), the volatility of State politics ensures that a Federal government can not depend exclusively on such aid in making its longer-term policy decisions.
component than in the health area, where hospital and medical services are largely funded by the Federal government and administered by the State and Territory governments.

The strong political mandate for Medicare, the electoral imperative of operationalising the scheme "within twelve months of assuming office", the sheer weight of administrative detail involved with such a deadline, the political complexion of the State governments at the time, and the consensus style politics that was the hallmark of the Hawke government's approach to policy negotiations, all combined to have the Section 17 proposals themselves a little less well thought out, and their legislative passage much less stringent and critical, than might otherwise have been the case. For both the government and the medical profession, there were simply many more important and pressing broad policy issues to attend to than the possible implications of specific Section 17 proposals.⁸

In particular, the range of possible responses to the legislation from the medical profession went almost entirely unforeseen by the Hawke government. This was not only because it had been in opposition for so long, and had not built up close relationships with the organised medical interest groups; nor only because it had so many other pressing issues to which to attend. It was also because it was a labourist political party, and as such was historically linked to health policy principles imetical to the perceived interests of those medical groups. Even though, as Gillespie points out, Labor never really

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⁸ Nancy Millo argues that because the Federal government "placed highest priority on the quick and unhindered passage of Medicare", several significant concessions were made to both the States and the medical profession. Millo, N. (1986), "Pressure groups and Australian health policymaking in the 1980s", Politics, Vol. 21, No. 2 (November), pp51-61.
attempted the wholesale abolition of fee-for-service private practice,9 this tradition took root in the Chifley government's attempted nationalisation of the health system in the 1940s, and was consolidated by the Whitlam government's continuation of that strategy through the Medibank scheme in the early 1970s. In this sense, large parts of the medical profession viewed Medicare as nothing more than the latest expression of the Labor Party's historical preoccupation with collectivist health schemes. Critical attention then was focussed largely on the broader issues and implications of a universal health scheme, such as its cumulative costs and budgetary effects, its elements of compulsion rather than individual choice, its impacts on the strength of the private health sector and its consequences for the primacy of professional autonomy and the doctor-patient relationship.10

This is not to contend that the implications of the Section 17 proposals, especially for the medical profession, went entirely unrecognised. The Opposition's spokesman on health, Peter Baume - himself qualified as a medical practitioner and an active member of the AMA - clearly enunciated his concerns over the impact of the proposals in the Senate debates on the legislation in September 1983. For example, he argued that the proposals gave the Minister

unfettered authority to alter or to cancel new or existing contracts governing the terms and conditions of employment between salaried or self-employed medical practitioners and recognised [i.e. public] hospitals.11


10. See for example, House of Representatives (1983), Parliamentary Debates (Hansard), 14 September; Senate (1983), Parliamentary Debates (Hansard), 20-22 September.

His main concern in this regard, echoing that of the AMA, was that there were no provisions for parliamentary scrutiny of the Minister's determinations on services and conditions under the VMO contracts; or for mechanisms for doctors to appeal against such determinations. The Democrats' Janine Haines in part shared these concerns, which were to form the core of the medical profession's increasing opposition to Section 17 during late 1983 and early 1984. Similarly Bernie McKay, then Secretary of the NSW Department of Health, refers in his account of the dispute to the (albeit unique) "prescience of Dr. Trevaks in Victoria" in foreseeing the general resistance of the medical profession to the proposed amendments.

However, the conclusion that the final implications of the Section 17 amendments were not generally recognised in full until well after the legislation had been passed remains unavoidable. In over 200 pages of House of Representatives and Senate Hansard on the Health Legislation Amendment Bill 1983 in which the amendments were included, matters relating to Section 17 are directly addressed in only six of them. Bernie McKay concludes that "in retrospect, the doctors' suspicions were predictable". However, given that State health officials were "so comfortable" with the Medicare proposals in general, he remains "not surprised" that they did not anticipate the profession's reaction to Section 17. Finally, while drafts of the guidelines were

12. Ibid., p911.
circulated to the AMA (and State Ministers of Health) in the month preceding the parliamentary debates,\textsuperscript{16} the medical profession's formal campaign against the amendments only emerged, as noted above, a full two months after the legislation received assent.

'Sharing the sacrifice'

The third feature of Section 17's political context is Medicare's location within the overall policy package of the Hawke government. Medicare was not only the central component of Hawke's health policy strategy. It also represented an integral component of Labor's broader economic policy package. Its provisions for universal health insurance and free public hospital care had implications beyond the immediate policy concerns of the health portfolio. At the macro-economic level, these provisions were explicitly aimed at increasing the social wage of the labour force as part of the Prices and Incomes Accord negotiated with the trade union movement.\textsuperscript{17}

During the period in which the amendments were being drafted and debated, there was widespread community support (shown or implied) for a relatively equitable distribution of the pain involved in any adjustments necessary for national economic recovery, often referred to by Hawke as "sharing the sacrifice". Indeed the union movement, through the ACTU, made such a distribution a precondition for its involvement in the new consensus politics of the Hawke government. The electorate had given Labor a very strong mandate for political

\textsuperscript{16.} Ibid., p226.

\textsuperscript{17.} House of Representatives (1983), \textit{Parliamentary Debates (Hansard)}, 6 September p399.
consensus and economic restraint as the central strategies in the national management of the recession. The Accord's emphasis on wage restraint and the avoidance of industrial confrontation directly reflects those strategies.

The implications for the medical profession of the wide support for the Accord were clearly demonstrated in December 1983. With only two months before the commencement of Medicare, the AMA announced a 7% increase in its recommended fees for medical services, to be effective from January 1, 1984. Both the government and the unions reacted very sharply. Dr. Blewett said that the increase represented "a pretty paltry contribution" to wage restraint from the "wealthiest profession in Australia", and that it was "irresponsible, inexcusable and threatened the economic recovery".18 The Minister for Employment and Industrial Relations, Mr. Willis, condemned the increase as "deplorable", because it came on the eve of an Arbitration Commission review of medical fees, and less than a week after the Advisory Committee on Prices and Incomes - with membership drawn from the government, unions and the professions - had agreed to keep wage increases in line with national wage case movements.19 He urged the AMA to defer any fee increases until after the review.20


19. *Australian*, 22 December 1983:1,2. In response to Mr. Willis's criticism of the increase being outside national wage case movements, the AMA pointed out that there was a crucial difference between wages and private practice incomes, with the latter including a practice costs component. However, the perception of the AMA increase as being above wage case guidelines persisted.

Both Dr. Blewett and Mr. Willis explicitly linked the pay rise to the wage restraint implied by the Accord, and contended that "the doctors being in a highly visible position could undermine the strategy if they were seen to break ranks" by granting themselves such a large increase in income. ACTU President Dolan warned that if the professions persisted with such increases, the unions would seek legislation to control professional fees. Mr. Willis backed the ACTU warning with threats to consider a range of direct and indirect legislative measures to control non-wage incomes.

For their part, the Opposition parties, in an implicit recognition of the strength of Labor's mandate for sharing the pain necessary to stimulate an economic recovery, directed little overt political criticism towards those core strategies, if not wholeheartedly embracing them. Their criticism of the government's economic policies was more judiciously directed at the margins; while their criticism of the Section 17 proposals had barely developed into an identifiable argument. This made it very difficult for the Opposition to launch an assault against the amendments' provisions for income limits on diagnostic specialists without seeming to flout the widely-accepted notion of equitable sacrifice on behalf of an elite group of highly-paid professionals. In this sense, an outright attack on the amendments was politically indefensible. As a result, the Opposition parties concentrated their criticism of the Section 17 legislation almost solely on the "unfettered power" over hospital contracts its provisions gave to the health minister.


Perhaps the strongest push for "sharing the sacrifice" in the area of specialists' incomes came from within the Labor Party itself. McKay notes that the proposals on income limits were partly aimed at "meeting the concerns of some Labor Caucus members about abuses of private practice in the salaried setting".23 Similarly in his Second Reading speech, Health Minister Blewett noted that:

> concern has been expressed by Commonwealth and State health Ministers about the rights of private practice for salaried doctors in public hospitals...

The concerns about the operations of private practice rights particularly relate to diagnostic services and some therapeutic services - pathology, radiology, radiotherapy and nuclear medicine - where there is not usually any direct doctor-patient contact, where there is substantial scope for generating additional revenue, and where there is a significant technical component to the service [in the form of equipment and laboratory facilities] which is provided by the hospital rather than the doctor.24

Many of these concerns can be traced to some of the submissions presented to the ongoing Joint Committee of Public Accounts' inquiry into Medical Fraud and Overservicing since its commencement in 1982 under the Fraser government.25 The submissions indicated that there were large-scale abuses of medical service provision, particularly in the specialist diagnostic areas of pathology and radiology. Such abuses had been estimated by the Commonwealth Department of Health to total $100 million per year in 1982, and were adjusted to $130 million in April 1984.26 The profession was clearly troubled by

the critical front-page media attention received by these submissions.\textsuperscript{27}

A close examination of the methodology used later produced some doubts about the accuracy of this estimate.\textsuperscript{28} However, these doubts were not given the same type or scale of publicity that the news items on the original estimates received.\textsuperscript{29} One of the members of the Joint Committee, Labor's Ros Kelly, explicitly referred to the submissions in the Second Reading debates on the \textit{Health Legislation Amendment Bill} containing the Section 17 amendments, and argued that the Committee's investigations had led to "a new attitude in the community today about health care costs and about efforts that should be made to curb health care costs".\textsuperscript{30}

The findings of the Joint Committee and the concern over them expressed in parliament - and in media reports on the findings - lent considerable legitimacy to Dr. Blewett's repeated claim that the amendments were exclusively aimed at introducing some cost control

\textsuperscript{26} See for example, \textit{Canberra Times}, 3 April 1984:3, next to an item on talks between the Federal government and the AMA on a possible joint submission to the Pennington inquiry.


\textsuperscript{28} See the AMA's first cautions on the Health Department estimate in \textit{AMA Gazette}, October 1982:12-13. The AMA had withdrawn its initial acceptance of the estimate by 1984, and in March 1985, Dr. Blewett formally conceded that the Fraud and Overservicing Detection System (FODS) on which the $100 million estimate was based was "overly bureaucratic and inefficient". However the Public Accounts Committee, while accepting the inherent limitations of the methodology used, continued to regard it as a conservative estimate of fraud and overservicing under Medicare. See \textit{Age}, 21 March 1985:1; \textit{Medical Practice}, April 1985:9,12; Australia, Parliament (1986), Joint Committee of Public Accounts, \textit{Medical Fraud and Overservicing, Minutes of Evidence}, Volume 15.

\textsuperscript{29} For example, the front-page headlines of the \textit{Australian}, 4 February 1982: "Doctors milk the system of $100m a year".

\textsuperscript{30} House of Representatives (1983), \textit{Parliamentary Debates (Hansard)}, 14 September, p768.
mechanisms into the rights of private practice in public hospitals, and not at abolishing such private practice *per se*.\(^{31}\)

Memories of the exodus of specialists under Medibank in 1974, the almost impossibly tight schedule for the implementation of Medicare, and the widespread support for the notion of equitable income restraint, contributed to a limited and suspended awareness of the implications of the Section 17 amendments. This greatly facilitated their passage through parliament, which, considering the intense conflict they generated in the months after assent and throughout 1984, was remarkably smooth and amicable.

**The Penington inquiry**

However, by December 1983 and January 1984, the medical profession's formal opposition to the amendments had begun to escalate.\(^{32}\) Negotiations between the government and the profession (predominantly through the Federal AMA) on many aspects of Medicare's implementation had been taking place since the previous July.\(^{33}\) The amendments had become the central issue of dispute in those negotiations.

The medical profession objected to many of the amendments' provisions, including the Minister's control (or "unfettered power") over

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31. See for example, House of Representatives (1983), *Parliamentary Debates (Hansard)*, 6 September, pp405-406.

32. Jane Smith, a member of Blewett's ministerial staff at the time, recalls that "[t]he calm erupted, however, when the implications of Section 17 became apparent in a statement issued by Dr. Blewett on January 17, 1984". Smith (1985), *Op. cit.* p30.

the terms and conditions of specialists' contracts; the requirement to charge at or below Schedule fee levels; the hospital bill-raising and administration requirements; and in particular, the Federal government's limitations imposed on the specialists' total income from private practice in public hospitals.

On 11 January 1984, less than three weeks before the commencement of the Medicare scheme on February 1, Dr. Blewett told a meeting of AMA representatives that he was unwilling to make substantial changes to the guidelines on contract conditions. Three days later, AMA federal president Dr. Lindsay Thompson announced that consultations with State branches revealed that specialists in most States would not sign the proposed contracts. They were willing to work under the existing arrangements negotiated with the individual hospitals, but threatened industrial action unless the dispute was satisfactorily resolved. Such action would ensure that patients would not be able to receive medical benefits for diagnostic services after Medicare commenced on February 1, the date from which the amendments came into force.34

On 24 January, 1984, after consultations with NSW Health Secretary Bernie McKay, Dr. Blewett announced an inquiry into private practice rights in public hospitals as a means to help resolve the dispute over the contracts.35 Melbourne University's Dean of Medicine, Professor David Penington, agreed to act as the independent chair of the committee of inquiry, and Dr. Blewett suggested an AMA nominee and

a government nominee as the other committee members. The application of the guidelines limiting VMOs' drawing rights were suspended pending the report of the Penington inquiry, scheduled for June 1984.

The AMA initially refused to participate in the inquiry, contending that it was "a diversionary tactic designed to obscure the real issues in the dispute". The AMA claimed that its main concern was still the ultimate discretion over the terms of the contracts held by the Minister under the new amendments, "so irrespective of what a committee [of inquiry] determined, the minister would still have the unfettered power to do what he likes". At the February meeting of the AMA's peak policy group, Federal Council reaffirmed its opposition to the amendments.

The AMA, particularly its specialist member groups, also objected to the inquiry on the grounds that its terms of reference covered all private specialist services in public hospitals. This reinforced widespread suspicions within the profession that the Federal government intended to extend the amendments' income limits and contract controls on diagnostic services to all other specialist services in public hospitals.

The suspicions of the medical profession were not entirely without foundation. On March 1 1984, Blewett was explicitly asked if the

37. Ibid.
government did intend extending the contracts to other specialist services. He replied that he "could not predict what would happen in the future", but that there was no intention to do so "in the period I can plan for". The Penington inquiry noted that some of the submissions it received contained evidence to support the profession's suspicions in the form of "statements and actions by government officers in several States or Territories". Shadow Health Minister Jim Carlton later claimed in parliament that Blewett had told a meeting of the Doctors Reform Society (DRS) in August 1983 that "it was agreed at the July [1983] Health Ministers' Conference that attention to these problems should be initially directed to the area of diagnostic services, with the intention to move more broadly in due course". Dr. Blewett effectively maintained the suspicions of the profession in this regard by not directly replying to or denying the charge during the rest of the dispute.

However, the AMA continued negotiations with the Minister over the terms of reference for the inquiry. After two meetings with the Minister, the Association announced on February 16, 1984 its willingness to participate in the inquiry under wider terms of reference that included recommendations on review and appeal mechanisms for the Minister's determinations under the amendments. The government agreed that no limitations on earnings for salaried or

39. SMH, 1 March 1984:1; Canberra Times, 1 March 1984:1. See also Jane Button in Canberra Times, 26 January 1984, p3: "The new contracts applied only to prescribed diagnostic services, but it was clear most hospital medical officers expected the contracts would soon be widened to take in all medical services".


visiting specialists would apply during the inquiry, and that the level of facility charges would be determined by each State rather than by the Federal government. The remaining guidelines on institutional bill-raising and fees at or below Schedule levels would still apply, but specialists already working under these or similar conditions would not have to sign new contracts. 42 In addition to Professor Penington, Dr. J.D. Cashman (AMA nominee) and Dr. B.J. Kearney (government nominee) were appointed to the inquiry.

While endorsing the decision to participate in the inquiry, subsequent meetings of AMA State branches rejected the modified guidelines, and urged the Minister not to introduce them. However the new Guidelines were gazetted a week later on February 29 - the day before Medicare officially commenced - and provided for benefits to be paid for diagnostic services where either the specialists had contracted to charge at or below Schedule fees, or where the State governments had regulations limiting the charges to the Schedule fees. At the same time, the Minister announced that all Labor States (NSW, Victoria, WA and SA) and the Commonwealth (acting for the ACT) would introduce, or already had introduced, such regulations. In Queensland and Tasmania, where there were limited rights of private practice in public hospitals, diagnostic specialists would have to agree in writing to charge at or below Schedule fees before Medicare benefits were payable.

The Penington inquiry commenced its hearings on 16 March 1984. Negotiations continued between the Federal Minister and the AMA.

amid further threats of State and national industrial action by the specialists working in public hospitals. With the support of the Australian Democrats, Section 17 was further amended on 2 April 1984 to provide for the guidelines to be subject to parliamentary disallowance, and for ministerial discretion to waive the need for contracts where State legislation ensured that fees conformed with the Schedule.

Three days later, AMA Federal President Thompson, Industrial Relations Minister Willis and Health Minister Blewett reached a provisional agreement on the new arrangements. Under the agreement, the AMA would cease all current and proposed industrial action against Section 17, and agree to observe the Schedule fees. In return, the government agreed to formally limit the types of services effected by Section 17 conditions to those provided by radiologists, pathologists, radiotherapists and physicians in nuclear medicine, so negating the profession's fears about the provisions being extended to other specialist hospital services. It also agreed to make a joint submission with the AMA to the inquiry on consultative, appeal and arbitration mechanisms where disagreements on the guidelines occurred; and to fully implement the inquiry's final recommendations on such mechanisms.

At this stage, the principal concerns of both the Federal government and the specialists seemed substantially accommodated. The government could get a form of cost control on Medicare benefits payable for diagnostic services for private patients in public hospitals, in the form of observance of the Schedule fee. For their part, the specialists could have the "unfettered power" of the Minister removed
by the provisions for parliamentary scrutiny and appeal procedures for contested decisions under Section 17. However, the tensions between the profession and the Federal government over private practice rights were not entirely eased by this formal agreement. McKay refers to the agreement as "a truce of sorts"; while the AMA regarded it at the time as "an uneasy truce".\footnote{McKay (1986), Op. cit., p222; and Australian Medical Association (1985), Annual Report, 1984, p10, respectively.}

At the end of June 1984, the inquiry issued its Progress Report, which was sent to all doctors in Australia under a joint government-AMA covering letter. While the joint letter focussed on the issues of agreement between the two parties that had emerged during the inquiry, their independent interpretations of the report suggested that considerable areas of disagreement over Section 17 remained. In their media statements on the report, both Dr. Blewett and Federal AMA representatives claimed that its preliminary findings provided justification for their respective stands in the dispute over the Section 17 provisions.

Dr. Blewett welcomed the suggestion of the report that the general observance of Schedule fees and income limitations for salaried specialists was appropriate for private diagnostic services in public hospitals, and commented that the report "basically supports the Government's position" on institutional billing, and that it "'endorsed unequivocally' the government's objective of proper accountability of private practice in public hospitals".\footnote{Weekend Australian, June 30-July 1, 1984:4.} He also pointed to the Committee's unreserved acceptance of his previous statement that the
government's "over-riding responsibility is to ensure that $2,000 million in Medicare benefits paid annually to the medical practitioners in this country is wisely and properly spent".45

The AMA, on the other hand, contended that the report "vindicated the stand taken by doctors during the dispute", and that it "showed that there was no justification for the Government to introduce the Section 17 legislation",46 especially in light of anomalies relating to some of the disputed guideline provisions, and the Committee's reservations over the accuracy of Health Department figures on the rate of recent increases in diagnostic service provision and cost.47 As the AMA's Lindsay Thompson commented, while the progress report provided some grounds for further negotiation between the profession and the government, "we're at half-time - the game isn't over".48

Such caution is probably a reflection of Dr. Thompson's difficult position within the AMA, caught in the tension between moderate and more militant groupings among the national membership. There were already growing doubts about the willingness of the NSW Branch, which had an historically antagonistic relationship with the federal organisation,49 to accept the Penington inquiry as the basis for resolving the Section 17 issue. Moreover, the federated structure of

47. Australian, 29 June 1984:2.
48. Ibid.
the AMA gave the federal executive only limited control over the actions of State branches. It was this tension which later intensified to produce a serious split between the Federal AMA and the NSW Branch over the profession's formal strategy in the dispute.

The Penington inquiry's Final Report was issued in October 1984. The report recommended that diagnostic services provided by private practice in public hospitals be charged at or below Schedule fees, and that the Schedule be subject to yearly review by government and medical profession representatives. The report found that while limits on income from private practice for full-time salaried diagnostic specialists were appropriate (25% on top of hospital salary), they were not justified in the case of visiting specialists. The report also found that the government's claims of "double-dipping" by visiting specialists - whereby VMOs were earning extra private fees during periods for which they were being paid sessional fees for public patients - could not be unequivocally validated.

The report offered two options in relation to fees charged by other (non-diagnostic) specialists for private services in public hospitals. Either fees were to be charged at or below the Medical Benefits Schedule levels; or higher-than-Schedule fees were to be regularly monitored by Billing Review Committees, with the obligation on the practitioner to inform patients of the higher fees before service delivery. These committees were to be constituted by three elected


51. Although its occurrence was not firmly established, "double-dipping" by VMOs continued as a recurrent concern for governments, and in mid-1993 the Commonwealth and the States agreed to share hospital payments data to make monitoring mechanisms more effective. See Australian, 15 June 1993:5; Australian Doctor, 30 July 1993:1
medical staff and one medically-qualified hospital management representative. The report also recommended the establishment of formal consultative and appeal procedures for ministerial decisions made under Section 17, and the establishment of institutional bill-raising and appropriate facility charges.

Although they were later withdrawn with the rest of the Section 17 amendments, the Billing Review Committees are an example of an important mechanism by which the influence of medical expertise is conveyed into the health policy arena: that of peer review. Later chapters focus on the political advantage for the profession provided by various state-sanctioned peer review mechanisms which have been successfully implemented. As discussed further below, if the Billing Review Committees had been established, they would have provided the means by which the medical profession could have effectively neutralised the accountability and fee constraint objectives of Section 17, and left the scrutiny of VMOs' income from private practice in public hospitals entirely within the hands of the profession itself.

The AMA's response to the Final Report was generally positive. Dr. Thompson said the report was "constructive", offered a "workable compromise", and with further negotiations could lead to a sustainable settlement of the conflict. He concluded that:

> While we can all rant and rave, ultimately things can only be resolved by consultation.\(^{52}\)

The AMA also agreed to join a proposed interim consultative committee to consider all those matters raised in the recommendations which required legislative amendment. Membership

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\(^{52}\) *SMH*, 12 October 1984:1; *Canberra Times*, 12 October 1984:1.
of the committee was limited to an independent chairperson, three
nominees of the Minister and three nominees of the AMA. The
response of the government to the report was consistent with the
undertakings it had given as part of the agreement with the medical
profession to participate in the inquiry. The government accepted as a
package the report's 25 "core recommendations", including those
relating to the Billing Review Committees, and agreed to consider the
remaining negotiable issues.

Up to the release of the Penington report, the dispute over Section 17
between representatives of the medical profession and the Federal
government contained all the elements of a routine policy conflict
between a strong organised interest group and the state. The
government had proposed legislative changes in health care which the
profession assessed as inimical to its interests. The profession,
represented by the AMA, entered orderly negotiations with the
government through well established channels in an effort to reach
mutual accommodation between government policy objectives and the
profession's interests.

As in many preceding conflicts, the AMA was demonstrably successful
in lobbying the government and the other political parties to modify
health policy proposals to be more congruent with the professional
interests of its members. For example, the government's unqualified
acceptance of the Penington recommendations on the incorporation of
an appeals mechanism in the contract process, the yearly bilateral
review of fees in the Medical Benefits Schedule, and the conditional
allowance of fees higher than the Schedule, can be unambiguously
traced back to specific, stated demands of the profession. Similarly,
the joint AMA-government submission to the Penington inquiry, the
distribution of the Final Report to doctors under a joint AMA-
government covering letter, and the joint AMA-government interim
consultative committee, are compelling illustrations of the health
policy significance to the government of the medical profession and its
organised interest groups.

These examples imply a large measure of compatibility between the
general politico-economic goals of the state and the general
professional interests of the doctors in the health area. While there
may be acute disagreements about methods and implementation, the
overall objectives of the state and the profession are not diametrically
opposing ones. With the general operating principles of health policy
negotiations - the rules of the game - so clearly established between
the government health agencies and the profession, disputes do not
tend to centre on irreconcilable policy goals or incompatible ideological
tenets. Rather, they tend to involve secondary or peripheral policy
issues or differing approaches and means to very similar policy ends,
all of which are amenable to resolution through direct, structured
negotiations between representatives of the government and the
profession.

However, these illustrations reveal something more than a well
organised interest group successfully lobbying government. They also
reveal the strongly determinative presence of medical knowledge and
expertise. They reveal the profession as the officially recognised and
routinely consulted source of medical expertise required for the
development and implementation of health policy. This expert role was
epitomised by the entirely medical make-up of the proposed Billing
Review Committees. These illustrations also reflect the AMA's position as a traditional, integral part of the very structure of health policy-making in Australia. As in the other case studies, the illustrations support the notion of the medical profession as not just another interest group trying to influence what comes out of the policy machinery, but as an interest group so dominant as to become, in practice, a part of the policy machinery itself.

Like other health interest groups, the profession has some capacity to direct health policy towards its members' interests through its conventional lobby group activities. In this mode, the profession is trying to influence the inside workings of the policy process from the outside, where it is directly competing with a variety of other health interest groups. However, the profession also has the capacity to promote its interests from its health expert role within the system, often under the guise of providing impartial technical advice to the government. The Billing Review Committees, based on medical peer review, would have provided the means for the profession to influence policy through such an internal role.

In this sense, the political ideology of the party in office, as noted in the discussion on the history of Australian medical politics in Chapter One, is not the most important determinant of policy outcomes. Rather, it is the particular abilities of the representatives of government and the medical profession to reach consensus on outstanding policy differences through well-worn negotiating mechanisms. Active participation by other groups effected by the policy outcomes - whether directly, such as health consumers or other
health workers, or indirectly, such as taxpayers or other interest
groups - is implicitly excluded from or marginalised by this process.

Health policy is presented here as a constellation of issues that are
predominantly the preserve of the medical profession, as the bearers
of the medical expertise on which all health strategies must ultimately
rest, and of the government, as the formal representatives of the
citizens underwriting their cost. Within this perspective, the Section
17 dispute arose because the new Labor government, inexperienced in
the traditional art of health policy making, did not fully appreciate the
intricacies of the established procedures and negotiating mechanisms
with the medical profession, and attempted hasty policy measures
outside the conventional, implicitly agreed frame of reference.

In contrast to the acrimonious relations between the Whitlam
government and the AMA over the introduction of Medibank, and to
the divisions that emerged within the AMA over the possibility of
developing a working relationship with the new Labor government,53
there was a high level of acceptance - or at least resignation - amongst
most sectors of the profession to the introduction of its successor in
Medicare. It was not so much the principles of Medicare itself which
were at issue, but rather the details of its administration and
implementation under the Hawke government. Even before Hawke
was elected, the AMA appears to have fully digested any remaining
ideological differences over Medicare, and was negotiating with the
Labor Party on health issues within the general framework of a
universal health insurance scheme. Then-president of the AMA, Dr.

Association?", Social Science and Medicine, 18, 11, p975.
Lindsay Thompson, was able to reveal to members in the Association's 1982 annual report that:

[j]In 1973 it was difficult for the AMA to engage in meaningful discussions with the then Labor Government because of the stated non-negotiability of many of its plans. However, in the past 18 months there has been considerable dialogue between representatives of the AMA and the Labor Party. Other circumstances have changed in the past 10 years, and the Association does not propose to start off its relationship with the new Government on the basis of confrontation.54

Dr. Thompson certainly abided by this assurance to the AMA membership. He commented in an interview in April 1985 that he fully recognised the Hawke government's electoral mandate to introduce a "tax-financed scheme for the reimbursement of medical expenses". However, he said,

[w]hat it did not have approval for...were some of the details - the plans to control the incomes of diagnostic specialists and possibly other visiting hospital staff, the drastic effects on hospital practice from the swing away from private health insurance or the higher cost of that insurance to many families.55

While there is almost certainly an element of sarcasm in his use of the word "details" to describe the central issues of the Section 17 dispute, Dr. Thompson's formal acceptance of the principles embodied by Medicare is undeniable, as is the implication that it is the natural role of the medical profession - and more specifically the AMA - to negotiate with the government over those outstanding anomalous "details". Here then, is the principal organised group representing the political and industrial interests of the medical profession, although traditionally conservative56 and staunch defenders of the values

embraced by private medicine, professional autonomy and freedom from interference by the state, accepting in principle a universal health insurance scheme which is in many ways the antithesis of those values. Moreover, the AMA was operating a health policy strategy based on cooperation and negotiation with the very government responsible for developing such a scheme.

In this sense, the dispute over Section 17 was not a conflict over irreconcilable ideological principles between the government and one of hundreds of organised interest groups. It was an internal dispute between the senior partners of Australia's health "policy community",57 with its contemporary parallel in the occasional friendly differences within the "joint enterprise" between the British Medical Association and the health ministry; and its historical parallel in the occasional differences within the "cooperative partnership" between the Menzies government, the AMA and the health funds.58 In this coalition, the state members represent the various health interests of the community, the health officials are responsible for the development and administration of policy, and the medical profession members provide - often in combination with government members - the medical expertise deemed intrinsic to the maintenance of those community interests.

56. The then-federal president of AMA described his personal politics at the time as "very much to the right of centre". SMII, 23 February 1985:4.


The policy success of the medical profession is undoubtedly associated with the high levels of financial, political, human and organisational resources it can mobilise and coordinate in its negotiations with the government and health agencies. Thelma Hunter, for example, attributes such success to

the indispensibility of medical expertise [in both the clinic and the policy process]; the prestigious status of the profession in society; its wealth and economic resources; the dedication of its leaders...the absence of party consensus on health insurance, the longevity of non-labour parties in political office since 1901, the constraints of the Australian constitution [on compulsory fee setting by governments], the accessibility of decision-making institutions and a federal culture receptive to pressure group activity.59

Like many interest group approaches, however, some of the factors suggested here, such as "the prestigious status of the profession", are in fact measurements or indicators of the AMA's health policy effectiveness rather than underlying reasons for it. Moreover other factors, such as "the accessibility of decision-making institutions" and "a federal culture receptive to pressure group activity" cannot by themselves provide an explanation for why the AMA is so successful compared to many other pressure groups operating in the same political environment. The medical profession's policy success, as demonstrated more fully below, must also be associated with the medical knowledge and expertise which underpins its authority as "a partner in the administration of its own policies".60

60. Ibid., p195.
From medical issue to industrial dispute

Before the shift to NSW, and the more distinctly industrial issues which emerged there, the dispute centred on issues which both sides treated as essentially medical in nature, and so ultimately dependent on medical expertise for their resolution. No other types of knowledge, parties or interest groups were considered necessary or useful to this process. The concessions on the appeals mechanism, above-Schedule fees and the Schedule review, the joint submission and covering letter, and the make-up of the interim consultative committee, all testify to the implicit assumption on the part of the government that the problem of containing Medicare costs was largely a technical problem requiring a technical fix. The substance of such a technical fix could only be found in the medical knowledge held by the medical profession and institutionalised as medical expertise.

Thus, only the medically-qualified members of the Billing Review Committees (three elected medical staff, and one medically-qualified hospital administrator) were deemed to have the cognitive capacity to determine whether above-Schedule fees charged by VMOs for specific procedures were set at an appropriate level. Indeed, the structure of the bilateral Schedule review mechanism presumes that only medical expertise - from the representatives of the AMA and the Department of Health - could assess appropriate benchmark levels for the fees in the Schedule itself.

Similarly, the interim consultative committee of AMA and Health Department representatives was explicitly established to make sure that the legislative process giving effect to the Penington recommendations was fully cognisant of, and in harmony with, the
medical issues raised by the profession. The medical expertise provided by the AMA and government representatives was clearly seen by the participants as central to this aim. As no other forms of expertise or representation were sought for the committee, the issues involved in the recommendations were equally clearly seen as exclusively medical in nature.

The constitution of the Penington Committee itself is even more indicative of this dependence on medical expertise in health policy. The primary requisite for members of the Committee, the central mechanism by which the Section 17 dispute was to be resolved, was that they were medically qualified. The specific interest areas for which they were nominal representatives - the medical profession, the government, and an independent chairman - were secondary requisites. This is well illustrated by the layout of the title page of the Final Report. Accompanying each committee member's name are his full medical qualifications and College memberships. No indication is given of the type of occupation or of the formal position(s) held at the time.

The terms of reference for the inquiry effectively exclude other types of qualifications, jobs or representation on the Committee - which is all the more intriguing given the consensus style of politics under Hawke, and the direct effect of Medicare on the Accord and wider economic policies. No need was seen for, or relevance accorded to, representation from health consumers, trade unions, taxpayers, other health professionals, social workers, welfare groups or the legal

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profession. Even the administrators and managers of the hospitals in which the Section 17 terms and conditions were to directly apply were excluded from this resolution mechanism. The consistent presumption here is that the dispute is essentially a medical problem, and that the only people capable of making appropriate judgements on such a problem are those with the necessary medical expertise, the doctors themselves.

The argument here is that it was not the effectiveness of the AMA as an organised interest group which by itself determined the policy outcome to this stage. This interest group effectiveness was bolstered by, and underpinned by, the pre-existing, implicit agreement between the government and the profession on the basic rules and parameters of health policy negotiations. Under this implicit agreement, the dispute is effectively divided between political issues and medical issues; and while the political issues are rightfully determined by parliamentary and legislative processes (albeit in consultation with the medical profession), the so-designated medical issues are ultimately the sole or dominant preserve of the medical profession as the legitimated bearers of medical expertise. In this sense, it is the expertise of the medical profession which excludes competing interests from the policy process, and so provides the bounded political framework in which the profession's organised interest groups can claim such a consistent record of policy success.

**From Section 17 to the NSW Doctors' Dispute**

There was a qualitative change in the nature of the dispute between the initial period in which the Section 17 proposals were the central
issue, and the latter period, known as the NSW Doctors' Dispute, in which other issues dominated. While the subject matter of each was quite distinct, there was a considerable degree of temporal overlap between these two phases. While the Penington inquiry was proceeding - from about March to October 1984 - both phases of the dispute were operating simultaneously.

Whereas the first stage involved political expressions of both medical knowledge and interest group power, the second stage was largely restricted to expressions of the latter. The outcome here was not directly dependent on built-in presumptions about the medical nature of the issues involved and their resolution through the application of medical expertise. These were not generally perceived as technical problems requiring technical solutions. Rather, as the discussion below establishes, the issues were clearly treated by all concerned - government, health agencies, medical profession, media - as primarily industrial issues, requiring explicitly negotiated political solutions.

The release of the progress and final reports of the Penington inquiry did little to resolve the intense conflict over politico-industrial issues between parts of the medical profession and State and Federal governments. This conflict had continued since the inquiry was announced in February 1984, and by the Final Report's release in October, had shown few signs of producing a permanent settlement. During this period, the centre of the conflict shifted from the Federal level to the State level, and was concentrated in New South Wales. The main protagonists in the dispute now also included the Wran Labor government of NSW, the NSW Branch of the AMA and specialist sections of the NSW medical profession.
Such a shift had been strongly indicated from as early as February 1984, when NSW surgeons rejected the guideline compromises made by Dr. Blewett as part of negotiations to get the (Federal) AMA to participate in the Penington inquiry. The surgeons acted through the Australian Society of Orthopaedic Surgeons (ASOS) and the Council of Procedural Specialists (CPS), both headed by Dr. Bruce Shepherd, and the Australian Association of Surgeons (AAS), led by Dr. Michael Aroney. They made a commitment to a 24-hour stoppage of all non-urgent services in the State's public hospitals on March 1 1984, although they themselves were not directly effected by the Section 17 guidelines. They were later joined in this stoppage by NSW radiologists, and supported by the NSW Branch of the AMA.

The shift to NSW can be largely attributed to several events and local issues that form the background against which the campaign against Section 17 was mounted. First, the relations between the medical profession and the NSW government had been severely strained for some time. In 1982, well before the election of the Federal Labor government and its mandate for Medicare, NSW Health Minister Laurie Brereton embarked on a series of rationalisation measures within the State's hospital sector. They were aimed at controlling the growth rate of the State's health budget that was predominantly attributable to ballooning hospital costs.

The core initiatives were the capping of hospital budgets to preclude further growth in real terms; the proposed "Beds for the West" program, aimed at redistributing the allocation of hospital beds from the inner city locations favoured by specialists to the expanding
western suburbs region; and legislative measures empowering the Minister to recommend the closure or amalgamation of public hospitals and to regulate the establishment, funding and staff organisation of private hospitals.\(^62\)

Mr. Brereton also antagonised specialists by accusing them of overservicing and of intimidating patients to retain their private insurance after the introduction of Medicare.\(^63\) Relations were further soured by Mr. Wran's "seven-year ban" legislation passed in June 1984 (later repealed), by which VMOs resigning in protest against the Section 17 proposals after 26 May 1984 would be banned from re-employment in NSW public hospitals for a period of seven years, and by his government's threats to recruit overseas specialists to cover the shortfall in public hospital staffing levels.\(^64\)

Second, the Section 17 amendments had particular implications for specialists in NSW stemming from that State's unique mixture of private and public hospital services. In NSW, the private hospital sector is significantly smaller than those of the other States, and a relatively high proportion of private practice in hospitals occurs within the public hospital system. For example, about 80% of NSW hospital beds are in public hospitals, with much lower rates in the other States.\(^65\) As a consequence, the impact of the decrease in private

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64. Bernie McKay, then secretary of the NSW Department of Health, believes that Wran's seven-year ban manoeuvre destroyed a promising settlement plan being pursued by NSW Health Minister, Ron Mulock. McKay (1986), "A Participant's Account...", p226.
insurance coverage accompanying the introduction of Medicare, and of any controls on private practice incomes in public hospitals, would have been greatest in that State, especially in view of the oversupply of doctors in some specialties there. Similarly, the exodus of diagnostic specialists in 1974 under Medibank - which effectively removed their private practice rights - had been most evident in the NSW public hospital system.

A further factor contributing to the distinctiveness of the situation in NSW was the close proximity of State elections there, due in March 1984. Indeed, many of the NSW specialists' negotiations on industrial action took place in the middle of the party campaigns for those elections. The high electoral significance of the dispute to the State government is indicated by the continuous personal interventions and compromises made by Premier Wran in his efforts to settle the escalating dispute with the specialists. The dispute's electoral significance is also reflected by the personal intervention of Prime

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66. While there were State and regional variations, the national decline from 1983 to 1984 was about 14%, from 63.7% to 50%, after which there was a much more gradual decline. See Commonwealth Department of Health, Housing, Local Government and Community Services (1993), "Reform of Private Health Insurance: A Discussion Paper", Canberra: AGPS, p5. At the time, however, the estimates varied enormously. Many observers accepted the estimate of about 20%. See for example, Pensabene, T. (1985), "The New South Wales Doctors' Strike: End of an Era", New Doctor, No. 36, June, pp5-8, at p6; Australian, 28 February 1985:3; SMH, 9 April 1985:11. AMA estimates tended to be much higher, such as president Lindsay Thompson's estimate of 30%, and up to 50% "in some country areas". Daniels, J. (1984), "The Recent NSW Dispute", New Doctor, No. 33 (September), p3; and Australian, 28 February 1985:3.

67. McKay (1986), "A Participant's Account...", p221. Pensabene notes that previous disputes in Australia between the medical profession and the state have tended to occur when there is an oversupply of doctors increasing competition and reducing income stability. With a doctor to population ratio of 1 to 480 in NSW at the time, compared to a national average of 1 to 520 (and higher ratios of specialists to population in orthopaedics and other procedural areas than in the other States), he finds it "not surprising" that the dispute was most intense in that State. Pensabene, T. (1985), Op. cit. Davis, A. and George, J. (1988), States of Health: Health and Illness in Australia, Sydney: Harper and Row, p120. See also Sax, S. (1990), Health Care Choices and the Public Purse, Sydney: Allen and Unwin, p76.
Minister Hawke, at the request of Mr. Wran, in the lead-up to the State elections in March, and with Federal elections due later in the year. The significance of the timing of the dispute was not lost on sections of the NSW medical profession, which, unlike the profession in general, were vehemently opposed to the new Labor government's Medicare scheme.\footnote{See for example, the half-page advertisements in the \textit{Daily Telegraph} of 27 January 1984, and the \textit{Melbourne Age} of 28 January 1984, authorised by Dr. Michael Aroney, Federal Secretary, Australian Association of Surgeons. The text consists of a fifteen point critique of Medicare, including: "Under Medicare, you will become just another number in the computer file"; "Medicare is not medical care - it is a doctrinaire socialist theory which has failed everywhere it has been tried"; and "Medicare is an economic ploy being imposed in your name by the government on an unsuspecting public".}

The final factor impacting on the situation in NSW is what Bernie McKay refers to as the "Great Conspiracy Theory". As Secretary of the NSW Health Department at the time, he argues that large sections of the State's medical profession viewed with great suspicion the ongoing negotiations and legislative cooperation between the NSW and Federal governments over the dispute. They mistakenly concluded, he suggests, that these interactions were evidence of a joint State-Federal Labor conspiracy to wholly nationalise medical practice in Australia. This perception persisted, despite several explicit, public guarantees - written and verbal - to the contrary from the leaders and health ministers of both the NSW and Federal governments. The first of these guarantees came as early as January 1984, before the Medicare scheme was fully operational.\footnote{McKay (1986), "A Participant's Account...", p223; SMII, 18 January 1984:2. See also Larkin (1989), \textit{Op. cit.}, p70; and Catts, P. (1985), "The Doctors' Dispute In N.S.W." \textit{Australian Surgeon}, March, pp3-6. In same issue (p7), see reproduction of joint statement by NSW Minister for Health, Mr. Mulock, and Federal Minister for Health, Dr. Blewett, opposing nationalisation of medicine and supporting role of private practice. See report of similar guarantees given by Mr. Wran and Mr. Hawke in Canberra on January 23 and February 27, 1985, in \textit{Medical Practice}, January/February, 1985:7; and March 1985:7, respectively.}
These factors, and the traditional independence of the NSW Branch of the AMA from its Federal counterpart,\textsuperscript{70} contributed significantly to the atmosphere of acrimony and mutual suspicion that surrounded relations between the NSW medical profession and the State and Federal governments in the early months of 1984. As McKay suggests, the particular combination of local and historical factors made the situation in NSW around the time of Medicare's introduction "fairly explosive",\textsuperscript{71} and provide compelling reasons for the transformation from a routine conflict over Section 17 at national level, to an unusually intense conflict over wider health care issues centred in one State, and generally referred to as the NSW Doctors' Dispute.

By the middle of 1984, NSW visiting specialists had resolved to step up their campaign of industrial action by resigning from their public hospital appointments. At this time, their claims began to range well beyond the original issues over contracts with public hospitals. This agenda expansion process continued throughout the remainder of the year and the early months of 1985, right up to the official resolution of the dispute in May. The principle claims in the specialists' dispute revolved around the loss of private practice income resulting from the decline in the level of private health insurance with the introduction of Medicare, the levels and methods of remuneration for visiting medical officers in NSW public hospitals, and the effective long-term reductions in government funding for hospital services and equipment.

\textsuperscript{70} For more on the strained relations between the NSW and the Federal AMA, see Chapter Five.

\textsuperscript{71} McKay (1986), "A Participant's Account...", p221.
The development and uneasy resolution of the NSW Doctors' Dispute are not of themselves central to the concerns of this case study, and have been examined in detail elsewhere.\textsuperscript{72} However, they retain relevance to the extent that the terms of the final outcome of the dispute are a useful indicator of the strength of the medical profession as an organised interest group, measured by the extent to which its original stated objectives are met. The outcome, and the pattern of political processes generating it, is also relevant in assessing the size of the role that can be attributed to the medical knowledge held by the profession.

While the Section 17 amendments became more marginal to the NSW Doctors' Dispute after the final report of the Penington inquiry, they were never entirely put aside. They were certainly included in the negotiated package of measures and compromises that led to the official resolution of the dispute in April and May, 1985. Indeed this package included (despite a sustained defence by Dr. Blewett), the repeal of all the Section 17 amendments that sought to limit the fees and incomes of visiting specialists from private practice in public hospitals.

The package also included $150 million in Federal funding over three years to upgrade equipment and facilities in teaching hospitals, considerable increases in sessional payments for doctors treating Medicare patients in public hospitals,\textsuperscript{73} with an option of fee-for-


\textsuperscript{73}
service payments in some hospitals; the automatic classification in public hospitals of privately insured patients as private patients, unless they choose to be treated as Medicare patients; a series of measures aimed at making private health insurance more attractive, including the allowance of "gap insurance" to cover the (then 15%) difference between the Medicare benefit and the Schedule fee for services provided in hospitals; and the transfer of Commonwealth control over the classification and organisation of private hospitals to the States and the private health funds.

The expansiveness of the settlement package, especially in terms of its effect on specialist incomes, led many observers to suggest that it amounted to a resounding victory for the medical profession, and a total breakdown on the part of the Federal and NSW governments in the lead-up to the critical Federal elections later in the year. They contended that the visiting specialists "laughed all the way to the bank". The scope of the settlement terms, and their impact on the principles underlying the Medicare scheme, was widely viewed as so substantial as to constitute an entirely new scheme, "Medicare Mark II". Neville Wran commented at the time that the surgeons had

73. The increases - "unprecedented in arbitration history" (Medical Practice, December 1985/January 1986, p11) - were granted by Arbitration Commission deputy president Macken in late 1985, and represented up to 90% above existing sessional rates. His contention that medical incomes had suffered a significant relative decline under Medicare was strongly questioned in a later assessment of the decision by the (NSW) Public Accounts Committee. See Medical Practice, December 1985/January 1986, pp11-12; Australian, 9 June 1989:4; Daily Telegraph, 9 June 1989, p1 and p10 (editorial); SMH, 9 June 1989:1,8, and p14 (editorial); and SMH, 19 June 1989:19. See also Stuart Rees's criticism of the decision in Australian Society, May 1986:10-12.

74. See for example, 'Doctors win soft Medicare', in AFR, 3 April 1985:1; 'Hawke caves in on Medicare', in Age, 3 April 1985:1; and 'Govt backs down in doctors' row' and 'NSW doctors' row: Government caves in', in SMH, 3 April 1985:1,4.

75. Age, 3 April 1985:1.

76. For example, Age, 3 April 1985:1; Medical Practice, April 1985:6.
received "a very generous offer from the federal Government - some of us might think too generous...".\textsuperscript{77}

Such claims gain some support from a consideration of the cost control concessions provided in the package. For example, gap insurance provides a financial incentive - or at least removes a financial disincentive - for practitioners to charge above the Schedule fee for privately insured patients, since 100% of that fee can be recovered from the health fund, and the consumer incurs no extra out-of-pocket expenses. As health economist Paul Gross argues, this provides an incentive for doctors to treat more patients in hospital rather than in their office surgeries.\textsuperscript{78} It also lessens somewhat the effect of the Medical Benefits Schedule in 'pegging' the fees charged for medical services - which was one of the original core objectives of the Section 17 provisions. It was precisely because of this fee-drift effect that the original Medicare arrangements, based on the experience of the Whitlam government with Medibank and the findings of the 1980 Jamison Inquiry,\textsuperscript{79} explicitly prohibited gap insurance cover as part of its recommended strategy for cost containment.\textsuperscript{80}

Similarly, the government's concessions on remuneration arrangements not only failed to contain fee-for-service practice in public hospitals, but resulted in its considerable extension in NSW

\textsuperscript{77} Canberra Times, 15 April 1985:3.

\textsuperscript{78} Australian, 16 April 1985:9.

\textsuperscript{79} Jamison, J.H. (1980), Chairman, Commission of Inquiry into the Efficiency and Administration of Hospitals, 3 Volumes, Canberra: AGPS.

\textsuperscript{80} See for example, House of Representatives (1983), Parliamentary Debates (Hansard), 6 September 1983, p402.
and further entrenched it within the Australian health care system. They also removed any direct Federal government control over the level of total VMO remuneration, and left it to the States and to the profession itself to guard against budget blow-outs. As part of its "honourable settlement", the Federal government stated that it was:

prepared to take on trust the medical profession's assurance of a high level of schedule fee observance in public hospitals, and abandon its [the government's] current regulatory powers in this area.81

The increases in Federal funding associated with these arrangements is an all the more impressive achievement by the profession in light of the significant reductions in Medicare expenditure being actively sought at the time by the Hawke Cabinet's Economics Committee, in preparation for the 1985-86 Budget.82 It is also impressive considering the strong view held by sections of the ALP that "the doctors have been given too much already".83 Several ministers and backbenchers regarded the terms of the package as "far too generous",84 while some union representatives thought that the package represented "sheer capitulation to the unscrupulous tactics of a group of greedy doctors".85

81. Age, 3 April 1985:10. There is a certain irony here in returning the responsibility for cost-containment to the States, for it was the States which "enjoined the [Federal] Government to amend Section 17 in the first place because they found cost-containment politically impossible". Ibid.

82. SMH, 19 February 1985:3; AFR, 19 February 1985:1. 18. This cost-cutting pressure was intensified by the Hawke government's previous election pledge not to increase the Medicare levy in its next term of office. See Age, 19 February 1985:3.

83. SMH, 1 April 1985:3.

84. SMH, 29 April 1985:2.

85. SMH, 4 April 1985:1.
Moreover, the later arbitration of VMO sessional rates by the Arbitration Commission - a condition of the settlement package - produced "incredibly generous" increases, and resulted in total VMO payments in NSW rising by 345% over the next five years. From 1985-86, the rate of increase in sessional payments to VMOs outstripped that of fee-for-service payments. As a result of these measures, the final settlement package largely negated what remained of the cost control measures contained in the Penington inquiry's final recommendations.

However, this is not the only plausible view of the dispute's impact on the relative positions of the key players in health policy. For example, George, Field and Davis argue that the government gave only minor concessions to the profession, did not compromise on the central aims of the reforms, and managed to exert more control over the profession, not less. They see four factors as central to this outcome.

First, the profession was not united during the dispute, with sometimes fierce conflicts between the Federal AMA and the NSW Branch (with little support from other AMA State Branches), and between the specialist groups (especially the proceduralists) and the Federal AMA. Second, community and media attitudes moved against the specialists, measured mainly by a survey of the editorial comment


of newspapers during the dispute. Third, George et al. argue, the NSW government was in a strong position at the time, having been "safely re-elected" early in 1984. Fourth, the "relatively minor" nature of the concessions made to the doctors was inevitable, given the increasing role played by government in the funding of high-technology, institutional medical practice, and its concomitant demand for "greater rigour" in accounting for public funds.\(^90\)

There are some significant problems with George et al's argument. First, they do not specify in which ways the concessions granted to the profession are "relatively minor" in scope and nature. Second, they provide no evidence to substantiate the claim that "the government retained control over the key areas of administration of the public hospital system, particularly the conditions of employment of VMOs and the right to determine the role and activities of the public hospitals".\(^91\)

Third, and crucial to understanding the first two problems, the article was published in Spring 1984, well before the official resolution of the dispute, and even before the Final Report of the Penington inquiry was released. At this time the final terms of settlement had not been negotiated, and, most importantly, the Section 17 provisions for the terms and conditions of employment for VMOs had not been repealed. This makes premature the implication they draw that the events of the NSW doctors' dispute represent "the end of medical dominance" in Australia.\(^92\)

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A more substantial argument in this vein is provided by Barnett.\textsuperscript{93} For somewhat different reasons, he argues that the terms of the final settlement of the dispute do not constitute a "cave-in" by the government. In this view, the government merely agreed to spend some money on updating hospital equipment and to correct an "unintended effect" of the new Medicare arrangements. The equipment update was made necessary by the Fraser government's ending of Federal-State cost-sharing arrangements in 1981, and the associated relative decline in expenditure on new equipment in public hospitals, especially the major teaching hospitals. The "unintended effect" arose when Medicare patients needed treatment under several different doctors (and/or underwent several different procedures) during a hospital stay. As a result, they faced sometimes sizeable out-of-pocket costs made up of several gap payments between the fees charged and the Medicare rebates for them.\textsuperscript{94}

Moreover, Barnett argues, many of the measures to make private health insurance more attractive to consumers, such as the gap insurance provision, and extending coverage to include the cost of prostheses and appliances used in surgery, hospital charges, and same day procedures, collectively effect a shift in costs from the government to the private health funds. In other words, while the measures might make private cover more attractive, the price is largely borne by the health funds in terms of the higher premiums they need to charge in order to meet the extra services covered - a

\textsuperscript{92} \textit{Ibid.}, Footnote no. 9, p255.


\textsuperscript{94} \textit{Ibid.}, p29.
point that the health funds were quick to recognise in their assessment of the settlement package. In the process, the government stood to benefit electorally from these changes, through the reductions they could bring to the politically sensitive public hospital waiting lists for elective surgery procedures, such as hip replacements.

**Industrial gains and professional costs**

Whatever the assessment of the degree of success of the organised medical groups at the end of the NSW Doctors' Dispute, it came at an unprecedented price: a significant fall in public esteem for the medical profession, and growing doubts over the neutrality of their role as health experts. In the Section 17 phase, while the contested issues were defined or perceived as largely medical in nature, requiring the application of some soothing medical expertise, the profession generally, and the AMA in particular, had a broad measure of strong community support. Editorials and media reports generally accepted the legitimacy of the profession's arguments against the Section 17 proposals, or at the very least considered them legitimate concerns worthy of resolution through orderly bilateral negotiations with the Federal government. They reflected the widely-held view that while cost control under Medicare was certainly important, so too was the doctors' professional autonomy.

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95. See for example, *Age*, 3 April 1985:1, 10; *SMH*, 3 April 1985:4, and 6 April 1985:1.


Even the main protagonists did not appear to be many significant concessions removed from a mutually satisfactory settlement, as epitomised by the conditions of the AMA's agreement to participate in the Penington inquiry. Under the agreement, the AMA called off planned industrial action and urged doctors to charge no more than Schedule-level fees, in exchange for a joint AMA-government submission to the inquiry, and the expansion of the inquiry's terms of reference to include recommendations on arbitration and appeals mechanisms for Section 17. In the end, it was really only minor parts of the union movement and the Labor caucus which actively supported the full measure of Dr. Blewett's original Section 17 cost-control proposals.

This high level of agreement on the principal issues was also reflected by the progress report of the Penington inquiry. On releasing the report, Professor Penington told a press conference that although there were significant amounts of "common ground" between the government and the profession, they had been overshadowed by communication difficulties. While both parties accepted the principle of accountability for the public funds spent on private services in public hospitals, the dispute had persisted, he said, because

[each side has been speaking a language of its own, misinterpreted by the other as control for the sake of control on the one hand, or independence and protection of earnings as ends in themselves on the other.]

However, when the centre of the dispute shifted to NSW and the issues focussed more specifically on the level of remuneration for one

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98. See for example, Canberra Times, 6 April 1984:1.

sector of the profession - the visiting specialists - the wide support for the profession's position was quickly eroded. The proceduralist groups split off from the AMA, and stated that the AMA no longer represented them, and that their dispute with the Federal and State governments would continue regardless of the outcome of the Penington Report.  

This was now much more a straightforward industrial issue about the level of pay for a small segment of the medical labour force, which continued to press its claims despite the seemingly generous compromise arrangements suggested in the Penington Report. The very privileged, high-status, high income positions maintained by the members of this segment made it difficult to garner the same level of community sympathy for their fight with the government. This difficulty was increased by the broader industrial and economic context, characterised by equitable (and effectively enforced) wage restraint under the Accord, an electoral pledge not to increase the Medicare levy, and Hawke's public commitment to capping the "economic trilogy".

This shift was reflected in the language used by the main actors and the media to describe the respective positions and strategies of the State and Federal governments and specialist sections of the medical profession. In the first phase, the language portrayed negotiable differences between two reasonable parties over the cost of various methods of applying expert medical knowledge and the appropriate level of autonomy of the medical profession. Numerous variations of

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101. Hawke promised that all of his major policy reforms would be costed so that there were no increases in the percentage of GDP represented by the deficit, tax receipts or government outlays.
words and phrases such as "willing to negotiate", "collaborative approach", "consider their proposals", "appreciate their concerns", "willing to discuss", "manoeuvrability on both sides", "basis for conciliation", "compromise solution", "resolution", "concessions", "constructive talks", "flexible", "softened their attitude", and "dropped their insistence", were frequently used to describe developments in the dispute.\textsuperscript{102}

In the latter phase, this language began to reflect on the privileged position of the specialists, and their quest for even greater financial rewards. Words and phrases like "rich", "elite", "wealthy", "powerful", "influential", "greedy", "privileged and greedy", and "motivated by greed and power", became much more frequent.\textsuperscript{103} The *Sydney Morning Herald* ran a feature article on the escalating conflict, including a typical career profile of the visiting consultant surgeon. He (sic) was said to earn "more than $100,000 gross annually", while those "at the top of his profession can gross more than $300,000". Moreover, "with a limited earning period and a career vulnerable to physical failure, a [visiting] surgeon sees it as essential to earn as much as he can in a short time".\textsuperscript{104}

The shift from a medical issue to an industrial issue was also evidenced by the widespread use of language usually reserved for the actions of an activist trade union, rather than a highly regarded

\textsuperscript{102} See *SMH, Age, Canberra Times* and *AFR*, mid-January to mid-July 1984. For example, *SMH*, 18 January 1984:2; *Australian*, 25 January 1984:1; *Canberra Times*, 6 April 1984:1; *Australian*, 6 April 1984:2; *AFR*, 29 June 1984:4; and *Age*, 29 June 1984:13.

\textsuperscript{103} For example, *SMH*, 16 January 1985:1, 4 April 1985:1, and 23 February 1985:4.

\textsuperscript{104} "The Sick Hospitals", *SMH*, 17 January 1985:1,9.
profession. Examples of this union-type language included "industrial action", "black-bans", "mass walkouts", "scab' medical labour" "hardliners", "hard-line specialist group", "maverick doctors", "elite strikers", "rebel surgeons", and "militant surgeons".105 Towards the end of the dispute, a Canberra Times editorial commented that:

There seems little doubt that Dr Shepherd and Dr Aroney were playing the game too rough and were adopting tactics and language more appropriate to the Builders' Labourers' Federation than to a group of professionals.106

However, the language focussed not only on the industrial nature of the dispute, but also on the severity of the surgeons' actions. In addition to the "hardline" and "militant" examples noted above, such language included "medical terrorism", "extremists", "blackmail", "knock-'em-down and drag-'em-out militants", "aggressive stance" and "plain greedy and stubborn to the point of stupidity".107 The Sydney Morning Herald feature article referred to the surgeons as "the elite band of strikers who threaten to throttle the NSW hospital system".108 Perhaps the most telling example of language reflecting on the extremist character of the surgeons' actions came from Dr. Shepherd himself. At the height of the dispute, he stated that "the only thing


107. See the same newspapers over the same period as for the examples of union-type language above. For example, SMH, 23 February 1985:4, and 11 April 1985:2; Canberra Times, 25 February 1985:2, and 15 April 1985:3. See also, Pensabene (1985), Op. cit., p8.

this Government understands is someone standing with one foot on their throats and the other kicking their private parts".\textsuperscript{109}

During this phase, there was also increasing concern expressed for the effects on patients, including the possibility of deaths directly attributable to the surgeons' strike. Human interest stories in the media highlighted the plights of individual patients - "the casualties of the cause" - who were unable to receive operations vital to their health, including some on older women and young children.\textsuperscript{110} In a long letter to the \textit{Sydney Morning Herald}, Professor Penington rebuked doctors who were prepared to "hold the community at risk" as a negotiating tactic.\textsuperscript{111} A death threat was made to Dr. Shepherd by the husband of a woman unable to have a hip replacement operation because of the strike. Publicly at least, Dr. Shepherd took the threat seriously enough to obtain police surveillance of his home and surgery.\textsuperscript{112}

Amid arguments on the limits of action imposed by the Hippocratic Oath and the medical profession's code of ethics, Premier Wran pointed to the increasing possibility of patient deaths, and threatened legal action under the (NSW) \textit{Medical Practitioners Act} against doctors who refused to treat patients because of the dispute.\textsuperscript{113} Stories circulated about specialists not answering telephone calls, or having


\textsuperscript{110} For example, \textit{SMII}, 23 February 1985:4.

\textsuperscript{111} \textit{Medical Practice}, January/February 1985:24.

\textsuperscript{112} \textit{SMII}, 23 February 1985:4.

them filtered through family members, in an attempt to avoid potential legally liable behaviour. Dr. Thompson also expressed concern that there could be deaths as a result of the specialists' strike, and believed that this realisation would finally force the bulk of the surgeons to break with their leaders.

While often taken as public relations rhetoric or intemperate outbursts in the heat of the moment, there did at times appear to be some substance to such concerns. For example, when the NSW Labor Council directed members of its affiliated unions not to provide services to doctors refusing to treat patients in public hospitals, the surgeons' spokesman, Dr. Michael Aroney, explicitly threatened to refuse medical treatment to union officials. As more and more specialist services became unavailable, and emergency services were put under increasing pressure, the entire NSW public hospital system seemed in danger of imminent collapse. Dr. David Adler, assistant secretary of the NSW branch of the AMA, commented that "as yet stories have not surfaced about clinical damage, even death occurring for patients; [but] some very grave incidents are known to us."


116. In newspaper advertisements arguing for the resumption of VMO work in the hospitals, Dr. Thompson quoted sections of the Hippocratic Oath: "I will practise my profession with conscience and dignity"; and "The health of my patient will be my first consideration". He claimed that both principles, implicit in the Geneva Convention, were jeopardised by the strike, and appealed to specialists to consider their moral responsibilities under the AMA's code of ethics. See SMII, 22 February 1985.


In view of the increasingly desperate situation in the public hospitals, and of the strained nature of the negotiations between the main parties, three specialist Royal Colleges publicly expressed serious misgivings about the surgeons' actions, and implicitly withdrew their moral support. The presidents of the Royal Australian College of Physicians (RACP), the Royal Australian College of Obstetricians and Gynaecologists (RACOG), and the Royal Australasian College of Surgeons (RACS), appealed to the striking surgeons for a four-week moratorium on their resignations in return for the NSW government postponing its overseas recruitment campaign. The surgeons flatly rejected the proposal, and vowed to resume negotiations only when the NSW and Federal governments had rescinded all legislation relating to the Section 17 proposals.\textsuperscript{119} Soon after, medical professors from the universities, through the Association of Clinical Professors of Australia (ACPA), publicly called for the surgeons to return to work and resume negotiations with the government.\textsuperscript{120}

When the surgeons rejected the settlement package developed between the AMA and the government over four weeks of strenuous negotiations,\textsuperscript{121} and so widely viewed as an "unexpectedly generous list of concessions" from the government,\textsuperscript{122} the last remnants of support for their position rapidly dissolved. Editorials in almost all of the major newspapers vigorously condemned the surgeons' continued

\textsuperscript{119} Ibid., pp144-145.

\textsuperscript{120} Canberra Times, 26 February 1985:3.

\textsuperscript{121} As negotiations on the package edged towards a conclusion, Dr. Thompson commented that the talks had been "frank, fruitful and frankly exhausting". SMH, 27 February 1985:1.

\textsuperscript{122} SMH, 3 April 1985:4.
industrial action as unreasonable, militant and irresponsible.\textsuperscript{123} This in part reflected wider community attitudes, and consolidated majority public opinion against the specialists' original decision to go on strike.\textsuperscript{124} Mr. Wran reckoned that in rejecting the settlement package, the surgeons had "run out of common sense and public support", while Dr. Thompson confidently agreed that the surgeons were rapidly losing support for their stand against the settlement package.\textsuperscript{125}

The surgeons did not only lose support from the media and from other interested parties to the dispute. They also lost it from sources which had previously accepted their actions, or had been active supporters of their campaign. In late February 1985, as part of their bid to take some control the dispute, the surgeons began the process of organising an extraordinary meeting of the AMA to consider a motion of no-confidence in Dr. Thompson. This was the first and only time in the Association's history that its president had faced such a motion.\textsuperscript{126}

The surgeons contended that in agreeing to negotiate a settlement to the dispute with the government, his leadership had undermined the interests of the medical profession at large, and threatened the viability of private sector medicine.

Dr. Thompson responded by arranging a postal plebiscite on the issue, covering all medical practitioners in Australia. By April 1985, 

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\textsuperscript{123} See the editorials in the SMII, Australian, Canberra Times and the AFR in the period encompassing the release of the settlement package, the surgeons' rejection, and the processing of the AMA's plebiscite; say from early April to mid-May, 1985.

\textsuperscript{124} In April 1984, a Morgan Gallup Poll showed that 60% of respondents were against the specialists' decision to go on strike, 29% supported it, and 11% were undecided. See Bulletin, 1 May 1984:23.

\textsuperscript{125} SMII, 15 April 1985:3.

\textsuperscript{126} Medical Practice, June 1985:6.
early returns of the ballots indicated that at the national level, 81.5% of respondents favoured a return to work, with the rate at 66% for surgeons. In NSW, the overall rate was 73.4%; and for the striking doctors, it was 55% of respondents. Striking surgeons were the only group in the country with a majority in favour of continuing the strike. Moreover, it was a fairly narrow majority of 87 to 74, or 54% to 46%.\(^{127}\) The final returns in May, based on an "exceptionally high" return rate of nearly 40%,\(^{128}\) strengthened the push for a return to work, and further isolated the decreasing minority of hardline NSW surgeons who were still refusing to accede. A few days later, the formal no-confidence motion against Dr. Thompson was rejected by an overwhelming 86% of the vote.\(^{129}\)

Support from the Coalition parties had also declined. Opposition spokesman on health, Jim Carlton, and Deputy Leader of the Liberal Party, John Howard, had initially been "vociferous in their support for the doctors' cause".\(^{130}\) Their first response to the settlement package was that it was merely a restatement of previous offers, and that the government had "dressed them up and called it fruitful negotiations".\(^{131}\) This was largely in accord with the response of the visiting surgeon groups, which assessed the package as "a little bit of window dressing and a few crumbs".\(^{132}\)


\(^{128}\) Medical Practice, June 1985:11.

\(^{129}\) Australian, 9 May 1985:3; SMI, 9 May 1985:2; Medical Practice, June 1985:11,15, and July 1985:12; Canberra Times, 12 May 1985:1 ["Surgeons are scalped"].


\(^{131}\) Australian, 28 February 1985:3.
However Mr. Carlton and Mr. Howard became much more neutral - even evasive - in their comments on the surgeons as the general acceptance of the settlement package became more widespread. They became totally silent on the issue as the strong support from members of the AMA for Dr. Thompson's leadership began to emerge, and made no further statements of support for the specialists' role in the dispute.

Perhaps the most significant loss of support for the striking surgeons was that of their salaried colleagues. A few days before the early results of the AMA's plebiscite were released, the Public Medical Officers Association (PMOA), representing 800 salaried specialists in the NSW public hospital system, withdrew their unconditional support for the striking VMOs, and indicated their guarded acceptance of the NSW government's plans for recruiting overseas specialists as replacement staff. PMOA president, Dr. Jean Lennane, stated that:

> If the proceduralists take a very extreme line we can't continue to support them...[If the NSW government continues to show goodwill in tidying up some of the loose ends, we would find it hard to continue to support extremists.][133]

This move was crucial to the negotiating position of the surgeons, for the salaried specialists had previously been their strongest allies, staunchly supporting their stand, and refusing to do their colleagues' work while attempting to maintain a viable level of emergency services in the hospitals. The PMOA had threatened to join the strike action if

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132. Dr. David McNicol, National Secretary of ASOS, and a Council member of the AMA's ACT Group, in Medical Practice, March 1985:7-9.

133. SMH, 11 April 1985:2.
the NSW government proceeded with the seven-year ban proposal. It was largely because of this threat that Mr. Wran was persuaded to repeal the seven-year ban legislation.\textsuperscript{134} Dropping its support for the surgeons' stand represented a considerable shift in the PMOA's position, in that it came less than two weeks after Dr. Lennane had threatened a mass walkout to support the visiting VMOs if Mr. Wran's overseas recruitment proposal went ahead.\textsuperscript{135}

It was the continued militancy of the visiting surgeons in rejecting the settlement package which finally lost them support from not only the AMA "moderates", the media and the community, but also from their previous allies, the salaried specialists. As the results of the plebiscite came in, it became evident that even among NSW surgeons, support for continuing the strike was "dwindling rapidly".\textsuperscript{136} The isolation of the striking surgeons as intractable extremists prepared to risk lives for the sake of their incomes served to highlight the AMA as the authoritative voice of calm reason, conciliation and ethical responsibility. The plebiscite, by extending its reach beyond AMA members to include all active, medically qualified doctors in the country, reinforced this view. It also consolidated the AMA's traditional role in Australian health policy as the legitimate representative of all sectors of the medical profession in its negotiations with the state.

\textsuperscript{134} In an interview with leaders of the hospital salaried officers and the resident officers, Ann Daniel was told that their meeting with the Premier over the issue persuaded him to "review his strategy for resolving the conflict". Wran himself conceded that this meeting was "not uninfluential" in his decision to repeal the seven-year ban legislation. Daniel (1990), Op. cit., p124-125.

\textsuperscript{135} See SMH, 1 April 1985:3 and 11 April 1985:2.

\textsuperscript{136} Australian, 9 May 1985:3. See also Canberra Times, 11 May 1985:9.
The hidden fallout

The AMA and the profession at large were deeply disturbed by the strong divisions which had emerged during the dispute - between the Federal AMA and the State branches, especially the NSW branch; between specialists and non-specialists; between the proceduralists and other specialists; and between visiting specialists and salaried specialists. While many of these divisions were evident before the dispute, they had been largely confined to the status of internal matters, and acted on only within the bounds of the profession. Not only did they increase in intensity during the dispute, but they also spilled over into the public arena for the first time, and produced open hostility and rancour between opposing individuals and groups across the profession. This effectively brought to an end the carefully nurtured image of professional medical solidarity - within Australian medicine in general, and within the AMA in particular.

Perhaps the epitome of this factionalised conflict was Dr. Thompson's heated condemnation of Dr. Shepherd and Dr. Aroney when they rejected outright his call for a return to work pending further negotiations with the Federal and State governments. He accused them of indulging in "belligerent and divisive posturing and unrealistic demands", the effects of which, he suggested, would be the "total collapse of the NSW hospital system, leading inevitably to many patient deaths...". He also publicly called for their exclusion from further talks with the government over the dispute.137 This front-page

137. SMH, 22 February 1985:1,2. While not reported in any of the major media outlets, Dr. Thompson said after the final settlement package had been released that "in hindsight he regrets those strong words". Medical Practice, April 1985:24.
outburst was the first time that an AMA president had so publicly - and so vehemently - condemned the position taken by the leaders of a formally affiliated body.\footnote{138}

As seen in the next chapter, the AMA was well aware of the potential problems posed by the development of splinter groups and sectional infighting, especially for its overall effectiveness as a health policy interest group. In order to retain its position as the principal political and industrial negotiating body for the medical profession, the AMA needed to be viewed by both the government and medical practitioners in general as representative of the majority interests of all of the main sectors and groups within the profession.

After the dispute had been formally resolved, the AMA embarked on a full-scale strategy to reunite the opposing factions under its aegis as the one legitimate, representative body for the entire medical profession. Emerging from the extraordinary general meeting in which he survived the no-confidence motion, Dr. Thompson declared that the profession's most pressing task "is to heal the rifts and restore unity."\footnote{139} Similarly, AMA secretary-general, Dr. George Repin, said that the "biggest problem" facing the association was the strong feeling among specialty groups that the AMA no longer "represented them properly".\footnote{140} Even orthopaedic surgeon Dr. David McNicol, who had joined in the bitter public split between the surgeons' groups and the AMA, and had personally organised the no-confidence motion against

\footnote{138. \textit{Medical Practice}, April 1985:24. Ironically, within five years, Dr. Shepherd assumed the office of federal president of the AMA.}

\footnote{139. \textit{Canberra Times}, 12 May 1985:1.}

\footnote{140. \textit{SMH}, 13 May 1985:9.}
Dr. Thompson, called for changes to the profession's political and industrial representation under the umbrella of a united and extensively reformed AMA. While general intentions to reform the AMA were evident since the early 1970s, they had "remained dormant" until "revived rapidly in the divisive and bitter atmosphere that was generated by the NSW hospitals" dispute in 1984.\[142\]

The AMA sought the services of "an eminent, well-regarded, non-medically qualified person" to head an extensive review of the Association's "structure, function and constitution". In late 1985, the AMA appointed Former Liberal Senator, Sir Robert Cotton, to head the review. Announcing the appointment, and the general rationale for the review, the new federal president of the AMA, Dr. Trevor Pickering, said that:

> Dissension between different sections of the profession and questioning of the capacity of the AMA to represent all groups [became] evident during the recent New South Wales Hospitals dispute.

> We aim to work out recommendations for change which will produce an organisation more effective in: Reflecting the interests and aspirations of the medical profession as a whole; Relating to governments; Anticipating and responding to change; Serving the community interest.\[144\]

The Cotton Report made a wide range of detailed recommendations on the structure of the AMA, and over the next few years the majority of


these were wholly or partly adopted. The most significant of these in light of the hospitals dispute experience was the shift in the basis for representation from geographic location to craft groupings. The newly constituted peak decision-making body included representatives not only from each of the State branches, but also from each of the main craft groupings within the profession, including procedural specialists.\textsuperscript{145}

There is no doubt that the restructuring of the AMA after the dispute was part of a conscious effort on the part of an interest group to retain its policy influence and industrial clout through reducing its internal divisions and strengthening its professional and industrial cohesion. This was consistently reflected in the submissions from AMA members and affiliated groups to the Cotton Task Force. For example:

\begin{quote}
There is no escape from the fact that governments will not continue to deal with a body that does not have the support of those for whom it purports to speak.
\end{quote}

Similarly:

\begin{quote}
Governments are becoming increasingly frustrated with the profession’s inability to resolve its internal differences and with the difficulties of dealing with multiple sectional interests...[G]overnments and their departments find it much easier to deal with one body than with a number of separate groups each concerned with its own sectional interests.
\end{quote}

And:

\begin{quote}
These differences [between various sectors] also have been destructive to the profession’s capacity to influence health policy and to negotiate within the health care system...
\end{quote}

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145. For details, see \textit{ibid.}, Chapter 6.
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The strategy to regain some of its former interest group power is most
tellingly illustrated by the AMA's decision to shift its national
headquarters from Sydney to Canberra, "within sight of Parliament
House". First formally proposed as a possible future option in the
Cotton Report, the move received formal Federal Council support in
1988, and was fully implemented by 1991. The explicit objective of the
shift was to get closer to the ministers, staff and bureaucrats involved
in health policy-making, and to "develop the national presence of the
AMA and to significantly increase the level of dialogue and
communication with Government".

Indeed, such was the determination to become more directly involved
with politicians and the parliamentary process, that this "new-look"
AMA was officially launched outside the front of Parliament House.

However, the rationale for the Cotton Report, and the
recommendations it produced, were not informed solely by the need to
improve the AMA's effectiveness as an interest group in dealing with
the government. They were also informed by the need to repair the
damage that the dispute had done to the standing and prestige of the
profession; and such prestige is inextricably bound up with the
medical expertise provided by the profession to the state in the
process of shaping health policy. The argument here is that an
integral part of the AMA's influence resides in its traditional role -

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150. *Australian Medicine*, "New-look AMA launched: Reform to change face of medicine", 6 March
under both Labor and Coalition governments - as the legitimate, exclusive source of medical expertise crucial to the administration of health policy. Such a role lends additional authority and strength to the lobbying efforts of the profession’s interest groups. The AMA was fully aware of this source of influence, and purposefully acted to consolidate it.

The loss of esteem was reflected most directly in the language of the media reports and editorial comment on the dispute, many examples of which are provided in the discussion above. As the row over the Section 17 proposals escalated into the NSW Doctors’ Dispute, the image of the medical profession reflected in this language shifted from one of respect, expert authority and reasonableness to one of venality and denigration. At its most extreme, it indicated a widespread perception of the medical profession as more interested in money than patients.151

This shift did not translate into significant changes in public opinion polls on the perceived honesty and integrity of the medical profession. This level of honesty did not fall appreciably over 1984 and 1985, and doctors maintained their very high ranking relative to other occupations and professions.152 This is arguably a demonstration of the "opinion poll effect", in which individual respondents' answers reflect more of their actual experience with their personal doctor than


152. The series of Morgan Gallup Polls on the honesty and ethical standards of various occupations have consistently shown high percentages of “high” and “very high” ratings for doctors, ranging from a low of 62% (1979, 1981 and 1989) to a high of 70% (1990), with an average of about 64%. Since the polls began in 1976, doctors have been rated at the highest or second highest (after dentists or pharmacists) level of honesty. Derived from "Public Opinion" sections of Bulletin, 1976 to 1992, May or June issues.
their opinion of the profession as a whole. As the Cotton Report wryly notes, there is a widespread concern among doctors that "most patients think the individual doctor is wonderful but the profession is a crowd of sharks".153

Regardless of the opinion polls, the loss of public esteem was felt very strongly within the profession, and became a focus for concerted strategic action. As a settlement to the dispute began to appear likely, Federal AMA President Dr. Thompson began to look to its aftermath. In February 1985, he publicly expressed his fears that as a result of the dispute, there would be "permanent damage to the standing and reputation of the profession".154 Similarly, many of the submissions to the Cotton Task Force indicated that through the events of the dispute, there was "considerable damage done to the reputation of the medical profession both within the profession and in the eyes of the public".155 Indeed, the report enthusiastically suggested that the AMA emulate the American Medical Association in formulating a "strategic plan" to "strengthen public and professional confidence" in the association, and to increase "public confidence in the competence and reliability of physicians".156


156. Ibid., page CR34.
Striving for such public confidence is an integral part of maintaining the AMA's influence as an interest group. As the Cotton Report openly acknowledged,

> a body not respected or trusted by the community will not have access to governments whose function it is to represent and implement the wishes of the community.\(^{157}\)

However, it is at least equally a part of maintaining both the public's and the government's trust in the medical profession as reliable and authoritative experts in health matters. Such a role is fundamentally dependent on the clear separation of expertise from self-interest. When AMA representatives are involved in the health policy process - whether directly as members of decision-making committees or peer review mechanisms, or indirectly as advisors or consultants - their input must be seen to be informed by the scientific principles underlying objective medical knowledge and neutral, technical expertise.

If this policy input becomes regarded by the state, the media or the general public as contaminated in some way by economic, political or social interests, then the profession's role as impartial health policy experts is, by definition, totally undermined. In this scenario, the AMA's policy influence is reduced to that of a lobby group attempting, like hundreds of others, to protect its material interests. The degree of this reduction in influence is measured precisely by the extent to which its policy input is seen as contaminated by such interests.

While the officers and members of the AMA were certainly concerned about its level of internal cohesion as an interest group, they were at

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157. ibid., page CR34.
least equally concerned with the level of "interest contamination" associated with the actions of the militant surgeons. Across all sectors, there was an express acknowledgement that the final stages of the dispute had seriously damaged the standing of the profession by fostering an image of doctors more interested in their incomes than in the lives and welfare of their patients. Such an image was further consolidated in early 1986 when, less than two months after the large increases in VMO sessional rates granted under the Macken decision, NSW surgeons demanded fee-for-service increases of up to nine times the existing Schedule fees.\footnote{SMH, 8 February 1986:3; 10 February 1986:3.}

There are strong parallels between the internal divisions and loss of public esteem experienced by the profession over the NSW Doctors' Dispute, and that experienced over Medibank during 1974-1975. Diane Mackay argues that AMA's aggressive campaign during this period against the introduction of Labor's Medibank scheme alienated the public, with doctors widely perceived as "elitist, insensitive and divorced from reality", and as "'coteries of political reactionaries' with an obsession for money".\footnote{Mackay, D. (1989), "Politics of reaction...", p295.}

Mackay suggests that the medical profession was reviled not just by the wider community, but also from within its own ranks. Doctors accused the AMA of "lying and cheating" during the campaign. In the three years of the campaign, membership of the AMA, both in the percentage among doctors, and in absolute numbers, declined for the first time since independence from the British Medical Association in
1961. Moreover, the AMA’s anti-Medibank campaign was a direct determinant in the formation of the alternative Doctors’ Reform Society through the early and mid-1970s.¹⁶⁰

The president of the Royal Australian College of Physicians (RACP) Professor Priscilla Kincaid-Smith, calling for professional unification through structural reform of the AMA, observed that:

Events like the New South Wales (hospital) dispute and the much publicised practices of some medical entrepreneurs¹⁶¹ have given the medical profession a public image of a self-interested group determined to squeeze as much amoney as possible out of the health care system and disinterested in the welfare of their patients.¹⁶²

She also noted that the current image of the AMA is that of "an industrial organisation preoccupied with fees".¹⁶³ Professor Penington contended that "if the profession behaves just like a trade union it loses the standing it has built up over centuries".¹⁶⁴ Similarly, the Cotton Report concluded that:

While individual medical practitioners continue to be held in high regard by their patients, the image of the profession as a whole is deteriorating. The AMA is seen by some as a body fighting for improvement in financial returns for a group of people who are already thought to be elite and whose incomes already are regarded as high.¹⁶⁵

¹⁶⁰ Ibid., pp295-297. See also, Australian Medical Association (1987), Cotton Report, Chapter 4.
¹⁶¹ See Chapter Four.
¹⁶² Medical Practice, 3 August 1987:5.
¹⁶³ Ibid.
In order to regain its previous high level of public confidence, the AMA needed a strategy to counter the profession's image as a self-interested, sometimes militant, industrial group, and at the same time to nurture its role as the impartial experts to be consulted over all aspects of health policy. The Cotton Report, in collating the many submissions to the task force on the need for a reformed public profile, provided some guidelines for such a strategy. Again emulating the "strategic plan" of the American Medical Association, the report recommended that the AMA adopt six "principal aims" on which all other policies should be based. One of these aims is:

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\text{to take an active part in the promotion of health programs for the benefit of the people and to participate in the resolution of major social and community health issues.}^{166}
\]

The report argues that if the AMA is to be successful in "improving and maintaining the overall credibility of the medical profession within the community", then it must be active in areas outside more strictly scientific and clinical medicine. Moreover, the AMA "must not only act but be seen to act" in these areas. The report suggests that as the emphasis in medicine is shifting from curative to preventive, "community aspects" are increasing in significance, so that the AMA should become more involved in "community welfare programs". It concludes that the "promotion of health programs in the interests of the prevention of disease should become a major function...of the AMA".\(^{167}\)

\[\text{\textsuperscript{166}} \text{ ibid., page CR32.}\]

\[\text{\textsuperscript{167}} \text{ ibid., page CR34.}\]
While the stated logic of this strategy may at times be a little disjointed, its intention is clear: clean up the profession's tarnished public image by applying its medical knowledge and expertise to social health issues. In the period after the dispute, the AMA initiated information campaigns or bolstered its stance on a wide range of "matters of public interest in the health field", including AIDS, abortion, alcohol abuse, firearms control, drug addiction, nutrition and diet, the clinical use of heroin, in vitro fertilisation, adolescent health, aged care, aboriginal health, occupational health and safety, and - inspired by the example of its US colleagues - anti-smoking legislation. 168

In early March 1989, the launching of the "new-look" AMA in Canberra placed strong emphasis on the strategic role of these various community issues. The new AMA embraced a commitment to "exercise national leadership in areas where it has specific expertise". In these areas, the Association's objective was to

marshall the medical expertise it has and...work to identify solutions. Many social issues are in essence public health issues, and cannot be effectively resolved without input from doctors. 169

By implementing the public image recommendations of the Cotton Report, the AMA was attempting to publicly portray itself as something more than a privileged group preoccupied with maintaining its high levels of income. It represents a conscious effort to restore


that component of the AMA's health policy influence which is based on its public-spirited provision of disinterested medical expertise. The public health campaigns form a central component of this effort, and were viewed by the RACP's Professor Kincaid-Smith as one of the AMA's most promising means to "restore the profession to a position which it had occupied in the past as a trusted and respected expert group able to advise on all aspects of health care".170

Conclusion

While the extent of the medical profession's victory - as reflected in the content of the dispute's settlement package - is arguable, all sectors of the profession agreed that it was achieved largely through the militant actions of the surgeons' groups. Even after a bitter, public split with the surgeons, Dr. Thompson acknowledged that the final terms of the package "could not have been achieved without the determined action, including resignation, taken by doctors in NSW [hospitals]", and that the profession as a whole "owes them a very special debt of gratitude".171

However, the price paid by the profession for this industrial action was very high. The AMA, and the profession in general, was rocked by the dramatic loss of public esteem suffered as a result of the action, and was forced to embark on an extended public relations strategy in the attempt to retrieve it. Moreover, the profession also recognised


that, while the surgeons' strong industrial action might have been a fruitful tactic in this dispute, such action can only be used sparingly within its long-term strategy to shape health policy towards medical interests. As Dr. Thompson argued, "while the profession had learned to use industrial tactics [during the dispute] it had to be very careful in avoiding the overuse of that arm". This paralleled Professor Penington's earlier conclusion that strike action by the medical profession "should never be used lightly".

Within these cautionary notes is an implied recognition of the strong role often played in policy negotiations by the profession's medical expertise. If the profession were to become regarded as a predominately industrial body - through the "overuse" of industrial tactics - then the only resources it could draw on to influence such negotiations would be its (albeit abundant) financial and organisational resources as an interest group. This would strip the profession of the considerable policy influence attached to its monopoly over medical knowledge and expertise - widely accepted as technical and impartial, but in reality, as we saw in Chapter Two, subject to the same socio-political forces, interests and biases as 'non-expert' or lay knowledge. In this sense, the medical profession would be effectively deprived of the use of one of its two main "arms" (to borrow Dr. Thompson's term) of health policy influence. Indeed, given the interdependence and mutual reinforcement which characterises the "power" and "knowledge" aspects of medical dominance, the


profession's policy influence in this context would be comprehensively qualified.

While it certainly failed in its attempts to impose direct and effective cost control mechanisms on specialist hospital services through the Section 17 proposals, the Hawke government emerged from the dispute with a significant negotiating advantage for future disputes with the medical profession. The Cotton reforms on extended representation among craft groups made it easier for governments and the state health agencies to enter negotiations with the profession over health policy. Rather than dealing with different medical groups for different policy areas, the government can more often deal directly and solely with the AMA as the legitimate peak representative group for the whole profession. In effect, the Cotton restructuring has shifted much of the onus for developing consensual policy positions across conflicting segments of the profession from the state to the AMA.

However, as we see in Chapter Five, this restructuring of the AMA and the internalisation of the profession's sectional tensions, did not mean the end of serious splits within the profession over political and industrial issues. While the GPs may have gained extra representation on the AMA's peak council, they were not necessarily satisfied with either the direction or adequacy of the council's promotion of GP interests, and sought to bypass the AMA by negotiating directly with the government.

It has been argued here that the inroads made by the Hawke government into the policy influence of the medical profession were largely facilitated by the widespread perception that the issues
involved in the latter stage of the dispute were essentially industrial in nature. To this extent, the profession was prevented from steering the resolution process more towards its advantage through the political application of seemingly apolitical medical expertise. Unlike the Billing Review Committees of the first phase, there was simply no medical peer review mechanism available in the later phase by which the profession could seek to pursue such a strategy.

When doctors enter policy conflicts with only partial access to the mutually reinforcing armoury of the power-knowledge dyad, their level of offensive and defensive protection is seriously reduced. The profession's access to relatively high levels of funding, resources and organisational capacities, and the other internal and environmental factors suggested above by Hunter,\textsuperscript{174} undoubtedly contributed to the government concessions made to many of the specialists' demands. However, without a significant complementary role for the profession as disinterested medical experts, these interest group (or "power") resources could not by themselves prevent the disproportionate costs associated with the concessions.

In the short term, these costs took the form of the public unveiling of the "interest contamination" inherent in medical expertise, and the faltering of political support as community perceptions of doctors shifted from altruistic professionals to militant unionists. In the longer term, the costs represent the potential impairment of the profession's overall strategic capacities to shape the health agenda towards its own

\textsuperscript{174} Hunter (1984a), "Medical politics...", p973.
interests through the interaction of medical knowledge and medical power.

Peer review as the source of influence which both complements interest group power, and is essential to maintaining medical dominance over health policy, forms a recurring theme throughout this research. In the next case study on medical fraud and overservicing, the relevant peer review mechanism had already been operating for several years. However, the fact that the policy issues remained identified as essentially medical in nature throughout the course of negotiations, enabled the profession to maintain its strong control over its own work and over the direction of accountability measures against fraud and overservicing. Indeed, the profession was able to actually strengthen that control, and moreover, it did so without paying the high price incurred for the repeal of Section 17.
CHAPTER FOUR

MEDICAL FRAUD AND OVERSERVICING
Introduction

The disturbing public revelations of the Joint Committee of Public Accounts' (PAC) inquiry into medical fraud and overservicing\(^1\) (1982-1986) provided the Hawke government with a unique opportunity to impose cost restraint and accountability mechanisms on doctors to an extent that would be difficult to even contemplate in less turbulent circumstances. The revelations on the scale of medical benefits abuse by some doctors under Medicare were, as we see below, quite remarkable in themselves, and certainly unprecedented in the history of medical politics in Australia.

In reporting on those revelations, however, the media often implied that most, if not all, doctors were unethical opportunists voraciously milking millions in public funds from Medicare, and entirely contemptuous of both the letter and the spirit of the law. While this was something of an exaggeration, it helped to create for the government the political space within which to attempt tough regulatory and accountability measures against the excesses of a profession traditionally accorded a pragmatic

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respect and a high level of self-regulation, and at the same time to effect significant savings on Medicare costs.

The Hawke government did indeed take some measures aimed at curbing Medicare abuse by doctors - especially in the area of pathology. It implemented the most extensive restructuring of the private pathology industry since its emergence as a financially significant sector of the health care system in the 1950s and 1960s. The government changed the basis on which the level of pathology fees is ultimately determined, to include not only skills and formal qualifications, but also technological advances that alter operating costs, resulting in the significant reductions in a group of MBS fees. It also restricted the criteria for who can provide pathology services under Medicare, what sort of qualifications they must hold, the financial and organisational arrangements under which they can provide services, and, albeit to a limited extent, even the number and type of services they can provide.

Such changes were directly aimed at constraining the well publicised activities of the "medical entrepreneurs", exemplified by Dr. Geoffrey Edelsten, who, in the eyes of the PAC, "rank the pursuit of profit and market control over and above patient care".\(^2\) It is argued in this chapter however, that while the restructuring may have restricted some entrepreneurial practices in private pathology, it has at the same time effectively reduced avenues for public scrutiny of the industry's use of Medicare funds. Furthermore, it has further entrenched pathologists as

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the ultimate arbiters of their own activities. In other words, against all its intentions, intervention by the government has in this instance tended to consolidate - or even increase - the level of autonomy for medical professionals, rather than constrain it.

The explanation provided here for this unintended consequence rests largely on the social and political quarantining of the medical knowledge on which pathology practice is based. It is argued here that the implicit - and sometimes explicit - acceptance by all government health agencies of the essentially objective character of pathology expertise, its impenetrability to the non-medically qualified, and the uncontested nature of its knowledge content, combine to immunise pathologists against some of the more intensive and intrusive government scrutiny to which other occupations can be subjected.

As a result of this protective effect of pathology expertise, combined with the complementary political strength of the medical profession as an organised interest group, the ultimate extent and effect of the Hawke government's reforms of the industry were very limited. Not only were they limited in terms of reining in the level of professional autonomy of pathologists and subjecting their publicly funded activities to a higher level of accountability, but also in terms of the narrower effort to constrain the long term expansion of aggregate pathology costs under Medicare.
The PAC inquiries

Following widespread media reports in February 1982 of large-scale financial abuse by doctors of the medical benefits system, the Joint Committee of Public Accounts (PAC) asked the Federal Department of Health for a detailed briefing. The Department confirmed its earlier estimate of at least $100 million per year in "medifraud" in the form of fraud and overservicing. The federal executive of the AMA formally agreed with this figure, despite some internal dissent which later re-emerged to effect a turnaround in the Association's position. The presidents of the Royal Colleges of pathology (RCPA), obstetricians and gynaecologists (RACOG), surgeons (RACS) and general practitioners (RACGP) also formally accepted the accuracy of the Department's figures. According to these figures, each of the estimated 900 doctors involved in fraud and overservicing practices derived an average of $110,000 per year from such practices.

In response, the PAC commenced an inquiry in May to assess the extent of medical fraud and overservicing, and to recommend procedures to minimise its occurrence. As a result of the evidence presented at its initial hearings, Liberal Health Minister Jim Carlton announced in August additional budget provision for eleven positions in the Department to help with the detection of medical fraud and overservicing.


5. AMA Gazette, October 1982, p12.
The PAC's Progress Report was tabled in December 1982, and its main recommendations centred on the need for more staff and resources to combat the increasing levels of "medifraud", and legislative changes to facilitate detection and prosecution of benefits abuse. The report also called for the replacement of the existing Medical Services Committee of Inquiry (MSCI) system for investigating overservicing with a Medical Benefits Tribunal system. The PAC considered the MSCIs too procedurally restrictive, complex and ineffective, and also "too closely associated with the AMA" to fully protect the public interest.\(^6\)

The three subsequent PAC reports were equally critical of the MSCIs as a mechanism for establishing and processing incidents of overservicing. While the profession initially agreed with the government on the scale of benefits abuse, and on the need to contain it through legislative reform, the MSCIs have remained in place with only minor procedural changes. As seen below, the first principles view by all policy players that the occurrence of overservicing can only be established by the application of medical expertise has severely limited the available options for containing the overservicing problem. As a direct result of this view, the MSCI system left in place at the end of the PAC's five-year inquiry was still unable - as it is to date - to process more than a small fraction of the estimated total number of overservicing cases.

The timing of the report's release - at the end of the year, and in the lead-up to an election promising substantial shifts in health policy under a new Labor government - left the implementation of its recommendations largely in the hands of the new health minister. By the time Dr. Blewett was installed as Labor's new health minister in March 1983, the issue of medical fraud and overservicing had already become a political "hot potato". One of his first initiatives, in keeping with the recommendations of the first PAC report, was to significantly bolster Departmental resources available for the monitoring of fraud and overservicing. By October 1983, there were 205 such positions, compared to 94 in June the previous year. In its second report in 1983, the PAC noted that "it appears substantial progress has been made in this area".7

The PAC was "most pleased" with Dr. Blewett's prompt action in preparing legislative changes aimed at reducing the opportunities for fraud and overservicing.8 However, the Committee remained "concerned" that the Department had "not made significant progress" in implementing the recommended changes to the medical committee system for dealing with overservicing cases.9 Indeed, it was to be another two years before these changes were even partly implemented, making a total of well over three years from the time of the original PAC recommendations.

By 1983, Health Department estimates of total fraud and overservicing had increased to a minimum of $120 million per annum, while one submission to the Committee estimated it at nearer to $200 million.\textsuperscript{10} Given that the lower estimate represented about 7\% of the total medical benefits bill at the time, and that the total national loss from burglaries and "conventional" property crimes at the time was also about $200 million,\textsuperscript{11} the Committee's concern with implementing mechanisms to stem the level of medical benefits abuse is not surprising.

Because of the relatively large amounts of public money involved, the PAC strongly urged the Minister and the Health Department not to allow preparations for the introduction of Medicare to divert resources and energy away from their efforts to contain medical fraud and overservicing.\textsuperscript{12} However, while the introduction of Medicare did not necessarily cause a complete loss of momentum in this area, it did mean that the issue of fraud and overservicing was somewhat overshadowed by it. There is little doubt that Medicare's strong electoral significance, and a firm public commitment to have the system operational by 1 February 1984, gave its implementation a higher priority - for both Dr. Blewett and the new Hawke government as a whole. As the Minister later told the Committee:

Upon coming to office, the Government chose not to make sudden changes in the fraud and overservicing area pending the introduction of Medicare. After February 1983, I felt it


necessary to give both systems - Medicare and FODS - a chance to settle down...\textsuperscript{13}

As indicated by the scope and detail of the Health Department's formal responses to each of the 45 recommendations of the PAC's 1982 report, Medicare's introduction, and the substantial changes in arrangements that would accompany it, made the administrative environment in which fraud and overservicing measures were being contemplated that much more demanding, complex and uncertain. The submission to the PAC of the Administrative and Clerical Officers' Association (ACOA) lends weight to this view. For example, in assessing the workload of ACOA members working in the Department at the time, the submission noted that:

Additional strains on resources have been created by the preparation of responses to PAC inquiries, the work generated by the Pennington (sic) Inquiry and the considerable resources involved in conversion of patient identifiers due to the introduction of Medicare.\textsuperscript{14}

Similarly, Brian McDermott, working as a Computer Auditor in the Department to help set up the nation-wide computer network system needed to service Medicare, recalls that "We broke all the rules" in the frenzied rush to meet the February 1 deadline.\textsuperscript{15} Indeed, the impact of the introduction of Medicare strongly influenced the investigative direction of the PAC itself.

\textsuperscript{13} Australia, Parliament [1982-86], Minutes of Evidence..., Vol. 15, p5861. FODS is the computerised Fraud and Overservicing Detection System developed by the Health Department from 1981 to alert officers to possible medical benefits abuse by generating profiles of the service patterns of doctors, which can be compared with the relevant practice averages.

\textsuperscript{14} Australia, Parliament [1982-86], Minutes of Evidence..., p5807, emphasis added.

\textsuperscript{15} Personal communication.
Unlike Medibank, medical benefits under Medicare were to include the provision of diagnostic services for private patients in public hospitals. The Hawke government's concern over the possible increases in cost and utilisation of these services prompted the development of the Section 17 proposals noted in the previous chapter. These proposals were aimed at containing diagnostic costs in public hospitals, and were later embroiled in the NSW Doctors' Dispute. The Penington inquiry on private practice in public hospitals was established as part of the resolution mechanism for that dispute, and it spent a considerable part of its deliberations on diagnostic service costs and the arrangements existing at the time in the areas of pathology and radiology.\textsuperscript{16} The Penington Report's findings, and the change to ALP majority representation on the PAC since the Hawke election, complemented by the sometimes sensational evidence produced at the PAC's hearings, were determining factors in the Committee's decision to focus the next phase of its inquiry exclusively on the pathology industry.\textsuperscript{17}

The Penington Report revealed that while the number and cost of services in radiology had decreased significantly between 1973/74 and 1982/83, those for pathology services had increased significantly, especially in the private sector. Pathology utilisation per 100 medical consultations increased by almost 40%, while overall pathology


\textsuperscript{17} Australia, Parliament (1985), PAC 236th Report..., Chapter 1.
expenditure increased from about 24.5% to nearly 28% of total expenditure on consultations.\(^{18}\)

The Report also revealed that a growing proportion of pathology services were being charged at the higher levels of MBS rates. There were three available rates at the time: the lowest "Hospital Pathologist" (HP) rate was reserved for pathology service providers using public hospital equipment; the middle-range "Other Pathologist" (OP) rate was reserved for other, non-specialist providers; and the highest "Specialist Pathologist" (SP) rate was reserved for specialist providers working outside public hospitals.\(^{19}\) Between 1979/80 and 1982/83, the number of tests charged at the lowest HP rate increased by 22%; those charged at the middle OP rate rose by 29%; while those charged at highest SP rate rose by nearly 49%.\(^{20}\) The disproportionate increase in SP rate services had a considerable impact on total pathology outlays, because that rate was 33% higher than the OP rate, and some 50% higher than the HP rate.\(^{21}\) Moreover, this skewing towards the higher MBS pathology rates was occurring at a time when automation in pathology laboratories was


\(^{19}\) The variations in schedule fee levels for pathology tests have been progressively reduced under the Hawke and Keating governments. From 1 February 1992, there is a single level schedule fee for all pathology services, except for two items of cytology and histopathology and four high volume tests. Commonwealth Department of Health, Housing and Community Services (1992), *Annual Report*, Canberra: AGPS, p33.


\(^{21}\) The HIC estimated at the time that a 10% shift in the number of pathology tests performed at the OP rather than the SP rate would reduce total Medicare benefits paid per year by at least $7.37 million, or 2.2%. Australia, Parliament (1985), *PAC 236th Report...*, p5.
decreasing the operational costs involved in a wide range of high volume pathology tests.\textsuperscript{22}

The PAC found that despite the increasing number of tests provided at the SP specialist rate, the actual number of specialist pathologists performing or supervising tests was fairly small. A statistical analysis of medical benefits payments for pathology revealed that the top 25 pathology groups received about half of the total of $300 million of benefits each year. Each charged almost all of their services at the SP rate - ranging from 94.6\% to 99.9\% of services - while "few" of them employed any full-time specialist pathologists at all. Fifteen of these groups had part-time specialist pathologists associated with them, and only three of them had "relatively large" teams of full-time specialist pathologists. While the top 25 laboratories received half of the total medical benefits for pathology each year, they collectively employed only a quarter of the full-time pathology specialists.\textsuperscript{23}

The bulk of the SP services then, were actually performed by other non-specialist employees, such as laboratory technicians, medical scientists and GPs. However, they were nominally supervised by a small number of part-time and full-time specialist pathologists. Some of the specialists were clearly "remote" supervising tests performed at different laboratories and locations, and/or were associated with two or more pathology groups at the same time.\textsuperscript{24}

\textsuperscript{22} Ibid., p6.

\textsuperscript{23} Ibid., pp12-24.
In addition to the strongly oligarchical nature of the pathology industry revealed by this analysis, the Committee was concerned that some large-scale laboratories were applying very broad interpretations of their formal supervision obligations. Like others before them, Committee members were very critical of the Department of Health's Approved Pathology Practitioner (APP) scheme, which sets out the terms of those obligations.25 It concluded that its design and administration was "grossly deficient and requires immediate reform".26

The Committee's main concerns about the APP scheme were that there was no regular, effective review of APPs by the Department; there was no inducement for APPs to abide by the conditions of the Undertaking and associated Code of Conduct they signed; considering the financial size of the industry, the one-off $10 licensing fee was "an immaterial amount"; and that the associated legislative arrangements encouraged fee splitting, which increased the potential for overservicing.

The Committee was also concerned about the eligibility criteria for the scheme, and its potential implications for the total amount of pathology services provided under Medicare. The *Health Insurance Act* permitted

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25. The APP scheme had been widely criticised by a broad range of organisations - government and professional, pathology and non-pathology - since its inception in 1977. The criticism focused on its loosely worded provisions, which created large loopholes for avoiding the conditions of the Undertaking signed by APPs, and on its lack of effective laboratory accreditation provisions. The AMA, the Pathology Services Working Party, the National Pathology Accreditation Advisory Council (NPAAC), the Royal College of Pathologists of Australasia (RCPA), and Health Department officers all agreed in general terms on the inadequacies of the scheme. *Ibid.*, Chapter 2.

anyone employing a medical practitioner to provide pathology services to be an APP, and any medical practitioner (specialist or non-specialist) to be an APP. The Committee feared that this "open-ended" membership arrangement could lead to a "huge" number of licensed APPs, with a strong associated pressure on the supply of total pathology services. It also noted the "strong and continuous" growth in the number of APPs since the scheme started in 1977. By 1985, the number of APPs was "far in excess" of the total membership of the Royal College of Pathologists of Australasia (RCPA). As a specialist pathologist told the Committee in assessing the entry requirements of the APP scheme:

You just ring up the Department and say: "I want to be a provider". It sends you a form, you send your $10 and you are in business...

As a result of these concerns, over half of the recommendations in the Committee's third report in 1985 were aimed at overhauling the scheme's operation and administration. In summary, these recommendations called for a mandatory, actively reviewed accreditation system for pathology laboratories, with the payment of benefits restricted to services performed in laboratories accredited through formal peer review procedures; restriction of APP status to natural persons (not companies), with recognised medical qualifications; a significant increase in licensing fees to better reflect the scale of private pathology incomes from

27. Ibid., pp40-41. From 1977 to 1985, the number of licensed APPs had increased from about 1,500 to over 3,000 (from Table 3, p20).

28. Ibid.

29. The reforms that were later implemented on the basis of these recommendations also provided for a small number of existing approved medical laboratory scientists to have APP status. See House of Representatives (1986), Parliamentary Debates (Hansard), 8 May, p3416.
Medicare; a tightening up of the supervision requirements for SP benefits; and amending legislation to specifically prohibit the practice of fee-splitting between the referring doctor and the pathology laboratory. This peer review approach to containing medical benefits abuse had characterised previous (largely unsuccessful) attempts in this area, and as seen below, also characterised later, similarly unsuccessful attempts.

"Overall", the Committee was satisfied with the government's response to its recommendations on pathology services. Indeed, it proposed that the response may be unique. Legislation directly addressing many of the Committee's recommendations was drafted by the Government, agreed to by the Parliament and assented to in the eleven months between the tabling of the Committee's (1985) Report and receipt of the Government's response.30

34 of the Committee's 41 recommendations were accepted by the government (fully, partially or in principle), including all those addressing the APP scheme. However, as argued in the next section, there are two major difficulties with the new arrangements in terms of their capacity to contain fraud and overservicing. First, the "personal supervision" provisions applying to pathology services eligible for the highest SP rate remain open to broad interpretation. Second, the peer review accreditation system does little to remove financial incentives for excessive servicing.

Although the *Health Legislation Amendment Act 1986* states quite unambiguously that Approved Pathology Practitioners must "carry out pathology services or...supervise pathology services personally", the specific conditions necessary to achieve the intended or appropriate level of personal supervision in a laboratory setting are not provided. The Act does attempt to define personal supervision, but only in the most general terms. For example, the Act states that personal supervision occurs where the APP "exercises a reasonable level of personal control over the rendering of the service". Similarly vague criteria are offered in the Medicare Benefits Schedule's section on "Notes for the Guidance of Medical Practitioners". For example,

> Personal supervision by approved pathology practitioners means that they have to exercise a reasonable level of personal control over the rendering of the services and they have personal responsibility for the proper performance of the services....

> In practice, personal supervision means that an approved pathology practitioner must, to the fullest extent possible, be responsible for exercising an acceptable level of control over the proper rendering of pathology services performed.

As the Committee observed, the language used in these attempts to define personal supervision renders the term subject to a wide variety of interpretations. This makes it difficult for conscientious APPs to know whether or not their level of specialist supervision is adequate for their services to justify the highest SP rate of medical benefits. It also provides less scrupulous APPs with an opportunity to legally justify low levels of


specialist supervision. This is somewhat at odds with the Committee's repeated intention of constraining "medical entrepreneurs" who usually, but not always, appear to work just within the bounds of the law, pay lip service to professional ethics and vigorously scrutinise regulatory measures (both professional and governmental) for loopholes and areas of imprecise interpretation/specification.34

Moreover, the amending legislation does nothing towards prohibiting the practice of "remote" personal supervision. The Committee collected compelling evidence that such practices were common among the top 25 pathology groups responsible for about half the tests and associated Medicare benefits.35 Despite this evidence, the legislation does not specifically require an APP to be in attendance at all locations of a pathology group with a central laboratory and a network of branch or regional laboratories. Nor does it specifically prohibit the practice of APPs working part-time for several laboratories as the means of providing "personal supervision" for all of the pathology services provided through those laboratories.36

Perhaps even more significant as an impediment to the effective constraint of fraud and overservicing is the laboratory accreditation system itself. Although the recommendations of the PAC's 1985 report placed considerable emphasis on the need for an effective accreditation system to reduce fraud and overservicing, the PAC itself seemed well

35. Ibid., Chapter 1.
36. Ibid.
aware of its limitations in this regard. In that report, the Committee observed that:

Even with accreditation it is possible that commercial pathology laboratories...may perpetuate and possibly institutionalise overservicing.\textsuperscript{37}

Expanding on this in the 1986 report, the Committee recognised that it (accreditation) will not necessarily reduce the amount of medical overservicing or the overall cost of medical services as accreditation is only concerned with the assessment of technical competence and the ability of a laboratory to generate reliable data.\textsuperscript{38}

As specialist pathologists told the Committee, "commercially oriented pathology practices will become accredited and will continue to offer kickbacks"; and:

Practices operating illegally or which flourish by promoting overservicing are quite capable of reaching the standards required by the strictest accreditation guidelines...\textit{Adequately performed tests may still be unnecessary.}\textsuperscript{39}

Even the designated laboratory accreditation body, the National Association of Testing Authorities (NATA), explicitly warned in its submission to the PAC that:

...the questions of technical competence and overservicing should be recognised as two separate problems and that accreditation for technical competence will not achieve the Government's goal of containing costs due to overservicing.\textsuperscript{40}

\begin{flushleft}
\textsuperscript{37} Ibid., p46.
\textsuperscript{39} Ibid., p73. emphasis added.
\textsuperscript{40} Australia, Parliament (1985), \textit{PAC 236th Report}..., p163.
\end{flushleft}
Given this disjunction between a pathology group's technical proficiency and its propensity for overservicing, it is difficult to view the accreditation system as part of an effective, front-line assault on the provision of unnecessary pathology services. The PAC recognised this disjunction, and stressed the need for further broad measures to complement the APP/accreditation system reforms. These measures included strengthening professional ethics, improving government-profession cooperation, enhancing information flows on entrepreneurial activities, and researching the ownership structure of the pathology industry.41

However in all four reports, the Committee failed to detail the ways in which the accreditation system itself could help to restrain fraud and overservicing. The only direct reference to such mechanisms is a judgment by the Committee that the system "should satisfactorily address (the) problem" of small "'backyard'" laboratories using specialists' names to claim SP rates for tests. While it is very likely that accreditation would have this effect - as there is no incentive for specialists to lend their names to non-approved laboratories - the PAC recognised that such laboratories "may be relatively few in number and small in significance when compared to the operations of the major laboratories".42 Even the health minister - while accepting the general thrust of the reports - openly expressed his reservations about the adequacy of the PAC's recommendations in this regard.43

41. Ibid., p102.
42. Ibid., p100.
Despite this lack of evidence and an almost complete failure to demonstrate how accreditation reduces fraud and overservicing, the Committee concluded that its reforms should quickly remove unscrupulous 'entrepreneurs' from the non-Approved Pathology Practitioner market, and to some extent dampen the undesirable side of some Approved Pathology Practitioner and specialist Approved Pathology Practitioner commercial laboratories' 'entrepreneurial spirit'.

Fee-for-service and pathology abuse

Whatever its intentions, the effect of the PAC's emphasis on accreditation as remedy is to ignore entirely the effect of the fee-for-service system of remuneration on the incidence of pathology fraud and overservicing in particular, and on medical service costs in general. This stems at least partly from the Committee's formal requirement not to "question the adequacy of policies laid down by the Government". PAC chairman, Senator George Georges, told parliament that he had, during the inquiry, "tried as much as possible...to place ideological positions to one side and to look exactly to what is needed within the (health) system as it operates at present" - as opposed to what could be done in a health system without fee-for-service.

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46. Senate (1986), Parliamentary Debates (Hansard), 10 June, p3682.
However, to avoid in its reports any reference to the fee-for-service system is to ignore significant evidence presented to the Committee during several of its hearings - under both the Coalition and Labor governments - strongly suggesting that such a remuneration system is a primary determinant of fraud and overservicing in pathology, and of escalating medical costs in general. Doctors' groups, health economists and medical academics provided detailed submissions to the inquiry pointing to the very strong financial incentives to defraud and overservice which are inherent in a system largely based on fee-for-service remuneration.47 During one such hearing, the PAC chairman agreed that "while you have fee for service you have an open-ended arrangement which can be misused and abused".48 Indeed, this view was publicly endorsed by the health minister himself. Responding to the Committee's 1985 report, Dr. Blewett suggested that:

the real factor causing fraud and overservicing was Australia's traditional fee-for-service arrangements. The incentive is to maximise the provision of those (pathology) services, that is the key cause of our problem.49

The fact that the system of fee-for-service remuneration failed to make it onto the Public Account Committee's agenda - despite its very strong links to medical fraud and overservicing - is in itself something of a victory for the organised medical profession. While not the product of an overt lobbying campaign by medical groups against specific proposals to

47. See for example, Australia, Parliament (1982-86), Minutes of Evidence..., Vol. 3, pp963-996; Vol. 4, pp1462-1520; and Vol. 13, pp5162-5212.

48. Ibid., Vol. 13, p5174.

include fee-for-service in the PAC's terms of reference, the basis for this tacit victory nevertheless lies with the profession's organisational capacities to mobilise politically in defence of its members' interests, rather than with its role as the exclusive bearer of medical expertise. It represents an operational example of the process Bachrach and Baratz refer to as "nondecision making".

As seen in Chapter Two, any form of organisation of political interests represents the "mobilisation of bias", so that "some issues are organized into politics while others are organized out". In this particular case, the traditional organisation of medicine and the state in Australia, with the medical profession as the interest group most deeply and directly involved in the policy process, effectively precluded the issue of fee-for-service remuneration from getting onto the health policy agenda. As a result of this preclusion, a "nondecision" was made to retain the general form of existing remuneration arrangements, and not to formally assess the implications of fee-for-service for the overall level of medical fraud and overservicing.

The specific form of policy power exercised here by the organised medical profession is based on Friedrich's "rule of anticipated reactions". This occurs when political actor A does not pursue a particular preference or


issue because he or she anticipates significant, even overwhelming resistance from actor B. Through this perspective, fee-for-service was omitted from the terms of reference of the PAC inquiry because first the Fraser government, then the Hawke government, faced with the task of taking decisive action on a sensitive and intractable problem, needed a large measure of broad-based support to legitimate any such action. Both the medical profession and the Opposition parties at the time could not provide this support if the government attempted to subject fee-for-service to close critical scrutiny under the PAC inquiry.

Indeed, both would present a fierce resistance to any attempts to undermine fee-for-service, having traditionally defended it as the key to medical autonomy and an effective private practice system. When the inquiry began in 1982, the doctors, in the light of the profession's experience under Medibank, were already greatly concerned over the possible income restraints flowing from Labor's proposed Medicare scheme. It was precisely these concerns which later fuelled the NSW Doctors' Dispute. As seen below in the case of the Medical Services Committees of Inquiry (MSCIs), one of the largest evidentiary difficulties facing inquiries into doctors' practices is the very strong reluctance of members of the medical profession to testify against fellow members. Many witnesses are reluctant to come forward and provide evidence of dubious practices to the inquiry when they are members of the same profession or specialty - and often work in the same location - as those who are thought to be engaging in those practices. While a few

53. See Chapter Three.
witnesses are clearly prepared to put personal ethics above professional concerns by testifying to the committee (albeit often *in camera*), the inclusion of fee-for-service in the terms of reference would tend to unite them with the rest of the profession against the government's inquiry, and so jeopardise their already fragile cooperation.

For their part, the Coalition parties' defence of fee-for-service was also particularly strong at the time, and they promoted it as an essential counterweight to the collectivist elements of Labor's new Medicare system. Under these circumstances, both the Fraser government which excluded fee-for-service, and the Hawke government which did not extend the terms of reference to include fee-for-service, were fully aware that if it were to be included, the unanimous, all-party recommendations which characterised each of the PAC reports, and the general bilateral support for the legislative measures arising from those recommendations, would have been seriously undermined.

Such an approach to fee-for-service by the Coalition government is entirely in keeping with its longstanding promotion of a strong private practice sector in medicine. However, the Hawke government's failure to expand the PAC's terms of reference to include fee-for-service - despite the scope and intensity of benefits abuse revealed by the inquiry - did not represent an ideological aberration. Indeed the Hawke government here

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54. See for example, Brian Howe, Minister for Health, *News Release*, "Howe to step-up crackdown on pathology rorts", 28 April 1992. Howe notes here that officers investigating fraud and overservicing practices "encountered an unwillingness on behalf of those with detailed information to testify or provide evidence". For an account of such reluctance on the part of physicians in the US (in this case, to attest to clinical errors by colleagues), see Freidson, E. (1970), *Profession of Medicine*, New York: Dodd Mead and Co., Chapter 7.
was carrying on a long party tradition which had its roots in Labor's failed health nationalisation attempts of the 1940s, the bitter conflicts with the medical profession triggered by those attempts, and the formal entrenchment of fee-for-service in the Page health insurance system during the 1950s and 1960s. The strong political message underlying this tradition can be best summarised as: "Hands off fee-for-service!"

Even Gough Whitlam, with a huge electoral mandate for radical changes to the financing and delivery of medical services, listened very closely to this message. During the 1960s, Labor's electoral position gradually improved from the devastating impact of the 1955 split, and some of the policy themes from the 1940s were revived by a more optimistic caucus. During this time, Labor developed a detailed plan for the overhauling of the health system - the Cass Plan - which included the replacement of fee-for-service remuneration with a salaried system of GPs located in medical centres. However, this radical plan was dumped in favour of a new scheme which focussed on access to medical services, and left their organisational structure largely intact. Gillespie argues that this system

was a victim of Labor's electoral catastrophe of 1966. Under Whitlam the shift of the party towards electoral pragmatism led to the abandonment of such schemes which had little likelihood of AMA support.


As the end product of this new scheme, Medibank retained the existing system of fee-for-service remuneration because "Labor accepted the permanence of the structures set in place during the 1950s".57

The major difficulty with trying to empirically establish the occurrence of "nondecision making" forms of power, as Polsby points out, lies in the presence of alternative, equally viable explanations for the same policy outcome or decision.58 An issue may be kept off the agenda because of deliberate, routine collusion between interested parties against the interests of other groups, in which case a form of "nondecision making" has occurred. On the other hand, it may also be kept off the agenda because there is a genuine, broad-based consensus on that particular issue, "in which case nondecision-making is impossible".59

However, in this case, the presence of conflict (both overt and covert) required by Bachrach and Baratz to confirm the occurrence of a nondecision, can be clearly established. For example, covert conflict was present in the form of the internal Labor Party wrangling over the Cass Plan and its rejection of fee-for-service remuneration. Any consensus on fee-for-service was also undermined by the emergence of doctor and consumer groups explicitly lobbying for the abolition or reduction of fee-for-service remuneration for health services. For example, the Doctors'

57.  Ibid.


Reform Society (DRS) was originally formed as a political counterweight to the AMA's intense resistance to the implementation of Medibank, and has consistently sought the replacement of fee-for-service with other types of remuneration, such as capitation and salary.60 Although they were established after the PAC inquiry began, the Health Issues Centre in Melbourne, and the Consumers' Health Forum in Canberra continue this overt conflict by actively pursuing similar positions on fee-for-service remuneration.

Finally, while neither the Hawke nor Keating governments have attempted the outright abolition of fee-for-service remuneration, some deliberate attempts have been made to reduce its prevalence. For example, the government's active push for the introduction of health maintenance organisations (HMOs) from 1985 to 1988 was largely aimed at containing health costs by reducing the proportion of medical services provided on a fee-for-service basis, as were the Health Program Grants introduced under the previous Medibank scheme in 1975.61 Indeed in 1985, Dr. Blewett was enthusiastically promoting HMOs as the possible "ultimate solution" to the widespread fraud and overservicing revealed by the PAC inquiry, and publicly identified fee-for-service as the primary determinant of such abuse.62

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60. See for example, Palmer, G. and Short, S. (1989), Health Care and Public Policy: An Australian Analysis, Melbourne: Macmillan, p273. See the same position put by the DRS to the PAC. Australia, Parliament (1982-86), Minutes of Evidence..., Vol. 3, pp963-996; and Vol. 13, pp5162-5212. For an opposing view of the DRS's position on fee-for-service, see David Legge's letter to the editor in New Doctor, 15, 1980, p.4-5.


The fee-for-service omission reflects the profession's strength as an organised interest group long involved in the development and implementation of health policy in Australia, and in this sense is an example of the exercise of Steven Lukes's "second dimension" of power.\textsuperscript{63} There are other aspects of the pathology reforms, such as the accreditation arrangements, which reflect more on the profession's policy influence as the exclusive provider of legitimate medical expertise. The argument developed in the next section is that, as such, these other aspects collectively illustrate the exercise of Lukes's "third dimension" of power.

**Peer review and the power of expertise**

As seen in Chapter Two, the "first dimension" of power characterises the pluralist approach, and can be traced by the decisions emerging from the formal, open process of conflict resolution through the institutions of the political system. The "second dimension" of power rests on Bachrach and Baratz's notion of "nondecision making", where there is a covert, informal alternative agenda operating to systematically exclude some issues from the political process - a "mobilisation of bias".\textsuperscript{64} Lukes's "third dimension" of power involves the shaping of people's needs or preferences without overt or covert conflict, so that their "subjective" interests seem preserved while, in fact, their "real" interests are compromised. "A


\textsuperscript{64} *Ibid.*, pp16-20.
exercises power over B when A affects B in a manner contrary to B's interests.\textsuperscript{65}

As is detailed further below, the accreditation reforms flowing from the PAC's recommendations show a considerable degree of congruence with the requirements of Lukes's third dimension of power. There was no observable conflict over either the principle of accreditation or the peer review means of implementing it. All parties with an input into the decision-making process shared an implicit consensus on both the need for an accreditation system (despite some misgivings about its ultimate effectiveness in reducing the level of benefits abuse by providers), and on the role of medical professionals as the natural, inevitable (and only) agents through which such a system could operate.

Even though the Public Accounts Committee was itself part of an attempt to protect the interests of constituent groups and the general public which were disadvantaged by medical benefits abuse, there was no recognition of the potential for those interests to be undermined by the medical profession's ultimate control over the accreditation system. All other forms of expertise - legal, social welfare, ethical, administrative, economic or political - were effectively excluded from the only formal mechanism offered as a constraint on benefits abuse. All parties, including those openly opposed to fee-for-service as the principal means of remuneration for health services, tacitly agreed that the medical expertise of the profession was the only legitimate means by which the

\textsuperscript{65.} \textit{Ibid.}, p27.
crimes of the profession could be detected, assessed, scrutinised and regulated.\footnote{Even those aware of the potential for the partisan application of medical knowledge by those involved in prosecuting medical fraud and overservicing cases regard medical knowledge as an essential prerequisite. For example, Paul Wilson argues that "properly trained investigators, both within the [Commonwealth] Department of Health and the Australian Federal Police", could significantly increase the historically low rates of prosecution in this area. He adds that "While there is some risk having medically trained persons in these positions - because they might well identify unduly with the profession - such investigators should be medically trained in order to cope with the complex technical nature of much fraud and overservicing", Wilson, P. (1986), "Professional Crime: The Case of Doctors", in D. Chappell and P. Wilson (eds), The Australian Criminal Justice System: The Mid 1980s, Sydney: Butterworths, pp97-114, at p110.}

In the context of keeping fee-for-service off the agenda, the government's rapid response to the APP/accreditation recommendations does not only stem from a bipartisan determination to directly confront and reduce fraud and overservicing per se. It also stems from a political necessity to be seen to be responding decisively to the intractable and widespread incidence of pathology abuse publicly revealed during the inquiry. This approach by the government was particularly noticeable shortly after the release of the 1985 report on pathology, when the inquiry was hastily reconvened because of disturbing new evidence of benefits abuse presented to the Committee by several NSW pathologists, and widely reported by the news media.

During this period, it was revealed that large commercial laboratories were "cutting corners" and failing to employ enough properly trained staff. Fee-splitting, secret commissions and kickbacks (in the form of provision of cars, paying for surgery leases, repainting surgeries, weekly deliveries of food and alcohol), and "sink testing" (where the blood sample is poured down the sink and a "normal" result returned), were revealed
as common practices in the industry. The evidence also revealed that intimidation and even death threats were used in the pursuit of commercial advantage. The result of such practices, the Committee was told, was that patients were dying as a direct result of inadequate and false pathology diagnoses.67

These revelations gained considerable prominence, even notoriety, through their coverage in the media, and the need for public assurances that the government was taking steps to control the situation was highlighted by front-page headlines such as "Pathologists kill and cheat", and "Pathologist tells of death threats and bribes".68 Responding to the new revelations, Dr. Blewett highlighted the gravity with which the government viewed the situation:

The allegations that people may be dying because of the shoddy work and unscrupulous practices of commercial pathology firms has made this a matter of the gravest concern.

While the Public Accounts Committee's work had already produced considerable evidence of waste of taxpayers' money, this threat to the health of patients is another matter altogether.69

The need for public assurances was also intensified by the electoral sensitivity of Medicare at the time. In place since February the previous year, the Medicare system was still relatively new. The first-hand experience of the system for most voters involved familiarising


68. SMII, 24 October 1985:1; Australian, 24 October 1985:1, respectively.

themselves with its operational procedures, and assessing the individual medical and financial outcomes it produced for them. Because Medicare was a central feature of the Hawke government's 1983 campaign platform, its level of acceptance with the public could be closely aligned with the general level of acceptance of the government's performance in office.⁷⁰

In responding to the revelations of the PAC's inquiry, the Opposition parties actively sought to exploit this alignment between the credibility of Medicare and that of the government. Raising the issue of medical fraud and overservicing in an urgency debate, Opposition health spokesman Mr. Porter contended that the bulk-billing feature of the Medicare system was primarily responsible for the high levels of fraud and overservicing in the pathology industry, and that the Royal Colleges of both the pathologists and the radiologists⁷¹ had endorsed this position. He told Parliament that "the Government's promotion of fraud and overservicing through its policy of universal bulk billing" under Medicare was a matter of public importance and that:

> It is only since Medicare and bulk-billing that entrepreneurial practices such as Dr. (Geoffrey) Edelsten's have blossomed and taken advantage of this Government's stupidity.⁷²

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⁷⁰ This alignment between perceptions of Medicare and of the government's general performance continued well after Labor's 1983 election victory. Palmer and Short note that opinion polls on health insurance reveal "a similar level of support for Medicare as that registered for the ALP". Palmer and Short (1989), Op. cit., p68.

⁷¹ Royal College of Pathologists of Australasia (RCPA) and Royal Australian College of Radiologists (RACR) respectively.

⁷² *Canberra Times*, 14 September 1985:16.
While generally supporting the legislation for the APP/accreditation reforms, the Opposition continued to press this view, despite the minister pointing to a large body of compelling evidence to the contrary. Dr. Blewett noted, for example, that since the introduction of Medicare, estimates of the extent of fraud and overservicing had not significantly changed, and nor had the rate of increase of the total number of pathology services that had been performed.73

Given the electoral significance of Medicare, it was almost inevitable that Dr. Blewett would move quickly to repair any cracks in the public's confidence in Medicare arising from the PAC inquiry. Adopting the dramatic language of the newspaper reports, he proclaimed that the Hawke government "would not tolerate graft, corruption, kickbacks and death threats in an industry completely underwritten by $300 million of taxpayers' money", and that the legislation for the APP/accreditation reforms was needed to "root out the corruption that has spread through the diagnostic industry like a cancer".74 However, in less exuberant moments, the Minister conceded that, with the fee-for-service system "so ingrained" in Australia, "the only policy (to combat fraud and

73. Ibid., and House of Representatives (1986), Parliamentary Debates (Hansard), 8 May and 26 May. This evidence was later confirmed by Deeble's studies of medical and pathology services under Medicare, which showed that there was no demonstrable link between bulk-billing and the volume of services provided. See Deeble, J. (1991), Medical Services Through Medicare, National Health Strategy, Background Paper No. 2, February, Melbourne; and Deeble, J. and Lewis-Hughes, P. (1991), Directions For Pathology, National Health Strategy, Background Paper No. 6, July, Melbourne. However despite such evidence, Federal President of the AMA, Dr. Bruce Shepherd, has continued to use this argument as the rationale for abolishing bulk-billing. See for example, Advertiser, 15 June 1992.

overservicing) we have left primarily is to encourage the service provider to be responsible in the use of their services".  

Clearly the success of such an indirect policy depends to a large extent on cooperative relations between the government and the profession. Given the long-term ambitions of the profession for an accreditation system, and its enduring criticisms of the old APP scheme, the reforms can be more usefully interpreted here as part of the government's attempt to procure and maintain that necessary cooperation. While the closed-door nature of the negotiations make it difficult to provide unambiguous empirical verification for such an interpretation, it is nevertheless strongly supported by the content of the Minister's Second Reading speech on the accreditation reforms. Here he argued that one of the main benefits of and reasons for the accreditation proposals - along with uniform laboratory standards and the removal of backyard laboratories - was that they would be "welcomed by the profession".  

For the PAC, given that the subject of fee-for-service remuneration was effectively off limits for its recommendations, the reforms can be seen as part of those "further measures" needed to "improve co-operation between the profession and the Government" and to "strengthen professional ethics and their application" in dealing with the problem of fraud and overservicing. For while the PAC was well acquainted with

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75. Canberra Times, 14 September 1985:16.  
76. House of Representatives (1986), Parliamentary Debates (Hansard), 8 May, p3417.  
the reforms' limitations in this regard, it fully appreciated the long-held
desire of the profession for an accreditation system. Several submissions
to the Committee explicitly detailed the history of attempts by the
profession to secure an accreditation system and to reform the APP
scheme, most notably the RCPA submissions. The NSW AMA also
strongly supported an accreditation system as a means "to give teeth" to
the AMA's code of ethics. In the section of the 1985 report leading up to
the accreditation system recommendations, the Committee concludes
that:

The majority of professional pathologists and those allied to
the profession appear to welcome the introduction of a high
quality and nationally consistent accreditation programme...80

Finally, PAC chairman Senator George Georges, referring later in
parliament to "some of the extravagances of certain members...of the
medical profession" involved in fraud and overservicing, stated that the
PAC "asked the Australian Medical Association to take particular heed of
the fact that it was not possible without the co-operation of the
profession itself to contain the problem".81

While the profession finally gained an accreditation system it was clearly
supportive of, the means by which the system can constrain fraud and
overservicing is not so apparent. Indeed, as the next section

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78. Australia, Parliament (1982-86), Minutes of Evidence..., Vols. 11, 13. See also Australia, Parliament


81. Senate (1986), Parliamentary Debates (Hansard), 10 June, p3681.
demonstrates, what is far more apparent are the ways in which the APP/accreditation reforms can consolidate professional control over the occupational territory of pathology. First, they restrict APP status to medically qualified persons, which ensures that the testing services of pathology companies are ultimately controlled by pathologists rather than by lay, business-only people. Second, and directly related to the first, they impose limits on open competition. Finally, accreditation ensures that the eligibility of pathology services for Medicare benefits, although ultimately sanctioned by the health minister, is largely based on assessments made by pathologists themselves.

*Medical control*

Within the submissions and evidence presented to the PAC by individual pathologists and the RCPA, the idea of pathologists or medical practitioners being separate from the dubious commercial practices revealed by the inquiry - and dramatised in the media - is consistently promoted. Sometimes it is implied in the evidence; sometimes it is explicitly asserted. However, it is always used by the profession as an argument for combatting fraud and overservicing by restricting APP status to specialist pathologists or medical practitioners. The following assessment of the source of the industry's problems by a specialist pathologist illustrates this idea:

It was only when the automated machines came on the market that a few very clever, let us not denigrate their intelligence, a few extremely clever medical entrepreneurs saw their opportunity. They had a vision of buying some expensive machine, putting a person in front of it and making a million dollars - and they did. The little people get squeezed out because they do not have that mentality. You probably know, I do not have to tell you, that all the big commercial laboratories are owned by non-pathologists.
There is not one that is owned by a pathologist. They are owned by medical entrepreneurs.82

This presumes that pathologists are not also large-scale operators ("little people"), and that they do not contribute to or benefit from the commercialism of the "big commercial laboratories (that) are owned by non-pathologists". It implies that pathologists are not commercially oriented ("they do not have that [entrepreneurial] mentality"), and that fraud and overservicing in pathology did not exist - or was of a much lower order - before the arrival of "the automated machines".

Making similar assumptions, the RCPA suggested to the Committee that most of the problems engendered by deliberate attempts to overservice without regard to the quality of service could be eliminated if the provision of pathology services was controlled by an accreditation system with a restriction to specialist pathologists as the main providers of pathology except in special circumstances.83

However, both the College and the PAC were well aware that pathologist control of laboratories cannot guarantee that only specialist-supervised tests are billed at SP rate or that dubious practices - such as specialist pathologists "lending" their names to laboratories - are halted. For example, during a public hearing in September 1984, the PAC chairman raised the issue directly with the Vice-President of the RCPA, Dr. W.E.L. Davies:

PAC: What is to prevent a pathology business from being in the hands of a pathologist, or supervised by a pathologist, but


still having all those other elements you talk about (ie SP rate abuse, name "lending" etc) at the lower levels (of the organisation)?

RCPA: It is possible for that to happen. I am aware of some specialist pathologists who are attached to laboratories that are commercially operated and are lending their name to it for the purpose of obtaining SP benefits...

The new arrangements do not require that the overall business operations of pathology companies are directly controlled by medically qualified persons. However, under a new Approved Pathology Authority (APA) scheme accompanying the reforms, the non-medical owners and/or managers of pathology companies are required to sign undertakings which subject them to the same restrictions and conditions of practice as the (medically-qualified) APPs are subjected to through their medical code of ethics. The contents and conditions of such codes are in the direct control of the medical profession, and in this sense override commercial decisions or considerations.

Restricting competition

The second way in which the reforms effectively consolidate the occupational territory of the pathologists stems directly from the first. Because of the requirement for both medical and non-medical laboratory owners to adhere to the conditions laid out in both the legislation and the professional code of ethics, there is an associated, formal ban imposed on the advertising or marketing of services available from individual or group pathology practices. Any attempts to reduce

pathology costs through price competition are thereby effectively preempted by this requirement.

No such prohibition applied to non-medical providers, and the pathologists were concerned that such providers thereby gained an unfair market advantage. This concern was expressed to the PAC by Dr. Davies:

The problem with pathology laboratories is that a commercial operation being promoted by advertising can attain a large subsegment of the market and can actually be turning over very large volumes of work...

In other words, a big stratum of true professional service still exists. It is perhaps losing ground in terms of total volume or share of benefits paid to organisations which simply turn out the numbers.85

Clearly the support of the RCPA for the APP/accreditation reforms is based on its concern not only for the quality of pathology services provided by the bigger "commercial" laboratories, but also for their quantity as a proportion of the total pathology market.

Self-regulation

Finally, the reforms help the pathologists guard against breaches of their occupational territory by allowing the profession itself to patrol its borders in this particular area. The accreditation system recommended by the Committee, and accepted by both the government and the Opposition parties, was jointly developed by - and is jointly operated by - the Royal College and the National Association of Testing Authorities. While NATA is the official laboratory accreditation body, with a governing

85. Ibid., Vol. 13, pp5142-43.
council of "government, regulatory, industrial and commercial interests",\textsuperscript{86} its principal role lies in administering the system. The technical expertise underpinning the accreditation process is primarily supplied by volunteer members of the RCPA, with the assistance of representatives from other associated medical science organisations.\textsuperscript{87} It is these members who actually visit the pathology laboratories and evaluate their technical competence in areas such as staffing, equipment and practices.\textsuperscript{88} The decisions to grant or disallow accreditation - which in turn determine the numbers and sizes of laboratories whose services are eligible for Medicare benefits - rest largely on what are regarded as technical reports from these members.

If the government wished to directly or indirectly contest the recommendations of the RCPA assessors, it could only do so by mounting a superior opposing case. The basis for such a case would be restricted to technical arguments and evidence, since the accreditation arrangements, which are organised around objective measurement, explicitly exclude all other non-technical considerations. The very framework within which the rules and regulations are developed preempt any argument based on social, political or economic grounds from being formally considered, let alone approved and implemented. The ultimate authority for accreditation assessment is technical pathology expertise,

\textsuperscript{86} Australia, Parliament (1985), PAC 236th Report..., p53.

\textsuperscript{87} These organisations are the Australian Society for Microbiology, Australian Association of Clinical Biochemists and the Australian Institute of Medical Laboratory Scientists. See \textit{Ibid.}, Appendix 7, p161.

\textsuperscript{88} For details, see excerpt from NATA submission to PAC in \textit{Ibid.}, Appendix 7, pp158-163.
which by *a priori* consensus, is both defined as asocial in nature, and exclusively located within the professional domain of the pathologists.

The previous APP scheme, even with its obvious flaws, contained the potential for a comparatively wide range of interest representation, because it was administered by the Department of Health and subject to change and review by the minister. The new accreditation arrangements amount to a professional peer review process for pathologists, which is administered by NATA, and which almost excludes non-pathology representation in its mechanisms of scrutiny.

Again the RCPA was able to point out to the Committee the comparative advantages of this system so that a strong separation between specialist pathologists and inappropriate commercialism was clearly implied. Referring to the experience in New Zealand where a similar accreditation system had been operating for several years, RCPA President Professor P.B. Herdson informed the Committee of the advantages such a system could provide in terms of the quality of pathology services:

> ...people visit each other's laboratories and suddenly think "Good Lord, I should be doing this", or "Actually, I am better than I thought I was". So very soon you bring up almost a camaraderie, if you like, between the various people involved in laboratories - it is not just pathologists - and in that sense, you improve quality control immediately. Of course, you cannot do that through commercial labs with no one very interested (in peer review). 89

The Committee was fully aware that the College's position on accreditation and the APP scheme was "essentially a constructive but

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pragmatic one". However, it remains the case that the Committee's reforms in these areas erect considerable selective barriers to individual entry into the private pathology market. They also provide the pathologists, through the NATA/RCPA arrangements, with a controlling interest in a mechanism through which the total supply of provider laboratories can be directly influenced. This could be effected, for example, by adjusting the stringency of eligibility criteria for accreditation and/or the rigour with which they are applied in the assessment process. In these circumstances, accreditation can be used to influence the number of approved laboratories upwards or downwards in response to changes in the total demand for services in the pathology market. It represents both the potential and the means by which to actively protect financial and political interests under the guise of technical detachment.

Through this inbuilt potential influence on supply, it is the profession itself, rather than competitive market forces, or the government providing the bulk of its income on behalf of the public, which can exert the most leverage on the market value of its services. No evidence can be provided here to unambiguously establish the use of the accreditation process by pathologists in this way. However, indirect support is provided by changes in the level of market concentration that have occurred since the PAC's report in 1985.

In that report, the Committee expressed concern at the high level of concentration in the pathology market, and the relatively low level of competitiveness it implied. In the year to March 1985, nearly half of the total of 21.5 million\(^1\) (Part 7 MBS) pathology services were provided by the top 25 pathology groups, while one quarter of them were provided by the top seven groups.\(^2\) The National Health Strategy's review of pathology services revealed that more than three years later, nearly half of the total pathology services were provided by the top 20 pathology groups, while (slightly over) one quarter of them were provided by the top six groups.\(^3\) In other words, the notional level of concentration of pathology provision has risen between 14\% (based on one-quarter market share) and 20\% (based on one-half market share) during this period.\(^4\) These figures very strongly suggest that at best the Committee's reforms have done little to change the oligarchical nature of the pathology industry; and at worst they have considerably exacerbated it.

While the government's response to the PAC findings had only a limited effect on the profession's control over its occupational territory, it might be reasonably presumed that the response contained the potential to impose some restrictions on pathologists' professional autonomy over

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1. The figure of 21.5 million was derived from Tables 8A, 8B, 8C and 8D in *Ibid.*, pp25-28.


4. Another indication of market concentration at this time came from the Australian Association of Pathology Practices. In November 1988, AAPP claimed that its eighteen private pathology group members "handle 60\% of pathology services in Australia". *Courier Mail*, 2 November 1988:22; 10 November 1988:24. (This was consistent with the 59\% level of private pathology provision assessed by the National Health Strategy's 1991 paper on pathology. Deeble and Lewis-Hughes, *Directions For Pathology...*, p13.)
their work practices. In attempting to make them more accountable for the public monies funding their clinical decisions, we might expect some change in the patterns of those clinical decisions. However the evidence points to the opposite effect. The argument here is that the government's response actually increased the level of professional autonomy for pathologists and consolidated existing mechanisms for self-regulation. In this sense, the shared presumptions and lack of overt conflict over the integral role of medical expertise in constraining fraud and overservicing served merely to extend the reach of the "third dimension" power seen above in the accreditation reforms.

**Medical Services Committees of Inquiry**

In its 1985 report, the PAC strongly reaffirmed its recommendations for the replacement of Medical Services Committees of Inquiry (MSCIs) with Medical Benefits Tribunals, first made in the Committee's 1982 report and repeated in its 1983 report.95 The Committee concluded from the evidence provided that as "the only avenue of formally questioning the provision of excessive services...the MSCI system is unworkable, inefficient and ineffective", that the committees are "largely inoperative and wasteful of public resources devoted to their underlying administrative requirements", and as such were in need of "urgent reform".96


96. Ibid., pages 56, 47, and 58, respectively. For a comprehensive history and analysis of the MSCI system and the overall approach to fraud and overservicing in Australia, see the submission and evidence presented to the PAC by Dr. D.R. Harvey in Australia, Parliament (1982-86), Minutes of
Where overservicing is indicated, MSCIs are convened to examine the evidence and determine whether any action should be taken leading to the recovery of overpaid benefits. From the early stages of the PAC inquiry, the MSCI system was strongly criticised by the AMA, Department of Health officers and other public officials involved in their operation. The problems which were most commonly cited were the "cumbersome and time consuming" procedures involved because of the legislative requirement that even large numbers of patient services had to be individually identified and examined (rather than using a representative sample to establish servicing patterns); the limiting of available sanctions to recovery of overpaid benefits, especially in relation to larger instances of blatant overservicing; and the fixed membership structure of the committees, by which a practitioner could evade sanction on the claim that the committee lacked the relevant specialist expertise needed to establish that overservicing had in fact occurred.

As a result of these limitations, the MSCI system's rate of processing cases of overservicing was rather low. A Health Department medical

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counsellor working with the system suggested to the PAC that, at best, the committees could effectively deal with the cases of six medical practitioners per year. Each case was taking an average of twelve months to complete. In the five years to March 1982, the MSCIs had completed only 31 cases of overservicing;\(^{99}\) and at the end of 1984, the backlog of overservicing cases waiting for referral to an MSCI hearing represented over thirteen years at current rates.\(^{100}\)

The PAC was also concerned about the composition of the MSCIs. Membership was restricted to five medical practitioners, four of whom were selected by the Minister from nominations provided by the AMA, while the chairperson was a Health Department Medical Officer. In addition, the Committee was presented with evidence alleging "that at least one MSCI has been [acting] in favour of doctors appearing before it".\(^ {101}\) This was more indirectly supported by an article referred to the PAC from the NSW AMA's *Monthly Bulletin*. The article implied that the AMA expected members appointed to MSCIs to be more loyal, in the last instance, to the profession than to the government.\(^ {102}\) The Committee concluded that "current MSCIs are too closely associated with the AMA", and that in choosing members the Minister should not be restricted to nominations from the profession.\(^ {103}\)

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Further evidence on the reluctance of doctors - including Health Department medical officers - to pursue cases of medical benefits abuse by other doctors emerged from the Committee's hearings of the operations of the Health Department's Victoria Office, and of its general counselling procedures. The PAC received allegations that individual officers of the Victorian Office "had actively and intentionally condoned criminal fraud by some doctors". As a result of a follow-up investigation by the Australian Federal Police (AFP), it was revealed that while there was no direct evidence of kickbacks, there was "apparent evidence" that Department officers had used their influence to limit the extent of action against doctors suspected of benefits abuse, had actively condoned possible criminal fraud, had used counselling sessions as an opportunity to advise doctors that they were under investigation, and had negotiated with doctors over the amount of monies to be recovered. The AFP report revealed that many cases of possible fraud were not referred to the AFP for investigation, but to the Department's own counselling and investigation mechanisms. In some cases, no action at all - including counselling - was recommended or taken.

The PAC's concerns over the Department's counselling procedures arose from uncertainties over the role of counselling by the officers involved. The Department employed several Medical Counsellors to provide advice to doctors whose patterns of Medicare benefits claims fell outside established practice norms, and indicated the possibility of some form of


overservicing. Their formal role, constructed under established guidelines, was to bring such patterns to the attention of the doctors, counsel them on their obligations under the *Health Insurance Act*, and to inform them that "failure to correct the problems may result in referral to an MSCI".\(^{106}\)

However, the Committee was concerned that, in addition to the "impossibly" small number of counsellor positions provided by the Department,\(^ {107}\) the actual practices of the Medical Counsellors differed considerably from State to State. Individual counsellors placed a wide variety of interpretations on their role. These ranged from a strict adherence to the procedures detailed in the guidelines, to a much looser, more informal approach, under which, in one example, the counsellor "occasionally" mentioned that the possible overservicing "may get to the Minister and the Minister may, without prejudice to the Department, ask for a restitution of funds". The Committee pointed out that this sort of warning "did not amount to much pressure on the doctor".\(^ {108}\) could provide him or her with "the opportunity of virtually laughing all the way to the bank".\(^ {109}\) and amounted to a "second chance" mechanism not available to members of any other occupations suspected of funds abuse.\(^ {110}\) The Health Department counsellor replied that:

\(^{106}\) Ibid., p121.

\(^{107}\) Ibid., Chapter 5, and p124.

\(^{108}\) Ibid., p125.


\(^{110}\) Ibid., pp941-945.
We are public relations men; we cannot get involved in squabbles with doctors.\textsuperscript{111}

In its response to the PAC reports, the government sought to clarify the guidelines for medical counsellors, especially in relation to separating more clearly the "educating/advising" role from the "investigating/warning" role.\textsuperscript{112} However, its response to the specific issue of medical counsellors was somewhat sidelined by its approach to the more general issue of pursuing benefits abuse through formal committees. For the government's response did not directly address the Committee's assessment of the MSCIs, nor its recommendations on replacing them with Medical Benefits Tribunals whose members are less closely associated with the AMA. Instead, it decided to introduce an additional "alternative mechanism",\textsuperscript{113} and left the medically dominated composition of the existing MSCI system largely unchanged.\textsuperscript{114} This was despite the Minister's previous evidence to the Committee that the government fully accepted that the MSCI system was problematic, and that it needed urgent reform.\textsuperscript{115}

\begin{thebibliography}{115}
\bibitem{111} Ibid.
\bibitem{113} Australia, Parliament (1986), \textit{PAC 260th Report...}, p43.
\bibitem{114} The membership of four medical practitioners nominated by the AMA, and one directly by the Minister, remains. Later, Medical Services Review Tribunals (MSRT) were established to review the decisions of MSCIs, and consisted of a legally-qualified chairperson and two medical practitioners. See \textit{Medical Journal of Australia}, Vol. 154, 15 April 1991, pp503-504 and pp563-564.
\bibitem{115} Dr. Blewett told the inquiry that he "would agree with the comments that the Committee has made in the past (on the ineffectiveness of the MSCIs) and that the Government has accepted, that we need a system that will deal with overservicing cases much more quickly". Australia, Parliament (1982-86), \textit{Minutes of Evidence...}, Vol. 15, p5869.
\end{thebibliography}
The "alternative" Medicare Participation Review Committees (MPRCs) were established to decide on a practitioner's participation in the Medicare system in cases where abuses have been proven in a court of law, and to investigate and make determinations in _prima facie_ cases of breaches of APP Undertakings. The committees are composed of an experienced legally-qualified chairperson, and two of the convicted practitioner's peers, one a nominee of the Minister from the same profession or specialty as the person being reviewed, the other a nominee of the AMA.\(^\text{116}\) New legislation provided the MPRCs with penalty options ranging from no action or counselling, through to full or partial disqualification from medical benefits for up to five years.\(^\text{117}\)

The overall effect of these arrangements is to place fraud cases in the hands of MPRCs, and leave overservicing cases in the hands of MSCIs. This is certainly in keeping with the PAC's (and the government's) consistent approach to peer review as a primary means of constraining medical benefits abuse. However, the argument here is that it also reflects the inherent capacity of the medical profession to significantly enhance its level of self-regulation when the government intervenes on issues whose very definitions are dependent on medical - rather than administrative or political - judgements.

During the PAC inquiry, evidence emerged which strongly suggested that overservicing abuses constituted in dollar terms a far bigger problem


than fraud abuses. The second submission of the Administrative and
Clerical Officers' Association (ACOA) for example, contended that it "is
generally accepted within the Department of Health that, with respect to
the official estimate of $130 million a year in abuse of medicare benefit
(sic), the greater proportion of this amount is attributable to
overservicing, rather than fraud".118

Four months before its report on pathology, the Committee had reached
similar conclusions. The PAC Vice-Chairman told the Minister in the
opening address of the hearing on 27 March, 1985 that:

Reducing medical overservicing appears to be the main and
most difficult challenge facing both the government and the
profession at present.119

Ros Kelly, Chair of Sectional Committee on Medical Fraud and
Overservicing, stated during the same hearing that "[o]verservicing
continues to be the major problem, more major than fraud...."120

The Minister himself agreed. Asked directly by the PAC Vice-Chairman if
he (Dr. Blewett) thought that overservicing was a bigger problem than
fraud, the Minister replied:

It has been my belief from an early stage - it may not have
been initially - that probably overservicing is in economic
terms the bigger problem, and I would have thought that
increasingly the evidence I have read that has appeared
before this Committee points in that direction...I would say
yes to your question.121

119. Ibid., p5688.
120. Ibid., p5860.
121. Ibid., pp5873-5874.
Even the Opposition agreed that overservicing was the bigger problem in terms of the amounts of money involved.\textsuperscript{122}

If overservicing was so widely acknowledged to be the more pervasive problem, the question arises as to why almost all of the government's legislative response was directed towards the constraint of fraud. Such a response seems even more inappropriate in view of the PAC's recognition that a tightening of fraud control measures, and no accompanying action on overservicing measures, could lead to an actual increase in overservicing, as providers shift from fraud to overservicing to maintain the illicit proportion of their incomes under Medicare.\textsuperscript{123} Despite very little opposition to the proposed legislation on fraud, and despite the accompanying legislation on the controversial Australia Card attracting most of the attention of both the parliament and the media, this question was raised by the Opposition several times during the parliamentary debates.\textsuperscript{124} However, the final legislation on benefits abuse focussed largely on the fraud problem, while the larger overservicing problem was effectively sidelined.

\textsuperscript{122} For example, Opposition spokesman on health Mr. Porter, in House of Representatives (1985), \textit{Parliamentary Debates (Hansard)}, 15 October, p2075; and Senators Baume and Walters in Senate (1985), \textit{Parliamentary Debates (Hansard)}, 2 December, pp2721-22; and 3 December, pp2748-2749, respectively.

\textsuperscript{123} Australia, Parliament (1983), \textit{PAC 212th Report...}, p9. This possibility was also recognised by the ACOA. See Australia, Parliament (1982-86), \textit{Minutes of Evidence...}, Vol. 15, p5799.

\textsuperscript{124} See Mr. Porter's comments in House of Representatives (1985), \textit{Parliamentary Debates (Hansard)}, 15 October, p2075; and those by Senators Baume and Walters in Senate (1985), \textit{Parliamentary Debates (Hansard)}, 2 December, pp2721-22; and 3 December, pp2748-2749, respectively.
The explanation for this lies partly in the legal definitions of the terms fraud and overservicing. Fraud in this context usually refers to a breach of the *Health Insurance Act* where, for example, a Medicare benefits claim is made by a practitioner for a service that was not rendered, or where the service is incorrectly described when billing the patient in order to attract a higher fee. Overservicing, on the other hand, is defined by Section 79 (1B) (a) of the Act as the provision of medical services which are "not reasonably necessary for the adequate medical care of the patient concerned".  

The process of establishing whether or not fraud has taken place is relatively straightforward, because it deals predominantly with matters based on documented and mostly uncontested or verifiable information. Examples of the questions involved in the investigation of these cases are: Did the doctor claim benefits for a service that was not actually provided? Did the doctor claim benefits for higher level services than the ones actually provided? Did the doctor claim for more services than can be accommodated within a working day? Overservicing on the other hand, as the Committee quickly concluded, "is largely a matter of medical judgement, and is therefore often very difficult to identify".

It is this medical judgement component that tends to direct the legislative efforts of both Labor and Coalition governments towards fraud and away from overservicing. While governments continue to accept

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medical knowledge and expertise as objective and apolitical in character, they effectively limit their own attempts to contain overservicing to one type of option: peer review mechanisms controlled by the profession itself. Such acceptance presumes that people holding non-medical knowledge and expertise, including the legal system’s "reasonable person", are intrinsically incapable of assessing the appropriateness or otherwise of specific services provided by specific doctors under the Medicare system. It also presumes that members of the profession would not or could not shape their medical judgements to benefit their own interests - or those of the profession generally - rather than to establish the medical necessity of a given service.

Thus the objectification of medical knowledge means that, while governments can provide the legislative framework, in the end only medical practitioners are seen as the legitimate judges of whether or not one of their peers has provided excessive services. The government may well be able to decide on the range of penalties that can apply, but only members of the profession are permitted to determine if, and to what extent, overservicing has occurred in the first place. In tabling the Committee's final report in the Senate, the chairman of the PAC explicitly acknowledged this limitation - though not its wider implications:

As previous reports for this inquiry have emphasised, a legislative response to medical overservicing is appropriate only to establish the framework within which professional review mechanisms can operate effectively. It remains that medical overservicing is a problem where the judgement of providers by their peers is required.127

The medical judgement component also helps to account for the government's decision to retain the MSCI system, with all its operational shortcomings, for overservicing cases, and to use the new MPRC system to handle proven cases of fraud. As the Department of Health noted in its response to the Committee's first report: "Significant legal policy issues arise in defining overservicing". However, it does not adequately account for another related change of arrangements: the considerable softening of the penalties for fraud that were part of the MPRC legislative package.

Before the changes, medical practitioners who had two or more fraud offences proven against them were automatically disqualified from participation in Medicare for three years. However under the new arrangements, the penalties are not automatically applied. Rather, they are determined by an MPRC with options, as noted above, ranging from no action to full or partial disqualification for up to five years. In other words, it is the members of the profession themselves, rather than automatic, unmediated legal provisions, which ultimately determine the penalty applicable in each case.

During the debates over the legislation, the Minister told parliament that the previous penalty system was "unreasonably rigid and insensitive and, in some cases, unnecessarily harsh". It did not discriminate between practitioners found guilty of medical benefits fraud through intent or through "reckless or gross careless conduct". However, this rationale is

considerably opposed to the intent of the original PAC report. There the Committee recommended that doctors found to have provided excessive services over a certain amount, or on two separate occasions, "should be automatically disqualified for medical benefits purposes, in the same way that current legislation provides for automatic disqualification of doctors convicted of fraud". The Committee's reasoning for this recommendation was that without such penalties, there was little financial incentive not to overservice, as the worst that could happen to doctors found overservicing was the refunding of the benefits paid.

Thus not only did the government's final legislative response fail to introduce such penalties for overservicing, but it also actually softened those already existing for fraud. Moreover, the legislation also provided for doctors currently disqualified under the old provisions to have their cases reviewed by a MPRC under the new, more lenient rules. In assessing a case under review, the MPRC is empowered to retain or decrease the period of disqualification, but is specifically prohibited from increasing it.

This rather abrupt disjunction between Committee recommendation and government response can be better understood in the light of the organisational requirements of peer review mechanisms. Such mechanisms require that the government gain the co-operation of the


131. Ibid, p133.

medical profession in providing committee members to make the necessary medical judgements on the activities of their peers accused of medical benefits abuse. This provides the profession with an opportunity to formally or informally seek concessions from the government in return for its co-operation in providing the medical expertise necessary to operate the MPRCs (and the MSCIs).

When a "summit" was convened in November 1984 for the profession and the government to discuss the problems of fraud and overservicing, it emerged that the profession felt considerable discomfort over the automatic disqualification provisions and other features of the government's investigative procedures. This general discomfort, its extent within the profession, and the reasons underlying it, were fully reported in the AMA's political-industrial journal at the time.\textsuperscript{133}

From this reporting, it can be concluded that the profession viewed the removal of the automatic disqualification provisions as part of a larger package of concessions from the government. Accompanying the provisions were several significant administrative changes. These included the dismantling of the Health Department's computerised Fraud and Overservicing Detection System (FODS), by which computer generated profiles of an individual doctor's service patterns can be compared with the relevant practice averages; and the transfer of fraud and overservicing investigations from the Department of Health to the Health Insurance Commission.\textsuperscript{134} This package of concessions was

\textsuperscript{133} Medical Practice, March 1985:17-18; May 1985:10-13.
developed from negotiations between the profession and the government
to secure the former's co-operation in providing the necessary medical
expertise for the MPRCs and the MSCIs, and in the control of fraud and
overservicing in general.

There were some suspicions raised over the timing of these changes.
While the government denied that there were any secret deals made
between the profession and the government over the NSW Doctors'
Dispute, the changes were decided on, and implemented, within a few
days of the final agreement on the settlement package for that dispute. As
Wilson and Grabosky note:

(c)ynics...might be excused for remarking that this change in
policy was announced only days before the resolution of a
dispute between the Government and the medical profession
which had seriously disrupted public hospital services since
late 1984 (the NSW Doctors' Dispute).\textsuperscript{135}

The retention of the MSCIs, and the total lack of government attempts to
make them more efficient and effective, can be similarly accounted for in
this context. While the operations of MSCIs are limited by restrictive and
time-consuming procedures, their very low rate of processing cases
tends to work to the benefit of the profession. As long as the processing
rate is low, the profession has been able to defend against sporadic
accusations of medical fraud and overservicing with formally correct
arguments that very few practitioners have actually been proven guilty of
such practices.

\textsuperscript{134.} See for example Australia, Parliament (1982-86), \textit{Minutes of Evidence...}, Vol. 15, pp5858-62; \textit{Medical
Practice}, April 1985-9, 12.

\textsuperscript{135.} Wilson, P. and Grabosky, P. (1986), "Investigating and detecting...", p163.
For example, responding to the new evidence before the PAC of widespread corruption and death threats within the pathology industry, the Federal vice-president of the AMA was able to make the legally correct statement that "only 10 out of 25,000 doctors claiming Medicare fell into the overservicing and fraud group". Similarly, when an article in *The Australian* in March 1988 produced a claim that the extent of "medifraud" had risen to $300 million per year, the Federal AMA president "pointed out that in five years only a handful of Australia's 35,000 doctors had been found guilty of fraud or overservicing...". This stands in considerable contrast to the AMA's earlier estimate at the start of the PAC's proceedings that some 900 doctors - or 3% of the national total - were guilty of "gross abuse" of medical benefits worth about $100 million per year.

This defensive strategy approach to the MSCIs is also supported by one of the ACOA's submissions to the PAC. ACOA staff in the Department noticed that the AMA "appears to be altering its stance" in its public statements, from generally supporting Department estimates of the extent of fraud and overservicing in 1982, to explicitly discrediting them by 1985. The officers contended that the AMA's attitude during this shift was "best summarised" as: "Since the Department hasn't caught many


137. *Medical Practice*, 4 April 1988:3. This is presumably a reference to the PAC's 1982 report, which noted that in the five year period to March 1982, only 31 cases of overservicing had been completed by MSCIs - although "a handful" is generally taken to refer to a number somewhat less than 31. *Australia, Parliament* (1982), *PAC 203rd Report...*, p128.

offenders, then the problem may not exist at all".\textsuperscript{139} In this context of the government providing substantial inducements for the medical profession to cooperate with the MSCI system, it is entirely appropriate that Dr. Blewett should consider the softening of the fraud penalties to be "the most significant amendments contained in the Bill" arising from the PAC's reports.\textsuperscript{140}

**Indeterminate judgements**

The government's scope for effective intervention to constrain medical benefits abuse is considerably limited by its dependence on the profession's medical judgements to define overservicing - the largest dollar component of such abuse - and to determine appropriate penalties for each case. The profession's influence on health policy here is in some ways consistent with Jamous and Peloille's notion of the "indetermination/technicality ratio" of professional power.\textsuperscript{141}

As seen in Chapter Two, this has a parallel in the notion of medicine as part art, part science, and represents a measure of a profession's capacity for resistance to the Weberian process of rationalisation. The "technicality" factor refers to that part of the body of knowledge used by doctors which, because it is broadly presumed to consist of universal,

\textsuperscript{139} Australia, Parliament (1982-86), Minutes of Evidence..., Vol. 15, p5812.

\textsuperscript{140} House of Representatives (1985), Parliamentary Debates (Hansard), 11 October, p1884.

uncontested "facts", can be codified or routinised. Such knowledge is by its nature vulnerable to administrative intervention and control.

The "indetermination" factor refers to the forms of knowledge which underlie the mystique of medicine. Horobin refers to this as "professional mystery", Johnson refers to it as the "structure of uncertainty", while Lawrence refers to it as "incommunicable knowledge". This type of knowledge is a collection of data and information organised more by elements of art, "feel" or intuition than it is by the formal, rational rules of science. It is based on medical practitioners' accumulated personal experience in clinical diagnosis with individual patients.

Like the "technical" type of medical knowledge, only the medical profession is privy to this "indeterminate" clinical knowledge. However unlike "technical" knowledge, which is by definition universal, there are many different variations of "indeterminate" knowledge. Within the membership of the profession, each practitioner has a distinct, qualitatively different form of this knowledge, based on the individual's particular approach to clinical work, and his or her particular historical mix of patients and cases. Because of these individual differences in the experiential basis of clinical knowledge, the process of the standardisation of this knowledge is necessarily preempted. In this way,

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the "indeterminate" knowledge of medicine remains impervious to codification and thereby direct administrative control.

Jamous and Peloille contend that when attempts are made to impose administrative control over a particular area of occupational activity, the profession emphasises the "indeterminate" aspects of its knowledge in that area. By defining the issue in conflict in terms of indeterminate knowledge, the profession can fend off the administrative intervention. Applying the notion of the "T/I ratio" to this particular case, Jamous and Peloille would argue that when the state intervenes in medical practice in an attempt to reduce medical overservicing, the profession would respond by trying to emphasise the "indeterminate" nature of overservicing. Through this process, the problem of overservicing becomes defined as an exclusively medical problem requiring medical controls, so that other forms of control over the profession, such as political or administrative, are effectively precluded.

The "technicality/indetermination ratio" can provide a useful perspective through which to view the Hawke government's problems in dealing with the issue of medical overservicing. Because the concept of overservicing was implicitly accepted by all parties as fundamentally dependent on medical judgement - or "indeterminate" knowledge - the medical profession was able to thereby fend off the government's attempt to impose substantial political and administrative controls over pathology practice. As a result of this, the pathology reforms flowing from the PAC inquiry mean that pathologists maintain an even greater control over both the definition of overservicing (in that only the medical expertise of
pathologists can determine whether or not overservicing has occurred), and also the extent to which it has occurred.

There is certainly evidence of this kind of strategy being used in the case of the pathology reforms. As seen above, the pathologists consistently argued during the PAC inquiry that the non-pathologist, commercial and entrepreneurial influences over service provision were the root cause of fraud and overservicing problems in the industry, and that the legislative containment of that influence would proportionately reduce the level of benefits abuse. The focus of the government's response on peer review accreditation - despite its widely acknowledged shortcomings in reducing Medicare abuse - reflects and reinforces this argument. Precisely because the definition of overservicing is dependent on medical judgements that form part of the "indetermination" aspect of pathology knowledge and expertise, the government is legislatively incapable of directly controlling overservicing behaviour. In this sense, the "judgemental autonomy" of the profession that Freidson distinguishes from its "economic autonomy", was preserved intact.¹⁴⁵

The profession's vulnerability to administrative intervention in the "technicality" aspect of its knowledge can be illustrated by the government's response to the incidence of medical fraud. Unlike overservicing, the definition of fraud can be established independent of pathologists' expertise. While the penalty provisions seem to have been made more lenient, it remains the case, as seen below, that the

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government can unambiguously define and prohibit certain work practices for laboratory pathologists. Such vulnerability can also be illustrated by the government's response in the area of MBS fees for "self determined" pathology tests.

As part of the accreditation system legislation, provisions were included to reduce by 25% the medical benefits applicable to eighteen commonly performed pathology tests. Dr. Blewett's rationale was that the tests were "high volume and mainly automated", and the fees had not been reduced to allow for the new, more productive technology used in their provision. He also referred to the PAC evidence which revealed a low level of specialist input into these tests, with many performed by medical technicians using automated machines. He argued that under these conditions, the existing fees for these tests included a component for specialist input which was not present in practice, and so amounted to an "unwarranted premium".146

In this case, the fact that the tests were largely performed by machines rather than pathologists allowed for the quantification of the knowledge and work processes involved. Unlike the situation under manual testing, the government was able to make some indicative calculations on the capital and operating costs of the machines and other inputs to produce a cost-plus value for the eighteen tests that was independent of the

146. House of Representatives (1986), Parliamentary Debates (Hansard), 8 May, pp3413-3417. The PAC pointed out the lack of specialist input into some pathology tests and the lack of fee reductions from improved technology. However it did not specifically recommend MBS fee reductions in any of its reports. Indeed the [Labor] PAC Chairman explicitly criticised the reductions in parliament, suggesting that ethical pathologists would suffer while unethical pathologists would simply adjust their servicing patterns to maintain income, thereby increasing rather than decreasing overservicing. Senate (1986), Parliamentary Debates (Hansard), 10 June, p3682.
pathologists' clinical experience or medical knowledge. The 25% reductions represent the imposition of a government preferred policy through the shifting of health resources. This supports Horobin's contention that while the profession retains control over medical judgements, it cedes control to the government over health policy directions and the associated allocation of resources.\textsuperscript{147} As a general reflection of the relative effectiveness of the various measures used by the government to fight pathology abuse, the 25% fee reductions account for over three quarters of the estimated total annual savings in Medicare benefits flowing from the reforms\textsuperscript{148} and in this sense represent rather blunt tools for cost cutting.

This is not to say that governments are totally powerless to intervene in the activities of doctors where professional "indetermination" is evident. One of the other pathology reforms that arose from the PAC inquiry was the tightening of conditions under which "self-determined" tests can be performed. These are tests not specifically requested by the initiating doctor, but judged to be necessary by the pathologist in the light of the nature of, or the specific combination of, the ordered tests. The reform specifically restricts the number and type of tests which can be "self determined" by pathologists, and the MBS fees that apply to them. In other words, the government directly intervened in the "indetermination"

\begin{itemize}
\item[147.] Horobin (1983), \textit{Op. cit.}
\item[148.] The Minister estimated that this and other MBS adjustments would save the government about $60 million per year, with $47 million of that arising directly from the pathology fee reductions. See House of Representatives (1986), \textit{Parliamentary Debates (Hansard)}, 8 May, p3417. No estimate was provided for the savings from the other measures against Medicare abuse, including the APP/accreditation reforms.
\end{itemize}
aspect of pathology knowledge to make formal determinations on which tests are necessary and which are not.

This is qualitatively distinct from imposing a financial incentive on pathologists to alter their medical decisions. In these latter circumstances, the individual pathologist is still free to make such decisions as he or she deems medically appropriate, and absorb any financial penalty that may result from them. The government here is intervening to encourage, rather than directly impose, a particular type of medical decision. In the case of self determined tests, however, the government is in effect directly outlawing a particular set of medical decisions, no matter what the judgements of the pathologists may be in individual cases. Under the legislation, the Minister for Health decides which tests can be self determined, and which can not.

However, the extent of this incursion into the "indetermination" territory of pathology is somewhat limited; for while it is the Minister who formally decides on the tests, they are determined "in consultation with the Royal College of Pathologists of Australasia".149 Because the Minister could have no technical medical grounds on which to oppose the College's recommendations - and because it is deemed to be a medical matter than a political or economic one - the legislation in effect leaves it to the pathologists themselves to judge which tests cannot be self determined. The limited impact on the professional autonomy of private pathologists is reflected in the estimated savings in medical benefits afforded by this

reform. Of the total of over $300 million spent annually on pathology benefits at the time, the government expected to save "up to $10 million", or about 3%, through this reform.150

Jamous and Peloille's "technicality/indetermination" ratio seems especially useful in helping to understand the Hawke government's pathology reforms because it avoids the extremes of assigning the medical profession's policy influence exclusively to either its interest group power or to its knowledge-based expertise. There is a form of power-knowledge duality implied in its argument. Firstly, in assessing the impact of the medical profession on health policy, it provides a determinative role for expertise based on ("indeterminate") medical knowledge. Secondly, the argument also manages to incorporate the lobbying activities and capacities of the medical profession as an organised interest group. The medical profession here uses its interest group power to define policy conflicts in terms which privilege medical knowledge.

Despite these elements of power-knowledge duality, Jamous and Peloille's conceptual schema remains subject to the same sort of limitations we noted in Chapter Two. The problems of the specific historical conditions of indeterminacy, the arbitrary separation of knowledge into "indeterminate" and "technicality" categories, and the presumption of purely technical, apolitical knowledge, all become evident in applying the schema to the pathology reforms of this case study.

150. ibid., p3417.
However, the main limitation here lies in the presumption made by Jamous and Peloille that it is the doctors who can, and do, exclusively determine the definition of the issue in terms of "indetermination" rather than "technicality".

As seen above, all parties in the conflict implicitly accepted in advance that overservicing was essentially a matter of medical judgement requiring medical expertise, and explicitly confirmed this early in the PAC inquiry, and several times during the course of the inquiry. While the medical profession was actively involved in the inquiry on a wide range of related issues - through, for example, lobbying politicians, preparing submissions and giving evidence - it showed no signs of mobilising its interest groups to convince the government, the Department, the Opposition or the PAC that overservicing must be treated in this way. There was no cause for the profession to mobilise on this matter because it simply did not arise as a contested issue. There was no resistance to such an expertise-based perspective on overservicing to mobilise against.

That overservicing could only be formally defined - and therefore detected and policed - by the holders of medical expertise had already been tacitly accepted as an intrinsic part of the "rules of the game" by all players. Because the terms in which a problem is defined necessarily prescribe the range of possible solutions, the acceptance of this rule effectively shaped the policy responses to benefits abuse in advance of any formal negotiations. This is an example of medical involvement in health issues not only through direct lobbying, but also through a structural presence
in the very terms in which the issues are presented and debated. This latter type of policy influence forms part of what Starr refers to as the "cultural authority" of the medical profession, as distinct from its "social authority".\textsuperscript{151}

As briefly noted in Chapter One, while doctors' "social authority" can be seen, for example, in their formal control over nurses and other occupations in the health hierarchy, their "cultural authority" is measured by the extent to which perceptions and understandings of health problems, and the possible range of solutions for them, are circumscribed by ingrained cultural values about the general role and prominence of medicine in society. In the case of Western industrialised societies, Starr argues that these cultural values accord a very high priority to the products of rational, scientific methodology; so that doctors, as the exclusive bearers of medical knowledge based on such methodology, are assigned a relatively high degree of "cultural authority". This form of authority precedes any actions they take based on their "social authority", and inheres in the structure in which such actions take place.\textsuperscript{152}

In this case study, the universal acceptance of the "ground rule" that the concept of overservicing can only be defined through the science-based expertise of the medical profession cannot be solely attributed to the tactical interest group activities of the profession at a particular point in


\textsuperscript{152} Ibid., pp13-15.
time. Rather, such a rule was already an established, integral and largely unquestioned part of the very structure of the health system within which those activities occur. As such, it represents an additional, extra-interest group avenue of influence on the formal processes by which policy is developed within that system. Using Starr's approach here, the "cultural authority" of the medical profession to almost exclusively define and monitor overservicing both preceded and complemented its "social authority", as the dominant health interest group, to be a key player in the policy process aimed at constraining the incidence of overservicing.

It is at this point that Lukes's perspectives on power, noted earlier in this chapter, can extend the analysis of the pathology reforms provided by Jamous and Peloille's "indetermination ratio" (T/I). Lukes's "second dimension" of power is fundamentally dependent on the presence of overt or covert conflict. The absence of such conflict on this issue of accreditation and peer review limits the applicability of the "second dimension" or, after Bachrach and Baratz, "nondecision" view of power he formulates. However, there is considerable scope here for linking the accreditation reforms to the exercise of the "third dimension" of power through the medical profession.\(^{153}\)

Like Starr's concept of "cultural authority", the "third dimension" of power refers to the limiting of options, perceptions and preferences of political actors. Lukes argues that each party to a political conflict acts to preserve its "subjective interests" rather than its "real" or "objective

\[^{153}\text{Lukes (1974), Power..., and Bachrach and Baratz (1970), Power and Poverty.}\]
interests", and that the former may have been shaped and constrained by the structure and institutions in which they are located. The "third dimension" of power is exercised to the extent that there is a difference between the "real" and "subjective" interests which each party is acting to preserve. In the case of the pathology reforms, we see agencies of the Federal government severely limited in the possible options for action they perceive. The range of options for dealing with the problem of overservicing were restricted to those embracing the primacy of medical expertise through peer review. No options for limiting overservicing through lay or non-medical accountability mechanisms - in which the content of medical knowledge was recognised as political rather than technical - were ever formally proposed.

Indeed, in Lukes's perspective, such options were never directly considered by the agencies. This was not because the organised medical profession successfully lobbied against them, or because of a "nondecision" to exclude them from the pathology reform agenda. Rather, the agencies did not consider this type of option because they were not formally aware of them as viable options for reducing overservicing. They existed beyond the realm of the agencies' institutionalised thinking, constrained as it was by the structural privilege accorded to medical knowledge and expertise. For Lukes, they did not think of them because they were already preempted from consideration by the existing "rules of the game".

The effective limiting of possible options for parliament to counter overservicing was well illustrated by the comments of then Democrats
leader, Senator Janine Haines. Noting the possibility that unethical pathologists would continue to find ways around the new legislation, she contended that:

The profession itself may take some steps to remove those people who are putting the profession in a bad light, but I am not sure that we as legislators can do much more than we are currently doing.\textsuperscript{154}

For Lukes, this limiting of the possible options for remedial policies are part of an institutionalised power, expressed not in the specific actions of individuals or groups, but in the form of an inherent, systematic bias in the distribution of resources and priorities towards one set of interests and against others.\textsuperscript{155} It has been argued throughout this chapter, and throughout the thesis as a whole, that such a routine bias is built into Australia's social structure and value system. It is reflected in the dominance of the medical profession in health policy, and is based on the profession's exclusive holding of expertise which is widely presumed to be technical and neutral rather than socially constructed, and which provides the potential for the profession's political interests to enter the policy process under the guise of impartial medical judgements.

While the significant problems with Lukes's third dimension of power remain - especially not being amenable to direct empirical verification and the difficulties of trying to distinguish between "subjective" and "objective" interests - that the proposition of subjecting medical knowledge to lay scrutiny seems counter-intuitive is perhaps an

\textsuperscript{154} Senate (1986), \textit{Parliamentary Debates (Hansard}, 10 June, p3679.

indication of the extent to which such an "insidious" dimension of power applies here. For it seems natural, logical and inevitable to both medical and non-medical groups that only those with specialist medical knowledge can make judgements on the appropriateness of pathology services provided under Medicare. Such a perception is clearly illustrated by the widespread a priori acceptance of the peer review principle noted above. Yet there is also broad acceptance within our society of the principle of lay juries making precisely this type of judgement in relation to scientific evidence presented in the courtroom. The effective sequestering of medical evidence from such lay scrutiny severely limits our capacity to reduce the incidence of fraud and overservicing under Medicare.

Given the poor growth prospects for government social policy programs, and the economic and political limitations on the levels of taxation revenues within Australia's currently restricted fiscal context, the need for more political control over the allocation of health resources is increasingly apparent. While it is doctors who exclusively determine how many publicly-funded pathology tests are appropriate in a given situation, the community and its elected representatives are having decisions about how taxpayers' money will be spent in health and other policy areas effectively removed from their direct control. Even if an individual pathology test can be medically justified, the social expense may not be socially justified.
Conclusion

In locating the prime source of the fraud and overservicing problem in the unethical tendencies of a minority of medical entrepreneurs, rather than in the general social tendency to objectify medical knowledge and to uncritically accept peer review methods of monitoring - structural factors which effectively expedite and protect the activities of such entrepreneurs - the proposed solutions were necessarily only part solutions. They focussed more on some of the obvious symptoms of benefits abuse than on their underlying determinants. As such, the reform measures represent largely indirect means of control, and have not been very successful in reducing benefits abuse in pathology under Medicare. Indeed, in presuming that overservicing can only be a matter for medical judgement, to the exclusion of scrutiny informed by any other lay knowledges, they have helped to ensure that such abuse remains endemic within an industry largely underwritten by public funds.

Indications of the "graft, corruption, kickbacks and death threats" which so appalled the Minister for Health in 1985 are still evident within the pathology industry today, if in modified forms. For example, in October 1991, parliament in South Australia was told of specimen and result mix-ups, poor processing and the use of "unqualified staff with inadequate supervision" by Gribbles, the State's largest private pathology company. The same company was later investigated by the Health Insurance Commission over the securing of pathology business through "inducements" to medical practices in the form of payments for nurses's

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wages and for "excessive rents" for space used as (unlicensed) pathology
collection centres.\textsuperscript{157} As a result of the HIC's investigation, the Gribbles
case was handed over to the Australian Federal Police for further
investigation, as a prelude to a brief of evidence being submitted to the
Director for Public Prosecutions.\textsuperscript{158}

Similarly in April 1992, an investigative report from ABC Television's
\textit{Four Corners} program - entitled "Blood Money" - revealed the widespread
use of similar inducements in NSW. Here pathology companies were
paying inflated rents (of the order of $100,000) in advance to chains of
24-hour GP clinics, ostensibly for the use of a small room by the
company's specimen collector, but ultimately for exclusive receipt of the
clinics' pathology business. The Medical Director of the HIC, Dr. John
Nearhos, had "no doubt" that these new forms of kickback payments and
fee-splitting were occurring in the pathology industry, and that they were
the result of companies using the advice of lawyers to "get around"
revised legislation which had come into effect in February 1992.\textsuperscript{159}
Indeed, the Australian National Audit Office, using a 1992 report by
consultants Harvey Bates and Company on the HIC's attempts to combat
fraud and overservicing, cited anecdotal evidence suggesting that the
problem of kickbacks may have extended to areas beyond pathology and
diagnostic imaging.\textsuperscript{160}

\textsuperscript{157} \textit{Advertiser}, 12 March 1993:3.

\textsuperscript{158} \textit{Advertiser}, 11 October 1993:1,2.

\textsuperscript{159} ABC TV (1992), \textit{Four Corners} report "Blood Money" (Reporter: Neil Mercer), 27 April.
The MSCI process for inquiring into suspected cases of overservicing remains "cumbersome and time-consuming",\(^\text{161}\) constrained by the reluctance of pathologists to assess the practices of other pathologists.\(^\text{162}\) In the middle of 1993, newly appointed health minister Graham Richardson, in addressing the issue of fraud and overservicing under Medicare, was caught in the middle of a dispute between the AMA and the HIC over a proposal to give HIC investigators access to patient medical records. This reflects the profession's long term ambivalence to freeing up the prosecution processes for fraud and overservicing, epitomised perhaps by conservative GP Johdi Menon's claim that doctors participating in MSCIs must necessarily break doctor-patient confidentiality in the process, and thereby act in breach of the AMA code of ethics.\(^\text{163}\) Similarly, the Harvey Bates report noted above suggests that Medical Counsellors have continued to conspire to ensure that doctors are seen as cases for counselling rather than targets for fraud investigation, and that provisions against fraud offences in pathology are largely "unenforceable".\(^\text{164}\)

\(^{160}\) Australian Doctor, 15 January 1993:1,2. For the background on this report and a summary of its findings, see the HIC-supplied article, "Medicare and fraud and over-serving: What the Health Insurance Commission proposes", in Health Issues, 36, September 1993, pp6-10.

\(^{161}\) HIC general manager Mr. Lawrie Willett to AMA Federal Council, reported in Australian Dr Weekly, 5 July 1991:4.

\(^{162}\) See comments along the same lines made by the HIC's Ken Hazell in Australian Dr Weekly, 26 April 1991:26.

\(^{163}\) Australian Dr Weekly, 1 February 1991:6.

Moreover, the reforms have done little to stem the increase in the volume of pathology services provided under Medicare. From 1984/85 to 1989/90, the volume of pathology services under Medicare increased by 54.3%, while all other medical services rose by only 28.8%. In the same period, the average increase in pathology services per person increased by 7.3% per annum, well over double the rate of increase for other medical services of 3.1%.\textsuperscript{165}

In attempting to contain overservicing in pathology, the Hawke government resorted to strategies based on reducing the level (if not the number) of financial incentives, formalised accreditation arrangements, and peer review mechanisms, complemented by programs to educate providers and patients on the high costs involved in pathology testing. The first type of strategy, represented by the 25% reduction in the eighteen commonly performed tests, may have had some effect on constraining the rate of increase in the overall costs of pathology (as the average fee per service was lowered), but was complemented (and largely offset) by an increase in the total volume of pathology services. As noted above, the accreditation arrangements can impact on the quality of pathology services, but not necessarily on their quantity. And the continuing increases in pathology use suggest that the peer review and education strategy has not gained the complete cooperation of the

\textsuperscript{165} Deeble and Hughes-Lewis (1991), \textit{Directions For Pathology...}. Chapter 2. While the pathology volume increased very markedly during this period, the increase in total pathology costs was limited by the relatively slower growth in the average fee charged per pathology service. However as Deeble and Hughes-Lewis argue, a strategy based on the trading of lower price increases for higher volumes is loaded with several significant economic and policy problems. See \textit{Ibid.}, pp55-56.
pathology industry, and brings to life the PAC Chairman's earlier serious concerns over its inherent limitations.\textsuperscript{166}

Such strategies can only produce partial and indirect mechanisms for reducing overservicing, based as they are on encouraging a general type of work behaviour rather than directly prescribing it. Greater reductions in the level of overservicing can only be effected by monitor and review mechanisms which allow the State to directly assess the behaviour of practitioners in both the number and type of tests provided. However, the government cannot legislate for this type of mechanism when it consistently concludes that such behaviour is essentially a matter of medical judgement, to be assessed as appropriate or excessive by the profession itself, and exclusive of all other non-medical agents. As long as those medical members who do agree to sit on the MSCIs perceive some conflict between their dual roles as representatives of their profession and as protectors of the public purse, we can not realistically expect the MSCIs to be either enthusiastically committed to the active pursuit of overservicing, or wholly effective mechanisms for containing it.

This does not imply that the Public Accounts Committee or the government actively considered more direct means of control, and then rejected them as not politically or administratively feasible. It simply means that more direct methods had already been eliminated from open contention by the implicit, pre-existing privileging of medical knowledge reflected in the State's acceptance of overservicing as essentially a matter

\textsuperscript{166} Australia, Parliament (1985), \textit{PAC 236th Report}..., pp104-105.
of medical judgement which can only be meaningfully evaluated through peer review.\textsuperscript{167}

As is the case in Chapter Three, the next chapter on GP fees involves a proposed medical peer review mechanism which is never implemented - but not because its enabling legislation was repealed. Rather, it was due to the strong, passive resistance of the medical profession against providing the medical expertise on which its operation was predicated; and to the government's implicit recognition over time that, given the mechanism's potential impact on GPs' autonomy over their work, the profession was never going to provide such expertise. Because the policy issues at stake remained widely regarded as medical rather than industrial in nature, the GPs did not pay the high price for its new fee scales that the specialists paid for the repeal of Section 17.

While the peer review in this chapter enabled the medical profession to consolidate control over its own work, the same effect is achieved in the next case study in the total absence of peer review. This was not because the core policy issues were identified as non-medical in nature, for like those involved in the pathology reforms, they were consistently regarded as essentially medical issues. Rather, it reflects the capacity of the

\textsuperscript{167.} Despite the accumulated evidence on the ineffectiveness of current measures for combatting fraud and overservicing, the principles of peer review and clinical judgement remain largely unquestioned at the formal level, and are still at the core of the government's strategy. For example Health Minister Howe, responding to a report urging an increase in HIC's powers to obtain patient records from doctors suspected of benefits abuse, stated that the government "would not compromise privacy or impose unreasonable requirements on doctors and their clinical judgement". \textit{Australian Doctor}, 15 January 1993, p2. Similarly, the current Minister, responding to the same report, endorsed peer review's role in combatting overservicing, and suggested that "it's better to have peer pressure involved in overservicing than to have guns at heads". \textit{Australian Doctor}, 25 June 1993:1,2.
profession to use its expertise role to protect its own interests, not by slowing down the peer review process, but by stalling it altogether.
CHAPTER FIVE

REFORMING GP FEES
Introduction

If stated policy objectives are compared with actual outcomes, the 1989 package of GP fee adjustments, continuing education and vocational registration arrangements appears to be one of the more successful health initiatives of the Hawke government. Health Minister Blewett's stated aims for these initiatives were better paid, more qualified GPs providing higher quality services to their patients, without alterations to the fundamental structure of Medicare. The package of reforms that were formally implemented on 1 December 1989, despite concerted and often fierce opposition from parts of the medical profession, does have the potential to move GP practice some way towards those goals.

However, the events leading up to 1 December were not a simple case of a health minister getting his way against the preferences of the organised medical profession, for the direction and shape of those events were largely influenced by contingent political actors, medical groups and health consumer organisations outside the direct control of the minister. Indeed, the decisions and activities of such groups provided much of the political space within which the minister was able to manoeuvre towards his GP policy objectives. Most significant here was the emergence of deep divisions between GP and specialist groups within the AMA (despite the Cotton Report restructuring discussed in Chapter Three), and between the AMA and the Royal Australian College of General Practitioners (RACGP).

Moreover, the policy outcomes were not gained without important, implicit concessions by the government towards the interests of the
profession. The government (with the full support of parliament) effectively closed off all avenues for external, independent monitoring of the new fees system. This is reflected in the formal agreement to leave the categorisation of the content of GP clinical services (and the corresponding level of fees they attract) entirely within the hands of the profession, by means of a peer review mechanism. Such self-regulation significantly limits the ultimate scope and effectiveness of some of the reforms' key objectives, particularly in the area of constraining medical service volume, mix and total cost. This insulation of medical knowledge from lay scrutiny considerably attenuates the Minister's "victory" over the profession on other parts of the reforms, and, as is argued in this chapter, reconstitutes it as an overall "defeat".

The background

Well before the ALP took office in 1983, Neal Blewett formally recognised the crucial role to be played by general practitioners in any cost-effective primary health care system, particularly as gatekeepers to the medical services and procedures that ultimately account for the bulk of the nation's health outlays.1 Dr. Blewett also acknowledged that their standing within the health care system had declined significantly since the 1970s - especially in relation to their specialist colleagues - seriously undermining the morale (and arguably the standard) of GP practice in Australia.2

1. As an Opposition MP in 1981, Dr. Blewett argued that "effective cost containment in health lies in attacking the problem on the supplier side", especially through GPs. See AFR, 11 September 1981:60. By 1989, amidst the heated controversy surrounding the vocational register and GP fee proposals, he was referring to the GP as "the cornerstone of a cost-effective medical system". Cited in New Doctor, Winter 1989:22.

As a consequence, his term of office saw several measures aimed at enhancing and consolidating the relative position of the GP within the medical profession. For example, after the AMA withdrew from formal Medicare fee negotiations in 1986, Dr. Blewett adjusted the Medical Benefits Schedule (MBS) rebates unilaterally, with a significant income bias towards GPs and away from specialists.3 Government funding support for the RACGP's postgraduate Family Medicine Program (FMP)4 was expanded. And the Leeder and Doherty Reports, commissioned and accepted by Dr. Blewett, both provided strong affirmation of the need to bolster support for the GP's pivotal role in health promotion and illness prevention and to encourage the postgraduate education of GPs.5

These initiatives were the end result of widespread dissatisfaction with the GP system in Australia, and increasingly vocal calls for its extensive reform. Such dissatisfaction came not only from GPs themselves, but also from groups with less direct interests, such as academic health groups, health economists, consumer organisations and State health departments.

3. For example, from 1 August 1988 MBS fees and rebates were increased by 5.4% for GP services and 4% for all other services. Medical Practice 4 July 1988:1.

4. From July 1 1993, the FMP's name was changed to the RACGP Training Program, in order to emphasise that additional, postgraduate GP training was involved. Australian Doctor, 28 May 1993:2.

For example, in 1984 the RACGP commissioned an extensive survey of
general practice in Australia. The results very clearly elucidated some
of the main problems and issues facing the GP sector. Among them
was the fee structure of the MBS, which was seen as discriminating
against preventive, more holistic health care by emphasising the time
rather than the content of consultations, and by providing financial
incentives for medical procedures rather than preventive and health
education activities. The results also revealed a strong willingness on
the part of GPs to provide prevention-oriented services - if appropriate
rebates were available under Medicare; and a widely-based push for
postgraduate GP training and education, formal assessment
procedures and vocational registration as means of countering the
dominance of the specialties.

In the period 1984-1986, the Better Health Commission commissioned
a number of surveys on consumers' expectations of GP services. The
surveys revealed that about half of the population (aged 14 years or
more) obtain preventive and health promotion information from their
GP, and that over 90% think that GPs should provide such
information. The findings of these surveys have been confirmed by
subsequent observations that health consumers are increasingly
calling for GPs to provide them with the preventive advice and health
promotion information that is fundamental to a cost-effective health
system.


7. See for example S. Leedler, (1989) 'The Future of General Practice with Special Reference to
Prevention' in New Doctor, pp25-28 (Autumn), at p25; and J. Donaldson, "Community stress is
hitting GPs" in Australian Dr Weekly 18 May 1990:7.
In 1988 and 1989 the South Australian Health Commission (SAHC) conducted an inquiry into the State's GP system. The first report of the inquiry\(^8\) supported the oft-repeated claims of GPs that their incomes were being eroded under Medicare. It also revealed that GPs regarded specialist activities, such as obstetrics and anaesthesia, as preferred future activities much more than preventive medicine. Although cross-survey comparisons often preclude firm conclusions, Leeder contends that this represents a significant change in the attitude of GPs to preventive medicine from that of the RACGP survey in 1984.\(^9\)

However, the calls for GP reforms and the initiatives they generated were isolated and limited, and had only a marginal impact on the position of GPs within the health system. They provided some political ammunition for Dr. Blewett in his attempts to address GP concerns; they slightly narrowed the gap between specialist and GP incomes; they ensured the availability of postgraduate training for GPs; and they gave some morale support to a relatively neglected sector of the medical profession.\(^10\) But by themselves they could not provide the

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10. The SA Health Commission's survey of GPs reports that about half describe themselves as "dissatisfied". SA Health Commission/AMA (SA)/RACGP (SA) (1988), *First Report...*, p31. Referring to the survey, Professor Basil Hezel, Chairman of the SA Health Development Foundation, argued that this, as well as a lot of anecdotal evidence, indicates that GPs receive no encouragement in the fee schedule to provide preventive services, they feel isolated from community health services and they consider that their services are undervalued by specialists in the large public hospitals. *Medical Observer* 7 July 1989:10.
basis for a systematic and coordinated reform program for general practice in Australia. Dr. Blewett argued that such a program is fundamentally dependent on direct, formal links between postgraduate training and financial reward, as is the case with the medical specialties.\(^{11}\) In part, it is precisely those links that the new fee structure and vocational registration measures seek to establish.

These measures involve the establishment of a vocational register for GPs who have RACGP-approved training (or five years' clinical experience), and who agree to take part in quality assurance and continuing education programs accredited by the College. GPs on the register are entitled to use a new set of time- and content-based descriptors for their consultations, with boosted Medicare fees and rebates applicable. The standard time-based items remain in the Schedule, so that GPs who do not qualify for the register, or who choose not to enrol on it, are no worse off financially than before.

The first significant development in the push towards these GP reforms came soon after the end of the NSW Doctors' Dispute.\(^{12}\) By early 1986, GPs were becoming increasingly concerned over the perceived erosion of their incomes under Medicare.\(^{13}\) They contended


\(^{12}\) For more details on the NSW Doctors' Dispute, see Chapter Three.

\(^{13}\) Health economist Jeff Richardson's research found some evidence of a relative decline in GPs' income over a number of years. However, the period studied was before 1984, so that such a decline cannot be attributed to the structural features of the Medicare scheme. Nevertheless, the research does support the GPs' more general claim that their incomes had been falling. See Richardson, J. (1985), "An initial assessment of Medicare" [edited transcript of radio interview, 10 April 1984], in Australian Surgeon, March, pp19-22.
that the income erosion stemmed from an increase in the proportion of medical benefit card-holders amongst their patients. From 1970 to 1985 the proportion of card-holders - mostly age pensioners - whose medical services were automatically bulk-billed under Medicare, increased from 9% to 23%. This meant that traditional practices were treating fewer fee-paying patients and relying more on bulk-billed services to maintain their incomes. According to one survey, an average of 35% of GP consultations were provided to card-holders.

At the same time, bulk-billing practices were attracting a greater proportion of the remaining (potentially fee-paying) patients, and, to maintain their margins in a market made more competitive by an oversupply of GPs in urban areas, were increasing their volumes of consultations (through more return consultations for example). This process, traditional GPs argued, results in higher Medicare costs for the government, through more unnecessary services and prescriptions, and a lower standard of care for patients. In May 1986, the AMA formally responded to these increasing complaints from its members. Despite some internal dissent, the Federal Council of the Association rescinded its policy of automatically charging pensioners and other concessional card-holders no more than the patient rebate for their medical services.


15. Ibid. See also Medical Practice, May 1986, pp8-9.


The time-based Medicare fee structure in place at the time certainly appears to encourage the high service volumes cited by these GPs. For example, a "Brief Consultation" lasts less than five minutes, while the most common consultation, the "Standard Consultation", is rated between five and twenty-five minutes. This provides a strong financial incentive for GPs to make their consultations last as close as possible to six minutes, the minimum time required to qualify for the higher Standard fee. The earnings per minute for GPs decrease rapidly for consultations lasting between six and 25 minutes, as the same level of Schedule fee applies throughout.

The end result is so-called "six-minute" or "sausage-machine" medicine, driven by an emphasis on quantity and income maintenance rather than on quality patient care. RACGP member Dr. Peter Stone suggests that the time-based system forces GPs to choose between service quantity and quality:

People want time with their GP but under the present system this is the very thing we cannot afford to give them. It means GPs are forced to dispense antibiotics quickly rather than spending the time explaining how to avoid another infection.¹⁹

Similarly, the SA Health Commission's 1988 survey found that one-third of GP respondents felt that under the Medicare system of fees, "the income of a general practitioner was determined by numbers of patients and not by quality of care".²⁰

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¹⁸. For example, a member of the Victorian Branch told the Assembly that the recession was a "public relations disaster". See Medical Practice, May 1986:9.


²⁰. SA Health Commission/AMA (SA)/RACGP (SA) (1988), First Report...
In March 1986, the AMA, dissatisfied with procedures, delays and previous determinations, withdrew from the next scheduled Medicare fees inquiry. This is the mechanism by which the government and the medical profession negotiate the annual level of fees and benefits for services on the Medical Benefits Schedule. As a result, GPs were left without official representation in the formal process that largely determines their incomes from Medicare.

In the meantime, the RACGP, long dissatisfied with the existing GP fee structure, had begun to develop an alternative structure that was content-based rather than time-based. Under this system, the level of Schedule fee payable to the GP is determined by the nature, complexity and content of the consultation rather than by the time it takes to complete. A consultation involving simple problems and tasks, and a relatively low level of medical knowledge and skills, attracts a lower fee than one in which the problems and tasks are more complex and multi-dimensional, requiring a higher level of medical knowledge and skills. It is in effect a work-value system, where you "pay for what you get rather than how long it takes to get it".

**The conflict**

Although there was widespread and increasing discontent with the existing time-based fees for GPs, content-based fee systems remained marginal to the formal health agenda over the next two years. They

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22. AMA Queensland President, Dr. John Herron, in *Courier-Mail*, 16 September 1988:2.
were suddenly shifted near the top of the agenda on 14 September 1988, when the AMA unilaterally announced that it was replacing its time-based set of recommended fees with a content-based set, and that the new system was to be implemented less than seven weeks later on 1 November (See Table 1). The AMA developed the system in consultation with the RACGP and the National Association of General Practitioners of Australia (NAGPA), an AMA affiliate organisation representing the GP members of the AMA.

Table 1. Proposed AMA GP Fee Structure, 14 September 1988.

<table>
<thead>
<tr>
<th>Time-Based Services</th>
<th>Content-Based Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brief - less than 5 mins</td>
<td>Minor</td>
</tr>
<tr>
<td>Standard - 5-25 mins</td>
<td>Specific</td>
</tr>
<tr>
<td>Long - 25-45 mins</td>
<td>Extended</td>
</tr>
<tr>
<td>Prolonged - more than 45 mins</td>
<td>Comprehensive</td>
</tr>
</tbody>
</table>


The AMA did not release the actual fees applicable to the new service categories at this time. However, in general, as the tasks involved in the content-based services become progressively more complex (down the list), they attract progressively higher fees.

AMA representatives were evasive over the question of the effect of the new scheme on fee levels and doctors' incomes. For example, in announcing the new service categories, AMA federal president Dr. Bryce Phillips said that he "did not know" if doctors' incomes would rise under the scheme. Nevertheless, Dr. Blewett indicated a guarded willingness to negotiate with the AMA on the scheme,

23. In a speech to a Consumers' Health Forum conference in October 1988, Dr. Blewett stated that "the first any of us - including the government - heard of the AMA's desire to change the fee structure for GPs was a media release of September 14, 1988". Health Forum, November/December 1988 [insert], page 1.

provided that it did not have a marked impact on total Medicare outlays, and that it held some promise of delivering better services to patients.25 Other interest groups, such as the Australian Pensioners Federation, the Australian Consumers Association and the Queensland Council of Social Services, were less generous in the motives they attributed to the AMA. They expressed concerns that the level of both medical fees and doctors’ incomes would move inexorably upwards under such a scheme.26

The reasons for the AMA’s initial reluctance to discuss the financial impacts of the new fee structure began to emerge the following week, when an "internal AMA document" was leaked to Dr. Blewett. The document revealed that the parameters of the new scheme were deliberately calculated on the basis of increasing the average GP’s gross income by nearly $40,000 to $156,000 per annum, an increase of some 34%.27 The Minister suggested that the new scheme was not so much an attempt to increase the quality of GP consultations as a "cynical attempt to boost doctors' incomes" and a "naked grab for more money". He condemned the "dishonesty and greed displayed by the AMA" and withdrew his conditional endorsement of the scheme.28

The AMA defended the scheme, claiming it was aimed primarily at increasing the quality of patient care by moving the emphasis off "pushing people through at a great rate”. AMA Federal Councillor, Dr.

25. See for example, Health Forum, November/December 1988 (insert), page II.

26. See for example, Courier-Mail, 16 September 1988:2.


Rod Morris, claimed that GPs' "overall income" would increase by only 17%, based on raising average net taxable income (after costs) from about $55,000 to $82,000 per annum. Dr. John Herron had also contended earlier that "refunds from the Government to doctors have not kept pace with inflation for years" - although as seen below, this was very forcefully contested by other parties.

The AMA and Dr. Blewett accused each other of distorting the financial impacts of the fee scheme. However, over the next few weeks the AMA's proposals garnered little public endorsement. Indeed, they were subjected to considerable public criticism. Towards the end of October 1988, several prominent consumer, welfare and pensioner groups entered the fray with an unusual - even unprecedented - combined attack on the AMA's proposals. Among them were the Health Forum of Australia (HFA), the Australian Council of Social Service (ACOSS), the Australian Federation of Consumer

29. *Courier-Mail*, 27 September 1988:2. This actually represents an increase of nearly 50% in taxable income. Dr. Morris's figure of 17% is presumably the increase GPs would receive "in the hand" if they paid the full rate of income tax applicable to the new level of taxable income.


32. Pensioner and welfare groups in particular had become wary of the AMA's motivations in May 1986, when the Association announced that it was abandoning its traditional policy of charging no more than the MBS rebate for medical services to pensioners and the financially disadvantaged. This may have helped trigger their vigorous response to the AMA proposals. See *Commonwealth Record*, 26 May-1 June, 1986:838; and *Medical Practice*, May 1986:8-9. The AMA later acknowledged the damage this did to the Association's effectiveness as a lobby group. In 1991, Tasmanian Branch president Brendan Nelson - later federal vice-president and president - conceded that pensioners "had sometimes been publicly in conflict with the AMA", and formed a "liaison group" with the Australian Pensioners' Union to coordinate submissions to the government on health matters affecting the elderly. He said that "the way to influence governments is to have significant groups in the community identified with the AMA both nationally and in the States." *Australian Dr Weekly*, 31 May 1991:14.
Organisations (AFCO), the Health Issues Centre (HIC), and the Australian Pensioners' Federation (APF). They argued that the scheme would severely disadvantage the aged and the sick by increasing the gap between doctors' fees and Medicare rebates. They called for a consumer boycott of doctors who implemented the new scheme, and urged the AMA to meet with the Federal government to negotiate a new fee structure that was acceptable to GPs, consumers and the Government.33

The union movement was also strongly critical of the proposed scheme. ACTU president Simon Crean attacked the AMA proposals as "a further blow to ordinary wage earners". He contended that, in contrast to the compulsory Industrial Relations Commission procedures associated with increases for wage and salary earners, the AMA scheme would boost GP incomes by up to 30% per year without reference to any board or tribunal. He noted that since March 1983, the Standard consultation fee had risen by between 40% and 60% (depending on location), while award wages under the Accord had risen by less than 30% over the same period.34

While this seems at odds with the claims made above by Dr. Herron that Medicare fees had not kept pace with inflation, it does not necessarily directly contradict them. Award wages fell in real terms under the Accord, so that the Standard fee could simultaneously rise faster than award wages and fall behind the inflation rate. Assessing the level of GP incomes from Medicare over time is a complex


statistical exercise involving a large number of variables, and the outcome depends heavily on which indices and comparisons are used. For example, the trend using net incomes is significantly different from that using gross incomes, as it is using a comparison with average weekly earnings (AWE) or the consumer price index (CPI).

John Deeble's intensive analysis of fees under Medicare shows that for the period 1984-85 to 1989-90, GP revenue from average charged fees increased at a rate less than that of the CPI, but slightly greater than that of AWE. Although selective readings can generate different conclusions, Deeble's analysis makes untenable any claims that GP incomes from Medicare declined by a significant amount. However, the report also showed that all specialist incomes from Medicare (except psychiatrists') increased at rates "well above" both AWE and the CPI. Moreover, there is now some evidence emerging that the decreasing gap between GP incomes and the wages received by other occupations is as significant as that between GP and specialist incomes. Given the divisiveness which later developed over the fees issue between GPs and specialists in the AMA, this relativity aspect of GP incomes to specialist incomes is arguably the more important.


36. See for example, RACGP president Dr. Tony Buhagiar's assessment in Australian Dr Weekly, 8 March 1991:2.


39. For example, the RACGP's commissioned survey (noted above) revealed widespread concern amongst GPs over specialist encroachment of GP work, and the widening gap between GP incomes and specialist incomes. RACGP/Arthur Andersen & Co. (1985), Vision of General Practice... See also Dr. Hewlett's comparable comments on GP concerns in New Doctor, No. 50, Autumn 1989:6; and Hunter, T. (1984a), "Medical politics: decline in
Five days before the November 1 start-up date for the new scheme, the AMA officially released its list of recommended fees (See Table 2).


<table>
<thead>
<tr>
<th>Time-base</th>
<th>AMA Fee</th>
<th>Content-base</th>
<th>AMA Fee</th>
<th>MBS Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brief</td>
<td>$16.20</td>
<td>Minor</td>
<td>$12.00</td>
<td>$13.20</td>
</tr>
<tr>
<td>Standard</td>
<td>$21.50</td>
<td>Specific</td>
<td>$25.00</td>
<td>$18.60</td>
</tr>
<tr>
<td>Long</td>
<td>$41.50</td>
<td>Extended</td>
<td>$46.00</td>
<td>$33.50</td>
</tr>
<tr>
<td>Prolonged</td>
<td>$62.00</td>
<td>Comprehensive</td>
<td>$67.00</td>
<td>$53.00</td>
</tr>
</tbody>
</table>

Source: Courier-Mail, 28 October 1988:2.

The list contains some significant increases in the gap between AMA fees and existing Schedule (MBS) fees. For example, the most common type of consultation (Standard or Specific) increases by over 16%, bringing the gap between AMA fee and Schedule fee from $2.90 to $6.40. The list also reduces the recommended fee for the shortest or least complex service (Brief or Minor) by over 25%, in keeping with the AMA’s stated objective of getting GPs to spend more time with their patients. However, the effect of this change on GP incomes would be minimal, as this category of consultation makes up only about 3% of the nationwide total, and with even less financial return under the proposed system, would be expected to make up an even smaller proportion of GP consultations. Thus with the biggest increases centred around the most common type of consultation, the overall effect of the scheme on GP incomes is to significantly increase them.

On the proposed November 1 start-up date, the AMA, RACGP, NAGPA and Dr. Blewett formally met for the first time to discuss the new fee

gemonomy of the Australian Medical Association?", Social Science and Medicine, Vol. 18, No. 11, pp973-980.
proposals - nearly seven weeks after the AMA announced the scheme. Dr. Blewett offered to establish a joint government-profession working party to develop the AMA's fee proposals on condition that the AMA ask doctors to continue charging fees under the existing system. The RACGP accepted this offer, while the AMA rejected it outright. However the Minister remained open to further discussions.

Dr. Blewett objected to the proposed system on two grounds: accountability and cost. He maintained that the new descriptions for GP services were:

- too vague and too subjective, giving no scope for effective accountability to either patients or the Health Insurance Commission.

- Patients would have no way of knowing what type of service they were getting, and the Government would have no way of knowing whether the service described was actually given.

The ambiguities in the language used in the new descriptions certainly make them amenable to a variety of interpretations. For example, the Level B (Specific Service) involves "a selective history and examination of the patient, to assess and manage", while the Level C (Extended Service) involves "more complex tasks...with several alternative diagnoses which require a detailed history, multiple system examination, possible investigations and management." Even some

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40. Dr. Blewett contended that the AMA insisted on this date, while federal president of the AMA Dr. Bryce Phillips claimed that this was "the first mutually convenient date". *Courier-Mail*, 6 December 1988; *Courier-Mail*, 7 December 1988.


conservative sections of the medical profession expressed concerns about the vagueness of the definitions of the proposed descriptors.\textsuperscript{43}

Blewett's other main objection on the grounds of cost was based on the AMA's own figures. These showed that the cost of amending the Medical Benefits Schedule to correspond to the proposed system would be about $600 million per year. Blewett argued that this additional Medicare spending, on top of previous fee adjustments that since March 1983 had increased the Standard GP consultation fee by between 40\% and 60\%, could not be justified in the current climate of "economic restraint" under the Accord.\textsuperscript{44}

With the AMA maintaining its non-negotiable stance, the Health Department's then-Assistant Secretary (Financial Strategies, Health Benefits Division), Peter Read, suggested that the Department continue its negotiations on GP fees with the RACGP.\textsuperscript{45} A few weeks after the AMA's rejection of the Blewett offer, a joint RACGP-government working party was established to continue the development of a new fee structure and to report to the Minister by 1 March 1989.\textsuperscript{46}

The Government's principal concern was to have some sort of accountability mechanism incorporated into the new fee structure that would enable the HIC to maintain some oversight and control on

\textsuperscript{43} See the comments in this vein by Dr. Jhoel Menon, of the Private Doctors of Australia (PDA), in \textit{Australian Dr Weekly}, 14 October, 1988.

\textsuperscript{44} \textit{Australian}, 1 November 1988:3; and \textit{Courier-Mail}, 6 1988:8.

\textsuperscript{45} Personal communication.

\textsuperscript{46} \textit{Australian}, 17 February 1989:3; and \textit{Courier-Mail}, 18 February 1989:20.
aggregate GP fee costs under Medicare. The working party's final recommendation in this regard was to combine an element of the time-base from the old system with an element of content-base from the initial AMA/RACGP system. Under this scheme, GPs would charge fees according to both the length and the content of their consultations.

The Federal Council of the RACGP and its State faculties had agreed to this feature of the new fee system by mid-February 1989. The general terms of the RACGP-government agreement, based on the joint working party's report and to take effect from August 1, were announced on March 2. They included four new time-and-content based "descriptors"; and a two-tier fee and rebate system, with the higher level available to GPs who qualify for a (voluntary) vocational register through postgraduate RACGP training (or through five years' accumulated GP experience). A much more contentious proposal was the establishment of an Independent Peer Review Organisation (IPRO) to monitor and audit the use of the new fees schedule, including the use of random practice audits to assess the appropriateness of patterns of specialist referral, diagnostic testing and prescribing.

This proposal was ultimately attacked by all sections of the profession and by all of the non-government political parties, and developed into the central issue of the negotiations on the reforms package. The other parts of the agreement largely effect the terms and conditions under which GPs work, and as such are essentially industrial relations issues to be negotiated between the Federal government (as

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47. These are Minimum Service, Specific Service, Extended Service and Comprehensive Service.
paymaster) and the medical organisations (as worker representatives). The review body, however, had the potential to directly intervene in the autonomy of doctors over the content of their work. It would have exposed GPs' clinical judgements to formal review and evaluation by both medical and non-medical personnel, and implied that the medical knowledge underpinning those judgements is amenable to lay scrutiny, rather than institutionalised as unquestioned technical expertise.

Announcing the changes with the RACGP federal president, Dr. Geoffrey Gates, Dr. Blewett commented that postgraduate training for GPs was becoming more common overseas and that the system was expected to improve the standard and morale of GPs, give patients higher quality, more thorough consultations, and help contain the recent growth in prescriptions, specialist referrals and diagnostic testing. Under the new RACGP-Government system, he said, 90% of Australia's existing GPs would be immediately eligible for the higher level of fees (and their patients would be immediately eligible for the higher level of rebates).48

The system was opposed by the AMA, the NAGPA, the conservative Private Doctors of Australia (PDA)49 and the Rural Doctors' Association (RDA), who variously claimed that it was confusing, gave too much power to the RACGP, would create two classes of GP, and could cause an unacceptable loss of professional independence.50 However, the


49. Formerly the General Practitioners' Society of Australia (GPSA).

RACGP was not the only source of support for the system within the profession. For example, the Doctors' Reform Society (DRS) were in basic agreement with the RACGP on this issue, and enthusiastically endorsed the new fee system.51

Over the next few months the profession became markedly polarised around the issue. The tensions between the various medical groups generally in favour of the system and those generally against it intensified, and developed towards diametrically opposed positions with no common ground. Moreover, strongly polarised positions on the issue emerged within each of these groups, so that the profession was fundamentally divided across and between all of its major segments. The next section of this chapter examines the development and scope of this professional fragmentation, and assesses its impact on the profession as an organised interest group.

The profession divided
Shortly after the fee system was launched, the AMA announced its organisational restructuring based on the Cotton Report, which was commissioned by the AMA in 1985 and released in April 1987.52 As seen in Chapter Three, membership of the Association's federal governing body was previously restricted to representatives of the State Branches. Under the restructuring, the governing body also included representatives of the various craft-based groups, such as


GPs, surgeons and salaried medical officers. Combined with this "new-
look AMA" was a high profile public awareness campaign on public
health issues such as smoking and alcohol abuse, and a membership
recruitment campaign. In a move that was probably not wholly
coincidental, the Federal Council of the AMA also decided at this time
to reopen dialogue - suspended since the previous November - with
the Federal government on issues relating to GP fees.53

On 7 May 1989, only days before the legislation on the RACGP-
government fees package reached parliament, and in spite of the
Cotton restructuring, the RACGP decided to formally split with the
AMA and deal directly with the government on GP fees issues. The
College formed a formal committee structure through which to
channel such negotiations, and contended that the AMA had "nowhere
to go" and was "an organisation going through its death throes".54

In a fierce response, the AMA claimed that "[p]olitical novices within
the RACGP are being led like lambs to the slaughter over [the fees]
"Accord" being negotiated with the Federal Government..." Federal
president Dr. Bryce Phillips said that a leaked internal RACGP
document showed that the "Accord" was "a deal inspired by Labor
Party operatives with clear political objectives in the lead-up to the
next Federal election" and revealed "the amateurish and naive way in
which the RACGP [was] being sucked into a political storm".55


55. *Australian Medical Association*, *News Release*, "Political novices within the RACGP are being led
like lambs to the slaughter' says the AMA", 7 May 1989.
The AMA's "strong concerns" over the accord included: discrimination against those with non-standard GP experience, such as part-time GPs; RACGP acquiescence over the (as yet, largely unspecified) auditing and monitoring provisions; and "different interpretations" by the government and the College on the hybrid time-and-content descriptors.\textsuperscript{56}

On May 11, the day after the Second Reading of the \textit{Community Services and Health Legislation Amendment Bill 1989} (CS&HLA) containing the government-RACGP provisions, the new MBS fees and rebates for GP services were officially released (See Appendix, Table 3). The new fees represented a 5\% across-the-board rise (except for pathology services), effective from August 1, 1989. An extra 10\% was applicable to eligible GPs who joined the vocational register, to be phased in over a year from that date.

Towards the end of May 1989, the \textit{CS&HLA Bill} was debated in the House of Representatives along with several cognate bills dealing with private health reinsurance, pathology fees, day-surgery and nursing home classifications. House Leader Kim Beazley restricted debate on the Bills to two hours. The Democrats and the Coalition parties strongly objected to the cognate arrangements and the use of the guillotine, contending (in both Houses) that they were part of a government strategy to keep Medicare issues off the political agenda in the run-up to the next election.\textsuperscript{57} Although the government's numbers

\textsuperscript{56} \textit{Ibid.}

\textsuperscript{57} For example, House of Representatives (1989), \textit{Parliamentary Debates (Hansard)}, 25 May, p3010; Senate (1989), \textit{Parliamentary Debates (Hansard)}, 13 June, p3831.
ensured that the Bills went through the House of Representatives with only minor amendments, the Opposition parties pledged to subject the rest of the legislation - and in particular those parts relating to the fees package and the reinsurance measures - to "the closest possible scrutiny in the Senate".  

The bills were introduced into the Senate on the 26 May, 1989, with debate adjourned until June 13. The intervening period was marked by an escalation of the political lobbying and media campaigns by the groups most directly effected by the GP fees and reinsurance proposals. Activity over the fees proposals was mostly initiated by the major medical organisations and health, consumer and welfare groups. The reinsurance proposals were aimed at extending the Health Reinsurance Trust Account, an equalising pool that spreads the burden of insuring the elderly and the chronically ill across all health funds. In addition to the groups above, campaigning over these proposals came from the non-profit health insurance funds, the closed for-profit funds, private hospitals and pensioner groups.

The political parties found themselves subject to a barrage of intense lobbying activity by a wide variety of interest groups. Some of these groups focussed on either the fees or the reinsurance legislation (such as the private health funds and hospitals), while others had interests in both parts of the legislation (such as the medical and consumer organisations). As a result of this overlapping of interests, it was often difficult in practice for the parties to develop a stance on one part of

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59. The costs of this arrangement for the smaller closed health insurance funds, which have relatively few elderly and chronically ill members, is much higher than for the larger, traditional funds which have many more such members.
the legislation without contradicting - or at least partly undermining - its stance on the other. Such difficulty was reflected in a series of inconsistent pronouncements and policy about-turns that characterised the parties' responses to the lobbying activity.

The Opposition originally opposed both sets of proposals. After concerted lobbying by pensioner, health consumer and welfare groups, and the non-profit funds, they decided to pass the legislation but to defer its proclamation until after an inquiry by a Senate Select Committee.

As holders of the balance of power in the Senate, the Australian Democrats attracted a large part of the lobbying efforts. Like the Opposition, they also sought to refer the fees proposals to the Committee so that the monitoring and eligibility procedures for the vocational register could be more fully developed before the scheme took effect. After initially supporting the government, they were unresolved on the reinsurance issue. However, when the Senate debate on the Bills began on June 13, 1989, the Democrats voted with the Opposition to refer both sets of proposals to the Select Committee. The Committee's report on the fees package was scheduled for August 14, 1989, while that on the reinsurance changes was scheduled for March 1990.

The Opposition, in turn, twice supported a Democrat amendment to place a "sunset clause" on the reinsurance legislation, so that funding arrangements for the reinsurance pool would automatically expire after a period of one year, on 30 June, 1990. The government rejected the sunset clause in the House of Representatives. When the
amendment returned to the Senate, the Opposition suddenly withdrew its support from the Democrats, and the amendment was defeated. Opposition members contended that there was no reason for them to continue opposing the reinsurance legislation, since the government in the House of Representatives had agreed to their (the Opposition's) amendment deferring the implementation of the vocational register until the report of the Select Committee in August.63

It is very difficult to formally establish whether or not the government, the ALP and the health minister played any direct role in designing the legislative process so that the other parties would be placed in such difficult and contradictory positions on the reforms. However, some indirect and circumstantial evidence does point to such a possibility. For example, the government has far more control over the scheduling and ordering of proposed legislation in the House of Representatives than the other parties. In this context, the government has both the means and the motive to have the GP reform legislation debated in parliament with a restricted time limit (witness Kim Beazley's use of the guillotine), and in combination with the other cognate bills that so complicated the other parties' positions.

Moreover, Dr. Blewett was able to "muddy the waters" for the other parties by issuing media releases containing various collections of statements and letters on the proposals from consumer, welfare, pensioner and health insurance groups, all of which were largely

supportive of the government's position. It is not suggested here that Dr. Blewett would or could get these groups to support him on these issues against their will or against their own interests. However, the sustained, organised consumer group interest in the legislation was something of a novelty at the time, and occurred under a health minister who gave unprecedented support (both financial and ideological) for health consumer organisations as "ginger groups" within the health policy community. In addition, the identical dates on some of the collections of statements released by the Minister at least suggest that the different groups were not acting entirely spontaneously and without encouragement.

The Senate Select Committee on Health Legislation and Health Insurance was established on 13 June, 1989 to inquire into and report on the meaning and implications of Clause 10 of the Community Services and Health Legislation Amendment Bill 1989. This clause covers all aspects of the vocational register proposals. During the Committee's inquiry there was a limited campaign of industrial action against the proposals by some resident medical officers, culminating in stopwork meetings in all States in the latter part of July. The RMOs' principle concern with the new system was that it

61. See for example Dr. Blewett's appraisal of the Consumers' Health Forum (CHF) as an organisation "essential to the development of sane and sensible health policies"..."the opinions and views of which are valued, sought, listened to and heard by this government". Health Forum, November/December 1988 (insert), page 1 (original emphasis).

62. See for example Dr. Blewett's letter to Democrat Senator Coulter of 16 June 1989. Attached are copies of statements of support for the government's reinsurance proposals from the Australian Council on the Ageing (in combination with the Australian Pensioners' Federation), the Australian Retired Persons Association, the Victorian Council on the Ageing and the Voluntary Health Insurance Association of Australia. All of the statements deal with the same specific aspect of the reinsurance legislation [the "sunset clause" proposed by the Opposition and the Democrats], and all of them are dated 14 June, 1989. Ministerial Document Service (1989), Daily Collation of Ministers' and Opposition Leaders' Statements, 16 June, pp7424-7431.
forced them to undertake further training in order to become eligible for the higher level of GP fees. The AMA was active in participating in, supporting and coordinating the campaign.63

The Select Committee report, unanimously endorsed by its cross-party membership, was presented to the Senate on 16 August, 1989. Entitled "Vocational Registration of General Practitioners", the report recommended that Clause 10 of the CS&HLA Bill be proclaimed only after regulations on appeal procedures and alternative pathways to vocational registration had been fully developed and subjected to parliamentary scrutiny.

The report's other recommendations included the establishment of a body, independent of the RACGP, to consider registration for non-RACGP members and for doctors with non-standard medical experience and qualifications (for example, in sports medicine or family planning clinics); the establishment of an independent appeals/review mechanism for rejected registration applications; the return of the AMA to the role of principal negotiator for the medical profession in the area of Schedule fees and rebates, and the return of the College to its traditional role as arbiter of medical educational standards; (This was strongly and unanimously urged by the RACGP, the government and the Department); and that the proposed Independent Peer Review Organisation (IPRO) not go ahead, but that a tripartite (Government/AMA/RACGP) body called the Descriptor

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63. Over three years later, the RMOs' concern with the GP reforms remained, and led to strike action in some States. However by this time the Federal AMA had agreed to the (amended) reforms, and was formally opposed to the RMOs' action, despite conditional support for it from some State Branches. Australian, 21 September, 1992:3; 30 September 1992:3; Weekend Australian, 10-11 October 1992:10.
Utilisation Review Committee (DURC) be established to evaluate and monitor the use of the new fees system.

Federal AMA president Bryce Phillips endorsed the report, stating that the Senate Select Committee:

has addressed most of these concerns [over inadequate consultation with the medical profession] in a well-balanced way...The AMA will therefore adopt a constructive attitude to the recommendations of the Select Committee and will respond positively to proposals for its further involvement in implementing the general thrust of the report.\(^{64}\)

The Coalition, the initiators of the Committee of Inquiry into the scheme, contended that the AMA's acceptance was more like acquiescence forced on it by the majority "deal" between the Democrats and the government. It maintained its opposition on the grounds that it had "more to do with the regulation and control of general practitioners than with raising the standard and quality of patient care", and that it gave the RACGP "a monopoly power over entry to the vocational register".\(^{65}\)

Within two weeks, the government had agreed to accept all of the Committee's recommendations, and to make the initial 5% across-the-board fee and rebate increases - suspended pending the Committee's report - effective from September 1, 1989. The passing of the legislation in its final form postponed implementation of the vocational register and fee differentials until December 1, 1989. The differential fee increases, available only to GPs on the vocational register, were scheduled for February 1990. However in October, 1989, Dr. Blewett


announced that these increases would be brought forward to be applicable from the scheme’s December 1 start-up date.⁶⁶

In the lead-up to December 1, Dr. Blewett announced funding to expand the number of available places in the RACGP’s postgraduate Family Medicine Program (FMP) to meet the anticipated increase in demand from those seeking registration; and a reduction in the minimum time to complete the Program from four to three years. During this time the government also mounted a public awareness campaign on the new system. The Australian Doctors’ Fund (ADF)⁶⁷ and the NSW AMA ran a counter campaign during this time, urging patients to tell their GPs not to join the register because of its potential to undermine the confidentiality of their medical records.⁶⁸

The limited effectiveness of the ADF’s campaign was reflected in the wide endorsement of the register and fee structure by GPs and health consumer groups.⁶⁹ With minor amendments to associated regulations, the Federal AMA and the Democrats agreed to cooperate with the new scheme, which came into effect on December 1, 1989 (See Appendix, Table 4).

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⁶⁶. The minister contended that the advance was to help compensate the many GPs who had been financially disadvantaged by the Senate delay in passing the legislation. However at the time there was considerable speculation that the Opposition was set to release its health policy, and this may have also prompted the early increase. See Courier-Mail, 9 October 1989:3. As it happened, the Opposition was unable to release its health policy at that time.

⁶⁷. ADF was established earlier in 1989 to garner support for an extensive political campaign against Labor’s health policies - in particular the Medicare system.

⁶⁸. See the ADF’s large advertisements, headed “Who’s looking at your medical records?”, in Australian, 29 November 1989:7; and Weekend Australian, 25-26 November 1989:15.

⁶⁹. See for example Senate (1989), Parliamentary Debates (Hansard), 7 September, p1150 and p1155. But for an opposing view, see Ibid., p1161.
The new GP fees system

In the new system, there is no time limit applicable to the lowest service category (Level A), although the limited content of this category suggests a time similar to that for the old Item 1 - that is, less than five minutes. The corresponding rebate is reduced significantly. In keeping with Dr. Blewett's aim of increasing the quality of GP services through longer consultations, this provides a financial incentive for GPs to provide fewer services in this category. However, as noted above, Item 1 services traditionally constitute less than 3% of total GP consultations; so that the overall effect on GP service practices could only be marginal.

The maximum time for the most common service type, Level B (formerly Item 5, Standard Consultation, and currently accounting for about 85% of consultations70), is decreased from 25 to 20 minutes, allowing GPs to increase their incomes by either providing more of these (higher rebated) services per work session, or by "spilling over" into the higher Level C rate. The lower maximum times for Level C and D services have the potential to increase GP incomes in the same ways.

However, there is no minimum time limit specified for the Level B category. To qualify, the service needs to meet the content criteria or be less than twenty minutes long. Given the difficulties of measuring content, it would seem that there is no formal mechanism available to

prevent entrepreneurial GPs reverting to "six-minute medicine" - or even "four-minute medicine" - under the new fee structure. Earlier in the 1988/89 negotiations between the Government and the RACGP, an "insidious attempt" (in the words of an AMA representative) was made to place a minimum time limit of ten minutes on Level B consultations. This would have pre-empted the practice of "six-minute medicine" under the new system, even if it were replaced by some GPs with "eleven-minute medicine".

Information on the negotiations, leaked to the Medical Observer on May 3, 1989, clearly shows a ten-minute lower limit still applying to Level B consultations. However, one week later, when the Minister announced the official fees and rebates for the new system, this limit had been dropped from the fee structure, leaving only the upper limit of twenty minutes in place. This change represents a trade-off for an across-the-board acceptance by the profession of a time-and-content based system, rather than the entirely content-based system it originally proposed.

According to an "internal document from the Royal Australian College of General Practitioners", consultants involved in the joint RACGP/government working party suggested that the general practice reform package was "entirely dependent" on the inclusion of a time element within the new fee descriptors. The new descriptors would include the words "which typically lasts at least 10 minutes" on the

71. NSW AMA GP leader Dr. Peter Craig, quoted in Medical Observer, 7-20 July 1989:5.
most common Level B descriptor, the words "and lasts at least 20 minutes" on the Level C descriptor, and the words "lasts at least 40 minutes" on the Level D descriptor.\textsuperscript{74}

The government's reasons for the inclusion of a time element relate to its use as a guide to making budget estimates of the total public funds required to cover GP services under Medicare, and to concerns about the cost implications of a wholly content-based system. The consultants informed the RACGP that

\begin{quote}
the Government has frankly stated that without the provision for minimum time in levels C and D it would be impossible to sell the package to Treasury and the Finance Department, and the whole package would be lost.\textsuperscript{75}
\end{quote}

The final terms of the new descriptors, with minimum limits on Level C and Level D, but none on the more common Level B services, represent a compromise arrangement almost exactly half way between a system with no time element and a system with upper and lower time limits on all types of consultation.

However, the inclusion of a partial time element within the new fees system cannot fully preclude provider abuse. For even where the suggested time components of the services claimed for one working day total more than 24 hours, a case of abuse is not necessarily established. Unlike the old time-based system, the time-and-content system - or more accurately, the time-or-content system - allows GPs to claim for services on the basis of their medical content, regardless of the time taken. While the limitation on fees imposed by the total

\textsuperscript{74.} Australian Medicine, 6 March 1989:4.

\textsuperscript{75.} ibid.
length of the working day was a fairly loose one, it nevertheless allowed the HIC a minimum benchmark level of administrative control over the Medicare services claimed by individual GPs. Under the new fee structure, even that minimum control is seriously weakened.\footnote{76}{Dr. Blewett told the AMA that the inclusion of a time element in the new fee system was to "limit the potential for drift to higher priced services". Blewett (1989), "Speech to AMA...", p18. However given that three of the four descriptors allow for service categorisation on the basis of time or content (see Appendix, Table 4), it is difficult to see how the time element could effectively constrain such drift.}

While any fee-for-service system will harbour an element whose practices are directed more to quantity than quality, the auditing and review provisions of the new fee structure had the potential to make "six-minute" practices more prone to exposure and thereby more difficult to sustain. However, in addition to the practical problems of enforcing and administering such provisions, there remained a major sticking point in the Government/AMA/RACGP negotiations on the form such provisions were to take.

\textbf{The profession united}

While the profession was severely divided on the issues of the new fee structure, vocational registration and continuing education requirements, it was far less divided on the issue of auditing and review. The AMA and the more conservative professional groups, such as the NAGPA, the Private Doctors of Australia and the Australian Doctors' Fund, vigorously opposed the GP reforms in their entirety, but singled out the auditing provisions as especially undesirable.\footnote{77}{For example, see PDA's submission to the Senate Select Committee, reprinted in Australian Private Doctor, July/August 1989:16-17; and AMA's response to the proposed IPRO in Daily Mirror, 8 June 1990:7.}
For example, as noted above, the campaign against the new system mounted by the Australian Doctors' Fund in conjunction with the NSW AMA, was based almost exclusively on concerns that the auditing provisions would breach doctor-patient confidentiality. Full-page advertisements proclaimed to "all Australians" that under the new system:

You will lose your privacy. The new deal will allow Government agents to access your medical records - and you won't even know. Confidentiality between you and your doctor will be lost forever. Tell your GP not to sign the register! Tell your GP you don't want your medical records exposed.78

However, the auditing provisions also generated considerable resentment amongst those generally supportive of the reform package. For example, "about 100" GPs who applied for (and received) vocational registration through the HIC - and thereby who presumably accepted the other reforms - deleted all references to the Descriptor Utilisation Review Committee (DURC) on their application forms. In other words, they signed up for vocational registration without formally acknowledging that the proposed DURC might review their service practices under the new descriptors.79

The divisions within the RACGP over the reform proposals were largely based on concerns over the auditing provisions of the legislation. While members were also dissatisfied with the low level of consultation with College members by the RACGP executives negotiating with the


79. Australian Dr Weekly, 6 April 90:1,3. HIC assistant general manager (Medicare division), Mr. Ken Hazell, warned that, if introduced, DURC would apply to all GPs, including those who deleted the DURC references. Ibid., p1.
Government,\textsuperscript{80} they were especially concerned over the proposed auditing arrangements, both as a general slur on the integrity of the profession, and in view of the expectation that members gain registration before the details of the guidelines and procedures had been revealed.\textsuperscript{81}

Such resistance to the auditing provisions was also reflected in the parliamentary and committee debates on the reforms. For example, then-Opposition health spokesman Senator Puplick expressed "concerns about certain sections of the \textit{[Community Services and Health Legislation Amendment]} Bill, particularly that which would set up an Independent Peer Review Organisation \textit{[IPRO]}".\textsuperscript{82} Even the Democrats, who were otherwise supportive of the reforms from the outset, had considerable reservations about the auditing provisions. Indeed their decision to refer the reform legislation to the Senate Select Committee was largely based on such reservations.

The Senate Select Committee was unanimous in recommending the abolition of the original auditing body (IPRO), and replacing it with a considerably toned-down DURC. The Committee's recommendation was based on the view that there had been widespread misunderstanding over the use of the term "peer review" in the

\textsuperscript{80.} Such inadequate consultation with the profession was unanimously acknowledged by the cross-party Senate Select Committee. See for example, \textit{Australian}, 17 August 1989:6.

\textsuperscript{81.} For example, \textit{Australian}, 14 July 1989:5.

\textsuperscript{82.} \textit{Canberra Times}, 14 June 1989:21. For details of Senator Puplick's concerns on the IPRO, see also Senate (1989), \textit{Parliamentary Debates (Hansard)}, 13 June, pp3835-3836. For Opposition concerns generally on this issue, see \textit{Ibid.}, 13-14 June, especially pp3915-3923.
proposed IPRO, so that the problem "was one largely of the choice of language by the Government".\textsuperscript{83}

The Committee explained that the original intention was to establish a body "to monitor the costs of the use of [the] new descriptors".\textsuperscript{84} The profession uses "peer review" to refer to the "review of the professional activities of doctors by their peers".\textsuperscript{85} However, the inclusion of the term in the title of a body aimed at monitoring the new descriptor items led many to believe that the government itself, through the HIC, was to perform the peer review function. It was this perceived lay evaluation of medical judgements which the Committee viewed as the basis of the profession's strong resistance to IPRO.

The Committee addressed the misunderstanding by changing the title of IPRO to the Descriptor Utilisation Review Committee (DURC), and by emphasising that DURC's "much narrower role" would be "carried out by professional people - it would not involve non-professionals looking over the shoulder of doctors".\textsuperscript{86} Dr. Blewett maintained that he had never planned an auditing system run by the government or health bureaucrats. He had always envisaged a peer review mechanism operated solely by the medical profession: "an independent professional organisation",\textsuperscript{87} operated by "qualified GPs

\textsuperscript{83} Senate (1989), \textit{Parliamentary Debates (Hansard)}, 16 August, p117.

\textsuperscript{84} \textit{Ibid.}, p124.

\textsuperscript{85} \textit{Ibid.}, p118.

\textsuperscript{86} \textit{Ibid.}, p122.

\textsuperscript{87} House of Representatives (1989), \textit{Parliamentary Debates (Hansard)}, 10 May 1989;2387.
quite separate of both Government and the Royal Australian College of General Practitioners". 88

However, while the general objectives for IPRO might have remained unchanged in the government’s view, the scope of its functions underwent a considerable change. These functions shifted from auditing and monitoring "which will extend to examining referral and prescribing patterns and the ordering of diagnostic tests" 89 to a general practice research and review role oriented towards achieving "uniformity in the use of these descriptors". 90

Peer review procedures for medical practice, whether aimed at quality assurance or the identification of fraud and overservicing, have a long tradition in Australia of being rendered largely ineffective through a sustained - but informal - lack of enthusiasm and cooperation on the part of the profession. Such professional inertia for peer review is not simply part of a more general political response to the perceived threats posed by Labor government policies of universal health care systems. For example, in 1976 Liberal health minister Ralph Hunt, concerned at the growth of medical services under Medibank, warned doctors' organisations that unless they imposed professional peer review mechanisms to monitor the quality of those services within three years, the government would impose its own review mechanisms. 91 Some seventeen years later, peer review mechanisms


90. Senate (1989), Parliamentary Debates (Hansard), 16 August, p122.
have not been developed by the profession, with the partial exception of medical services in hospitals through the accreditation procedures of the Australian Council on Hospital Services (ACHS). As seen in the pathology case study in the previous chapter, peer review mechanisms to detect fraud and overservicing, such as the Medical Services Committees of Inquiries (MSCIs), have tended to become bogged down by procedural complexities and to process cases at an excruciatingly slow pace.

Equally, despite the threats by Ralph Hunt and other health spokespersons, a succession of Federal governments has not actively sought to impose their own direct forms of review onto the profession. Since the explicit agreement and cooperation of medical practitioners is required for peer review to work, it cannot, by definition, be forced onto an unwilling profession by outside bodies. In this context, Mr. Hunt's threat of government imposed peer review mechanisms was an empty one, and reflected more a hope that the profession would move on the issue rather than a means to actually achieve it.

The enormous resentment generated by the misunderstandings within the profession over the auditing provisions, and reflected through the political parties, made their effective implementation uncertain, if not improbable. By May 1990, six months after the new fee structure was implemented, the AMA/RACGP/Government Standing Review Group on General Practice, as the advisory body on the procedures for DURC, had not agreed on the specifics of such procedures. Another

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year later, by which time the focus of its proposed activities had shifted from random practice audits on individual GPs, through the monitoring of the aggregate costs generated by the new descriptors, to general research on practice trends in the GP sector, and DURC (the "son of IPRO") was quietly dropped.\textsuperscript{94}

Its replacement has taken the form of a subcommittee, consisting of an HIC commissioner and two AMA representatives, to advise the HIC "on issues affecting general practice".\textsuperscript{95} With the demise of DURC, the principal objection of the AMA to the GP reforms was removed, and Federal Council members gave the vocational register their tentative endorsement. In November 1991 they resolved that:

\begin{quote}
since the Descriptor Utilisation Review Committee and some other concerns related to the general practice vocational register have been resolved, Federal Council can see no reason why those general practitioners who wish to do so should not join the vocational register...\textsuperscript{96}
\end{quote}

The elimination of the original proposals for random practice audits on individual GPs, and the government's essential commitment to any evaluation arrangements being developed and implemented primarily by the profession itself,\textsuperscript{97} remains as the Achilles' heel of the new system as far as overservicing and cost-containment are concerned. There are currently no mechanisms in place (or planned) through

\begin{enumerate}
\item \textit{Australian Dr Weekly}, 18 May 1990:1,3.
\item \textit{Australian Medicine}, 2 September 1991:8.
\item \textit{Australian Medicine}, 2 and 16 December 1991:7.
\item For example Senator Crowley, presenting the report of the Select Committee to the Senate, stated that "we now make it beyond doubt that that evaluation and monitoring [involved in the auditing provisions] has to be done by the profession on the profession." Senate (1989), \textit{Parliamentary Debates (Hansard)}, 16 August, p114, emphasis added.
\end{enumerate}
which an assessment can be made of specific applications of the new descriptors. It is entirely up to the individual GP to decide, for example, whether the medical content of a particular consultation belongs to the Level B category or the higher Level C category. The GP is formally accountable to no one for either the patterns of practice generated in assigning descriptors to individual services, or the total Medicare income so produced - not even to fellow GPs.

The interest group approach to medical politics would attribute such an explicit and formal consolidation of clinical autonomy to the political astuteness of the profession's organisational representatives, to the relatively high level of resources to which they have access, and to the influence their collective mobilisation strategies were able to exert on the policy process. Here a profession strongly divided over the bulk of the reforms becomes wholly united in its opposition to the review proposals, and as a result presents an overwhelming political force of resistance to the government's intentions. Indeed, it is undeniable that the profession's organisations fully and quickly exploited the misunderstanding over the nature of the original monitoring provisions to mobilise an effective resistance to them. While the profession was deeply divided over many components of the reform package, it was very strongly united over the issue of clinical evaluation by non-medical bodies. The interest group approach bases its explanation for the policy outcome primarily on the government's awareness of the strength of that unity and of the political viability of trying to break it.

However, the outcome can also be attributed in part to the general acceptance - by the state, the media and the community at large - of
the knowledge base of the profession as scientifically generated, objective expertise, which is neither suitable for nor permeable to lay evaluation. According to the Minister's formal statements and media releases, and to the parliamentary debates and Select Committee transcripts, the government never intended to subject the content of GPs' clinical decisions and judgements to evaluation by non-medical personnel. Such is the implicit, total acceptance by the government - and indeed by the Opposition parties and society at large - of the apolitical, taken-for-granted nature of medical knowledge, that this type of evaluation was not even raised as a possible option. Under this paradigm of Western scientific medicine, only doctors are deemed capable of judging whether or not GPs are applying the new descriptors inappropriately to generate extra income from Medicare (for example, by claiming consultations with Level B content as Level C consultations).

So even before the negotiations on the review mechanism began, there was an unexpressed agreement by all the interested parties that only the profession was capable of assessing the appropriateness of its members' clinical decisions. At the end of the negotiations, however, even that agreement on peer review as an accountability mechanism did not bear fruit. Without the formal ability to directly assess the appropriateness of the medical judgements made in assigning consultations to particular descriptors, the government has no effective means of monitoring individual use of new fees system, or of legally substantiating suspicions of fraudulent use. Dr. Blewett's original concern that "[p]atients would have no way of knowing what type of service they were getting, and the Government would have no
way of knowing whether the service described was actually given remains largely unresolved within the new fees system.

However, the new fee structure does do more than simply pay higher fees to vocationally-registered GPs. The new fees have the effect of slightly flattening out variations in the rate of earnings over the range of service categories. For example, under the old fee structure, dollar per minute earnings for a Standard Consultation progressively reduce to a minimum of $0.74 at the upper time limit of 25 minutes. Dollar per minute earnings for a new Level B consultation reduce to a minimum of $1.03 at the upper time limit of 20 minutes - an improvement of nearly 40%. Similarly, the minimum rate per minute for a Long consultation is $0.74 compared to $0.91 for a Level C consultation (up 22%).

The same sorts of variations can be seen in hourly earnings across a range of service categories. For example, under the old fees system, six ten-minute (Item 5) consultations return $111.60 in MBS rebates for the hour, while two thirty-minute (Item 7) consultations return $67, representing a decline in hourly income of 40%. With the new system, six ten-minute (Level B) consultations return $123 for the hour, while two-and-a-half 24-minute (Level C) consultations return $91.25, a decline of less than 26%. The overall effect is that GP earnings per work session under the new scheme are less significantly effected by an increase in the length of the consultation. No longer is such a sharp drop in income incurred by GPs shifting from short to longer consultations. In other words, the new fee structure helps fulfil one of

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the Government's main objectives in reorganising GP practice by removing some of the financial penalties imposed by the old structure for spending more time with patients to develop preventive health strategies.

However, this in no way guarantees that those GPs basically sympathetic to the aims of the reforms will spend more time with their patients on all occasions. Many GPs feel that the overriding factor in determining the length of a consultation is the number of people in the waiting room. Consultations tend to be longer when the patient workload is low, and shorter when it is high. In the case of very high or very low workloads, the new fee structure could be expected to have little, if any, impact on the length of consultation; for it is still far more lucrative to the GP to have more frequent, shorter consultations than fewer, longer ones - whether one uses the old fee schedule or the new one.

In many ways, the proportion of patients receiving longer consultations depends on the degree to which GPs are prepared to sacrifice income for the work satisfaction of (presumably) more thorough, effective servicing. Given the intense history of government-profession disputes over the level of fees, and the residual contention amongst GPs that their incomes remain quite inadequate in


100. For example under the MBS fees applying to vocationally registered GPs from December 1 1989, two-and-a-half 24-minute (Level C) consultations return $91.25 for the hour, while six ten-minute (Level B) consultations return $123.00, an increase of some 35%. Under the non-vocational register fees, the difference is even greater: two thirty-minute (Item 7) consultations return $67 for the hour, while six 10-minute (Item 5) consultations return $111.60, a difference of some 67%.
comparison to their specialist colleagues, that proportion may not prove to be a majority one, or even a large one. But regardless of its ultimate size, control over the proportion of longer consultations under the new fee structure remains far more in the hands of the profession than in those of the government’s health agencies.

As for the register itself, the initial response from GPs was far from overwhelming. At the beginning of April 1990, Health Insurance Commission figures showed that 5,149 of the 15,636 GPs invited to apply for vocational registration were on the register. By the end of 1991, the number had increased to about 9,000, representing 75% to 90% of the estimated total of 10,000 to 12,000 GPs eligible for registration. By 1992-93, there were more than 15,000 GPs on the Register, representing over half of all GPs in Australia, and more than three quarters of all GP services under Medicare. However, these figures do not necessarily express the profession’s conclusive response to the registration system. Given the divisiveness within the GP sector over the issue of vocational registration - not only between the AMA and the RACGP, but also within the RACGP itself - there is arguably a significant number of GPs who adopted a "wait-and-see" approach to joining the register, especially in relation to the final form of the DURC

101. Even then-RACGP president, Dr. Geoffrey Gates, one of the principal architects of the new fees scheme, agreed that GP rebates "should be higher". *Australian Dr Weekly*, 25 May 1990:3.

102. *Australian Dr Weekly*, 6 April 1990:3.

103. RACGP President Dr. Tony Buhagiar, in *Australian Medicine*, 2 and 16 December 1991:7.


auditing procedures. Now that the original function of DURC has been effectively dropped from the GP reforms, the proportion of eligible GPs joining the register could reasonably be expected to increase.

Initially, the modest size of the fee increments attached to registration make the financial penalty of a wait-and-see approach relatively small. The fees incurred for RACGP refresher and training courses, and the time taken out from practice (or vacation leave) to participate in them, reduced that penalty even further. However, if the gap between VR fees and incomes non-VR fees and incomes increases significantly, then more GPs could be expected to join the register. Indeed, there are indications that the gap is in the process of widening. From 1 November 1992, Medicare fees for GPs on the register increased by about 2.5%, while there was no increase at all for non-VR fees, taking the Schedule fee differential between VR and non-VR GPs to about 20%.106

**Power, knowledge and the AMA**

Marmor and Thomas' contention that "doctors get their way over methods of pay"107 is strongly supported by much of the history of doctor-government negotiations on fees and incomes in Australia. As the principal organised interest group for the medical profession, the AMA has played a major part in such negotiations, and has been a

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crucial player in shaping the criteria for and level of remuneration for the medical profession. This role gained widespread recognition through the Association's involvement in the precedent-setting "most common fee" negotiations with the Liberal Gorton government following the Nimmo Inquiry in 1969.\footnote{Nimmo, J.A. (1969), (Chairman) Committee of Inquiry into Health Insurance Report, Canberra: AGPS. To establish a set of uniform fees for medical services and procedures, the Gorton government surveyed GPs and the various specialties to determine the "most common fees" charged by them. These have been used as the benchmarks for government-profession negotiations on subsequent fee rises.}

The AMA's role has been no less crucial since the implementation of the Medibank and Medicare health schemes under Labor governments. Indeed the considered decision of the Whitlam government, and all successive governments, to retain fee-for-service remuneration under a universal health insurance scheme has done much to entrench it even further. It also lends further support to Marmor and Thomas's cross-national evidence that doctors' preferences usually determine the method of payment, and that this method usually has "a remarkably close resemblance" to what doctors were used to before the new health scheme.\footnote{Marmor and Thomas (1972), Op. cit., p437.} All of these governments have formally recognised the AMA as the profession's principal representative in negotiations over fees and incomes. This is despite a serious and more or less continuous decline in the Association's membership since the early 1970s, to its current level of about 50% of all doctors.\footnote{Australian Medical Association (1987). Cotton Report..., p30; Bulletin, 13 June 1989:47; Australian, 2 June 1989:13; Australian, 13 March 1989:11.} Membership of many of the formal committees involved in negotiations between the government and the
profession has been restricted to Government representatives and AMA nominees.\footnote{111}

The government recognition, in turn, is based on a fairly constant and widespread acceptance among medical professionals of the AMA's right and competence to represent them in financial and industrial negotiations with governments at State and Federal levels. This is particularly reflected in the traditionally high levels of conformity among AMA members to the terms of the final agreements reached with the government over fees and incomes.\footnote{112}

However, during the negotiations over the new fee structure and registration measures, the legitimacy of the AMA as representative of the medical profession - especially the GP segment of the profession - was significantly eroded. The AMA played no direct role in the negotiations with government on the development of the vocational registration arrangements, which are central to the package of reforms implemented in December 1989, and which have a direct effect on the level of GP incomes under Medicare. The vocational registration system was largely initiated, developed and negotiated by the RACGP, with almost no formal input from the AMA.

\footnote{111}{Under the \textit{National Health Act} and the \textit{Health Insurance Act}, there is a formal requirement for the Health Minister to consult with the AMA before making appointments to such committees. See Blewett, (1989), "Speech to AMA...", p10.}

\footnote{112}{This is not to imply that all doctors - or even the majority of doctors - abide by all of the AMA's recommendations on fees. For example, only 7% of GP services and about 15% of specialist services are charged at or above the AMA List fees. \textit{Bulletin}, 13 June 1989:47. However, there is a strong tradition of the AMA acting as the principal representative of the profession in formal negotiations on economic, industrial and political issues, widely recognised by both doctors (AMA members and non-members) and governments.}
Throughout the negotiations, the AMA’s legitimacy in this role was undermined by two main factors: the effective depiction of the AMA’s hardline approach as an inaccurate reflection of the sentiments of the majority of medical professionals; and the increasing internal divisiveness between New Right specialist groups seeking the abolition of Medicare, and more moderate GP groups willing to negotiate with the government over the reform of Medicare, from which they derive a larger portion of their income. These factors were cumulative and mutually reinforcing, and finally resulted in an AMA backdown on fees and incomes that is arguably its biggest and most humiliating.

The portrayal of the AMA as intransigent and minority-based was given an initial boost of credibility by the very style of its September 1988 announcement on the fees proposals. At the time the AMA was not formally talking to the government on the issue of fees. In March 1986, it had decided to withdraw from the medical benefits inquiry which sets the MBS fees because of "unacceptable" delays by the government and because pathology benefits were excluded from consideration. In 1987, the AMA postponed further meetings of Medical Benefits Schedule Revision Committee (MBSRC) after Health Minister Blewett unilaterally altered Schedule items during the AMA’s boycott on fees talks. And in July 1988, the AMA Federal Council decided to "cease all participation in both the Medical Benefits Schedule Revision Committee and the Medicare Benefits Advisory

113. Skotnicki, T. (1988), "Blewett faces new health flare-up", Business Review Weekly, 21 March, p93. Health Minister Blewett contended that the new fees would be in place twelve months after the previous rise, so that the inquiry had not been delayed; and that pathology benefits should be excluded pending the final report of the Joint Committee of Public Accounts' Medical Fraud and Overservicing Inquiry on pathology services. For more on the latter, see Chapter Four.

Committee [MBAC] and, in the case of the latter, to withdraw endorsement of its current nominees."\(^{115}\)

Although the AMA at the time was not formally representing the medical profession's position on the issue of fees and rebates under Medicare, it nevertheless decided to announce its new content-based fees system - with its enormous implications for Schedule fees and rebates and Medicare funding - without consulting the Federal government. Indeed, the AMA did not formally notify Dr. Blewett of its proposals until November 1, the day the scheme was supposed to commence.\(^{116}\) The AMA acknowledged that it had not assessed the impact of the system on the Medicare budget, and claimed that it had not assessed its impact on GPs' incomes.\(^{117}\) Moreover, the AMA simultaneously announced that the system was to formally take effect in less than seven weeks. This left the AMA very vulnerable to criticism in the areas of consultation procedures and economic responsibility and accountability.

While Dr. Blewett's initial response to the proposals was cautious, he soon made full use of the opportunity to discredit the AMA's approach on these grounds. The "internal AMA document" leaked to the Minister made his contention that the AMA was more interested in boosting GP members' incomes than in improving patient services a very

\(^{115}\) Medical Practice, 15 August 1988:6. The MBSRC is a departmental committee with equal representation from the AMA and the Department. Its function is to make recommendations to the Minister on changes to individual items on the Medical Benefits Schedule (for example, new items, amended descriptions). The Medicare Benefits Advisory Committee is a statutory committee under the Health Insurance Act. Although it has wider powers, it has limited its activities to considering rebate claims for complex or unusually long services. \textit{Ibid.}, p6.

\(^{116}\) \textit{Australian}, 1 November 1988:3.

compelling one. His case was given further support by the subsequent admission by Federal Councillor Dr. Rod Morris that the AMA scheme was consciously aimed at improving GP incomes; by the unprecedented combined attack on the proposals by health consumer, welfare and pensioner groups,118 and by the ACTU’s comparison of GP and wage-earner incomes under the Accord. Dr. Blewett’s consistent statements of confidence that the majority of GPs and the general public would reject the scheme119 were clearly more substantial than rhetorical.

The AMA’s image problem was further exacerbated by the release of its Medicover proposals the following May (1989). The timing of the release – during the adjournment of debate on the CS&HLA Bill in the Lower House – suggests that the AMA Councillors saw the scheme as a way to help shake off the "greedy" and "arrogant" connotations, and to regain some of their public credibility as constructive, competent and caring medical professionals. Medicover was heavily promoted by the AMA as a scheme which could overcome the endemic inefficiencies of Medicare by revitalising the private medical sector, but at the same time protecting the disadvantaged.120

However, the general response to the scheme did little to restore that credibility. Neal Blewett referred to the scheme as "Medibroke".

118. These included the Health Forum of Australia (HFA), Australian Council of Social Service (ACOSS), Australian Federation of Consumer Organisations (AFCO), Health Issues Centre (HIC) and the Australian Pensioners' Federation (APF). See Courier-Mail, 24 October 1988:2.

119. For example, see Courier-Mail, 27 September 1988:2 and 28 October 1988:2.

120. For example, federal AMA president Dr. Bryce Phillips explained that "[T]wo main principles guided the design for Medicover - to establish a system of financing arrangements that is fairer, and more efficient than Medicare". SMII, 26 May 1989:15.
arguing that its cost would bankrupt both individual Australians and the country, and that only doctors - especially specialists - would benefit from its implementation. The Doctors' Reform Society labelled the scheme an "unmitigated disaster" that would inflate doctors' incomes and health costs in Australia, and called on both main political parties to reject it.\textsuperscript{121} Pensioner, welfare and health consumer groups were unanimous in their spirited rejection of the scheme's regressive financial burden on the aged, poor, chronically ill and disadvantaged, and of its relative benefits to those on higher incomes.

The criticism of Medicover was not confined to those groups traditionally opposed to the AMA's general principles and values. The Voluntary Health Insurance Association of Australia (VHIAA), representing forty of Australia's largest health funds and a traditional ally of the AMA, expressed serious concerns about its lack of built-in cost containment mechanisms.\textsuperscript{122} Several prominent medical writers and health economists roundly criticised the scheme, arguing that it had "glaring weaknesses" and that it "contained such a basic list of defects that it did not constitute a workable program".\textsuperscript{123} Two months after its public release, Secretary General of the AMA, Dr. Allan Passmore, acknowledged that the Association was "disappointed by the negative reaction to date".\textsuperscript{124}

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\textsuperscript{122} \textit{Australian}, 15 May 1989:5.

\textsuperscript{123} \textit{SMII}, 17 May 1989:17; \textit{Age}, 19 June 1989:22. The AMA's Medicover scheme also did very little to improve its relations with GPs, given the limited scope under the scheme for GPs to improve their incomes relative to specialists. See for example Ross Gittins's analysis in \textit{SMII}, 17 May 1989:17.

\textsuperscript{124} \textit{Australian Medicine}, 5 June 1989:155.
While the AMA reeled under this broad-based barrage of disapproval, the medical profession as a whole was also subjected to criticism over its incomes and practices. In late April 1989, the Economic Policy Advisory Council (EPAC) released a paper calling for more competition and less restrictive practices in the professions. Titled "Promoting Competition in Australia", it specifically targeted the medical profession, urging a review of doctors' restrictions on advertising and hospital visiting rights, and of the Australian Medical Council's (AMC) examination procedures for doctors with overseas qualifications. Dr. Lindsay Thompson, president of the Australian Council of Professions (ACP) and former president of the Federal AMA, responded rather limply that there was "no evidence of lack of competition [amongst professionals] or failure to exercise restraint as far as fees were concerned."  

The Trade Practices Commission (TPC) and the Business Regulation Review Unit were at the time conducting an extensive study of the restrictions of professional licensing and registration controls. While recognising the constitutional limitations imposed on the Trade Practices Act, EPAC recommended that the TPC become more involved in the deregulation of the professions.

125. *SMH*, 1 May 1989:8; *AFR*, 12 July 1989:3. At the time less than 50% of overseas trained doctors passed the AMC's registration test for practice in Australia. *AFR*, 12 July 1989:3.

126. The ACP represents major organisations of doctors, lawyers, engineers, accountants, architects, dentists, veterinarians, surveyors, pharmacists and actuaries.


128. By June 1990, the TPC was poised for a full-scale inquiry into competition within and between the professions, with the final report due towards the end of the year. *Australian Dr Weekly*, 18 May 1990:8. The AMA initially voiced serious concerns about both the legitimacy of the inquiry and its possible outcomes, but later decided to cooperate. *Australian Medical*, 2 July 1990:6; 20 August 1990:7. However, the TPC's capacity to dismantle anti-competitive practices within the profession - like restrictions on advertising - was rather limited because the TPC's jurisdiction
In July 1989, Cabinet authorised the establishment of the National Office of Overseas Skills Recognition (NOOSR). The Office was to take over overseas skills assessment from the Council of Overseas Professional Qualifications, which itself took this function over from the Department of Immigration earlier in the year. The task set for the Office was to liaise with the States to establish national accreditation and assessment standards for overseas qualifications, and to encourage the use of assessment based on competence rather than on qualifications alone. Again the Medical Council's procedures for assessing overseas qualified medical professionals were specifically targetted for criticism.\textsuperscript{129}

Further pressure on the profession came from the ALP's Senator George Gear, as the Chairman of the Federal government's Prices Task Force. While the Senate Select Committee was in the process of holding its open hearings on the vocational registration scheme, Senator Gear announced moves aimed at getting the States to use their constitutional powers on pricing to prohibit doctors charging above the Medicare Schedule fees.\textsuperscript{130} While the moves ultimately failed, they served to publicly highlight the fact that there are no direct means available for the Federal government to control how much doctors charge and how much income they earn under Medicare. With the Australian constitution explicitly prohibiting the "civil conscription" of medical practitioners, the Federal government must

\textsuperscript{129} SMII, 1 May 1989:8; AFR, 12 July 1989:3.

\textsuperscript{130} Australian, 12 July 1989:2.
rely on an awkward combination of financial inducements to the profession and the States' legislative controls over prices to constrain doctors' fees.

Despite belated attempts by the AMA to improve its credibility in relation to doctors' incomes and the GP proposals - including an internal "survey" released to the media contending that GPs make less than TV repairers or teachers¹³¹ - the depiction of the AMA as "greedy" and "arrogant" was entrenched for the duration of the dispute.¹³²

Divisiveness within the AMA was evident long before the issue of content-based fees was publicly raised in the AMA's Media Release in September 1988. The AMA has traditionally been very successful in containing its internal divisions, so that its organisational public persona has been characterised by high levels of industrial and political cohesion. Tensions between conservatives and moderates, between State and Federal branches, between one State branch and another, and between one craft group and another, have tended to be kept well away from the public arena. However, as discussed in Chapter Three, the NSW Doctors' Dispute in 1984-85 exposed all of these internal tensions to an intense and sustained public scrutiny - especially those between the Federal AMA and the NSW Branch, between visiting and staff specialists, and between moderate doctor groups and more militant specialist groups.


¹³².  Even towards the formal conclusion of the dispute, when the Select Committee reported to the Senate, Committee chairperson Senator Crowley noted that the AMA's submission was "less helpful" than others, and contained "mischievous representation of the facts". Senate (1989), *Parliamentary Debates (Hansard)*, 16 August, p112.
In the wake of the NSW dispute, dissension over the ability of the AMA to competently represent all medical groups, and concern over the debilitating effects of such exposure on the organisation's political and industrial capacities, prompted the AMA to consider an extensive organisational restructuring. The task force to review the "structure, function and constitution" of the AMA formally commenced on January 1 1986, and tendered its report on 27 February 1987.133

One of the main recommendations of the resulting Cotton Report was that representation on the AMA's committees and peak policy council be more craft-based, rather than wholly State-based. This would allow AMA representation to be divided amongst the different craft and special interest groups of the membership (such as salaried doctors, GPs, specialist groupings), rather than divided along purely State lines. This recommendation was aimed at dissipating the increasing discontent among general practitioner members and other groups134 over the level and quality of their representation. While GPs constituted over 40% of the AMA's membership,135 the proportion of their representation on the important committees and policy groups was considerably less. On the other hand, specialists were considerably over-represented on these groups relative to their numbers.

However, this recommendation had not been implemented during the period from the formal release of the Report in April 1987 to the start

134. For example, salaried medical professionals. See Ibid., Chapter 6.
135. Of an estimated 35,000 doctors then registered to practice in Australia, 19,000 were members of the AMA. Of these some 8,000 were GPs. Bulletin, 13 June 1989:47.
of the fees dispute in September 1988. Although the original AMA proposals for content-based fees expressly concerned the level and method of remuneration for GPs, the campaign to implement the proposals was largely conducted under the existing specialist-dominated organisational structure. The only concession to GP representation in this process was through consultations with the affiliated NAGPA group and the RACGP through their membership of the working party which developed the content definitions for the new service categories.\footnote{136}

The process of reorganising the AMA's Federal Council to include craft representatives occurred during late 1988 and early 1989, the period in which significant public differences emerged between the AMA and the RACGP over GP fees. It was also during this period that the RACGP began negotiations with the government to the exclusion of the AMA. In November 1988, Dr. Eric Fisher, immediate past-president of the RACGP and an AMA member for forty years, was elected as GP craft representative in the "new look" Federal AMA.\footnote{137} The long delay between the Cotton Report's recommendation and its implementation strained the credibility of the AMA as an enthusiastic structural reformer; and the final timing of Dr. Fisher's appointment invited some scepticism from GPs as to the AMA's motivations and sincerity in this regard. While these views of the AMA were largely speculative at the time, they are given some substance by assessing the effectiveness of the GP representation in the period following the Cotton Report changes.

\footnote{136}{Courier\textit{Mail}, 7 December 1988:8.}

\footnote{137}{Australian, 24 May 1989:5; AFR, 25 May 1989:6.}
Any easing of GP dissent which might have flowed from the new craft representation on the Federal Council was quickly reversed within six months of Dr. Fisher's appointment. For in May, Dr. Fisher resigned "in disgust" from his position as GP representative. He contended that during his time in office he had "rarely been consulted about general practice matters", making his position as untenable, that the AMA was "obsessed" with attacking the RACGP, and that it had "lost the opportunity to become a constructive organisation". Dr. Fisher's resignation came at the same time that the CS&HLA Bill was before parliament, providing strong evidence to support the government's argument that the AMA was not representing the interests of GPs in their opposition to the government-RACGP proposals. Dr. Blewett made full use of this timely evidence in the debates on the Bill.

The AMA federal conference held the following weekend provided further, albeit more ambiguous, illustrations of internal divisiveness. NSW AMA president Dr. Bruce Shepherd moved to gain endorsement for a non-cooperation strategy in its battle with the government over the new fees and vocational register system. This followed from an earlier NSW AMA vote urging the Federal Council to rescind its (the Council's) March 1989 decision to resume talks with the government on GP fees. The move again highlighted the deep political

138. Ibid.


141. SMH, 1 May 1989:8.
differences between the New Right NSW Branch (personified by Dr. Shepherd) and the more moderate Federal AMA (personified by federal president Dr. Bryce Phillips) that had first emerged during the NSW doctors' dispute. However, the sound defeat of Dr. Shepherd's non-cooperation motion at the conference signalled that the majority of the profession was unwilling to see a repeat of the divisiveness which had so encumbered its relations with the government in 1984-85. Not only did the conference endorse a joint approach with the RACGP on the fee structure, but it also strongly defeated a motion for the removal of Dr. Shepherd from his AMA position.¹⁴²

However, his position was not retained entirely without cost. On the final day of the conference, about 100 GPs from around Australia resigned from the AMA to form the General Practitioners' Council of Australia (GPCA). Their resignations were in protest at the AMA's opposition to the RACGP and the new fee structure, and at the AMA's emphasis on specialists' interests over GPs' interests. Announcing the move, GPCA spokesman Dr. Charles Ovadia stated that:

Many GP members of the AMA are following the example of the AMA's senior GP representative, Dr. Eric Fisher, and resigning from the AMA in protest...

We feel, as GPs, that the AMA has not represented us for many years and now we see its objections to the new Bill as not helping push improvements for GPs.¹⁴³

He also contended that the AMA had conducted a misinformation campaign in urging the Opposition and the Democrats to oppose the

¹⁴². *Australian*, 29 May 1989:3. In mid-1990, Dr. Shepherd replaced Dr. Phillips as federal president of the AMA.

changes in the Senate, and that he hoped to convince the Democrats to cease their opposition to the Bill.\textsuperscript{144}

An AMA spokesman denied any knowledge of the group, but claimed that the move was merely a "stunt" by the Doctors Reform Society (DRS). This is probably a reference to Dr. Ovadia, who had resigned from his office with the DRS to help establish the GPCA.\textsuperscript{145}

The image of the AMA as unrepresentative of the GP segment of the medical profession was further consolidated by the release during the dispute of a GP survey by the Doctors' Reform Society. The survey was sent to all GPs in Australia, and revealed that over three quarters of respondents did not believe that the AMA was representing them adequately. Moreover, it showed that:

\begin{quote}
    doctors believed the AMA had become dominated by conservative medical specialists and, in some States, had been taken over by New Right extremists.\textsuperscript{146}
\end{quote}

The DRS's persistent ideological opposition to AMA policies must be taken into account when evaluating the significance of the survey's findings.\textsuperscript{147} Similarly, the timing of the survey's public release - during an adjournment of debate on the Bill in the Lower House - and the indirect association of the DRS with the formation of the GPCA

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\textsuperscript{144} \textit{Australian}, 29 May 1989:3.
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\textsuperscript{146} \textit{Australian}, 12 May 1989:2. The "New Right extremists" section presumably refers to the AMA's fundamentalist conservatism in the NSW Branch under its president Dr. Bruce Shepherd.
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(through Dr. Ovadia), indicate rather more than a casual interest in the issue. However despite these reservations, the survey strongly suggests that, at the very least, a large portion of GPs - possibly a majority portion - did not fully support the AMA's harsh approach to negotiations on the new scheme.

The final and perhaps most telling instance of divisiveness within the AMA lies in the campaign against the reforms in the lead-up to the commencement date. Aimed at countering the concurrent RACGP-Government public information efforts, the campaign's message was that "there's a catch" involved in the higher rebates available to patients after December 1, 1989:

You will lose your privacy. The new deal will allow Government agents to access your medical records - and you won't even know. Confidentiality between you and your doctor will be lost forever.148

The sanctity of the doctor-patient relationship is a well-worn theme in Australian medical politics. Medical organisations have traditionally resorted to it when opposition to government cost-control measures is difficult to sustain on other grounds.149 Given that such other grounds for opposition had been effectively undermined by the widespread consensus on the GP reforms at this time, it is hardly surprising that the campaign adopted a traditional strategy based on concerns over doctor-patient confidentiality.150


149. For example, the campaigns against the Medibank and Medicare schemes were largely based on characterising such schemes as unjustified intrusions into the confidentiality of the doctor-patient relationship by a third party - namely the Federal government - and, as such, the "thin edge of the wedge towards socialised medicine".

150. Exposure of patient records to government agencies is not significantly effected by the reforms; so that the confidentiality argument in this case is perhaps more difficult to rationalise than in
However, the source and timing of the campaign is a little more surprising. It was financed and authorised by Dr. Bruce Shepherd, Chairman of the Australian Doctors' Fund and president of the NSW AMA, and Dr. Michael Nicholson, Medical Secretary of the NSW Branch of the AMA. Moreover, the campaign began some three months after the Federal AMA's public undertaking to cooperate in the implementation of the reforms. While the intransigence of the NSW Branch may have been the exception that made the rule, such a fervent and public expression of State-Federal differences highlighted the fundamental divisiveness in the AMA over the issue of GP reforms.

Internal divisions over the GP reforms were not confined to the AMA. The RACGP was certainly far more united and cohesive in its negotiations on the reforms, but did not entirely avoid internal rifts. On April 1 1989, the RACGP held an Extraordinary General Meeting, called by Brisbane GP Dr. Bruce Biggs. The meeting's purpose was to discuss the concerns of a group of members over the RACGP-Government fees negotiations that had commenced the previous November after the formal withdrawal of the AMA. Dr. Biggs contended that the group included "[p]ast Chairmen of the RACGP State Boards, Past Federal Councillors of the College and former AMA State Presidents". The meeting resolved by 876 votes to 762:

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previous cases. For example, Dr. Blewett later publicly stated that the DURC legislation would not be introduced without the backing of the AMA and the RACGP, and that the privacy of patient records would not be breached by DURC procedures. *Australian Dr Weekly*, 6 April 1990:1.3.


152. Media release from Dr. Bruce Biggs, "Rank and file members to requisition extra ordinary (sic) meeting of Royal Australian College of General Preactitioners", 24 May 1989, Brisbane, p1.
that the council of the RACGP, prior to commencing or continuing negotiations with the Government, shall convene urgent and frank discussions with college membership, other colleges and medical organisations on the implications for general practitioners and the profession generally of the Terms of Reference agreed to by the council with the Government.\footnote{153}

The high ranking of the members of the group, and the close voting result (about 53.5\% to 46.5\%), both indicate that there was considerable concern over the GP reforms within the College, especially on the extent of consultation by the executive with members during the negotiations with the government.

Less than two months later (and on the same day as Dr. Fisher resigned as craft representative of the AMA), Dr. Biggs began the push for another Extraordinary General Meeting of the RACGP. He wished to discuss concerns among members that the College's negotiators were "not representing the views of the wide cross-section of doctors in private practice today", that the vocational register legislation before parliament would create "two classes of General Practitioners", and that the level of Medicare rebates were "far from realistic in relation to todays (sic) economy".\footnote{154}

In the middle of June, a meeting of "about 250 general practitioners" in Brisbane showed, in the words of the \textit{Medical Observer} magazine, "an almost entirely united opposition to the RACGP-Federal Government deal".\footnote{155} At the same time a joint meeting of the ACT

\footnote{153. \textit{Medical Observer}, 12 May 1989.}
\footnote{154. Media release from Dr. Bruce Biggs, "Rank and file members to requisition extra ordinary (sic) meeting of Royal Australian College of General Practitioners", 24 May 1989, Brisbane.}
branches of the RACGP, the AMA and the NAGPA sent a message to their federal counterparts "telling them to get their act together" on the GP fees issue. While the federal bodies were at odds over the issue, there was "no division between these groups at the local ACT level." The meeting urged the federal bodies to present a united front to the government to prevent "further disintegration" of the profession.\textsuperscript{156} A similar meeting of the Queensland RACGP and AMA reached agreement on "some aspects of the issue", and foreshadowed further discussions aimed at developing a "joint approach" to the government over GP Medicare rebates.\textsuperscript{157}

However over the next few weeks, the dissension within the RACGP membership declined dramatically. This is most compellingly demonstrated by the low level support among members for the second EGM. By the middle of July 1989, as the Senate Select Committee was holding its open hearings, Dr. Biggs had still been unable to garner the 200 College members' signatures needed for the calling of an Extraordinary General Meeting.\textsuperscript{158}

While divisions within the RACGP were not as deeply entrenched as those within the AMA, they nevertheless provided some ammunition to those opposing the changes. Although they were by no means used as the centre plank of its argument, the AMA regularly referred to these internal divisions in making its public case against the College's deal

\textsuperscript{155.} Medical Observer, 7 July 1989. Given that the magazine cannot be regarded as an entirely independent source, its assessment of the strength of opposition to the reforms shown at the meeting must be treated cautiously.

\textsuperscript{156.} Canberra Times, 15 June 1989:5; Medical Observer, 7 July 1989:1, 87.

\textsuperscript{157.} Australian Dr Weekly, 7 July 1989:1.

\textsuperscript{158.} Australian, 14 July 1989:5.
with the Government. This was part of the AMA's more general contention that the RACGP represented only a minority of GPs in Australia, yet under the changes would have wide discretionary powers effecting all of them. In addition, this contention was often reflected in the Opposition's contributions to the parliamentary debates on the changes.

Although tensions from within and from without the medical organisations shaped the contours of the conflict over GP reforms, it was the political parties and the parliamentary process through which the formal decisions on its resolution were made. In this conflict, the public stances adopted by some of the parties were made unusually awkward by the specific combination of constituencies lobbying them. This combination in turn can be largely attributed to the mix of amendments contained in two parts of the CS&HLA Bill.

The CS&HLA Bill was debated in parliament in combination with several other Bills. There was broad agreement on the provisions of

159. For example the AMA's GP affiliate, the NAGPA, on the eve of the CS&HLA Bill debate in the Senate, stated that there was "no tangible evidence" that the College Council had fulfilled its promise to further consult with the members, and that it was "imperative that College Members ensure that the Council of the RACGP more properly assess and represent the Members in agreements with Government now and in the future". Similarly the AMA referred to the Councillors negotiating with the government as "the small group of RACGP negotiators" and as only "elements within the RACGP". National Association of General Practitioners of Australia, Media Statement, "Future of general practice at stake", 12 June 1989; Australian Medical Association, News Release, "Political novices within the RACGP are being led like lambs to the slaughter" says the AMA", 7 May 1989.

160. Of Australia's 15,000 GPs at the time, 6,000 were College members, while about 8,000 were AMA members. Canberra Times, 15 June 1989:5; Courier-Mail, 8 May 1989:2; Australian, 2 June 1989:13.

161. See especially Dr. Wooldridge and Dr. Woods in House of Representatives (1989), Parliamentary Debates (Hansard), 25 May, pp2998-3000 and 3002-3004, respectively.

162. In the House of Representatives, with the Supported Accommodation Assistance Bill 1989; and in the Senate with that Bill and the Aged or Disabled Persons Homes Amendment Bill 1988.
these other Bills across all parties in both Houses - or certainly insufficient disagreement to precipitate a split along party lines. There was similar agreement on those parts of the bill involving pathology and day-surgery services, confidentiality provisions in the Australian Institute of Health Act and nursing home classification procedures. However, the amendments in Parts Three and Four of the Bill - relating to health reinsurance and the GP reforms respectively - contained overlapping and sometimes conflicting policy implications for the Coalition parties and the Democrats. As a result, they found it difficult to effectively accommodate both the diversity and intensity of the lobbying efforts generated by these parts of the bill.

The AMA strongly opposed the (Part Four) GP reforms and equally, in coalition with closed, for-profit health funds, surgeons' groups and the private hospitals, the (Part Three) reinsurance proposals.\footnote{163} The larger, non-profit funds of the Voluntary Health Insurance Association of Australia (VHIAA), which benefit from an extended reinsurance pool for their many elderly members, supported the reinsurance proposals. Pensioner, aged, welfare and health consumer groups generally supported both Parts Three and Four of the Bill.

Once the Bill had passed through the House of Representatives, the lobbying efforts of these groups intensified, and shifted to the parties in the Senate - especially to the Democrats as holders of the balance of power. As a party formally committed to securing equity for minority and disadvantaged constituencies often overlooked by the major parties, the Democrats had little difficulty in supporting the

\textit{See, for example, the full-page campaign advertisement lodged by 27 of these groups - headed by the AMA - under the heading “Private Health Care at Risk”, in Australian, 17 March 1989, p.11.}
lobbying efforts of the groups on the consumer side of the equation. Pensioners, the aged, health consumers and welfare recipients have traditionally formed a significant part of their electoral support base. The Democrats supported the GP reforms in principle, because of their potential to improve medical services for such groups. However in their role as political watchdog over the major parties,\textsuperscript{164} they insisted on the Select Committee to ensure that the regulations and criteria applying to the vocational register were subjected to parliamentary scrutiny rather than left to the discretion of the Minister.

The Democrats similarly supported the reinsurance proposals for their potential to protect the aged and the chronically ill against commercial discrimination by health insurance funds.\textsuperscript{165} However their position on these proposals was not as straightforward as that for the GP reforms. It was complicated by groups on the supply side of the equation. As the de facto political advocate for small business interests, they were vigorously lobbied by the smaller scale, closed for-profit health funds who were opposed to sharing insurance risks with the larger non-profit funds with high proportions of older members. This meant that two groups of traditional Democrat allies had diametrically opposed interests in the CS&HLA Bill, so that the Democrats were torn between conflicting loyalties. For example, the Australian Pensioners' Federation directly criticised the Democrat (and

\textsuperscript{164} This is the role so elegantly described by Democrats founder Don Chipp as "keeping the bastards honest".

\textsuperscript{165} This is the "community rating" principle enshrined in the Medicare system. It ensures that registered funds can apply only two main categories of health insurance premiums: one for single people and the other for family groups, with the latter always set at double the rate of the former. Under this principle, health funds cannot legally charge higher premiums for the elderly or chronically ill, or exclude them from cover. To cover the cost of providing equal coverage to such high risk groups, the Health Reinsurance Trust Account distributes compensation to the funds according to the proportion of such groups in their memberships.
Coalition) position, seeing it as "putting the demands of small business ahead of the health care needs of older people".\textsuperscript{166}

Unlike the GP reforms, the Democrats' support for the (Coalition-initiated) referral of the reinsurance proposals to the Select Committee can not be so easily attributed to their watchdog role. It represents an attempt by the Democrats to balance the conflicting interests of the consumer and provider groups simultaneously lobbying them over the proposals. This is especially evident in their initiation of the "sunset clause" amendment, under which any reinsurance arrangements made under the \textit{CS&HLA Bill} automatically expire after a short period. This enabled the Democrats to indicate support for and opposition to the proposals at the same time, in the somewhat unrealistic hope of offending neither the pensioner groups nor the for-profit funds.

The Coalition had similar difficulties with the legislation. Neither the GP reforms nor the reinsurance proposals sat comfortably with the Coalition's customary promotion of private sector based health insurance, with minimal government regulation. Accordingly, they initially supported the AMA in opposing both of them. However, the Coalition faced pressure from the pensioner, welfare and consumer groups supporting both sets of proposals, in addition to their traditional big business allies in the older, larger health insurance firms supporting the reinsurance changes. Any Coalition support given to the AMA had to be measured against the political offence taken by those groups in favour of the reforms. The particular combination of constituencies pressing for the proposals was

undoubtedly a contributing factor in the Coalition parties' subsequent policy turn-around, where, as parts of the medical profession saw it, they "caved into pressure from pensioner groups and industry supporters of the changes".167

Supporting the AMA on these issues was made politically awkward for the Coalition not only by the size and composition of these groups, but also by the tarnished public image the AMA was projecting at the time. This image was of particular concern to the Coalition in the matter of the AMA's proposed Medicover scheme; for the principal architect of the scheme, Dr. David Chessell of Access Economics in Canberra, was also at the time a consultant to the Liberal Party on health policy. Given this connection, the widespread and intense antagonism shown to Medicover since its release had the potential to spill over into the Coalition's own health policy, if it so publicly supported the AMA's position.168

The AMA has been a traditional ally of the Coalition (especially of the Liberal Party) and its private-sector, free-enterprise policies are very comfortably accommodated within the Coalition's general ideological framework. In this case, however, the electoral significance of the pensioner, welfare and consumer groups and the larger, older funds was clearly considered by the Coalition to be greater than that of the AMA.


168. The Coalition parties certainly had good reason to be concerned in this regard. Their own health policy was so widely criticised when it was finally released in January 1990 - especially over its extra unfunded costs of up to $2.6 billion - that additional criticism by association with the AMA would have set back their recovery as credible health policymakers even further in the lead-up to the March election.
Conclusion

It is still too soon after implementation to determine what impact the reforms will have on the long term work practices of GPs and on the health budget in general. Although the exact size of the average increase in income under the new fees structure is not agreed on, vocationally registered (VR) GPs have the potential to earn significantly more in top-tier MBS fees than their non-VR colleagues on the lower tier. It seems likely that this financial incentive will eventually induce the great majority of eligible GPs to apply for registration, particularly if the Government further increases the gap between VR and non-VR fees in future MBS adjustments. This alone has significant implications for GP work practices, for with registration comes not only the financial incentive to spend more time with patients, but also the obligation to undergo further training and education programs under the auspices of the RACGP.

While the nature of the connection between further training and more effective primary health care has not been incontrovertibly established, the existence of some significant connection between

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169. See for example, Moorhead, R.G. (1989), "Commentary: The Proposed General Practice Descriptors - Will They Influence Preventive Medicine?" in Community Health Studies, Vol XIII, No. 3, pp343-346. Dr. Blewett used the Doherty Report's research to argue that the evidence available suggested that current university medical courses were inadequate preparation for "good quality general practice", and that vocational training for GPs is "highly desirable". Dr. Blewett, in a letter to doctors on 30 May 1989, cited in Senate (1989), Parliamentary Debates (Hansard), 13 June, p3881.

However, National Party Senator Shiel contends that the Doherty Report recommended against compulsory vocational training because there was no proof that it improved the quality of health care. Senate (1989), Parliamentary Debates (Hansard), 13 June, p3870. While entirely different conclusions can be reached by selective quoting, the Doherty Report's research review did conclude, that while the community could "intuitively" expect benefits from vocational training, "there are no studies available that demonstrate such benefits, or, conversely, the cost are
them is almost universally accepted. At the very least, we can expect VR GPs to be providing services while equipped with updated medical knowledge and skills. This represents a substantial change from the previous general practice system that had no formal requirement of further training during the entire working life of the GP - even if that life extended over half a century of medical and social transformation.

For the government, the expected financial spin-offs from GPs spending more time with their patients are decreases in the number of referrals to (more expensive) specialists and pathologists, and in the number of prescriptions for pharmaceuticals (especially to those patients eligible for the Pharamaceutical Benefits Scheme). Both have the potential to make substantial reductions in Medicare outlays. The logic behind such expectations is that if GPs spend more time with their patients, a significant proportion of that time will be spent either performing tasks that might otherwise be passed on to specialists - such as clinical diagnosis, minor surgical procedures and the development of management plans for treatment - or providing preventive health information and advice that could reduce the chances of the presented condition worsening or re-occurring.

Many of the sets of data presently available to determine if these changes are actually occurring under the reforms have ambiguous implications. Some sets directly or indirectly contradict other sets, and a variety of intervening variables are possibly involved. For example, some preliminary survey data suggest that the practice patterns of VR GPs and non-VR GPs are not yet significantly different. On the other
hand, after steadily increasing by about 6% per year for the preceding four years, the total number of GP attendances actually declined by a small amount in 1990-91, the first period after the reforms were implemented. While there were considerable variations across the States, the average number of services per capita was nearly 2.78 for non-VR GPs, but only 1.98 for VR GPs, and the total number of pathology services ordered fell by 2.5%.\textsuperscript{171}

However, at the same time, the total number of diagnostic imaging services rose by 8.2%, and the total number of specialist attendances increased by 4.3%. In the area of prescriptions, the total cost (including patients' contributions) fell slightly for 1990-91.\textsuperscript{172} This fall, however, may have been at least partly due to a number of PBS reforms introduced in 1990 to constrain escalating costs, such as increased co-payments (from 1 November, 1990) and the Minimum Pricing Policy (from 1 December 1990).\textsuperscript{173}

It remains that if some of the spin-offs from the reforms were eventually realised, they would also represent a considerable change in GP work practices. Instead of responding to incentives within the MBS fee structure to maintain their incomes through "sausage machine" medicine, GPs would be able to play an active role in preventive health care without incurring substantial financial

\textsuperscript{170} See the discussion of the results of a survey of morbidity and treatment in GP practices conducted by Helena Britt, of the University of Sydney's Department of Community Medicine, in \textit{Australian Dr Weekly}, 9 October, 1992.

\textsuperscript{171} The preceding figures were derived from Commonwealth Department of Health Housing and Community Services (1991), \textit{Annual Report}...[Supplement], Tables 63, 64, and 76.

\textsuperscript{172} \textit{Ibid}.

\textsuperscript{173} \textit{Ibid}., Chapter 6.
penalties. They could apply their skills more towards preventing illness than merely treating its symptoms. With some decrease in the pressure of time, the practice of writing a prescription merely to bring the consultation to a speedy conclusion could be significantly reduced.\textsuperscript{174} Moreover, VR GPs would have more time and financial security to gradually reclaim many of the occupational tasks and procedures yielded to the specialists since the "most common fee" arrangements introduced in 1970 turned much of their attention towards service quantity rather than quality.\textsuperscript{175}

Under such conditions, GPs would be likely to increasingly apply the diagnostic skills and clinical techniques that can make general practice so much more intellectually stimulating and challenging than the "six-minute" medicine they are aimed at replacing. This would not only help boost the productive value, morale and status of general practice, but also provide more thorough and skills-intensive services to patients and more cost-effective returns to the public funds supporting it.


\textsuperscript{175} The benchmark levels of fees derived from the Gorton government's "most common fees" survey were substantially higher for specialists than for GPs. As a result, specialists had formal sanction to apply a higher level of fees than GPs - even for the same service or procedure. Many feel that this created, or at least contributed to, a sharp divide between the two groups - in terms of both incomes and status - that has persisted to the present. There is a strong feeling within the GP sector that specialists recognised the future financial implications of the survey and greatly inflated their "most common fees" in their responses to the survey. GPs were effectively prevented from adopting the same strategy, because the data for their fees came from accounts previously submitted to the health insurance funds, while those for specialist services came from questionnaires completed by the specialists themselves. See for example, MJA, 5 June 1989:659-660; \textit{Medical Observer}, 7 July 1989:86; and Sax, S. (1984), \textit{A Strife of Interests: Politics and policies in Australian health services}, Sydney: Allen and Unwin, pp89-91.
However, the control over these outcomes lies principally with the profession rather than any government agency. The principal trade-off for vocational registration was to be the potential reduction in professional autonomy posed by the review and audit procedures. In return for access to the higher set of fees and rebates, the billing practices of VR GPs were to be subject to reviews by the Independent Peer Review Organisation's (IPRO) successor, the Descriptor Utilisation Review Committee (DURC). DURC's role was to detect and sanction any abuse or misapplication of the new service categories, especially in the form of "bracket creep" from categories with lower fees to those with higher fees. It was in effect a government-sponsored peer review system.

DURC's function would have focussed on the core of professional autonomy for medical practitioners: the freedom to make clinical decisions based on one's own medical knowledge, professional skills and interpretation of presented symptoms, independent of supervision or judgement by a higher authority. However, I am arguing that it is precisely because of this crucial focus on autonomy that the IPRO and the DURC proposals gradually withered away. Indeed, because it is so widely presumed that only the knowledge and expertise of the medical profession can be applied to a review mechanism for patterns of medical practice, the effective functioning of such a mechanism is pre-empted, or at the least, severely constrained.

By definition, the peer review process precludes the involvement of non-medically trained personnel, such as health consumers, departmental representatives and members of other professions. As with the pathology reforms in the previous chapter, the content of a
medical service forms part of Jamous and Pelloie's notion of the "indeterminacy" of medical knowledge and expertise. Under this form of self-regulation, GPs are only accountable to other GPs for their use of the new descriptors, and ultimately, for the incomes they derive from Medicare-funded services. With the demise of DURC, even this loose and indirect form of accountability for public funds has been removed from the new fees system.

In the light of the consistent claims by GPs that their incomes under Medicare are declining or insufficient, and of the growing oversupply of GPs in a static medical market, there is simply no sustainable reason to expect that GPs will individually forego potential income in order to rigorously and accurately apply the new descriptors to all of their consultations. While the government can monitor the aggregate levels of GP income from Medicare, it now has a much weakened formal means by which to detect and prosecute fees abuse by individual GPs. As seen above, even the time-only system's inbuilt limitation of the number of services possible in the length of a working day has been weakened.

In this policy conflict then, the Minister did manage to impose some measures aimed at attaining the government's stated objectives in the GP system over a bitterly divided professional interest group. The vocational registration scheme, linking postgraduate training to higher Medicare fees, forms the core of those measures, and provides an indirect mechanism of accountability as far as the overall quality of

GP services is concerned. However, by implicitly accepting the notion of medical knowledge and judgement as impenetrable to scrutiny outside the profession, the Minister, the parliament and the general public they represent, handed the profession a much more significant concession. This concession lies well beyond the profession's capacity as an organised interest group seeking to influence health policy towards its political and industrial advantage.

The consolidation of unfettered clinical autonomy represented by the demise of IPRO and DURC forcefully illustrates the generally tacit restriction of issues on health policy agendas to those concerned with the terms and conditions of medical work. Those more fundamental issues involved with the nature or content of medical work, such as the types of knowledge most effective in driving our health systems, and the ability of the medical profession to provide a level of accountability commensurate with the level of public funds it expends, are necessarily then "non-issues". They form part of the general presuppositions shared by all members of the health "policy community", and are thereby subject to Bachrach and Baratz's process of "non-decision" making.

Such issues are often left unconsidered even by active opponents of mainstream medical dominance, or the bio-medical approach to health. Indeed, they are not actually identified or defined as issues in the first place. As such, they can not reach the formal health agenda


in a fully developed, explicit form. While the review function of IPRO, and its successor DURC, became the central issue of the parliamentary debates on the new GP fees system, the exclusive right of doctors to monitor their own use of the system was barely questioned. Indeed, as seen above, the Health Minister claimed never to have even considered any form of review mechanism other than one which was wholly independent of both the government and the RACGP.

Implicit in the lack of questioning of this exclusive professional right, is a strong system-wide endorsement of the notion that the medical knowledge and expertise applied in a peer review system like IPRO/DURC is entirely technical in character. As such, it is viewed - and treated - in the political process as both impermeable to lay scrutiny and free of socio-political or financial self-interest on the part of the medical profession. Within the protection of this science oriented perspective on peer review, the profession maintains two important self-serving resources for policy influence. First, it is not subjected to direct forms of accountability by the government, or any other non-medical body, for individual applications of the new fees system to services provided under Medicare, overall patterns of prescribing and referrals, and the total level of income derived from those services.

Second, and simultaneously, this high level of clinical autonomy is protected from critical scrutiny because the medical expertise on which it is based, being universally accepted as non-political, is structurally preempted from occupying a place on the health policy agenda. The nature of medical expertise, and its potential for interest
contamination, is a non-issue. Under the process of the "scientization of politics" evident in Western industrialised systems, the profession cannot be held to account, and there is not even an explicit contention that it should be.

The overall effect of this unspoken policy circumscription is to leave the basic structural components of the health system unchanged and unchallenged. Medical knowledge, and the technical expertise derived from it, form the firmly entrenched foundation. From this emerges a health policy superstructure whose shape and scope tends to reflect that foundation. As this case study demonstrates, the medical profession can, within such a health system, maintain its key policy role not only as an active, well organised interest group, but also as the providers of partial, self-interested knowledge and advice under the guise of neutral scientific expertise.

Because the core issue in the conflict over the new fees system was ultimately defined as an exclusively medical issue, the profession generally avoided the widespread community opprobrium sustained during the final stages of the NSW Doctors' Dispute. While the AMA's initial fee proposals were forcefully condemned by Dr. Blewett as a "naked grab for more money", the shifting of the conflict's focus to the methods of review and monitoring prevented the mercenary image of the profession from taking a stronger hold. As with the pathology reforms in the previous chapter, the medical profession's success in


avoiding - or preempting - wider scrutiny through self-regulation is considerably enhanced when the issues at stake are structurally transformed from political and industrial, to essentially medical in nature.

However, as noted in Chapter Two, the "scientization of politics" is neither a universal nor linear process. While the medical profession may still dominate the health arena, its dual powers as an interest group and as the holders of medical expertise, cannot turn every conflict with the state or other health professions into a resounding, unambiguous victory. The "medicalisation" of social issues characterises the historical development of the medical profession's policy influence. However, the simultaneous operation of the reverse process - what I would refer to as the socialisation of medical issues - is also evident in that development, even if it is, as yet, less extensively entrenched.

The next chapter examines two areas of health policy in which this reverse process is currently operating. In birthing arrangements and aged care, we find a distinct trend emerging whereby medical knowledge and expertise, so impervious to lay scrutiny in the previous chapters, are extensively challenged by more broadly based, non-medical bodies of knowledge.
CHAPTER SIX

AGED CARE AND BIRTHING REFORMS
Introduction

In seeking empirical evidence related to the influence of the medical profession over the health system in general, and over Federal health policy in particular - that is, to test the thesis of "medical dominance" - I have followed two broad approaches. The first approach involves case studies of disputes under the Hawke government where the outcomes suggest that the profession has generally consolidated its policy influence and maintained its high level of autonomy and self-regulation against attempts to impose tighter supervisory and accountability controls. This is the approach taken in the preceding three chapters, where various contingent social, political and economic factors are separated out as contributing determinants of the final outcome, and assessed as to their more general function within the process of medical dominance. The part played by the profession's exclusive claim to expertise based on the knowledge of modern medical science, and the social privilege accorded such knowledge, was emphasised as a crucial component of medical dominance, in tandem with the profession's capacities as an organised and historically vigorous interest group in the arena of health policy.

The second general approach is to examine health policy conflicts in which the medical profession is less successful in defending its autonomy and occupational territory, and to establish which factors of influence are less evident or missing altogether, and/or which additional factors impeding that influence are present. This chapter analyses two case studies where the latter approach is taken, and strongly supports the conclusions of the other case studies regarding
the crucial determinate role of medical knowledge in reinforcing the profession’s political power as an organised interest group.

**Two challenges to medical dominance**

Two of the Hawke government’s lower profile health reforms are the development of independent midwifery practice for home births and changes to aged care policy through the establishment of the Home and Community Care (HACC) program and its associated geriatric assessment services. While their formal health objectives are quite different, situated as they are at opposite ends of the human life cycle, these initiatives have two basic features in common.

The first is that each forms part of Labor’s wider program of rationalising health services to constrain expenditures in areas noted for their high costs and/or for their (actual or projected) increases in rates of utilisation. For example, the HACC program was initiated partly in response to a wide recognition of the impact of Australia’s rapidly ageing population on the future costs of care for the aged in hospitals and nursing homes,¹ and the underdevelopment of at-home health care services which can help constrain those costs. Similarly, the increasing costs and utilisation of hospital services in general, and of procedures associated with hospital births in particular (related to higher rates of obstetric intervention²), helped to foster - or at least to provide an economic impetus for - the development of the home birth and independent midwifery initiatives. For example, hospitals account

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¹ Although as Sax argues, the overall impact of the ageing population on health services has often been greatly overestimated. Sax, S. (1990). *Health Care Choices and the Public Purse*, Sydney: Allen and Unwin, pp105-110.

² For example, analgesia, Caesarian sections, forceps deliveries, episiotomies and inductions.
for about 43% of the total recurrent expenditure on health, and pregnancy and childbirth related conditions form the largest admission category for women, and one of the largest categories for total occupied bed-days.\(^3\) In other words, each initiative has considerable potential to reduce the level of government contributions to specific areas of health services and, proportionately, the incomes and occupational roles of medical practitioners within them.

The second feature shared by these initiatives is their potential to erode the high level of autonomy and occupational control exercised by the medical profession in each area. For example, the HACC program can reduce or delay significant numbers of admissions to hospitals, nursing homes and hostels, where a large number of medical services for doctors' aged clients are provided. Moreover, the HACC program's multidisciplinary Aged Care Assessment Teams (ACATs),\(^4\) as we see below, significantly enhance the formal role of other health and welfare professionals - and thereby dilute the direct influence of doctors - in determining the direction and content of their elderly patients' treatment programs. Similarly, independent midwifery and home births can encroach on the occupational territory currently dominated by GPs, obstetricians and gynaecologists.

However, despite the possible implications of these reforms for doctors' incomes and occupational control - precisely the areas most

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4. Originally named Geriatric Assessment Teams (GAT), the change came in response to the negative connotations widely felt to be associated with the term geriatric. See Peter Staples, Minister for Aged, Family and Health Services, Media Release, "New name to preserve dignity and rights of the frail elderly", 14 August 1992.
often and most vigorously defended by the profession - their implementation has generated relatively little resistance from doctors and the politico-medical associations representing them. This chapter seeks to examine aspects of the social, political and economic environment which shapes these reforms - in particular, the relationship between those bodies of knowledge informing medical expertise in birthing and aged care, and the capacities of the medical profession to mobilise politically in defence of its occupational territory. It is through this process that I develop an explanation for the profession's uncharacteristic acquiescence to the reforms which is more systematically structured than conventional explanations based either on the contingent nature of interest group politics, or on the high social utility placed on medical knowledge and expertise.

HACC and geriatric assessment

The primary formal goal of the Home and Community Care program is:

To enhance the independence, security and quality of life of frail aged and younger disabled people by avoiding their inappropriate admission to long term residential accommodation through cost-effective care in the community and to provide support to those who care for them.5

The HACC program was introduced in 1985 in response to a series of official reports and inquiries which, to a greater or lesser extent, were critical of the fragmented, inconsistent and non-integrated nature of the services available in the States for home-based care of the frail aged, and called for the streamlining of their administrative

structures. Most of the reports were also critical of the relatively high proportion of institutionalised aged in the Australian health system, and of the considerable imbalance between the levels of public funds spent on institutional care and those spent on non-institutional (or home or community) care. At the time, for every $100 spent on hospital, nursing home and other institutional care for the aged, only $10 was spent on the provision of domiciliary care services; and Australia had "the highest per capita allocation of nursing home beds [and] one of the lowest coverages of domiciliary care in the Western world".

HACC is aimed at redressing this funding imbalance not by reducing the absolute number of nursing home beds available, but by steadily increasing the proportion of total available funds that is directed to the provision of domiciliary services. In this way the rate of expansion in the provision of nursing home beds is reduced while the rate of


8. See Community Services Minister, Senator Don Grimes, in Medical Practice, April 1986:16.
expansion in the provision of community care services is increased, leading to a medium term reduction in total expenditures for aged care.9

The program unites a number of previously independent State-based domiciliary care services under one funding umbrella. These services include delivered meals, adult day care, respite care, home nursing and rehabilitation care, house cleaning, shopping services, minor house maintenance and modifications, transport and allied health services such as podiatry, physiotherapy, and occupational therapy.10 Cost-sharing agreements on HACC between the Commonwealth and State and Territory health agencies were negotiated and signed during 1985/86 and the program became fully operational in 1986/87.11

The rationale for HACC is that by providing more extensive and more integrated domiciliary services, more of the frail aged (and younger people with disabilities) can remain in their own homes rather than being forced, through the lack of such services, to receive the assistance they need by living in a nursing home, hostel or other institutional accommodation.

9. For example, see Senator Grimes's assurances in _Ibid_. However as Mathers, Gillett and Harvey point out, it is unlikely in the medium term that there will be any real growth in the provision of nursing home beds. Cited in Sax (1990), _Health Care Choices_..., pp102-103.


Under the HACC program, two sets of health policy needs are satisfied. First, a greater number of (predominantly) aged people than would otherwise be the case are able to exercise their most preferred care option of remaining in their own homes, supported by a variety of community based health services. Second, because it is generally cheaper for the government to provide and maintain domiciliary care services than nursing home services, the pressures on the health budget exerted by the spiralling levels of nursing home expenditure can be eased to some extent without denying services to those in need of them.


13. Some research strongly suggests that the actual costs of home care may in many cases be more than those provided in a nursing home. This is especially so when the costs of the home care services provided by relatives - predominantly women relatives - and other volunteers are taken into account. See for example, Keens, C., Harrison, J. and Graycar, A. (1983), "Aging and Community Care", New Doctor, No. 28 (June), pp23-28; Bennett, C. and Wallace, R. (1983), "At the margin or on average: some issues and evidence in planning the balance of care for the aged in Australia", Community Health Studies, Vol. VII, No. 1, pp35-41; Braithwaite, V. (1986), "The Burden of Home Care: How is it Shared?", Supplement to Community Health Studies, Vol. X, No. 3, pp7a-11s. However in this context, it is the direct cost to the government that is being considered, so that the cost relativity between domiciliary care and nursing home care still applies.

Some of these works make more explicit the relationship between the shift from institutional to home care, and the additional, formally unrecognised, burden imposed on the predominantly female relatives providing the bulk of the care. As seen below in the medical subordination of midwifery, other writers explore the gender implications of these issues far more extensively than is possible here.

14. The McLeay Report attributes the spiralling government expenditures on nursing homes to the Commonwealth State funding arrangements for aged care that were in place throughout the 1960s and 1970s. These arrangements, it is argued, contained significant financial incentives for States to provide more nursing homes (the costs of which were fully reimbursed by the Commonwealth government, and so had no impact on the States' Budgets), rather than more domiciliary services (which were funded on a cost-sharing basis with the States, and so significantly affected their Budgets). Russell, C. and Schofield, T. (1986), Where It Hurts, Sydney: Allen and Unwin, p189.

One of the major recommendations of a later review of residential care services was a shift in the funding of nursing homes, over a five-year period, to a benefit system based on the average cost of care standards designated by the Federal government for "ordinary" and "extensive" care categories. Commonwealth Department of Community Services (1986), Nursing Homes and Hostels Review, Canberra: AGPS.
Although it has not been without some initial problems, the HACC program has expanded considerably since its inception. Commonwealth matched expenditure on HACC has increased from $78 million in 1984/85 to $342 million in 1992/93 (up by about 340%), while total HACC expenditure (Commonwealth and States/Territories) increased from $152 million to $565 million in the same period (up by about 270%), with an average rate of growth of about 20% per year.

The development of geriatric assessment services was a part of the same Federal government response to the reports that generated the HACC program. In general, HACC is aimed at alleviating the demand for expensive nursing home care by providing alternative, more cost-efficient home care services. As an integral part of HACC, the development of assessment services is aimed at restricting the supply

15. The adequacy of the home care services in meeting clients' medical and social needs, and the real cost of the voluntary support services for female relatives (discussed in the footnotes above), have caused some concern. In the attempt to shift from institutional to community care, these types of problems have the potential - as Hicks warns in another context - "to exchange institutional fires for community frying pans". Hicks, N. (1980), "Community Health and the History of Medicine", Community Health Studies, Vol. IV, No. 2, pp128-133, at p.133.


17. For example, the McLean Report in 1982 had recommended the establishment of geriatric assessment teams to monitor nursing home admissions. Additional reports advocating assessment reforms include: Senate Select Committee on Private Hospitals and Nursing Homes (1985), Private Nursing Homes in Australia: Their Conduct, Administration and Ownership, Canberra: AGPS, and the report of the Auditor-General on an efficiency audit, Commonwealth Administration of Nursing Home Programs, (1981). However the Nursing Homes and Hostels Review, initiated by the Commonwealth Department of Community Services in response to the strong criticisms of existing nursing home and community care arrangements contained in those reports, was the final catalyst for the implementation of the assessment system. Commonwealth Department of Community Services (1986), Op. cit., and Medical Practice, April 1986:16.
of places for the aged in nursing homes, hospitals and hostels to those whose health care needs could be most appropriately provided for in each type of accommodation. In this way the assessment program attempts to ensure that people seeking residential care get access to services appropriate to their needs, and as a corollary, that the only people admitted to nursing homes are those with a demonstrable need for nursing home care.

As an indication of the patterns of distribution of these types of services at the time, Keens et al. estimated that the proportion of nursing home residents which was inappropriately assigned through lack of alternatives, or which could receive the required care services outside a nursing home, was 15% to 25%. Other estimates range from a low of 10% to a high of 40%. This problem is exacerbated in rural areas, where the lack of alternative facilities and services can place an excessive burden on local hospital resources. In some cases, more than three-quarters of the local hospital’s patients were being admitted with no real medical condition beyond the fact that they could not fully take care of themselves in their own homes and that domiciliary support services (or less intensive hostel or nursing home services) were not available in their area.


In early 1986, Cabinet considered a series of proposals from the Minister for Community Services, Senator Don Grimes, to help control the government's nursing home expenditure, which had increased by a factor of ten in the twelve years to 1984/85.\(^\text{21}\) As a result, Cabinet decided to develop "an integrated program of reform of residential care services for aged people", including a needs-based system for planning the expansion of nursing home and hostel places, the development of national standards for nursing homes in the areas of funding, quality of life and quality of care, and the development of a nationwide network of geriatric assessment services.\(^\text{22}\) 

Before the reforms, the suitability of aged people for admission to nursing homes was predominantly determined by the assessments of attending GPs and Commonwealth Medical Officers. Under the new arrangements, the Federal government and State and Territory health authorities share the costs of developing and maintaining regional multidisciplinary assessment teams to process applications for aged residential care and to determine the most appropriate type of placement. These teams are typically attached to a large hospital, and include a geriatrician or community physician, registered nurse, social worker, occupational therapist, physiotherapist, and sometimes, a GP.\(^\text{23}\) 

\(^{21}\) Age, 19 February 1986:17, and 6 March 1986:15.


\(^{23}\) Peter Staples, Minister for Aged, Family and Health Services, Media Release, "$2.4 million for New South Wales geriatric assessment services", 13 June 1991; and Australian De Weekly, 15 March 1991, p5.
The Federal government established and maintained a solid funding base for the development of the geriatric assessment network. From $7.3 million in 1987/88, assessment funding more than doubled to nearly $15 million in 1988/89, and totalled more than $19 million in 1989/90. By 1990 the national network had achieved 100% coverage, with assessment services available in all cities, regions and rural areas across Australia. The rapid pace of development, and the supply of funds to sustain it, lend solid support to the claim by the Minister that "the development and expansion of [geriatric assessment services] is a government priority".

Soon after the assessment services began, the Department assessed them as effective mechanisms for meeting the initial objective to "reduce the number of inappropriate admissions to nursing homes, and [to] increase the number of more appropriate referrals to community care services". Aged Care Assessment Teams consistently found that about half those seeking admission to nursing homes would get access to what they considered to be more suitable care services in hostels or in their own homes through the HACC program. Such results underpin the Department's view of the

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24. Derived from Commonwealth Department of Community Services and Health, Annual Report, for the years 1987-88 to 1989-90. Additional funds for States to expand their geriatric assessment services were allocated for 1991/92. See for example, Peter Staples, Minister for Aged, Family and Health Services, Media Release, "Federal funding for South Australian Geriatric Assessment Services", 27 May 1991 (SA); and "$2.4 million for New South Wales Geriatric Assessment Services", 13 June 1991 (NSW).


assessment services as a policy "cornerstone linking the residential care program and the Home and Community Care program".\textsuperscript{29}

There was very little organised response by the medical profession until Cabinet formally discussed the geriatric assessment proposals in March 1986, and endorsed the recommendations of the Department of Community Services' \textit{Nursing Homes and Hostels Review}, released in April. In the following month, the Federal AMA reactivated its Ad Hoc Committee on Care of the Aged.\textsuperscript{30} While the Committee convened every three months or so to monitor developments in the Federal government's aged care program,\textsuperscript{31} the profession as a whole took no significant actions on the reforms until the AMA's Federal Assembly in May the following year. At the 1987 Assembly, a motion was carried that a section of the AMA's "Policy on Care of the Aged" be changed from:

The basic responsibility for the health care of the aged, including assessment for admission to a nursing home, should remain in the hands of the general practitioner, who \textit{should have access to and make use of} consultants and ancillary health and social services to assist his patients.

to:

The basic responsibility for the health care of the aged, including assessment for admission to a nursing home, should remain in the hands of the general practitioner who \textit{should have access to} consultants, including regional geriatric and rehabilitation services, and ancillary health and social services to assist his patients.\textsuperscript{32}

\begin{thebibliography}{9}
\bibitem{29} Commonwealth Department of Community Services and Health (1989), \textit{Annual Report 1988-89}, p12.
\bibitem{30} \textit{Medical Practice}, 7-21 December 1987:8.
\bibitem{31} See the brief reference to the Ad Hoc Committee's activities in \textit{Ibid}.
\bibitem{32} \textit{Medical Practice}, 6 July 1987:6, emphases added.
\end{thebibliography}
While the insertion of "regional geriatric and rehabilitation services" is an important acknowledgement of the changes in aged care occurring under the government's reforms, the more significant amendment here is the replacement of the words "should have access to and make use of" with the words "should have access to". This change strongly implies that although other health and welfare professionals are often involved in aged care and assessment, it is ultimately the treating GP who should make the final decisions on the nature and direction of treatment for individual cases, and on who is to provide it. It is the first formal (albeit implicit) acknowledgement by the medical profession of its concerns over the effect of the reforms on the roles of other workers in the occupational territory of aged care, and of its determination to retain its dominance in that territory.

In April 1988, the Minister for Aged, Family and Health Services, Peter Staples, announced a "major reform package" of measures as the next stage of the Federal Government's long-term strategy on aged care. The AMA protested to the Minister that the medical profession - and in particular the GP sector - was not given a significant role in developing or implementing the strategy, that the government "had ignored the GP in blind pursuit of the non-medical model", and that geriatric assessment process involved "too much bureaucratic control". These protests were mostly aimed at the composition of the multidisciplinary assessment teams (ACAT), and their function in assessing the suitability of individual aged persons for nursing home, hostel, or home care services.

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The AMA's Ad Hoc Committee on Care of the Aged met with Mr. Staples during the next month to "hammer (out) the role of the GP in aged care". The Minister assured the AMA that the association would be consulted in any further aged care reviews, and that he would consider trialling the direct involvement of attending GPs in assessment teams, conditional on the co-operation of State health authorities.34

Despite these assurances, and the acknowledgement by the Minister of the importance of the role of treating GPs, their role in the assessment process remained largely unchanged. For example, the Commonwealth Guidelines to Assessment Services, which resulted from this review process, state:

The primary medical carer for most people is their GP. Therefore it is vital that assessment teams seek to involve a person's GP in the assessment process from the time of referral and that they continue to work co-operatively with the GP, keeping him/her informed of all actions, until the person is discharged from the assessment service.35

While it is clear from the Guidelines that the GP is recognised as the "primary medical carer" for most aged persons, it is equally clear that the GP does not dominate the assessment process. The GP is to be kept informed of the actions and decisions of the geriatric assessment team, but other non-medical aged care workers determine them.36

Further discussions with Mr. Staples did little to alleviate the AMA's reservations about the role of GPs and other health professionals in

34. Medical Practice, 6 June 1988:5.

35. Staples (1988), 'New nursing home funding arrangements... p5.

36. See also Health Minister Brian Howe's similar comments in this regard in Australian Doctor, 4 June 1993:4.
the assessment process. In a cover story on aged care in May 1990 in *Australian Medicine*, the AMA's political-industrial journal, the Secretary of the Committee on Aged Care, Phillip Taylor, stated that the Committee still had

real concerns about [the assessment teams] and their procedures. There are very few doctors on those teams - they are mainly staffed by carers and nurses.

Of particular concern is the fact that in many cases the elderly patient's doctor is not even consulted in making an assessment or decision on referral of the elderly patient.37

Of the various non-medical personnel on the assessment teams, the AMA expressed particular concern about the role of nurses:

There are nurses knocking back patients for admission who have been referred by GPs...And some nurses on the [assessment team] are admitting the elderly to nursing homes without even consulting their GP.38

Included in this issue was a questionnaire for doctors dealing with the elderly. Mr. Taylor's assessment of initial responses to this questionnaire was that there were "two distinct attitudes" towards geriatric assessment. One embraces a view of the ACAT as a useful complement to the traditional role of the GP in dealing with the elderly, with generally acceptable levels of liaison and consultation, and with further direct GP participation in ACATs as a desirable feature. The other sees ACATs as "bureaucratic governmental interference in the decisions made by the patients' traditional family GPs", and reflects serious concerns about "their composition and reason for existence".39

38. Ibid., p8.
In addition to these two views of ACATs, the initial assessment of the survey also revealed that:

There is strong concern, raised in most questionnaires received to date, over nursing staff associated with [ACATs] overturning the decisions of GPs, particularly with regard to nursing home placement or home and community care services.  

However, this specific concern over the role of nurses was not quite so evident in the final analysis of the survey results, which emphasised the related issues of GP participation and the level of communication between ACATs and GPs. While 69.8% of respondents wanted a GP (at sessional rates) to be included in each regional ACAT, about two-thirds said ACATs always or usually contacted them before and after assessment of their patients, and over 80% said ACATs always or usually contacted them after assessment. Moreover, nearly two-thirds of respondents were "generally satisfied" with the assessment service in their regions, although the level of satisfaction varied "considerably" among the different States. These data reflect considerably less divisive views of ACATs among GPs than those suggested by the "two distinct views" of Mr. Taylor's initial assessment of the survey's results, and suggest some differences between the AMA executive and AMA members over the assessment issue.

A further meeting between the Minister and the AMA's Ad Hoc Committee on Care of the Aged resulted in an agreement for closer consultation between ACATs and GPs. Under the agreement, the Department instructed the members of ACATs to discuss with the

40. Ibid.


42. Australian Medicine, 1 October 1990:15.
treating GP the details of the assessment times for a patient and to invite the GP to attend; while the AMA recommended that members attend the assessment session (raising the relevant fee) "when appropriate and convenient".\textsuperscript{43}

The AMA and the GP sector seem to have accepted the implementation of this agreement, and indeed of the aged care reforms as a whole, for no further formal action has been taken against the arrangements of either the HACC program or the geriatric assessment services.\textsuperscript{44} While the reconstitution in March 1991 of the Ad Hoc Committee on Care of the Aged as a Standing Committee of the Federal Council indicates the AMA’s awareness of the increasing significance for the profession of aged care policy, the initial concerns about professional autonomy and intrusion by other workers into doctors’ occupational territory have been, at least at the formal level, diffused. Indeed the AMA has explicitly endorsed the reforms. In March 1991, the Federal Council accepted changes to the Association’s "Policy on Aged Care", recommending that, in line with the government’s aged care strategy, the preferences of the elderly be taken into account in organising their health care regimes, and in the further development of the home and community services system.\textsuperscript{45}

\begin{footnotesize}
\begin{enumerate}
\item Ibid.
\item The role of GPs in aged care assessment has been raised a few times since the reforms were implemented, but no significant changes to the assessment arrangements have been made, and the profession has not taken any further formal action against them. See for example, \textit{Australian Doctor}, 22 January 1993:15; \textit{Australian Doctor}, 19 March 1993:5; and \textit{Australian Doctor}, 4 June 1993:15.
\item \textit{Australian Medicine}, 1 April 1991:4.
\end{enumerate}
\end{footnotesize}
As I argue in more detail below, there are a series of related factors contributing to this apparent complacency on the part of the profession towards the aged care reforms. These include the location of aged care at the occupational margins of both GP and specialist work; the strong bilateral political support for the reforms; the potential reductions available in the health budget through increased use of health workers other than doctors; and the organisational difficulties faced by the AMA in its attempts to develop a unified strategy of resistance across the Federal-State axis.

However, historical precedents in Australian medical politics indicate that these factors alone cannot fully account for the profession's policy acquiescence. What distinguishes the aged care reforms from most of those in the other case studies is that the core policy issues at stake here are not identified by the key players as essentially medical in nature, requiring the medical expertise held exclusively by doctors for their resolution. Other knowledges, skills and expertise, held by other health workers and by the aged clients themselves, are identified as essential to the resolution of those issues.

Because of this significant role in aged care assessment for non-medical personnel, doctors are not regarded as the sole experts in the field. This precludes them from using their expert role as a means of shaping policy towards medical interests under the guise of applying apparently technical, non-partisan knowledge, leaving them relying entirely on their policy influence as a well organised, active interest group. As the relatively smooth implementation of the reforms suggests, such political power on its own, unaided by the legitimating authority of the expert role, and competing against other active health
interest groups, was insufficient to prevent a significant incursion into medicine's occupational territory by other health workers.

**Home births and independent midwifery**

In England, demarcation disputes between the medical profession and other health workers within the field of childbirth have a long and often tempestuous history, dating back to at least the seventeenth century.\(^{46}\) In Australia, the change from independent midwifery practice to its state-sponsored subordination to the medical profession (as a special branch of nursing) took until the late 1930s to be completed.\(^{47}\) However, the first experience of the Hawke government with the policy implications of these historical tensions within the childbirth area began with the recommendations of the Layton Report\(^{48}\) in 1985.

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The Medicare Benefits Review Committee, chaired by Robyn Layton, was established to make recommendations on anomalies and inefficiencies within the structure of rebates available under the new Medicare system. One of the Committee's major recommendations was that Medicare benefits be made payable for a wider range of paramedical health services, including independent midwifery for home births. The Committee also recommended the development of a $2 million pilot program for independent midwifery. These recommendations were not implemented by the Hawke government, and the level of activity over the policy issues of home births and independent midwifery declined considerably for a couple of years - until the release of a report by National Health and Medical Research Council (NH&MRC) in May 1987.

Prepared by the NH&MRC's Working Party on Home Births and Alternative Birth Centres, the report found no evidence to substantiate fears that home births supervised by midwives were more dangerous than traditional births in hospitals. While the Working Party was unable to directly establish the safety or otherwise of home births in Australia, parts of the medical profession viewed the report as open acceptance of and support for the practice of home births. This view

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49. However Evan Willis, a member of the Layton Committee, views the $6.4 million allocated in the 1989 Budget to independent midwifery programs as a "direct result" of the Committee's original recommendation. Willis, E. (1990), "Hierarchies, bureaucracies and professions: Medicare Review Part 'Two", Community Health Studies, Vol. XIV, No. 2.


51. See for example, Medical Journal of Australia, 19 September 1988:289.
is understandable given the central importance of safety issues in the medical profession’s general case against the practice of homebirths.52

The report also concludes that the rate of Caesarian sections and other birth interventions in Australia was relatively high by international standards,53 and recommends a system of accreditation and quality assurance programs for midwives, the extension of midwifery education, medical benefits rebates for homebirths and the authorisation of midwives to order routine antenatal and postnatal pathology tests, ultrasound and CTG examination.54

The approach to home births in the NH&MR report contrasts sharply with that of the Royal Australian College of Obstetricians and Gynaecologists (RACOG) and its Joint Consultative Committee (JCC) with the Royal Australian College of General Practitioners (RACGP). These organisations see "additional risks" and "unacceptable risks" associated with home births.55 The RACOG "does not accept the premise that homebirths are a safe alternative, nor does it support the

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52. See for example, the response to the NH&MR report of "one of Australia's most prominent obstetricians" in Advertiser, 6 November 1987, pages 5 and 16, particularly the contention that "[a] home birth places the baby at eight times the risk of death of a booked delivery at a major obstetric hospital".

53. For example, in the first half of 1986 the rate of induction at a public hospital in NSW reached 34.8%. 32.8% of deliveries at another hospital were forceps deliveries, while the Caesarian rate was 20.9%. New South Wales Maternal and Perinatal Collection. Half Yearly Report, January-June 1986, NSW Department of Health, 1988, cited in Medical Journal of Australia, 19 Sept 1988:289. See also the NSW Department of Health's comparison of birth intervention rates in the State's hospitals, which indicates similarly high rates of intervention. SMH, 30 April 1990:17, and 1 May 1990:10.


concept of midwives operating independently of medical and/or hospital services". This contrast reflects the different priorities and values evident within the medical profession between the clinical practitioners, whose livelihood is directly dependent on continued access to clients, and their more theoretically inclined academic colleagues.

The opposition of parts of the medical profession to the Working Party's support of home births and independent midwifery became more vigorous and widespread when the NH&MRC formally endorsed the report in November 1987, and changed its birth policy accordingly. Professor Warren Jones, professor of obstetrics and gynaecology at Adelaide’s Flinders University, stated that the NH&MRC’s reversal was " almonds", that "it is eight times more dangerous in terms of losing the baby by having your baby at home", and that the NH&MRC "must have been inappropriately lobbied by a vocal ratbag minority". The RACOG expressed "dismay" at the NH&MRC's endorsement, while the Federal AMA Co-ordinating Committee of Obstetricians and Gynaecologists regretted "such a blatant attempt to demedicalise obstetric practice". The AMA's Federal Council expressed "serious concern" about the NH&MRC's change in birth policy, especially over the "key issue of the safety of mothers and babies" and the "credibility of the NH&MRC in endorsing the [Working Party's] report." The Council decided to advise the NH&MRC of its serious concern, to request that "the report be reconsidered as a matter of urgency", and

57. Advertiser, 6 November 1987:5.
to seek discussions with the Minister for Community Services and the Chairman of the NH&MRC about the findings of the report.\textsuperscript{59}

In November 1989, the NH&MRC released its "Statement on Homebirths", a "supplementary statement" to the Working Party's report.\textsuperscript{60} Following the "many diverse comments" made in response to the initial report - especially by sectors of the medical profession - the Council undertook "an extensive process of consultation" over the intervening two years to clarify its position on the "highly controversial" issue. While acknowledging the RACOG's non-acceptance of the premise that homebirths are a safe alternative, and its opposition to independent midwifery, the Statement essentially confirmed the NH&MRC's existing support for homebirths and left its official policy unchanged.

In response to the release of the NH&MRC Statement, the AMA Federal Council decided to establish a working party "to consider the question of home births, birth centres and related issues (such as independent midwifery)" as a prelude to a comprehensive review of its own policy.\textsuperscript{61} Some of the Association's objections to the NH&MRC Statement were clearly based on concerns that it could encourage the expansion of midwives at the expense of sectors of the medical profession in the field of obstetrics. For example, the report of the AMA working party on birthing objected to the definition of a midwife used in the NH&MRC Statement because "it purports to endow midwives

\textsuperscript{59} \textit{Medical Practice}, 15 February 1988:8.

\textsuperscript{60} National Health and Medical Research Council (NH&MRC) (1989), "Statement on Homebirths".

\textsuperscript{61} \textit{Australian Medicine}, 4-18 December 1989:459.
with clinical responsibilities for obstetric care which were more appropriately provided by doctors." The report also contended that "there was no need for a practitioner category such as 'independent midwives' when adequate medical resources were already available to pregnant women in most of Australia".\textsuperscript{62} At the Federal Council meeting which discussed the AMA's draft policy paper, the SA Branch representative, Dr. Peter Joseph, stated these concerns over the demarcation issue in much less formal terms:

\begin{quote}
We have got doctors running out of our ears, and here we are giving work back to people who aren't even properly trained.\textsuperscript{63}
\end{quote}

After four months of discussions and consultation with members and other medical groups, the AMA formally adopted its revised policy on home births and independent midwifery in March 1990:

The Association considers that, in usual Australian conditions, the risks associated with home births outweigh the advantages anticipated by parents. The difficulties of providing necessary support services...plus unforeseeable transport problems expose home births to unnecessary risks in most locations.

Particularly as such complications cannot usually be predicted before any delivery, the Association is opposed to home births as a matter of policy.

The policy also incorporated the sentiments expressed earlier by Dr. Joseph and others over the demarcation issues involved:

...with such adequate resources [GPs and specialist obstetricians] already available, the Association sees no substantive need for a category of practitioners such as independent midwives.\textsuperscript{64}

\begin{footnotes}
\item[62] Australian Dr Weekly, 30 March 1990.
\item[63] Australian Medicine, 2 April 1990:3.
\item[64] Australian Medicine, 7 May 1990:8.
\end{footnotes}
While the AMA and other medical organisations certainly maintained their strategies of active opposition during this period, other developments in the area tended to overshadow their efforts. Several reports were released which directly supported the NH&MRC position on safety and on the relatively high levels of intervention in hospital births, and recommended expanding the role of independent midwives. In February 1989, the Final Report of the Ministerial Task Force on Obstetric Services in New South Wales (the Shearman Report) was released. The Task Force was chaired by the professor of obstetrics and gynaecology at Sydney University, Rodney Shearman, and its report recommended the granting of hospital visiting rights to qualified, independent midwives, the expansion of the role of hospital employed midwives, and an integrated system of autonomous, salaried community-based midwives.65

In April 1990, the month prior to the release of the AMA's revised policy, a report by Dr. Mary Kearney from the epidemiology section of the NSW Health Department echoed the NH&MRC's concerns over high levels of medical intervention during births at hospitals. In a survey of NSW hospitals, the report found wide variations in the rates of intervention - variations that can not be entirely explained by medical or demographic factors. The report also found that the average levels of intervention at the State's hospitals was "far too high", and that intervention rates were generally higher at private hospitals. For example, in the survey period nearly 84% of the Armidale Hospital's births were spontaneous, whereas the corresponding figure for Sutherland Hospital was only 46%, with an

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overall average of 68%. Similarly, induction rates varied from 10% (Lismore) to over 33% (Sutherland), with an average of 20%. Caesarian rates varied from 7% (Armidale) to nearly 26% (Broken Hill), with an average of 16%; and forceps delivery rates varied from 2.4% (Armidale) to 31.2% (Sutherland), with an average of 14%.66

Events in the period just after the AMA's policy release also tended to undermine the profession's stance of opposition to home births. During the same month, a report by the National Perinatal Statistics Unit at Sydney University and Homebirth Australia,67 Home Births in Australia 1985-1987, was released. The report contains the "first comprehensive data on homebirths in Australia", documenting 3,400 cases across all States and Territories. The results reflect a perinatal mortality rate of 5.9 per 1,000 for home births, compared with the national rate of 10.7,68 and much lower rates of obstetric intervention than those in hospital births. While welcoming the availability of such comprehensive national data, the President of the RACOG, Dr. Con Michael, said that the report provided no evidence for the College to change its opposition to homebirth.69

In the following month, a ministerial review of birthing services in Victoria was released.70 Its final report, Having a Baby in Victoria,

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67. Homebirth Australia is a national, community-oriented home birth advocacy and support organisation, based in Canberra.

68. A relatively low rate is to be expected because of the higher proportion of low-risk pregnancies in the home birth sample - although some high-risk cases were included.


recommends a greater role for GPs and midwives in low-risk pregnancies and births, and a wider choice of birth services for women. This report, like the others in this period, seriously questions the current levels of medical intervention in childbirth. For example, only 40.7% of women in Victoria have a spontaneous labour and birth, only 11.5% have spontaneous labour and birth without an episiotomy, and about 20% of births are induced. The President of the Victorian Branch of the AMA, Dr. Richard Whiting, attacked the review as "an attempt to push birthing services out of hospitals". He said that the Branch "would regard any devolution [of birthing practice] away from medical practitioners as undesirable".

In the meantime, legislation passed through the Senate committing the Commonwealth to the principle of providing financial support for the payment of services of midwives attending home births. This commitment flowed through to the Budget in August, in which $6.44 million over four years was allocated for the Alternative Birthing Services Program. The Program provides funding incentives to help State and Territory governments to establish alternative birthing services for women.

71. In addition to those discussed above, there was also a review on birthing services conducted by a Ministerial Taskforce in WA during 1989/90. The review made similar findings on public support for home births and medical intervention rates.


73. Australian Dr Weekly, 13 July 1990:1.

74. The legislation forms part of the Community Services and Health Legislation Amendment Bill, 1989. For details, see Senate (1989), Parliamentary Debates (Hansard), 13 June, pages 3855, 3894-3908.

75. Commonwealth Department of Community Services and Health (1990), Annual Report, 1989-90, Canberra: AGPS.
While medical organisations generally maintained their formal position of opposition to home births and independent midwifery, that position was neither uniformly held within the medical profession, nor consistently applied by its members. Dr. Brian Spurrett, a Sydney obstetrician and gynaecologist, and Chairman of the NSW State Committee of the RACOG, demonstrated in an article in *The Medical Journal of Australia* that the differences in perinatal mortality rates of births in hospital and at home are smaller than Professor Jones so vehemently suggested in the above quotation. The estimated rates for home births vary from 4.6 to 7.4 deaths per 1,000 births, compared to a benchmark of 6.9 per 1,000 for a typical major obstetric hospital in NSW.\(^{76}\) He also took the view that the accreditation of midwives "would be a rational approach" if it were "properly administered".\(^{77}\)

Similarly, the AMA Federal Council meeting in March 1990, at which the shape of the Association's new birth policy was discussed following the NH&MRC endorsement,\(^{78}\) revealed a significant degree of divisiveness within the profession. In the "at times heated" debate, those who acknowledged the "reality of midwives and birthing centres in the community" and sought to impose a series of quality control

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\(^{76}\) Spurrett (1988), *Op. cit.* The hospital in question was the Nepean Hospital in Penrith, which handled 3,374 deliveries in 1987.

\(^{77}\) *Australian Medicine,* 20 November 1989:427.

\(^{78}\) The other development which seems to have precipitated the review of the AMA's birth policy was a "failed home birth" incident in Canberra three months earlier. When the planned home birth was transferred to a public hospital after complications arose, the mother, accompanied by two external midwives, refused to be treated by a senior obstetrician. She told him to "F... off" (sic), while her partner physically prevented him from entering the delivery room. Many doctors were outraged by the incident, and AMA Federal Vice-President Bruce Shepherd said that the AMA would apply for financial assistance from the Australian Doctors' Fund to "search for a way to ensure that such an event did not happen again". At the time, Dr. Shepherd was Chairman of the Board of Governors of the Fund. See *Australian Medicine,* 20 November 1989:427; and 4/18 December 1989:459.
measures, were "immediately attacked" by other members for being "too soft" in that acknowledgement. For example, then Vice-President Dr. Bruce Shepherd contended that "to allow too much latitude to the proponents of home birthing would seriously undermine the AMA's position of opposition." And the WA Branch's Mike Jones claimed that "such tacit recognition weakened the AMA's case of ensuring proper training and accreditation".79

Divisions within the profession became quite explicit in the responses of various medical organisations to the Having a Baby in Victoria report.80 While the Victorian Branch of the AMA was attacking the main thrust of the report, the Victorian faculty of the RACGP welcomed the report's recommendation that GPs be more involved in low-risk births in hospitals. Indeed the Chairman of the Victorian State Committee of the RACOG, in direct contrast to Federal RACOG policy, further endorsed this recommendation, stating that "the [Victorian faculty of the] college supported midwives and GPs having a greater role in childbirth".81 This particular difference of opinion may be partly explained by the bitter rift at the time between the AMA and the Royal College - and between GPs and specialists within the AMA - over new GP fees proposals. (See Chapter Five.)

Perhaps the highest expression of the medical profession's inconsistency in approaching the birthing reforms lies in the position of the Joint Birth Consultative Committee (JBCC). Established in

79. Australian Medicine, 2 April 1990:2.

80. Health Department Victoria (1990), Having a Baby in Victoria....

November 1989 as a vehicle for tripartite discussions on the changes occurring in birthing arrangements, the Committee consists of representatives of the RACOG, the RACGP and the Australian College of Midwives (ACM), and was chaired by Associate Professor G.J. Bishop of the RACOG. Despite some initial tensions between member groups of the Committee, a series of meetings over the next year produced a Progress Report with recommendations on the protocols and management of services for maternity care. The report notes that:

the Committee accepts that the responsibility for birthing is shared by all those involved. Each have individual and important roles to play - the mothers and families and all those responsible for the care of mothers and infant (sic). The ultimate responsibility must be shared by all concerned.

The Committee considers as acceptable several models of care for child birth, including:

Midwifery Care in which the pregnancy...is managed by a hospital accredited Midwife or team of accredited Midwives in a hospital or birthing centre, or by a Community or Homebirth Midwife in an appropriate setting with established medical support.

Thus while most medical organisations were vigorously maintaining their public opposition to homebirths and independent midwifery, two

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84. Just before the first meeting, the ACM made a public call for an inquiry by the Human Rights and Equal Opportunities Commission into unnecessary medical interventions in childbirth, which, it contended, often amount to "institutionalised acts of assault on women". The other member groups regarded the move as unhelpful to the development of cooperative relations between them. *Australian Medicine*, 20 November 1989:427.


of them were at the same time systematically negotiating - somewhat less publicly - with a midwife organisation to reach an agreement among themselves on the "roles, inter-relationships and responsibilities" of each professional grouping in the work area of childbirth.87

Apart from some sporadic protests against the principles of the Alternative Birthing Services Program - protests which seem driven more by ideological reflex than by systematic critique88 - the medical profession has taken no further organised action against the implementation of the birth reforms. Compared to the vigorous and sustained campaigns mounted, for example, against the Section 17 reforms or the GP fee reforms, the medical profession has in this case - and in the case of the aged care reforms - meekly acceded to state-mediated breaches of its professional autonomy and occupational territory by other health workers.

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While it is a relatively straightforward task to outline two instances of uncharacteristic acquiescence on the part of the medical profession, it


88. For example: by February 1990, the Department had issued guidelines to the States and Territories for the funding available under the Birthing Services Program. If the conditions set out in the guidelines are met, Commonwealth funding of $500 is available to accredited midwives attending home births. The response of AMA Federal President Dr. Bruce Shepherd took the form of a rather limp claim that the Health Minister, Mr. Howe, was "sacred to rampant feminism" in providing $500 to midwives, when GPs earn $425 and obstetricians $550 in Medicare rebates for the corresponding services. Commonwealth Department of Community Services and Health (1990), Annual Report 1989-90, and Advertiser, 16 April 1991. However, as Mr. Howe pointed out, the two sets of fees and services are not directly comparable, given that midwives spend an average of 45 hours with their clients during the pregnancy, birth and after care, while GPs and obstetricians spend an average of 5 hours with theirs. B. Howe, Minister for Community Services and Health, News Release, "Considerable demand for alternative birthing services", 14 May 1991.
is a somewhat more difficult task to fully explain them. However, if we are to gain an insight into the nature and operation of the profession's power in the field of health policy, then we need to explore the limitations of that power. Just as we must examine examples of the "re-medicalisation" of health policy issues, we also need to look at instances of demedicalisation, where the state weakens the professional autonomy of doctors and dilutes their input into policy by sanctioning the contribution of other, non-medical groups.

The outlines above clearly demonstrate that the two sets of reforms are quite distinct in their formal objectives, in their target groups, and in their means of implementation. Nevertheless they share several factors which help explain their common outcomes in terms of the unusual acquiescence of the medical profession to their incorporation into the Hawke government’s health program. This section seeks to identify these factors in order to elucidate some of the operational parameters of the profession’s influence on health policy, and to assess how that influence can be related to the proportions of relevant expertise controlled by the medical profession and by other non-medical groups.

**Occupational margins**

The aged care and assessment reforms are located within a practice area which does not rate very highly in terms of professional status, service volume and income. The birthing and midwifery reforms, while associated with a much more highly rated area of practice, have had only a minimal impact on the volume of clients serviced. In this sense,
both sets of reforms have not had a major impact on the work territory of the medical profession as a whole, and have been restricted to its occupational margins.

For the specialists, the practice area of geriatric medicine has a long tradition of being something of a poor cousin to mainstream medicine, and might well have stayed that way but for the sheer weight of numbers of people living longer through advances in treatment of respiratory and infectious diseases. Moreover, there is a strong temporal connection in developed countries between the period in which the study of the ageing process begins to be recognised as an important branch of medicine, and that in which the potential impact of a steadily ageing population on recession-bound government budgets is first recognised.

The relatively slow development of geriatric medicine is reflected in the low level of resources allocated to its teaching and research. It was only in the middle of 1991 that Australia's first Chair in Gerontology was jointly established by the University of Adelaide and The Queen Elizabeth Hospital. 89 The first Professor of Geriatric Medicine at Sydney University was appointed only a few years before, and at the end of 1985 there were only six doctors in specialist geriatric training in Australia. 90

89. *Advertiser*, 20 July 1990:15, and 11 July 1991:8; *Australian*, 23 July 1990:3. Illustrating the connection between the development of *gerontology* and the potential impact of an ageing population on government budgets, the Chair is located in the capital city with the highest percentage of residents over the age of 65. On the occasion of the announcement of the appointment, the vice-chancellor of the University of Adelaide commented that, in addition to improving our understanding of the ageing process, the research will "help cut the cost of health care". *Advertiser*, 11 July 1991:8.

Another reason for the relative neglect of geriatric medicine is the low level of professional work satisfaction experienced by doctors in treating those aged persons who are chronically ill. There is very little status attached to caring for essentially incurable patients, in that they do not, by definition, respond to treatment in any dramatic way, as is so often the case in the more heroic, preeminent acute care medicine. The field's relatively low status within the profession is reflected by its lack of direct representation on the AMA's federal executive.

The avoidance of geriatric practice illustrates Everett Hughes's notion of the shedding of "dirty work" within the general process of professionalisation; or as McKinlay refers to it, the practice of "creaming" clients by deflecting those whose treatment is not highly valued within the culture of the profession. Along with the treatment of chronic conditions and rehabilitation, geriatric care has traditionally been one of the "ugly sisters" of Australian medicine. GPs, on the other hand, have become more involved in geriatric care through the increasing proportion of their total patients represented by the elderly. Indeed, as noted earlier in the chapter, GPs claimed to have had their incomes significantly reduced in recent years partly

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because of the increasing numbers of bulk-billed age pensioners amongst their patients. Moreover, before the assessment reforms, attending GPs had been quite comfortable with the very difficult - sometimes traumatic - 'disposal' decisions about their older patients being made by another party. However, when the reforms changed that other party from a Commonwealth Medical Officer to a team of non-medical health workers, GPs tended to become more ambivalent about aged care assessment.

Such ambivalence to the ACATs was reflected in the AMA's survey of GPs' attitudes towards aged care arrangements, discussed above. While perhaps relieved to see the awesome responsibility of deciding on their aged patients' institutional placements in the hands of another group of health workers, they were at the same time keen to continue providing medical services to those patients on their own terms. Additional support for this view is provided by the results of a later survey on GPs' attitudes to ACATs, which showed that over 90% of GPs, while "wary" of the other health groups' representation on the assessment teams, wanted some form of outside assistance with the assessment and decision-making process.95 Moreover, while GPs may not have the final say on the placement of their aged patients, they still retain a high degree of control over the type and number of medical services provided to them once placement has been decided on.

95. *Australian Doctor*, 22 January 1993:15. The survey was conducted by the Community Rehabilitation and Geriatric Service, an Aged Care Assessment Team based at St. George Hospital, Sydney.
Perhaps the most significant reason for geriatric care being at the margins of both specialist and GP practice - and certainly the most pragmatic - is its basic incompatibility with the fee-for-service method of remuneration. From the medical profession's point of view, the fee-for-service method works very well in most areas of medicine because a wide variety of recurring packages of services can be continuously applied. This helps to consistently maintain a high volume of services, each of which attracts a separate fee.

From the practitioners' point of view, fee-for-service sits very comfortably with the care of patients in nursing homes and hostels, as indicated by the mid-1980s phenomenon of doctors providing services to large groups of such patients during a series of relatively short, "one-stop" visits before or after their normal practice hours.\textsuperscript{96} However, this method is often more difficult to apply to the care of the elderly in the context of home care type services. As Ehrlich asks:

> How can one pay, on a fee-for-service basis, for a half-day's home visit by a specialist geriatrician in the company of a social worker and occupational therapist, spent interviewing or instructing neighbours or relatives; or for running a training program for local volunteers; or for...trying to mobilize a supportive network around a patient about to be discharged from hospital?\textsuperscript{97}

Reflecting this, "virtually all" (medical) geriatricians in Australia are salaried.\textsuperscript{98} This payment compatibility problem, and the inherent

\textsuperscript{96} Such income-maximising practices were partly restricted by the Hawke government reducing the Medicare fees for the second and subsequent consultations within a single visit to a nursing home or hostel.

\textsuperscript{97} Cited in Sax (1984), Strife of Interests..., p219.

"limited scope for private specialist practice",\textsuperscript{99} has contributed to geriatric medicine being widely regarded within the medical profession as something of an "unpopular vocation".\textsuperscript{100} On the other hand, the current oversupply of doctors, especially GPs, but also in some specialties, combined with the overall ageing of the population and the recent expansion in geriatric research, may soon help to increase its attraction to doctors.\textsuperscript{101}

While obstetrics is a very well established sector of modern medicine, the increasing occupational strength of obstetric specialists has been complemented by the declining involvement of GPs in its practice. For example, in 1983/84 Australian GPs were supervising about 60,000 private deliveries per year. This has gradually fallen to its current level of fewer than 20,000 per year.\textsuperscript{102} According to the then-President of the RACGP, Dr. Tony Buhagiar, GPs have been dropping out of obstetrics "at an alarming rate", and the situation of GP obstetrics in Australia has "reached a crisis point".\textsuperscript{103} The reasons for this change are the subject of some debate.\textsuperscript{104} However, it remains the case that

\textsuperscript{99} Ibid., p250.

\textsuperscript{100} Sax (1984), Strife of Interests..., p219.


\textsuperscript{102} Australian Dr Weekly, 13 July 1990:1.

\textsuperscript{103} Australian Dr Weekly, 22 February 1991:1,4. The RACGP's rationale for rallying GPs to take up obstetrics is partly explained by Dr. Buhagiar's comment that obstetricians are softening their attitudes to GP obstetrics because "[t]hey have started to see that not all women necessarily want specialist attention. The gap will be filled either by midwives or by GPs. The obstetricians have become increasingly keen to see GPs well trained in obstetrics". Australian Dr Weekly, 22 Feb 1991:4.

\textsuperscript{104} Many claim that it is almost entirely due to the escalating costs of medical defence premiums in obstetrics. For example, while obstetricians represent about 3% of the medical workforce, they accounted for 16% of the Medical Defence Union's new policies between 1984 and 1987, and 30% of the total paid out in settlements. Australian, 14 May 1990:13. (For a list of current medical
obstetrics forms a small and still diminishing part of the average GP's practice, so that the possibility of losing clients (and income) in this area to another group of health workers is not necessarily perceived as a major breach of occupational territory. Moreover, the time-intensive nature of the care expected by women who choose home births and/or midwife supervised births is equally unamenable to fee-for-service remuneration as is geriatric care.

From the obstetric specialist's point of view, the birthing reforms are also of marginal occupational significance - but for different reasons. While many of the government reports on childbirth note the community's increasing awareness of, and demand for, alternative birthing arrangements, the actual number of home births in Australia remains very low. For example, the *Homebirth in Australia 1985-1987* survey found that home births comprised about 0.5% of all births, varying from 0.2% in Victoria to 1.7% in the ACT.\(^{105}\) While the Alternative Birthing Services Program provides $6.44 million for midwife managed births over the four years from 1989/90, Medicare benefits for obstetric services provided by medical practitioners is estimated at over $250 million for the same period, excluding ultrasound, pathology and other medical services used during pregnancy.\(^{106}\) That is, independent midwives stand to collect less than

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3% of the total Medicare funding available for the provision of birthing services.

The changing community attitude to traditional hospital births has been reflected much more in the expansion of "user friendly" birthing centres attached to hospitals, where intensive medical backup is on hand, than in a spiralling rate of home births supervised entirely by independent midwives. Even though registered midwives supervise most home births,\textsuperscript{107} the overwhelming majority of deliveries take place in birthing centres or hospital labour wards, and as such remain under the ultimate control of the specialists. In this sense, the birthing reforms for the specialists have a similar significance as they do for the GPs: in the short and intermediate term at least, the reforms are quite marginal to their core occupational interests.

**Community and political support**

All of the major legislative battles won by the medical profession, and most of those in which substantial concessions are made in its favour, are characterised by differences over the principle or application of policy between the major political parties. For example, in the parliamentary debates over the Section 17 amendments, the GP fee reforms and the restructuring of the pathology industry (Chapters Three, Four and Five), the Coalition or the Democrats have partly or wholly supported the position of the medical profession - or groups within it - and forced the government to make significant changes to

\textsuperscript{107} 83% of home births are attended by registered midwives, compared to 13% by unregistered midwives and 4% by medical practitioners. See *Australian Dr Weekly*, 25 May 1990:2.
the final legislation. However, in the case of both the aged care and birthing reforms, there was no substantial opposition mounted by any of the major parties, echoing a similar lack of formal opposition by the profession itself.\textsuperscript{108} Indeed both sets of reforms enjoyed bipartisan support from the outset, and as such were never dependent on the Democrats' hold on the balance of power in the Senate.

The dearth of substantive political opposition to the reforms in parliament is a reflection of the attitudes towards them held in the broader social arena. There was a considerable degree of general support for the reforms right across the community. Even the AMA, while maintaining a position opposing the birthing reforms, acknowledged the "public enthusiasm for homebirths", and the political clout associated with it.\textsuperscript{109}

Moreover the growth of this enthusiasm is not a uniquely Australian phenomenon, and was preceded by equivalent developments in many Western European countries.\textsuperscript{110} The support for the reforms stems not just from increasing levels of consumer awareness and demands, but also from the wider feminist movement which opposes the subjection of women's bodies to the control of the male-dominated medical profession using technology-based birthing practices.\textsuperscript{111} As Scambler argues, such opposition represents - in Habermas's terms - the

\textsuperscript{108} See for example Sax (1990), \textit{Health Care Choices}, ... p.102, and \textit{Australian Dr Weekly}, 30 March 1990.

\textsuperscript{109} \textit{Australian Dr Weekly}, 30 March 1990.

\textsuperscript{110} \textit{Australian Dr Weekly}, 8 June 1990.

"organized defence of the integrity of the lifeworld" of women, and is an example of the effectiveness of "progressive offensive movements" as agents of broad social change.\textsuperscript{112}

As indicated above, the debate within the AMA on the shape of the Association's new birthing policy revolved around the need to acknowledge the reality of the increasing community acceptance of home births attended by midwives. For example, the chair of the working party which drafted the new policy, Dr. Joan Lawrence, argued that:

> We have quite clearly said that we don't agree with home births, but we have to go beyond that point because the reality is that they are here....

> If we present a full statement of opposition without qualifiers, then I think we are making ourselves vulnerable to attack. We have got to have the follow up statement because we have to deal with [the existing] reality.\textsuperscript{113}

Even specialist obstetricians, who have most to lose under the expansion of midwifery and homebirths, openly acknowledged that "the profession has had to recognise the consumer demand for non-interventionist obstetrics".\textsuperscript{114}

State and Federal governments were clearly aware of the high degree of community acceptance of the birthing reforms. A plethora of groups supporting home births and independent midwifery\textsuperscript{115} had lobbied governments and health agencies directly, and made numerous


\textsuperscript{113} \textit{Australian Medicine}, 2 April 1990:3.

\textsuperscript{114} \textit{Ibid.}, p4.

\textsuperscript{115} For example, Homebirth Australia, Australian College of Midwives, Consumers' Health Forum and the Australian Society of Independent Midwives.
submissions to the series of official reviews and inquiries on the issue. In reply to Dr. Shepherd's protests about the level of government funds available to independent midwives attending home births, Health Minister Howe commented that:

[l]t seems that some medical practitioners seriously underestimate the extent of demand in the community for birthing services outside the traditional hospital setting.\textsuperscript{116}

Broad-based community support also characterised the aged care reforms. While the reforms were partly driven by the government's long-term need to control the cost of nursing home subsidies,\textsuperscript{117} they were also a response to the high levels of support for them within the community. As indicated above, surveys consistently demonstrate that the most preferred health care option for the aged is to remain living at home with the support of visiting ancillary health services.\textsuperscript{118}

The ability of the aged population to make governments clearly aware of their needs and wishes is reflected in the effective lobbying activities of "Grey Power" groups such as the Australian Pensioners' and Superannuants' Federation and the Australian Council on the Ageing. The political significance of the aged, based ultimately on the increasing proportion of the voting public that they represent, is also illustrated by the establishment of bodies such as the Office of Care for the Aged, and the Federal Health Department's National Consumer Forum for the Aged within each State and Territory Branch. The


\textsuperscript{117} See for example the McLay Report, \textit{Australia, Parliament} (1982), \textit{in a Home or at Home...}, p18; and Russell and Schofield (1986), \textit{Op cit.}, Ch. 10.

extensive lobbying activities of these organisations is as much a reflection as a cause of the prominent position of aged-related issues on the Australian political agenda, especially in relation to health and welfare services.

While there was little evidence of active "public enthusiasm" for the aged care reforms, it is clear that their consumer participation aspects, and the long history of participation in geriatric care by other health groups, would make it very difficult for the profession to gain popular or political support against the reforms on the basis that the doctor alone should decide.

In attempting to mobilise opposition to the reforms, the medical profession could not even rely on the backing of its traditional policy allies in the private health funds. The funds were generally supportive of both HACC and the birthing reforms, largely because of the potential financial benefits attached to them. For example, the funds are responsible for lower costs and outlays for insured patients who are discharged from hospital earlier than would otherwise be the case, supported by home nursing care services. Most of the major health funds readily agreed to meet home nursing costs for such patients because of the considerable price differential, and openly welcomed the "home nursing boom".\textsuperscript{119}

In the face of such widespread support for both the aged care and birthing reforms, and especially in the absence of obvious disadvantage to other social or professional groups, it became very

\textsuperscript{119} For example, private hospitals cost a minimum of $250 per day, whereas home nursing services cost about $30 per hour. See Australian Dr Weekly. 6 April 1990:16.
difficult for the medical profession to mount sustainable arguments against the reforms and supportive of its continued level of control and exclusivity.

**Economic rationale**

The case against the reforms is tenuous not only in social and political terms, but also in economic terms. In both instances, the reforms make conspicuous economic sense. While this represents some difficulty for the opposition case in most circumstances, it is especially so in the climate of slow growth and fiscal constraint which has characterised the Labor government's term of office.

The aged care reforms represent the most recent of a long, though sporadic, series of Federal government attempts to control spiralling expenditures on aged care. From the early 1950s onwards, major policy changes aimed at alleviating one political difficulty had unforeseen consequences which generated other - often larger - difficulties for subsequent governments, so that yesterday's solutions became part of today's problems.\(^{120}\) As we have seen, the cumulative effect of these changes was a very high rate of institutionalisation amongst the aged, and a formidable imbalance between funding allocations for institutional and domiciliary care. It is precisely the reduction of this imbalance which constitutes one the main long-term economic objectives of the reforms. Moreover, the expansion of available domiciliary care services means that older patients,

\(^{120}\) For details and assessments of these policy changes and their unintended legacies, see for example: the McCleary Report, Australia, Parliament (1982), *In a Home or at Home...*, Chapter 2; Russell and Schofield (1986), *Op. cit.*, Chapter 10; Sax (1984), *Sifting of Interests...*, Chapter 8; and Sax (1990), *Health Care Choices...*, Chapter 6.
accounting for 30% of hospital admissions and over 50% of hospital bed days, can be safely given earlier discharges, which help to contain overall hospital costs. Such economic arguments ultimately contribute to the marginalisation of doctors' concerns about professional demarcation issues.

The birthing reforms are equally difficult to contest on economic grounds. Hospitals consume nearly half the total amount of recurrent health expenditures in Australia, while public hospitals represent some 70% of government health expenditures. Childbirth is a major category of reason for admission to hospital, and the number of medical services and procedural interventions absorbed by birth admissions accounts for a considerable proportion of hospitals' capital, operating and staffing costs. Moreover, it is often the case that the use of one birth intervention in itself creates the need for further interventions. For example, the practice of induction, which has increased dramatically in the past thirty years or so even in the absence of any systematic evaluation of its efficacy, generates higher rates of premature delivery and its attendant risks of serious illness and more intensive treatment regimes, jaundice, Caesarian delivery, pain and forceps delivery. Such practices maintain an expanding cycle of intervention which imposes additional risks and discomfort on


mothers and babies, and which places increasing cost pressures on hospitals' birthing services and facilities.

Despite the large amount of hospital resources allocated to childbirth, 90% to 97% of deliveries are medically uneventful,\textsuperscript{125} and it is variously estimated that between 85% and 90% of all births could be safely conducted without any form of medical intervention.\textsuperscript{126} This pattern of practice stands at odds with the evidence consistently emerging from all major birthing inquiries that the overall rates of medical intervention in hospital births are unnecessarily high by international standards, and that the differences in intervention rates between various hospitals cannot be wholly justified on medical grounds.\textsuperscript{127} Such evidence has lent support to claims that a large proportion of birth interventions are medically unnecessary or are performed more for the convenience of obstetricians than for the safety of women and their babies.

Much of this evidence is based on the personal experiences of hospital staff working in obstetrics. For example, spokesperson for the Australian College of Midwives, Jane Thompson-Hardwicke, claims that in her experience with hospital deliveries, the induction of women at 41 weeks is an almost routine procedure, and that "the thing that controls a woman's delivery is the clock".\textsuperscript{128} Another midwife in Brisbane claims that:

\textsuperscript{125} Cited in \textit{Ibid.}, p68.

\textsuperscript{126} For example, see \textit{Australian}, 14 May 1990:13, and \textit{Courier-Mail}, 29 June 1989:15.

\textsuperscript{127} For highlights of these inquiries' findings and recommendations, see \textit{SMH}, 30 April 1990:17, and 1 May 1990:10; \textit{Age}, 26 June 1990:14; and \textit{Australian}, 14 May 1990:13.

\textsuperscript{128} \textit{SMH}, 30 April 1990:17.
The classic scenario is when the doctor ruptures the membranes at 8am and if the woman has not delivered by 5pm he'll do a caesarian....

When obstetricians stand at the end of the bed at five o'clock in their afternoon and say the baby could be in real danger, that it could die if they don't do a caesarian, it's not what you would call giving the patient informed choice. It's blackmail.\(^{129}\)

However, some of the evidence on unnecessary interventions comes from within the medical profession - even from practicing obstetricians. Dr. David Simpson, of the Sutherland Hospital, concedes that "we don't have a ready explanation" for the high obstetric intervention rates, or for the variations in those rates between different hospitals. He contends that intervention rates are high partly because "[s]ome doctors find it suits them":

They like obstetrics to be under their control, rather than it controlling them. Obstetricians work under a lot of stress. Most of them wish they could lead a fairly normal life - and so do their wives...I'm sure that [inducing for the sake of convenience] must go on.\(^{130}\)

The Chief of Obstetrics and Gynaecology at the University of Amsterdam concluded that:

In 95 per cent of deliveries all the doctor can do is offer pain relief and episiotomy, so there is probably an unconscious tendency for many professionals to see these practices as indispensable.\(^{131}\)

Further evidence has been more systematically researched. For example, a survey conducted by the South Australian Health Commission found that disproportionate numbers of hospital births

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131. Cited in Bates and Lapsley (1985), *Op. cit.*, p79. The fee-for-service system of remuneration, which rewards the provision of large numbers of procedures, could also contribute to this tendency among obstetric doctors.
occurred between the normal working hours of 8am and 6pm, compared to the numbers occurring outside these hours.\textsuperscript{132}

This is not to suggest that the continuing high rates of intervention in hospital births is entirely driven by providers. There is also a very strong emotional significance attached to birth and the birthing process, and a large number of women and their partners feel safer and more secure in a hospital, with its specialist trained staff and high technology support systems on standby in case complications arise. As noted in Chapter Two, the widespread practice of governments seeking technical solutions to social problems is at least partly driven by continuous community support for such solutions.\textsuperscript{133}

However, it remains that almost all of the research into birthing practices clearly demonstrates that intervention rates for home births are considerably lower for home births than for hospital births, even allowing for the larger proportion of higher-risk clients in hospitals.\textsuperscript{134} The major economic implication is that any increase in the number of deliveries supervised by midwives - either at home or in birthing centres\textsuperscript{135} - rather than by specialist obstetricians, has the potential to

\begin{itemize}
  \item \textsuperscript{132} \textit{Ibid.}, p73.
  \item \textsuperscript{133} \textit{Douglas, J.D. [1970] [ed], Freedom and tyranny: the technological threat, New York: Appleby-Century Crofts.}
  \item \textsuperscript{134} Refer, for example, to Chapter 4 of Bates and Lapsley (1985), \textit{Op. cit.}, or compare the hospital intervention rates from the NSW Health Department's survey in SMH, 30 April 1990:17 to those in the \textit{Homebirth in Australia 1985-1987} survey in \textit{Australian Dr Weekly}, 25 May 1990:1.
  \item \textsuperscript{135} Birthing centre intervention rates also tend to be lower than for traditional labour wards, largely due to the low-risk selection criteria applied to clients and to their inclination towards natural birthing procedures. See for example, the experience of the birthing centre at Sydney's Royal Hospital for Women in \textit{Australian Medicine}, 2 April 1990:4.
\end{itemize}
significantly reduce the resources absorbed by childbirth in hospitals in particular, and in health expenditures in general.

The aged care reforms and the birthing reforms are both based on a solid economic rationale. This does not mean that the state pushed ahead with the reforms on this basis alone, for as discussed in the final chapter, highly inefficient and uneconomic health reforms have been successfully implemented in previous policy episodes.136 Similarly, perfectly rational policy solutions have been jettisoned for fear of unknown or uncontrolled cost increases. For example, the Layton Committee’s recommendations to apply to make other treatment "modalities" - including independent midwifery - eligible for Medicare benefits were scuttled because the Federal government feared a cost blow-out.137 The much more limited scope of the new birthing arrangements precludes such fears, and indeed offers the potential of significant savings in hospital expenditures.

However, any attempts by the medical profession to undermine the reforms on economic grounds would be rather difficult to sustain in the face of the formidable body of economic evidence supporting their introduction, and the broad political and community support for them. The profession did not seriously embark on such a strategy - although some isolated attempts were made in this regard.138 Rather,

136. See Konner, M (1993), The Trouble with Medicine, Sydney: ABC Enterprises, Chapter 5.

137. Wills (1990), "Hierarchies, bureaucracies ...".

138. See for example, the concerns expressed by the AMA Victorian Branch President, Dr. Richard Whiting, on the opportunity costs of implementing the recommendations of the ministerial review’s Having a Baby in Victoria report in Australian Dr Weekly, 13 June 1990:1.
the economic arguments for the reforms were so strong as to effectively preempt any serious effort to even consider that strategy.

**Federal-State axis**

Another important feature shared by the reforms is their general form of funding and implementation. While the specific details, methods and scheduling vary enormously, both programs are implemented by the State governments under Federal government supervision, with funding subject to cost-sharing agreements between them. Both programs were initiated by the Federal government, which developed the guidelines and conditions under which funding is made available to the States. The funding agreements leave the States to organise the processes of local consultation with relevant groups, development of advisory and review bodies, and the day-to-day administration of the programs.

Although these arrangements are not unusual for the implementation of health programs, they pose specific problems for both governments and the organised medical profession. For governments at either level, the problems reside in the compromise made between funding and control. For the State governments, the compromise means that they get access to extra health funds which would otherwise not be available, but under conditions not subject to their full and direct control. For the Federal government, it means delegating many of the costs and responsibilities of implementation to State agencies, but at the cost of yielding some control over the specific features and operations of the programs at the local level.
The reduction in the level of control over the program can have significant implications for policy outcomes. For example, under the Alternative Birthing Services Program, the States can choose to allocate all of a specific component of available funds to additional midwife salaries in birthing centres, or to use some of the component to pay for independent midwives at home births "according to local need". This means that the decisions around the question of whether or not independent midwives are funded, and to what extent, are ultimately made at State level. Similarly, the Minister for Aged, Family and Health Services, Peter Staples, expressed concerns over the level of cooperation shown by some of the States in the implementation of HACC. He contended that there was evidence of "poor management" and substantial "inefficiencies" in the administration of aged care programs in these States, and that they had led to "the underspending of funds in home care, slowness in implementing national initiatives, and delays in program planning."

Moreover, Federal-State arrangements have to be negotiated across two levels of constitutional power between eight governments of varying political persuasion, with eight bureaucracies, each with their own distinctive structures, traditions and methods of operation, in addition to the various policy interest groups organised at local and national levels. As a result, inter-governmental negotiations tend to absorb prodigious amounts of energy and resources, and are notoriously slow moving.

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140. Peter Staples, Minister for Aged, Family and Health Services, Media Release, "States need to address inefficiencies", 20 November 1991.
Both the aged care and birthing issues illustrate the underlying problems the state faces in trying to develop consistent health policy whilst having to deal with its myriad of interconnecting internal components. In the health area, governments may be engaged in policy struggles not only against the resistance of the organised medical profession and other organised health interest groups, but also against State and Federal political parties and bureaucratic agencies which may benefit from existing arrangements, and are often working primarily towards their own internal objectives rather than towards unified and comprehensive health objectives. Such fragmentation and resistance to change may be exacerbated by some of the state's health agencies being 'captured' through the development of inappropriately close links with some of their client groups.142

Despite these political and logistical difficulties, negotiations between the different levels of government on both sets of reforms have not been unusually problematic or drawn out. Any problems that governments have encountered have been within the norm for these types of arrangements.143 Since Federation, State and Federal levels of government have cumulatively developed a series of mechanisms to

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143. For example, the Doctors' Reform Society became concerned in 1985 over the extended period in which the aged care reforms were in their "bureaucratic stage", but recognised that this was not entirely unexpected in that "[t]he wheels of government grind exceedingly slow". New Doctor, No. 35, June 1985:4. For more on the problems of inter-governmental relations as they apply to aged care reform, see Sax (1984), Strife of Interests..., pp214-218; and Sax (1990), Health Care Choices..., p102.
maintain smooth, if slow, negotiations between them. However for the medical profession, the combination of Federal and State elements in the programs has represented a different type of policy problem for which its coping mechanisms are not so well developed.144

As noted above, in May 1987 the Federal AMA reactivated its Ad Hoc Committee on Care of the Aged to monitor developments in aged care. Recognising the growing push towards some means of consistent geriatric assessment, the Association wanted to ensure that its members were included in any new system, and that they retained their position of dominance in the aged care area. By November, members' concerns over the new system had grown considerably. In monitoring the aged care reforms, the Ad Hoc Committee concluded that "the government funding arrangements for nursing homes, Geriatric Assessment teams and Home and Community Care Programs were cutting across patient care being provided by general practitioners to the elderly in the community".145

The Committee had found that, because the geriatric and community services were being jointly funded and developed by both State and Federal government agencies, "it had proven impossible [for the AMA] to influence priorities within State health departments and the Commonwealth/State axis". The AMA Federal Council accepted a recommendation from the Committee that State Branches and Territory Groups establish their own local aged care committees to


help deal with this strategic problem. Given the rapidity with which the assessment system was established, and the rather limited assurances given by the Minister on closer liaison between assessment teams and attending GPs, the establishment of these State and Territory committees did little to resolve the AMA’s problems in influencing policy at the “Commonwealth/State axis”.

While no corresponding evidence is available in the case of the birthing reforms, their basic similarity in terms of funding and implementation structures suggests that the AMA encountered the same sorts of organisational problems in trying to impact on government policies across that axis. The relatively fast pace of implementing the reforms - against what were in the end rather reckless rhetorical protests by the profession - suggests that those problems too remained unresolved.

From an organisational point of view, the AMA’s political strength resides at the national rather than the State level. The energy and resources that the Association has assigned to influencing the shape of health policy has been predominantly focused at the Federal government and its various health agencies. The policy issues that have the largest and widest implications for its members, such as MBS fees, health budget allocations and Medicare reviews, are generally centred at the Federal level of government, and the AMA has orientated its organisational priorities accordingly. The recent transfer

146. Ibid.

147. I particularly have in mind here the accusation by the AMA’s Bruce Shepherd that in implementing the birthing reforms, the Minister was “succumbing to rampant feminism”, and Professor Jones’s claim that the NIH&MRC committee on home births had been “inappropriately lobbied by a vocal rathbag minority”. Advertiser, 16 April 1991; Advertiser, 6 November 1987:5.
of the Federal AMA's offices from Sydney to Canberra (within sight of Parliament House) is a reflection of this orientation.

While the Federal AMA deals with the national issues, State health policy issues are generally handled by the State Branches of the AMA, which lay claims to a better acquaintance with - and access to - the local staff and institutions responsible for them. However in both of these case studies, the AMA's organisational separation of responsibilities was partly incongruent with the combination of Federal and State components involved in the development and implementation of the reforms. Although the failure of the AMA - and of the medical profession in general - to take decisive control of the policy process can not be wholly attributed to this incongruency, it certainly presented organisational impediments to any attempts it made to do so.

Lay knowledge vs. medical expertise

The factors discussed above clearly presented considerable difficulties for the organised medical profession in the face of the aged care and birthing reforms. The capacities of the profession's interest groups to mobilise effective levels of policy influence against the reforms were variously impeded by the occupational marginality of the reforms, in relation to both the number of medical professionals directly effected by them and their potential to limit incomes; the divisions of interest within the profession flowing from that marginality; the widespread community support for the reforms and the profession's unusual lack of allies with which to mount effective political resistance; and finally,
the compelling economic rationale underlying the reforms in a context of harsh fiscal restraint.

However, the history of medical politics in Australia suggests that these factors by themselves cannot satisfactorily account for the profession's ultimate acquiescence to the implementation of the reforms. The other case studies include illustrations of how the profession has in the past campaigned much more successfully in public policy debates in which these factors were clearly present. For example, the industrial campaign by a relatively small number of Sydney's Visiting Medical Officers (VMOs) against the Hawke government's attempted Section 17 amendments during 1984/85 was fought very effectively across the Federal-State axis, with State and Federal level medical organisations pitted against State and Federal government agencies, and with the personal intervention of both the Premier and the Prime Minister. Moreover, it was conducted in the face of very limited community, political and media support for the minority of doctors involved, and often in the face of outright hostility towards them. (See Chapter Three.)

Similarly, the objective of restructuring the pathology industry had enormous political support from the outset, which expanded with each new set of revelations of medical fraud and overservicing from the Public Accounts Committee, and which was complemented by strong economic arguments for imposing higher levels of accountability on pathologists. Yet the profession was able to mount sustainable arguments about the technical problems arising from direct accountability measures imposed right across the industry, and in spite of extensive changes to administrative arrangements, retained
effective control over pathology practice and expenditures. (See Chapter Four.) Finally, in the GP fees case study, fees for most GPs were increased by a considerable margin despite generally harsh economic conditions, and the profession gained exclusive control over the process of defining the content of GP service categories, despite bitter divisions between the RACGP and the AMA, and between GPs and specialists within the AMA. (See Chapter Five.)

The argument in this section is that the factor which distinguishes this pair of case studies, in which the profession yielded some occupational sovereignty, from the previous case studies in which the profession successfully retained (or even expanded) such sovereignty, lies in the area of medical knowledge and expertise. In each of the previous case studies, crucial components of the monitoring, supervision and accountability mechanisms were identified by all of the policy players as being fundamentally dependent on medical knowledge and expertise, and as such, allocated to the exclusive control of members of the medical profession. In these two case studies, however, the policy issues at stake were not defined only in terms of medical judgements, so that the knowledge and expertise of non-medical groups was also recognised as having a legitimate role in the final resolution of those issues.

For example, in the case of the Section 17 reforms, the doctors, their representative organisations, the State and Federal ministers, the State and Federal health bureaucracies, the non-Labor parties in both houses of parliament, and even the media commentators, all concurred that only medical knowledge and expertise was relevant to the assessment of patterns of VMOs' practices within NSW hospitals.
Similarly, in the case of the pathology restructuring, all of the key players, including the government and the Public Accounts Committee, explicitly acknowledged that medical knowledge (more specifically, specialist pathology knowledge) was the only type of knowledge applicable to the task of assessing whether or not the provision of a particular pathology service was medically necessary, so that only pathologists could do it. And in the case of the GP fee reforms, all policy players agreed that only medical knowledge could be used to assess the level of medical skills (and so the Medicare fee) applicable to a particular GP consultation, so that once again, only medical practitioners could do it.

Such acknowledgements are generally contained within the rubric of "peer review". While the profession tends to emphasise the quality assurance functions of peer review mechanisms, we have seen that they can also simultaneously serve the functions of excluding outside scrutiny of the work practices of doctors, and maintaining the integrity of the borders of their occupational territory. These hidden functions of peer review make it very difficult for governments (indeed parliaments) to impose direct, effective controls on the aggregate costs of medical service provision. However in the areas of aged care and birthing, where the knowledges of both patients and other occupational groups are formally recognised, there is no corresponding opportunity for the profession to maintain exclusive control through such peer review mechanisms - for peer review by definition rests on a monopoly of applicable knowledge.

Given that the other factors are evident to some extent in my previous case studies, and that none of these factors on its own was sufficient
to preclude the profession from retaining its autonomy and control over health policy. My argument here is that it was the profession's lack of undisputed scientific expertise in the practice of birthing and aged care - and the associated role of lay expertise and the expertise of other health professions - which most contributed to its acquiescence to the reforms.

The wide public acceptance of the principles embraced by the reforms is partly informed by a body of common, lay knowledge based on collective community experiences with the general processes involved in both birth and ageing. Everyone has had experience with someone who has had a baby or someone who is in their 'twilight years'. Through such experiences, they are aware that, although the processes involved have considerable biological content which can be appropriately addressed by specialist medical expertise, they also have strong social and cultural significance which lies well beyond the scope of such expertise. Such common, secular knowledge tends to undercut the implied argument of the medical profession that the needs of people involved in birthing and old age represent solely medical problems requiring medical solutions and medical expertise.

Over the past 150 years, the issues and problems of the aged in many developed countries have shifted from the welfare arena towards the medical arena. Medical dominance in the care of the aged, and the development of geriatric medicine, was largely based on medical

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science's identification of changes in neural, circulatory and other tissues associated with the ageing process.\textsuperscript{149}

However, while medical science still predominates in the practice of aged care, it has not precluded the retention of a broad awareness among the general lay population that the health problems of the aged are not entirely physiological in nature, and that the definition of those problems involves significant social and welfare criteria. For example, loneliness and bereavement can induce the clinical condition of depression, as anxiety about dependence and finances can contribute to a variety of physical health conditions.\textsuperscript{150} These 'common-sense', experiential notions of the aged are reinforced by the widespread traditional involvement of other non-medical groups in the care of the aged, such as social workers, physiotherapists, counsellors, district nurses and occupational therapists, as well as lay carers, such as close relatives (especially female relatives), and support networks of friends and neighbours.\textsuperscript{151}

Indeed the intermingling of social and medical needs is implicit in the AMA's inclusion of the "opinions and wishes of the elderly" section in its revised aged care policy.\textsuperscript{152} Whereas modern medicine gives ultimate authority to the diagnosis of the legally qualified practitioner, based on scientific medical knowledge, and regardless of the

\begin{footnotes}
\item[149.] This section draws heavily on the discussion in \textit{ibid.}, pp268-274.
\item[150.] \textit{ibid.}, p270.
\item[152.] See for example \textit{Australian Medicine}, 1 April 1991:4.
\end{footnotes}
assessments of the patients themselves, here the principal representative body of the medical profession is accommodating a strong role for the patient in the assessment process, and in determining the direction - and even some of the content - of therapy and treatment.

Such a role runs counter to one of modern scientific medicine's basic organising principles: the Cartesian divide between mind and body. It also partly reinstates the patient's narrative as the focus of diagnosis and treatment. As we saw in Chapter Two, the patient's narrative had been effectively displaced by the clinical examination of signs and symptoms with medical instruments developed during the nineteenth century for reading the diagnosis directly from the inner workings of the patient's body, without the necessity for interpretation by the patient.  

This policy change represents an acknowledgement by the profession that medical knowledge is not the only type of knowledge capable of making a useful contribution to the diagnosis and care of health problems related to old age, and that the knowledge and experience of patients, such as the widespread preference of older people to get health services provided within their own homes rather than in an

institution, can be equally significant in determining the type and content of treatment. This mixture of medical and lay knowledge, in addition to the long-standing involvement of other professions and bodies of knowledge, makes it difficult for the medical profession to claim aged care as its exclusive preserve on the grounds of a monopoly over relevant expertise.

Common or lay knowledge also tends to undercut the attempts of the medical profession to claim childbirth as its sovereign territory. Rather than an illness which needs treatment through the application of medical knowledge, birth is commonly viewed as a natural process by which the human race has successfully reproduced itself for countless generations without the benefit of the medical profession's expertise. The argument that medical control of the birthing process has been responsible for the very low perinatal mortality rates in developed countries, and that these rates would increase with the spread of home births, was seriously weakened by the very strong evidence that home births have comparable - and often lower - mortality rates than hospital births.

This was made particularly clear in the case of the Homebirth in Australia 1985-1987 research report commissioned by Homebirth Australia, and conducted by the National Perinatal Statistics Unit at Sydney University. Its large-scale nationwide sample helped to neutralise the medical profession's arguments that previous home birth research had not been sufficiently comprehensive in its coverage.

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154. See for example, the comments in this vein by the President of the Federal AMA in Australian Dr Weekly, 30 March 1990.
and "scientific" enough in its methodology - to allow strong conclusions about its relative level of safety to be drawn.

The reputation for the safety of home births was further reinforced by comparisons with the situation in the Netherlands, where a large majority of births take place in the home under the supervision of independent midwives, with minimal use of high technology and very low medical intervention rates. The neo-natal death rate is consistently lower in the Netherlands than in Australia, USA, Britain, and most other developed nations.\textsuperscript{155} Similarly, some of the medical interventions in hospital births, such as episiotomies, have never been systematically evaluated for their clinical efficiency or effectiveness - even though they are used almost routinely in many countries. And for many interventions, the evaluations that have been done are largely inconclusive.\textsuperscript{156} Such forceful comparative evidence is very difficult to disregard as a statistical aberration or as inapplicable to the Australian context. Similar evidence was presented by the home birth advocacy groups to all of the major government inquiries on childbirth, and certainly helped to give considerable legitimacy to the claims that midwife-supervised home births are a safe and more cost-effective alternative to traditional hospital births.

Such compelling evidence, based as it was on rigorous scientific methodology, placed those sectors of the medical profession opposed to the birthing reforms in a difficult tactical situation. One option was


to claim superiority for hospital births on the traditional grounds of scientific effectiveness. The basic approach here is to emphasise the association between the large reductions in birth mortality rates and the science-based technology, practice and expertise of the modern hospital.\textsuperscript{157} However the potency of this option is somewhat limited by the strong scientific evidence supporting the comparative safety of homebirths and births controlled by midwives.

On the other hand, if they avoid arguing the case against the reforms on scientific grounds, their claims of exclusive and superior expertise in birth become very difficult to substantiate. Without resort to a demonstrably better safety record, the claim to a monopoly over birthing procedures cannot be justified in terms of higher levels of patient care. Without the guise of such altruism, the claim can be revealed as a self-interested attempt to maintain occupational territory against the threat of incursion by independent midwives. In other words, those opposed to the reforms either cannot bolster their argument with claims to scientific expertise, or, if they do, stand to have the same argument turned against them.

\textsuperscript{157} Formal precedents for the development of such an argument in Australia lie in the findings and recommendations of the Report of the Commonwealth Royal Commission on Health in 1926, and the Report on Infant and Maternal Mortality in 1930. Established in response to the falling infant mortality rates being accompanied by an increase in maternal mortality, both viewed obstetric practice as lagging behind medical developments in other areas, and recommended higher levels of medical control over births. Davis and George (1988), \textit{Op. cit.}, p96. The decline in maternal mortality rates (and the continuing fall in infant mortality) which followed this period forms the basis of the medical profession's arguments on the safety of medically-controlled births.

More recently, Britain's Peel Report of 1970 recommended that all deliveries take place in hospitals. The data used as a basis for this recommendation was the statistical correlation seen between the increasing level of hospital births and the decreasing rates of maternal and perinatal deaths. As Cochrane argues, however, no cause and effect relationship was established, and the mortality data could be combined with other data in the Report on the length of hospital stays to support an equally spurious claim that shorter hospitalisations caused higher rates of mortality. Cochrane, A.L. (1972), \textit{Effectiveness and Efficiency: Random Reflections on Health Services}, London: Nuffield Provincial Hospitals Trust.
In this type of social and political environment, it becomes very difficult for the medical profession to mount an effective argument in favour of retaining its high level of control and exclusivity, and against the general thrust of either set of reforms. While parts of the profession might have strong objections to any incursions into their autonomy or work domain, no other identifiable professional or social groups are significantly disadvantaged by the reforms. Without the ability to garner political support through such allied groups, a campaign of opposition to the reforms can only be based on a "Doctor knows best" theme, and would tend to portray the profession as dogmatic, uncaring and seeking only to maximise its sources of income. In these circumstances, the chances of such a campaign being successful - even for a profession with such high levels of public esteem - are considerably diminished.

**Conclusion**

These two case studies, unlike the others in this research, are examples of the Federal government successfully implementing (albeit limited) health reforms based on principles which are historically anathema to the medical profession. Both the aged care and the birthing reforms are organised around the general principle that other groups of workers can provide particular health services more cheaply and effectively than doctors, and that they can do so to the greater satisfaction of the clients who opt to use them.

Despite the threats to professional autonomy and occupational territory represented by these reforms, the medical profession was
uncharacteristically acquiescent in its acceptance of their implementation. The attempts made to oppose or modify them have been much more modest in scope and intensity than those made against reforms with similar occupational implications, such as the Section 17 amendments or the pathology restructuring in Chapters Three and Four. The limited resistance offered by the profession has meant that the reforms were largely shaped by negotiations and consultations between governments and a range of generally non-medical interest groups.

At a very general level, the aged care and birthing case studies demonstrate that the political influence of the medical profession is neither unassailable nor ahistorical. Its level of influence is not constant, but is to some extent dependent on a variety of contingent factors and circumstances. This is not to contend, however, that these reforms represent the end of the medical dominance of health. The inroads made by other non-medical groups into the occupational territory and autonomy of the medical profession are quite modest in scale and extent, and doctors remain the preeminent workers in the health arena. Indeed, there is some preliminary evidence indicating that licensed midwives have made more practice and attitudinal changes in adjusting to the established, medically controlled system of childbirth than have doctors in adjusting to the formal entry of midwives.158

The factors identified in the case studies which contribute to this uncommon acquiescence can be used to provide some insight into the

extent and operational mechanisms of the medical profession's power to influence health policy in Australia - although it is not possible to accurately assess the contribution made by the individual factors, nor the ultimate validity of any generalisations based on them.

The wide community and political support for the reforms was bolstered by the strong economic arguments for them. These factors are largely interdependent; and indeed it is only for the purposes of analysis that they can be meaningfully separated. In the parliamentary debates, and in the wider public debates conducted through the media, the government's consistent emphasis on the reforms' economic benefits for the health sector testifies to the strategic importance that was placed on economic arguments. The almost total lack of substantive economic evidence produced for use against the reforms reflects on the efficacy of those arguments.

The strategic significance of the State-Federal factor in these case studies is perhaps the most difficult to assess. While the explicit statements of the AMA's Ad Hoc Committee are solid evidence of the organisational difficulties it presented for the medical profession in controlling the direction of the aged care reforms, there is no corresponding evidence available as to its role in the birthing reforms. Even allowing for comparable difficulties in both cases, the combined effect of the other factors may well have marginalised the profession's policy influence even before the Federal-State factor is considered. Moreover, as we noted above, the profession seems to have overcome the effects of this factor in previous policy disputes, such as that over the Section 17 amendments - although those amendments' more
extensive implications for the profession make direct comparisons difficult.

However, the factor which qualitatively distinguishes these case studies from the previous ones is the applicability of lay knowledges to the health issues involved, and the complementary diminution in the relative effective utility of medical expertise. In both of these cases, the medical profession found that the bipartisan support for the reforms could not be significantly divided by doubts or uncertainties arising from sustainable medical arguments against the scientific principles on which the reforms were based, or against their projected effects on the welfare of patients. The profession's traditional strategy of heading off health policy reforms which seem to threaten their occupational interests by raising doubts about their impact on the health care of patients has generally been well rewarded. However in these cases, the medical-scientific grounds on which to raise such doubts were severely limited. Indeed a large part of the available evidence raised significant doubts about the efficacy and prevalence of existing birthing practices. The high level of secular knowledge about the processes involved in birthing and aged care acted to compound this problem for the profession, and made its claim to a monopoly of relevant expertise seem both spurious and self-serving.

These case studies also go some way towards revealing the general nature of the medical profession's influence on health policy. Explanations based on the capacities of the profession as an active, organised and well-resourced interest group tend to marginalise or ignore the impact of its exclusive hold on the science-based knowledge and expertise of medicine. On the other hand, explanations based on
the high social priority afforded to medicine’s body of expert
knowledge cannot take into account both the lobbying capacities of
the profession and the structural advantage within the health system
such capacities have secured for the profession through its long
history of policy disputes with Australian governments. For example,
no other health profession, under either type of government, and
under such a variety of financing arrangements, has had its services
so heavily and continuously subsidised by public funds as has the
medical profession.

Clearly, both lobbying power and knowledge utility directly contribute
to the medical profession’s policy influence, and each is necessarily
dependent on, and reinforced by, the effects of other. Where medical
knowledge and expertise do not have exclusive application to a specific
health area - so that other non-medical or lay knowledges are
accorded significant levels of relevance - the profession in effect loses
one of its two key conduits of policy influence, and is forced to rely
much more heavily on its other conduit of influence, that of
organisational lobbying power.

As such, the organised medical profession becomes no more than one
of many competing interest groups in the health arena, albeit an
historically significant one. As these case studies illustrate, however,
such power at times may not be sufficient on its own for the
profession to fully maintain its position of control over its occupational
territory against state-legitimated incursions from other groups of
health workers.
CHAPTER SEVEN

LINKING KNOWLEDGE, POWER AND HEALTH POLICY
Introduction

The analyses of the policy case studies in the preceding four chapters, informed by the theoretical considerations of Chapter Two, enable us to draw several conclusions about both the origins and the scope of the medical profession's influence on health policy in Australia. The first section of this chapter discusses these conclusions with particular reference to the principle of medical peer review as a cornerstone of medical dominance.

In order to assess the contribution this research can make to our understanding of health policy in Australia, we need to gauge the strength of its conclusions, and the degree to which they can be usefully applied to other policy cases. The second section of this chapter examines some of the factors which might test the strength of our conclusions and their level of generalisability. We find strong evidence supporting the application of our conclusions to other areas of health policy. However, we must at the same time confront the limited amenability to direct empirical proof imposed by our particular theoretical perspective.

The third section proposes some ways of changing the procedures and structure of medical peer review. These are aimed at inhibiting its operational support of medical dominance by admitting other, non-medical types of knowledge and skills into the review process. Because such reforms can limit its high level of autonomy and self-regulation, some resistance can be expected from the medical profession. On the other hand, the reconstituted peer review proposed here holds the potential to significantly expand the range of social and
political values guiding the accountability process, and the general direction of future health policies. This process can then be informed not only by narrow medical interests, such as provider autonomy and income, but also by wider community interests such as social justice and equity in health.

Bringing medical knowledge back in

This study has used case studies to illustrate the mutually reinforcing role of "power" and "knowledge" in the maintenance of "medical dominance" over health policy in Australia. "Power" refers to those aspects of policy influence associated with the lobbying activities of the medical profession's organised interest groups within a liberal democratic polity. This is epitomised by the role of the Australian Medical Association (AMA) in negotiating with the state over the content and implementation of health policy. "Knowledge" on the other hand, refers to those aspects of policy influence associated with the profession's state-sanctioned monopoly over the knowledge base of Western scientific medicine, and over the medical expertise derived from it. I have argued that medical dominance over health policy cannot be adequately explained by reference to only one of these categories. As the case studies consistently reveal, wherever policy outcomes generally benefit the profession and protect its interests, we find the interacting presence of both "power" and "knowledge". Wherever the outcomes generally compromise the profession's

1. The title of this section is drawn from Theda Skocpol (1985), "Bringing the State Back In: Strategies of Analysis in Current Research", in P. B. Evans, D. Rueschemeyer and T. Skocpol (eds), Bringing the State Back In. Cambridge: Cambridge University Press, pp3-37.
interests, we find the presence of only one of these types of influence, unsupported by the other.

One of the two main types of conventional accounts of medical dominance - what we refer to here as the "knowledge" approach - tends to emphasise the high social functionality of the knowledge by which medical practice is informed. Here we find the bulk of the profession's policy influence attributed to its strong historical links with a body of knowledge based on scientific methodology, research and technology, to the high therapeutic efficacy of its treatments relative to those provided by other health occupations, to the expansive authority of medical expertise in health matters which flows from that efficacy, and to the high political and economic priority the community gives to policy issues about health and illness. In these accounts, the influence of the profession's organised interest group activities in shaping health policy is marginalised, or even excluded.

The other type of account of medical dominance tends to stress the policy influence derived from the profession's historical capacities as a network of organised interest groups. In this "power" approach, we find accounts of the profession working through active, well-resourced interest groups, lobbying the state for policies which privilege or protect medical interests over those of other health occupations and consumer groups. Through a long series of successful lobbying campaigns, the profession has entrenched itself as the state's most important client group within the "policy community" of health.2 These accounts give little or no recognition to the potential collective

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influence of doctors as exclusive sources of the medical expertise on
which the content and implementation of many health policies tends
to ultimately depend.

Accounts which emphasise interest group power are limited by their
inability to explain those intermittent failures of medical dominance
where negotiated health policies promote the interests of other health
occupations or community groups to the detriment of the medical
profession's interests. In these accounts, such occasional - but by no
means rare - lapses of policy influence can only be accommodated by
reference to the essentially contingent and provisional nature of
interest group politics. In this approach, in the absence of a set of
universal laws by which to accurately predict the outcome of a specific
policy conflict, we must rely on the second-level predictors provided by
underlying tendencies in the patterns of outcome emerging over time.
It is in this generalised, long-term sense that we tend to regard the
medical profession as the most powerful interest group in the health
arena. While it does not win all of its policy battles, it wins most of
them.

On the other hand, those accounts which emphasise doctors'
monopoly over medical knowledge cannot adequately account for the
relatively low levels of policy influence exerted by other knowledge-
based occupations - neither those whose social function appears
equally vital to that of medicine, such as plumbers, mechanics,
computer analysts and teachers; nor those whose body of knowledge
appears as equally connected to Western rational science as is
medicine's, such as physicists, nuclear scientists, marine biologists
and civil engineers.
In this account, I emphasise the essential interdependence of medical knowledge and medical power in the development of policies which sustain or promote the occupational dominance of the medical profession in the area of health and illness. This dominance is indicated by the profession's formal position of authority over the work of other health groups, its high level of self-regulation and freedom from public scrutiny, and its historical autonomy over the content of its work. Medical dominance here rests not on either "power" or "knowledge" as a single source of policy influence, but rather on the combined interaction of both.

While we can treat each as a distinct source of influence for the purposes of analysis, each implies the other conceptually, and is dependent on the other in practice. In the continuous conflict and manoeuvring over health policy, the medical profession's entrenched position as chief health experts in Australia enhances the influence of its organised interest group activities against those of other health interest groups; and at the same time, those activities cumulatively reinforce medical knowledge as the principal cognitive basis for the development of health policy and the organisation of health services. With this "power/knowledge dyad", we can more adequately account for both the exceptions and the rule of medical dominance over health policy.

In this research, I also illustrate the converse argument for the power-knowledge basis of medical dominance. Where the "knowledge"

conduit of influence is absent from or marginal to a policy conflict, the "power" conduit can be insufficient on its own to fully protect the profession's interests. Generally, the absence of the "knowledge" conduit occurs when the key policy players do not act under the presupposition that the issues involved are essentially technical and medical in nature, and so ultimately dependent on medical knowledge for their resolution; or when they do not collectively identify the issues as such. Thus we see in the later phase of Chapter Three, and again throughout Chapter Six, some weakening of medical dominance stemming from a broad-based recognition of other non-medical knowledges and expertise within both the definition of the policy problems at stake, and the policy measures proposed for their resolution.

As we noted in Chapter Two, since World War II, conventional accounts of medical influence over health policy have tended to emphasise either the "power" or the "knowledge" aspects of that influence. However, more recent accounts in Australia have generally eschewed explanations based on "knowledge", and have focused instead on the political capacities of the medical profession as organised interest groups. It was suggested that this tendency is part of a wider trend by Western social science researchers to avoid being associated with either the functionalism of Parsonian sociology, which unduly limits the medical profession to a passive instrument of social control, or the over-generalised claims of some neo-Marxist and neo-Weberian structural analyses, which provide very little scope for the state to actively direct health policy towards its own socio-political ends. It is for this reason that the approach taken here focuses more on the "knowledge" aspects of medical dominance. As such, it
represents an initial attempt to reinsert and re-emphasise the role of medical knowledge in the research and analyses of health policy in Australia.

Peer review as institutionalised medical knowledge

In the cases considered in this research, the characteristic means through which medical knowledge is channelled into the health policy process is the peer review mechanism. Common to the case studies where medical dominance is consolidated or extended is a formally established peer review mechanism which, as an integral component of the structure of policy administration, ensures that only those with medical qualifications can directly and legitimately scrutinise the decisions or judgements of medical service providers under Medicare. Conversely, where we note challenges to the medical dominance of health policy, there exists no peer review mechanism through which the profession can protect its industrial and political interests under the guise of applying technical, impartial medical expertise. It is in this sense that I suggest that doctors' exclusive control of the medical expertise driving such self-regulating peer review mechanisms represents the institutionalisation of medical knowledge within the Australian health system.

Medical peer review is also the primary means by which the theories on medical knowledge I invoke can be operationalised. As I argue below, when members of the medical profession make decisions within the peer review process, it is very difficult - even impossible - for them to cognitively separate their clinical and scientific assessments from the impact those assessments can have on general interests of the
profession as a whole. This argument is directly dependent on social constructionist theories, which deny the possibility of a body of scientific knowledge whose content is independent of the social and political context in which the knowledge was produced.

**Peer review as institutionalised medical power**

While the case studies may at times emphasise the knowledge aspects, the centrality of the interdependence of power and knowledge to my argument about the policy influence of the medical profession, means that power aspects must also be adequately discussed in this context. Again, peer review provides the means through which the theories about the political power of the medical profession, outlined in Chapter Two, and referred to in some of the case studies, can be operationalised.

When the peer review process is examined by reference to Lukes's theory on the three dimensions of political power, a coherent explanation is provided for the power aspects of medical influence over health policy, and for their connection to the constructionist theories of medical knowledge. Lukes's first dimension of power, analogous to that implied in pluralist approaches, is evident throughout all of the case studies. It is reflected by the sustained lobbying activities of the medical profession's organised interest groups - most notably the AMA - in its negotiations with the state over health policy, and in its direct competition against a variety of other health interest groups. The second dimension of power, outlined in Chapter Two, and illustrated at length in the overservicing case study of Chapter Four, encompasses those aspects of medical influence associated with the
long-term entrenchment of the professions' politico-industrial organisations within the formal development and implementation structures of health policy. In this type of exercise of power, the AMA has become an integral member of the "policy community" of health, whose closed nature enables the profession to influence the formal policy agenda towards its own interests, seen especially through the process of "non-decisionmaking".

These two dimensions of power are not exercised solely by the medical profession and its organised interest groups, and as the case studies illustrate, they are available to other groups in the area of health. On their own, these two dimensions cannot account for the full political power of doctors. The power aspect of medical influence which distinguishes the medical profession from other health interest groups is its capacity to influence policy through Lukes's "third dimension" of power. The case studies demonstrate the characteristic means by which the medical profession can regularly exercise such power through the formal process of peer review.

In this context, the principle of medical peer review reflects the widespread tendency within Western industrialised nations to accept medical knowledge, based on the precepts of rational science, and the expertise derived from such knowledge, as politically neutral and free of professional interests. In Lukes's terms, such uncritical acceptance is associated with a gap between society's "subjective interests", which do not recognise any political advantage or exercise of power by the profession through peer review, and its "real" interests, within which the potential for such power is clearly identified. What makes such
power the "supreme and most insidious" type of power,⁴ is the total absence of any conflict over its use. The apparently technical nature of medical expertise is taken as natural and inevitable, a presumption made by all parties within the health policy process. The principle of peer review, based on the application of such expertise, is identified as part of the consensus about policy issues, rather than as a channel for medical interests.

Medical peer review provides a very useful illustration of the exercise of "third dimension" power by the medical profession, and represents the institutionalisation of medical power over the content of health policy. As discussed in more detail below, such an illustration can be strongly supported by circumstantial evidence from the case studies. Moreover, peer review stands at the operational crossroads of medical knowledge theory and medical power theory. Through peer review, the social construction of medical knowledge and the political power of the organised medical profession can be integrated into a fuller and more coherent account of the policy influence of doctors than conventional accounts which ultimately depend on only knowledge or power aspects, to the exclusion of the other.

Section 17 and the NSW Doctors' Dispute

In this case study, the peer review mechanism reflecting the medical profession's power and knowledge aspects of policy influence took the form of the Billing Review Committee. The state and its health agencies sought to constrain the predicted rise in payments to visiting

specialists under the new Medicare system through direct controls over the terms of the contracts under which they treated their private patients in public hospitals. The core of this push for cost containment was the requirement to charge fees at or below those in the Medical Benefits Schedule (MBS), and the imposition of uniform limits on income from private patients.

However, this constraining effect was largely negated by the broad agreement negotiated between the government, the Opposition parties and the Democrats - and informed by the recommendations of the Penington Inquiry - to formally restrict the scope of such controls. Under the agreement, income limitations were to apply to full-time salaried specialists, but not to the Visiting Medical Officers (VMOs) who were responsible for the bulk of services provided to private patients in public hospitals. More importantly, the agreement allowed above-Schedule billing by all specialists, subject to regular review within the hospital by Billing Review Committees.

As seen in Chapter Three, the definitive criterion for membership of such Committees was medical qualifications. Three members were to be drawn from the pool of practicing hospital specialists, elected by their working peers, while the fourth member was to represent the administrative sector of the hospital, with the significant proviso that he or she held medical qualifications. Even though the public at large, through taxation revenues, funded most of the private practice income, the involvement of anyone with other than medical knowledge and expertise, representing wider community interests or groups, was thereby formally excluded from the process of scrutinising decisions to charge above-Schedule fees. In other words, the Billing Review
Committees would allow those whose practices would push up Medicare costs, and those who would monitor and assess such practices, to be drawn from the same professional group working within the same public hospital.

When the conflict over Section 17 developed into the NSW Doctors' Dispute, there was a qualitative shift in the nature of the issues being contested. In the Section 17 phase, the core issues over professional autonomy and government interference in specialists' decisions were identified as predominantly medical in nature, essentially dependent on the application of medical knowledge and expertise - through the peer-based Billing Review Committees - for their resolution. In the later phase, however, the focus shifted to issues more industrial than medical in nature, involving the rates of pay for VMOs and the impact of their strike action on hospital patients.

The distinctive characteristic identifying the transition from medical to industrial dispute is peer review. What makes the second phase qualitatively different to the first is that the process of resolution did not centre on a medical peer review mechanism. Rather, it focussed on an independent arbitration mechanism which is more characteristic of the settlement of industrial disputes involving trade unions than of health policy disputes involving the medical profession. Such an arbitration process is not fundamentally dependent for its operation on medical knowledge exclusive to the profession, but on legal and industrial expertise beyond the immediate control of the profession. In other words, there was in this later phase no consensus amongst the policy players that the medical profession could provide an expert, neutral assessment of the policy issues at stake.
As noted in Chapter Three, the change from medical to industrial issues was accompanied by a broad shift in community perceptions of medical practitioners. As the dispute escalated, their traditional status as trusted, impartial health experts was quickly transformed into the disreputable role of self-interested industrial warriors. However, in the context of the Hawke government's political need for a smooth transition to the Medicare system - which represented both the cornerstone of the ALP's social policy and the social wage centrepiece of its Accord with the ACTU - the specialists' raw industrial power was sufficiently strong to extract considerable concessions from the Federal and NSW governments. These included the complete repeal of Section 17, the provisions of which were the initial catalyst for the dispute.

However, the doctors' rather brutal wielding of this industrial power, untempered by the complementary legitimising influence attached to their customary role as impartial health experts, resulted in the medical profession incurring an almost unprecedented social and political cost for those concessions. There was widespread vilification of the profession for seeming to place hospital patients' lives at risk for the sake of a pay dispute with the government. It was of similar magnitude and intensity to the public opprobrium usually reserved for militant or protracted strike actions by trade unions, with whom many unflattering comparisons were made in the media reports on the dispute. The AMA's sustained public relations campaign following the settlement of the dispute was specifically directed towards shaking off the militant industrial image, and reinstating the profession as the impartial, but caring, experts on matters of health.
A power-knowledge approach to the analysis of medical influence over policy not only invokes different theoretical perspectives than a pure "power" or "knowledge" approach, but also reaches somewhat different conclusions about the outcomes of the same policy conflict. In this conflict about Section 17, a pure power approach might conclude that, in light of the considerable concessions granted by both the Federal and NSW governments, the medical profession as a whole succeeded in resisting unwelcome policy reforms by means of the heavy lobbying activities of the AMA and the surgeon groups. This conclusion is reached by reference to the locus of formal decisions through the dispute, beginning with the government's proposed Section 17 legislation, and ending with the repeal of that legislation and the funding concessions. Within this framework, the outcome is unambiguously a direct effect of the strong lobbying and negotiating capacities of the medical profession's organised interest groups, especially the strike action of the surgeons, and the continuous role of the AMA in bargaining with the state over the terms of settlement.

A pure "power" approach, restricted to the formal decisions of each policy conflict, cannot acknowledge any influence accumulated from the profession's previous policy dealings with the state, or any decline of influence which the outcome of current policy dealings might impose on future conflicts. It is in this sense that a "power" approach is entirely blind to the effects on future policy negotiations of the widespread public opprobrium directed at the profession during the final stages of the dispute. The AMA's sustained public relations campaign indicates that the profession itself was very aware of the decline in influence which could flow from that opprobrium. A "power"
approach to medical influence can only measure the immediate 'victory' aspects of the dispute, and give no recognition to its longer term costs.

Alford's "structural interests" approach, and Richardson and Jordan's notion of "policy community", can provide more adequate explanations for this policy outcome than that provided by the pure "power" approach. Both schema give due recognition to the potential of previous policy conflicts to impact on present ones, and to that of present conflicts to impact on future ones. "Structural interests" and "policy communities" are concentrations of influence which, by definition, have been accumulated over time. Changes in the scope of that influence relative to other groups and interests will, also by definition, directly effect the outcomes of future policy conflicts. In this way, these two pluralist extensions are not limited by the presumption of the pure "power" approach that the policy process takes place in a vacuum, with each policy episode historically and politically sealed off from all others.

However, their remains in both approaches the considerable difficulty of explaining away the substantial impact on the final outcome of the direct policy interventions by ministers of the Federal and NSW governments, epitomised by the very active participation of the Premier Wran and Prime Minister Hawke. Such participation belies Richardson and Jordan's notion of "post-parliamentary democracy", where closed, unelected "policy communities" exclusively control policy. It also underlines the inadequacies of Alford's conceptual schema of "structural interests", which literally has no category to
accommodate a significant policy role for government or the parliamentary process.

A "knowledge" approach to medical influence would draw different conclusions about the outcome of the NSW Doctors' Dispute. As with the pure "power" approach, the "knowledge" approach would regard the concessions made by the NSW and Federal governments as a measure of the success of the medical profession. While the former attributes this success to the doctors' lobbying activities, the latter would attribute it to the high social utility of the knowledge and skills of the medical profession, especially those of the specialist surgeons. As the turmoil created by the surgeons' strike dramatically illustrated, surgical knowledge and skills are a fundamental requirement for the smooth running of the public hospital system.

However, within its terms of definition, a "knowledge" approach cannot attribute any degree of influence to the intense lobbying activities of the medical groups, or to the strike action by the surgeons. This stands at odds with the experience of the major policy players, all of who explicitly acknowledged that the surgeons' actions were critical both to the development of the dispute, and to the terms of its final outcome. Indeed, a "knowledge" approach can have some difficulty accommodating the very idea of medical strike action; for such action directly contradicts its presumption of the high standing and rewards of doctors being a social trade-off for altruistic, non-commercial practice under the guidelines of a professional code of ethics.
This case study illustrates the general thesis that it is only by integrating the impact of both "power" and "knowledge" aspects of medicine that the policy influence of the medical profession can be more fully explained. While the core issues in the Section 17 phase were accepted by all policy players as essentially medical in nature, and so dependent on medical knowledge and expertise for their resolution, both mutually reinforcing arms of medical influence were at work within the policy process. The profession's formal role as "institutionalised experts on all matters relating to health",\(^5\) gave both legitimacy and authority to the activities of its well-organised - though sometimes divided - interest groups, while effecting a relative diminishment in that of other contending groups and interests. At the same time, those lobbying activities presented a more formidable source of resistance to the policy reforms of the government, because they were not mobilised by an ordinary health interest group, but by the acknowledged experts in the field. In this way, the full bilateral strength of medical influence was applied to the policy process. This strength was reflected in the monitoring of VMO incomes above the specified limits being left in the hands of the profession - through the Billing Review Committees - rather than in those representing wider social and political interests.

In the final phase of the dispute, however, when the core issues were no longer strictly medical in nature, the dynamics of medical influence changed. While the aggressive interest group activities of the surgeons were surely effective in producing several significant government concessions (even though the value of these relative the overall

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settlement package remains open to question), the impact of such activities was not tempered by the profession's health expert role. With no peer review mechanism through which to channel its political interests into the policy process in the form of nominally apolitical expertise, such interests were exposed to the full glare of public scrutiny, and the profession was uncharacteristically subjected to widespread condemnation as self-interested and callous dissidents.

Thus the cost of the concessions, won by industrial and political power, to the profession's future policy influence as the neutral authority of medical knowledge, may be extremely high. The "power-knowledge" approach, not being restricted to only one source of policy influence as the guide to medical influence, can more fully and more coherently explain the policy outcomes in this case study than either the "power" or the "knowledge" type of approach on its own.

**Medical fraud and overservicing**

In the case study on fraud and overservicing, the main medical peer review mechanism was the State-based system of Medical Services Committees of Inquiry (MSCIs). Many state health agencies and groups of health workers - including parts of the medical profession - had longstanding concerns about the structure and operations of the Committees. They were widely regarded as time-consuming, cumbersome and largely ineffective in processing cases of overservicing. Despite these concerns, and against the repeated recommendations of the Public Accounts Committee (PAC) to replace them with a tribunal system more independent of the AMA, the MSCI
system was retained with only marginal changes to its structure and operations.

The makeup of the MSCIs remained dominated by the medical profession, with all members required to hold recognised medical qualifications. Four of the five members were selected by the Minister from lists of nominations made by the AMA, while the fifth was nominated directly by the Minister.\textsuperscript{6} Because of the strong reluctance of doctors to be seen to be sitting in judgement of their colleagues, and the surviving legal and procedural restrictions which absorbed prodigious amounts of time and energy, they also remained very slow in the rates at which they processed cases of overservicing, and did very little to stem the increasing backlog of cases.

As noted in Chapter Four, the MSCI system leaves the essential defining, monitoring and prosecution of overservicing - the major source of Medicare benefits abuse - firmly within the hands of the medical profession. Despite the huge sums of public funds estimated to be drained from the Medicare system through overservicing, no other wider interests, groups or values, bearing different knowledges, skills and expertise, are given representation in the formal monitoring process.

The explanation for the development of such a policy arrangement - which has a lot in common with leaving the fox to guard the chicken

\textsuperscript{6} The only concession to non-medical expertise in the prosecution of overservicing cases lies in the Medical Services Review Tribunals (MSRT), which are established to review the decisions of MSCIs. The three-member tribunals are chaired by a person with legal qualifications. The other two members must be medical practitioners. See Medical Journal of Australia, Vol. 154, 15 April 1991, pp503-504 and pp563-564.
coop - lies in the conceptualisation of overservicing shared by all of the key policy players. This includes not only the medical profession's interest groups such as the AMA, but also those non-medical groups pushing hard for more rigorous and direct regulatory control over benefits abuse by doctors. As formally established at the beginning of the first PAC inquiry in 1982, overservicing is widely - almost universally - treated as "largely a matter of medical judgement". Under such a working definition, medical knowledge and expertise is deemed the only available means by which the occurrence of overservicing can be firmly established, and its extent reliably assessed. Such an approach to overservicing rests on the presumption that people without medical qualifications are intrinsically incapable of making informed assessments of the appropriateness or necessity of particular services provided by doctors to their patients.

A "power" approach to this study would suggest that the medical profession suffered a significant policy defeat as a result of the PAC's inquiry, and the legislation which was enacted in light of its recommendations. Almost all of the formal decisions made in response to the inquiry were aimed at limiting, and controlling more stringently, the medical activities of pathologists in order to reduce the impost of overservicing on the public purse. In this approach, the state, acting on behalf of taxpayers, health consumers and wider community interests, reformed health policy against the general objections of the medical profession.

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However, by measuring policy influence solely by reference to formal decisions, such an approach only considers one part of the outcome, and neglects that associated with the profession's role as health experts. With overservicing defined as "largely a matter of medical judgement", dependent on medical knowledge and expertise, the short-term costs to the profession of the legislation are overwhelmed by the long-term benefits inherent in not only maintaining, but expanding the formal role of medical peer review in monitoring and prosecuting overservicing by doctors under Medicare.

A "knowledge" approach to the overservicing study would also view the outcome as a loss to the profession, but for entirely different reasons. In this approach, the raft of changes to pathology arrangements implemented after the recommendations of the PAC inquiry are not the result of other pluralist groups winning on the day against the medical interest groups. Rather, they stem from a process of degradation in the social value of pathology expertise. This may be best characterised by the 25% cut in Medicare benefits imposed by parliament on the eighteen commonly performed tests. In effect, the increasing automation of the laboratory procedures involved in these tests significantly reduced the social market value of the medical knowledge and skills previously required to perform the tests manually.

However, a "knowledge" approach here not only fails to account for policy influence generated by medical interest group activities - positive or negative - but also ignores the potential of the increased

8. Ibid.
role of peer review to bolster the interests of the profession. The constancy of the pattern of MSCIs very reluctantly, and very slowly, processing overservicing cases; of the unwillingness of doctors to provide evidence against other doctors; and of the medical interest groups eagerly pointing to the small number of proven cases of overservicing as evidence of the general integrity of the profession - this constancy very strongly suggests that the process of peer review is neither innocent nor neutral in its application of medical knowledge and expertise. The power-knowledge approach emphasised in this research suggests that the outcome of this policy conflict does not represent a minor and isolated setback in the level of policy influence for the medical profession, but rather a significant consolidation of the medical dominance of health in the area of work autonomy and self-regulation, and of the formal means by which to maintain it.

**GP fees**

In the GP fees study, the peer review mechanism representing the institutionalisation of medical knowledge and power was the proposed Independent Peer Review Organisation (IPRO), later changed to the Descriptor Utilisation Review Committee (DURC). As originally contemplated, IPRO is the nearest we get in this research to an accountability mechanism with strong potential for effective monitoring and restraint of medical fees under Medicare. Its general provisions for random audits of GP practices, for reviews of individual providers' patterns of benefits claims, and most significantly, for the participation of non-medical representatives in the review process, promised to ensure a high level of compatibility between the type of
service received by the patient and the amount of fees claimed by the GP through Medicare.

However, IPRO was only ever a vague idea hastily conceived by the Hawke government to give the appearance of some systematic control over the costs of the new fee system for GPs. It was clearly recognised at the outset that any fees system needed some form of cost containment mechanism. Such a mechanism was an inherent part of the old time-based fees system, and took the form of the limiting effect ultimately imposed by the number of consultations that can be fitted into an acceptable length working day. While it was a very loose and limited form of control, it did allow for the easy monitoring by the Health Insurance Commission (HIC) of GP practice profiles which strayed significantly from the norm.

In a pure content-based fees system like that originally proposed by the AMA and the Royal Australian College of General Practitioners (RACGP), the government's budgetary need for some form of cost control mechanism is considerably greater than it is in a time-based system. Under a content-based system, GPs are given total discretion in assessing the medical content of their services and allocating them to corresponding fee categories. This discretion increases the potential for GPs to maximise their Medicare incomes by arbitrarily allocating a greater proportion of their services to high-content, high-cost categories, untrammelled by global time limits.

While the need for cost control is greater in the content-based system, its implementation is more difficult. Unlike a time-based system, a pure content-based system has no containment mechanism - however
loose or limited - which is already built into its structure. This problem was epitomised by Health Minister Blewett's comments on the open-ended nature of such a system:

Patients would have no way of knowing what type of service they were getting, and the Government would have no way of knowing whether the service described was actually given.\(^9\)

Such concerns provided the rationale behind the government's final compromise solution of a system based on both time and content, with the length of an acceptable working day again providing a workable outer boundary on cost. However, with GPs able to choose either time or content as the basis for their fee claims, the system required a further, external mechanism for monitoring aggregate GP service costs. This was the task originally envisaged for IPRO.

Because the government had insufficient time to work out the operational details, IPRO went before parliament as a general proposal to establish a body to monitor and regularly audit GPs' use of the descriptors in the new fee system. It was also to perform the function of reviewing their patterns of referral, prescribing and diagnostic testing. The operational structures and procedures were to be developed by the health minister after the legislation authorising the establishment of IPRO had passed through parliament.

Despite an intense and bitter conflict between the AMA and the RACGP over other aspects of the fee reforms, the profession's industrial and educational arms were temporarily reunited in most vigorously opposing the IPRO proposals. Both raised serious concerns about the potential for political control of the review process for the

new fee system, and the level of bureaucratic interference in clinical decisions it implied. This strategic reunification, and the strong support the profession received from the Coalition and the Democrats on the primacy of peer review, resulted in the scuttling of IPRO.

A "power" approach would recognise elements of both victory and defeat for the medical profession in the outcomes of this case study. In this approach, the disunity between the AMA and the RACGP, and the state's 'divide and rule' exploitation of it to force a compromise fees system, are viewed as an episodic reduction of the medical profession's interest group power over health policy. The reunification of the two medical groups, and their successful lobbying of the non-government parties in order to abolish the IPRO proposals, might be read as an episodic increase in the medical profession's interest group power over health policy.

However, there was also a "knowledge" factor which both reflected and reinforced this interest group influence. IPRO did not get implemented as originally envisaged because all parties involved in the dispute acted within the presupposition that the assessment of GPs' clinical decisions could only be performed by medical staff with medical knowledge and expertise. Again, peer review by other medical practitioners was seen as the only viable means by which the medical content of specific services, and the appropriateness of the fee categories under which benefits were claimed by GPs, could be monitored and assessed.

This is illustrated most strikingly by the Senate Select Committee's reports on the confusion created by the two different meanings often
attributed to the term "peer review" within IPRO's title. One meaning was as a form of in-house service quality control by medical peers, the other as a form of intrusive surveillance of GPs' clinical practices by non-medical government bureaucrats. The vigorous protestations by government politicians and state health agencies that the latter meaning had never been - and, moreover, should never have been - contemplated for IPRO's function, testifies to the pervasiveness of the presupposition about who is capable of evaluating medical decisions.

As noted in Chapter Five, even the quality control form of assessment mechanism was ultimately abandoned. During the negotiations between the state and the medical organisations over the reforms, the proposed role of DURC (the "son of IPRO") gradually shifted from fees monitoring and review body, to general GP research coordinator. Unable to reach consensus on what DURC could do and who would do it, the proposal was quietly and completely scrapped. This represents both an acknowledgement by the government that GPs' clinical decisions can only be authoritatively monitored by those with medical expertise, and a declaration by the medical profession that it is very reluctant to provide such expertise on a large scale when it may be used against the interests of its members.

The overall effect of the new fees system, then, was to actually reduce the level and efficacy of public scrutiny of GPs' benefits claims relative to that of the previous time-based system. While a simple "power" approach might, on balance, conclude that there was very little or no overall change in medical influence here, the power-knowledge approach identifies a significant consolidation of medical dominance. The abolition of both IPRO and DURC further entrenches the
profession's autonomy over its work, with a formal precedent being set for the sequestering of GPs' clinical decisions from any form of outside scrutiny.

**Aged care and birthing**

In the aged care and birthing studies, the policy players do not identify the issues at stake as predominantly medical in nature, and thereby ultimately dependent on medical knowledge for resolution. Rather, they are seen as issues with implications extending beyond the confines of the medical, involving wider arguments about the rights of consumers to participate in decisions about the content and scope of the health services they receive, and the types of health workers who provide them. As a result, knowledge, expertise and experience borne by people other than doctors - such as social workers, physiotherapists, lay carers, midwives and, most significantly, the consumers themselves - is directly and legitimately applicable to the development of policies involving both the care of the aged and the management of birth.

The limitations on medical dominance of these two policy areas is indicated both by the lack of a monopoly by the medical profession over relevant expertise, and by the active, state-validated participation of clients and other health workers. During all of the negotiations around the provision of aged care and birthing services, there was not even the suggestion of medical peer review as the primary means for assuring service quality or provider accountability - precisely because the issues involved ranged well beyond the medical. Without the policy influence attaching to the position of sole cognitive authority, and the
peer review mechanism through which to channel it in the guise of technical expertise, the medical profession had to rely entirely on the influence generated by its organised interest group activities in opposing the reforms. Against the lobbying campaigns of the other interest groups, the divisions within the profession, the organisational impediments of the Federal-State axis, the strong economic arguments for the reforms, and the high level of community and political support for them, such influence on its own was insufficient to effect the "remedicalisation" of aged care and birthing.

This is not to suggest that the medical profession suffered a crushing blow to its autonomy and policy influence in these two areas, or that other groups of health workers now fully control their direction and content. Indeed, by any measure, the medical profession remains in the dominant position. While other health groups, through the Aged Care Assessment Teams (ACATs), tend to control decisions about where aged clients will be treated - at home, in a hostel or in a nursing home - their GPs ultimately retain control over what sort of medical services they receive, and over the timing of their provision. Similarly, independent midwives can now legally supervise the entire birthing process of their clients without reference to medical authority, and have parts of their costs underwritten by public funds. However, while this represents an unequivocal reversal in the process of subordination of traditional midwifery to medical authority, the extent of the change in practice is very limited, with homebirths accounting for less than one percent of all births in Australia.10

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The significance of the aged care and homebirth cases lies in their support of the general hypothesis that both medical power and medical knowledge constitute the policy influence of the medical profession, and that the level of medical dominance is precisely related to the extent to which they interact to define as medical the nature of the issues involved in particular health policy conflicts. Where the medical knowledge conduit of influence is missing, or compromised by the presence of other bodies of knowledge recognised as providing relevant expertise, then the medical power conduit on its own may not be sufficient to retain full medical dominance. In the aged care case, the policy influence of medical knowledge is compromised by the majority representation on the ACATs of the expertise of other health workers, such as nurses, social workers and physiotherapists. In the birthing case, its influence is compromised by the state's legitimisation of the knowledge and expertise which accredited midwives bring to the practice of birth. In both cases, the preferences of the 'lay' client are given significant formal recognition in the decision making process. The attenuated influence of medical expertise associated with these lay and non-medical forms of expertise is confirmed by the absence of a medical peer review mechanism as the final authority over the decisions made by ACATs and the independent midwives.

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The notion of peer review as an instrument of health authority and accountability presumes a conceptual separation between medical knowledge and the interests of the organised medical profession. However, as we saw in Chapter Two, the social construction of medical knowledge (and indeed, of all types of knowledge) makes
problematic the notion of a body of objective, technical knowledge existing entirely separately from the values and interests inherent in the social context of its production. Within traditional approaches to science and medicine, medical knowledge is treated as an expanding collection of objective and universal facts, cumulatively discovered in Nature by the application of rigorous scientific methodology, and having an existence independent of the society which finds them. Within the constructivist approach, medical knowledge is treated as a collection of artefacts, shaped by the very process of discovery, and by the continual process of interpretation and renegotiation within the medical science community, and within society at large, about their significance for our concepts of health and illness. These artefacts of medical knowledge are thereby infused with some of the values and interests prevailing there. Given the exclusive control over medical knowledge held by the profession, and the privileging of scientific knowledge in general in Western societies since the Enlightenment period, the knowledge applied through peer review mechanisms cannot be expected to be pure, innocent and technical, nor the expert determinations they produce to be entirely free from "contamination" by medical interests. In other words, peer review mechanisms cannot realistically be expected to perform the very role they are so routinely and so uncritically assigned.

Evaluating the evidence
The case studies presented here provide strong support for the hypothesis about the mutually reinforcing influence of medical knowledge and medical power on health policy. While five case studies may not provide an extensive base of empirical evidence, these cases
are broadly representative of health policy in Australia - to the extent that it is very difficult to identify policy areas which can be characterised by unchallenged medical dominance, but which do not have medical peer review as the final authority for accountability and monitoring procedures.

The state has been able to impose various forms of indirect influence on the mix of medical service provision (seen for example in the financial incentives for longer GP consultations in Chapter Five), on the scale of applicable fees and benefits (as seen in the 25% cut to commonly performed pathology tests in Chapter Four), and on aggregate volumes of some services (as seen in the use of waiting lists for hospital procedures under Medicare). However, the state has been unable to directly control the type of services provided.

Indeed, the traditionally high level of professional autonomy enjoyed by doctors can be directly linked to the state's formal capacities to control some of the conditions or the terms of medical work, but not its content. The clinical decisions of doctors - to order a CAT scan, to refer to a specialist, to prescribe a particular drug, to perform a hip replacement - have been quarantined from direct state intervention and scrutiny. Such quarantining has been a defining characteristic of every health care system in Australia, under any type of government, and has been almost universally endorsed - sometimes explicitly, more often implicitly - by all other political parties and community interest groups.

The operationalisation of that autonomy over content can be clearly seen in the self-regulating capacities provided to the profession by
medical peer review mechanisms. Such mechanisms provide much of the strategic firepower behind the maintenance of medical dominance over health policy. In the Australian health system, there is a standard, routinised acceptance of medical peer review mechanisms as the only politically and "technically" feasible means of scrutinising the quality of service provision and medical judgement. It is in this sense then, that the conclusions based on these case studies are generally applicable to other health policy areas.

In this research, I do not present any direct, unambiguous evidence which can incontrovertibly establish the occurrence of medical representatives deliberately and systematically manipulating the procedures of peer review mechanisms to protect professional interests. Any "subjective" elements contained within the "objective" assessments made by peer review committees are hidden from view, precisely because they are defined out of existence by the principle of technical expertise on which the operation of such committees is predicated. As such, they remain impervious to systematic analysis by independent observers. The formal prerequisite of medical knowledge built into the structure of peer review preempts the access of such observers to the necessary evidence, and simultaneously denies any legitimacy to their conclusions. Indeed, adopting the principle of medical peer review fundamentally limits the formal scope of any outside scrutiny. All determinations made under its auspices are already presumed to be wholly technical in character, and thereby beyond evaluation by all but those with expertise based on medical knowledge.
However, if we apply the question which distinguishes Steven Lukes's approach to power from that of the pluralists - "who benefits?" rather than "who decides?" - we can point to indirect evidence strongly suggestive of peer review mechanisms being used by the profession in this way. For example, as discussed in Chapter Four, the peer review based MSCI system for dealing with overservicing clearly benefits the profession by severely limiting the total number (and extent) of cases it processes. The high public esteem for the profession remains protected from the taint of generalised corruption by the emphasis on the actions of "a few bad apples", an emphasis which carries with it the strong implication that the overwhelming majority of doctors are never involved in such actions. The integrity of doctors' public image as ethical, expert healers, only peripherally concerned with material rewards, is consistently reinforced over time, because the number of cases of proven overservicing remains almost negligible relative to the total number of services provided under Medicare. At the same time, these small numbers lend considerable weight to the argument that the profession has sufficient administrative capacity to comfortably manage the problem of overservicing among its members, without the need for external assistance and controls.

As an example of the "few bad apples" strategy, the Federal AMA vice-president was able to make the nominally correct claim, in responding

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12. For a good example of this approach, see the editorial comment in the Canberra Times a few days after the release of the Public Accounts Committee's third report on fraud and overservicing. Under the heading of "Fraudulent Doctors", the editorial laments the revelations that "millions of dollars of public funds are being paid to practitioners who over-diagnose and over-test their patients." It attributes the practice to "a minority of doctors", to "the few bad apples [who] are giving medical entrepreneurs a bad name, because of the ingenuity they display in milking Medicare", and finally to "loopholes in the Medicare legislation for the sharp operators to exploit." Canberra Times, 14 September 1985:2.
to the dramatic new evidence to the PAC inquiry about widespread kickbacks, "sink testing" and death threats in the pathology industry, that "only 10 out of 25,000 doctors claiming Medicare fell into the overservicing and fraud group". 13 Similarly, when it was reported in 1988 that the level of medical fraud and overservicing had risen to $300 million per year, the Federal president of the AMA was able to claim that "in five years only a handful of Australia's 35,000 doctors had been found guilty of fraud or overservicing". 14

Equally clearly, the state, and the general community of interests it represents, is disadvantaged by the operation of the MSCIs. The state formally endorses the MSCI system and validates the scope of its legal authority, while the community funds both the small proportion of unnecessary medical services which come before the MSCIs, and the large majority which do not. Both sets of interests are compromised by the large shortfall which exists between the amount of public funds recovered through the MSCIs, and even the most conservative estimates of total overservicing losses. The state and the community also incur the opportunity costs associated with public funds being diverted away from the maintenance or expansion of public health programs, into the private pockets of doctors who overservice.

While it is not possible to precisely map the thinking processes occurring within the minds of the MSCI members, we can confidently assume that it is very difficult for them to clearly separate their

13. *Australian*, 24 October 1985:2. This is vastly different from AMA president Dr. Lionel Wilson's estimate towards the beginning of the PAC inquiry in 1982 that "about 900 doctors out of a medical workforce of 27,000 were involved in gross abuse of the system*. *Australian*, 4 February 1982:1.

assessments of the medical necessity for the specific services under review, from the impact such assessments can have on the perceived integrity of the profession as a whole. As discussed in Chapter Four, this difficulty was reflected most markedly in the claim by conservative GP Dr. Johdi Menon that doctors participating in MSCIs place themselves within an irreconcilable conflict between professional and public interests. In urging his medical colleagues not to cooperate with the MSCI system, he claimed that because the review process necessarily breaches doctor-patient confidentiality, MSCI members (as well as the doctors standing before the committee) were acting in breach of the AMA's code of ethics, and so should face expulsion.\textsuperscript{15} The difficulty of separating the medical from the professional is also reflected in the continued reluctance of doctors to provide evidence against other doctors.\textsuperscript{16}

This is not to suggest that the individual doctors sitting on MSCIs deliberately conspire to impede the review process in order to avoid bad publicity for the profession. Rather, it is to suggest that both the content of the medical expertise represented by MSCI members, and the ways it is applied to the review process, are necessarily shaped by the social context in which they occur; and that a significant part of that social context is the high public esteem for doctors as the holders of medical knowledge based on rational science, and as trusted

\textsuperscript{15} Australian Dr Weekly, 1 February 1991:6. The continuing conflict between professional and public interests is also illustrated by the reports of Medical Counsellors in the HIC "conspiring to ensure providers were seen as cases for counselling rather than targets for fraud investigation". Advertiser, 17 December 1992:7.

\textsuperscript{16} See for example, Brian Howe, Minister for Health. News Release, "Howe to step-up crackdown on pathology rorts", 28 April 1992. Howe notes here that officers investigating fraud and overserving practices "encountered an unwillingness on behalf of those with detailed information to testify or provide evidence".
experts in health, rather than as income maximisers providing unnecessary services. In other words, members of the MSCIs do not, and can not, make their assessments whilst entirely blind to the collective consequences of adverse findings.

Circumstantial evidence in support of such a conclusion is provided by the historical reluctance of doctors to sit on the MSCIs, the consistently low rates of case processing by the MSCIs, the disinclination of the profession to significantly reform their procedures, and the strong indications that the overall level of overservicing has remained very high.17 Supporting evidence is also provided by the profession's sustained resistance to moves by the Health Insurance Commission to gain access to clinical records for evidentiary use in the prosecution of overservicing cases. This resistance has continued despite detailed HIC proposals for stringent "de-identification" protocols to satisfy the provisions of the Commonwealth Privacy Act 1988, and to avoid any breaches of doctor-patient confidentiality.18

The indirect nature of the evidence here is related to the methodology used in its production. When seeking to identify policy influence

17. On the basis of evidence in a 1992 in-house report by consultants Harvey Bates and Company on the HIC's performance in investigating benefits abuse under Medicare, the Australian National Audit Office suggested that the previous estimate of 7% of total benefits was still applicable. As Labor backbencher Mr. Chris Haviland told parliament, with total benefits amounting to $4.5 billion, this places the current estimated level of fraud and overservicing at over $300 million. 
Sunday Mail, 30 May 1993:9; and Australian Doctor, 15 January 1993:1, 2. Other reports suggest that the total figure is $400 million annually. Advertiser, 20 September 1993:4; Australian, 20 September 1993:4.

18. On the profession's resistance to giving the HIC access to clinical records, see for example, Australian Doctor, 19 February 1993:1,2; 16 April 1993; and 13 August 1993:1. On proposed "de-identification" protocols, see Health Insurance Commission (1993), "Medicare and fraud and overservicing: What the Health Insurance Commission proposes", in Health Issues, 36 (September), pp6-10.
according to Lukes's question of "who benefits?", we are confronted by the normative character of the means applied to answer that question. In suggesting that the medical profession benefits from the MSCIs at the expense of the state, we are unavoidably specifying what the profession's and the state's interests are (or ought to be), and how they are promoted or repressed. Implied here is a qualitative difference between the state's perceived or "subjective" interests in legitimating peer review of overservicing, and its "real" interests in replacing the MSCIs with some form of more broadly based scrutiny. Lukes's methodology also implies the researcher's ability to positively identify this difference, and the state's - and all of the policy players' and community groups' - coexisting inability to identify it. As Lukes himself reminds us, "the notion of 'interests' is an irreducibly evaluative notion", laden with the observer's unstated value judgements.¹⁹

This limitation, in turn, is part of a more general difficulty with Lukes's "third dimension" of power. Its scope is considerably larger than the pluralists' conception of power, which is restricted to the observed decisions of those in formal positions of power within the structure of established political institutions. This is generally the sort of approach taken in interest group power accounts of medical dominance, and is quite amenable to direct empirical verification through the tracking of those formal decisions. However, because it rests not on observable, formal actions but on unofficial, implied actions, the occurrence of "third dimension" power is much more difficult to demonstrate through direct empirical evidence. On the

other hand, not being amenable to direct empirical proof does not make the hypothesis implausible. It simply calls for the use of alternative means of verification. Lukes's suggestion of the counterfactual as the test for the strength of the available supporting evidence can be usefully applied to the MSCI example.

To do this, we are seeking an answer to the related question: "Given the choice, and given fuller information on the MSCIs, what approach to overservicing would be preferred by the state and by the community interests represented in health policy?" If it is accepted that the state and the community would, under these conditions, choose an overservicing review mechanism which is qualitatively different from the existing MSCI mechanism - by significantly increasing both the intensity and the breadth of the scrutiny process, for example - then to this extent, the hypothesis that the medical profession is exercising "third dimension" power over this area of health policy is supported.

The same sort of process can be applied to the other case studies where it is suggested that medical dominance has been maintained or extended. In the Section 17 phase of the study in Chapter Three, the question would take the form: "Given the choice, and given fuller information on the implications for cost control of the Billing Review Committees, what approach to VMO payments would be preferred by the state and by the community interests it represents?" Similarly, in the GP fees study of Chapter Five, the question would take the form: "Given the choice, and given fuller information on the implications for cost control of the abolition of IPRO/DURC, what approach to GP rees monitoring and review would be preferred by the state and by the community interests it represents?" If it were anticipated that the
answers in both cases would be significantly different to the existing arrangements, then the implication of "third dimension" power underwriting medical dominance is again supported.

Reconstituting peer review

If we wish to place limits on medical dominance and open up health policy to serve broader social interests, then we need to change the principle of medical peer review which, reinforced by organised medical lobbying power, underpins that dominance. I do not refer here to the more intensive application of peer review as currently defined, but rather to the extension of the concept of peer review to include non-medical knowledge and skills. Such a reconstituted peer review counts as "peers" not only the medically qualified, but also those groups significantly effected by the content and delivery of the type of medical services under review. Given the wider social implications of the way medical services are organised in Australia, and of the extent to which they are publicly funded; and given the social and political priority afforded to health issues in general, such a definition of the term "peers" could be expected to embrace representation from all main sectors of the community.

This is not to suggest that peer review mechanisms be established with memberships covering every social, political and economic interest related to health. Rather, it is to suggest that health policy become more like other areas of social policy in the breadth of community interests represented in its development and evaluation processes. Education and welfare policies, for example, have considerable representation from the teaching and social work
professions, but neither is dominated by it. Domination by one group is preempted by the traditional representation of other groups, such as other professions and workers in the field, a range of state agencies actively involved in social policy, and the main groups of consumers and clients. In the same way, a reconstituted peer review has the potential to limit medical dominance by exposing patterns of medical practice to the direct scrutiny of other health professions and workers, representatives of the government and its health agencies, and the major groups of health service consumers and general community interests.

To illustrate how such a concept of peer review might be operationalised, consider the Section 17 case from Chapter Three. Rather than the doctors-only Billing Review Committees, the medical decisions and patterns of practice of VMOs could be subjected to the scrutiny of review committees comprised of both medical and non-medical staff of the hospital, such as nurses, administrators and social workers, Health Department and HIC staff, and representatives from local patient and consumer groups. To prevent the non-medical interests being swamped by the medical interests, as Margeret Stacey argues has occurred recently with the lay representatives on Britain's General Medical Council,\textsuperscript{20} or vice-versa, the numbers representing each could be evenly balanced, with an independent chairperson.

If the review were to be guided by norms of "customary, prevailing, reasonable" medical practices\textsuperscript{21} over a range of procedures and


treatments, then explanations can be readily sought from those providers deviating significantly from the norms. Rather than leaving it entirely to medical professionals to decide whether a particular pattern of practice (leading to a particular pattern of VMO payments) can be justified, a multi-interest committee can be empowered to make these determinations. Such a committee would have a weaker, more diffused incentive to protect medical interests, and would be likely to accept a narrower range of variations from the practice norm than would a peer review committee composed entirely of medical practitioners.

However, while such multi-interest committees might be able to help constrain the rate of increase in VMO costs, they can neither fully nor directly control it. For under these arrangements, the medical profession retains control over the central measure by which work practice appropriateness is evaluated: the norms of "customary, prevailing, reasonable" practice. While the committees can be useful in monitoring variations from the established practice norms, they have no role in actually determining what those norms are, or indeed, what they should be.

This function lies entirely within the control of the medical practitioners, who currently have exclusive use of and control over the medical knowledge and expertise which fixes the central reference points for the norms. Under this system, non-medical staff and other wider interest groups have no say on what constitutes a reasonable or acceptable practice norm. Conversely, medical staff have no obligation to justify what they designate as practice norms, because they
represent the ultimate cognitive authority over the development of such norms. The main limitation on effective cost control here is that if VMOs cannot maintain their incomes by making their patterns of practice fit within the norm, then they may attempt to make the norms fit within their patterns of practice. Within this type of review system, the VMOs have both the financial incentive and the formal capacity to do so.

The "common fee" policy implemented by the Gorton government in 1970 provides an illustration of the ability of medical groups to 'shift the goal posts' in this way. It was suggested in the GP fees study in Chapter Five that when specialist groups realised that government surveys of fees being charged for a range of services and procedures would be used as the basis for setting general fee scales, specialist groups artificially inflated the fees they claimed to charge. This effectively established a significant gap within those scales between specialist and GP fees for the same service - a gap that has been generally maintained to the present.

In other words, the specialists shifted the practice norm. Having accepted medical norms as the exclusive guide to service fees, there was no means by which the government could independently verify or counter the specialists' claims. While this represents the shifting of a fees norm, there is no intrinsic barrier within medical peer review which would prevent the shifting of a clinical practice norm in a similar manner. Indeed, such an shift seems more likely given that the development of clinical norms, unlike fee norms over which the government can exert some global controls, lies entirely within the hands of the medical profession.
The only way to effectively impose direct controls over VMO payments is to broaden the membership of committees for conventional peer review of clinical decisions to include not only medical peers, but also non-medical, community and government "peers". All have a legitimate vested interest in the efficient and effective use of health service resources. Under this more broadly based peer review system, such representatives can make formal assessments of the appropriateness of particular practices and decisions made by medical practitioners. In so doing, they help to legitimate the counter-intuitive notion of non-medical members 'getting inside' the knowledge which is used to both inform and justify medical judgements. In this position, they can make more explicit the social constructs of that knowledge, and the interests they may serve. They can openly separate those components or constructs of the knowledge which may promote the practitioner's interests, from those which may promote the patient's and the community's interest, and decide on the most appropriate balance between them. In other words, reconstituted peer review mechanisms which include non-medical members can reveal as political that which may under medical peer review be presented as technical.

Moreover, there is nothing inherent in the nature or content of medical knowledge which makes it inpenetrable to non-medical members. As seen in Chapter Two, the content of medical knowledge, what is accepted as correct, factual knowledge at a given time within a given society, is largely the product of extended negotiations between various competing factions within the medical and scientific community, informed by the dominant Western paradigm of rational
science. Medical knowledge is not a collection of universal facts progressively discovered by researchers, but is the locus of consensually negotiated interpretations of the significance of various research outcomes and phenomena, first within the scientific community, and later within the general community. There is no fundamental reason why non-medical members of the committees cannot be involved in debates about the appropriateness of particular VMO decisions, getting briefs on the different interpretations of them, and making an assessment of their relative strengths - informed not by the need to protect narrow medical interests, but by the need to protect wider community interests in the area of health.

Non-medical members, then, can be directly involved in assessing the appropriateness of VMO decisions from within the inner sanctum of medical knowledge, rather than waiting in the nave to receive the secretly devised pronouncements of the medical high priests. In this way, the temptation to represent medical assessments, whose conclusions protect the profession's political and industrial interests, as technical, dispassionate and apolitical, is effectively precluded. Moreover, the efficiency and the level of community control over these decisions is increased by their exposure to assessments based not only on narrowly medical appropriateness, but also on wider social parameters, such as social justice, equity, and the opportunity costs involved of allocating additional scarce health resources to VMOs rather than to other areas within the health system.

A second example of how it might be possible to implement a reconstituted form of peer review is provided by the pathology case study. As seen in Chapter Four, when the Hawke government
abandoned the PAC's proposal for an independent Medical Benefits Tribunal system, it lost all potential for effective and direct control over benefits abuse by the medical profession. The retention of the MSCI system leaves the definition of overservicing, and the determination of its occurrence, entirely within the control of the medical profession.

To make practitioners more accountable for the financial costs of the decisions they make when they order pathology tests, prescribe pharmaceuticals, provide consultations or perform procedures, it is necessary to counter the effects of the perception of the members of medical peer review committees that a conflict exists between their role as representatives of their profession, and that as guardians of the public purse which underwrites those costs. While only medical professionals are in a position to determine the appropriateness or otherwise of clinical decisions, the effectiveness of peer review mechanisms will continue to be qualitatively limited to the extent to which such perceptions of role conflict remain.

This type of conflict of interest arises even where medically qualified staff from state health agencies are involved in the review process. As the AMA president, Dr. Brendan Nelson, acknowledges in relation to the "conflict-of-interest situation" created by the involvement of medical representatives of the Health Insurance Commission (HIC):

> It must be quite difficult for a medical employee of the HIC to sit in judgement on doctors, because they would have a loyalty to their employer, the Government and a loyalty to the profession.\(^{22}\)

\(^{22}\) Australian Doctor, 4 June 1993:1,4.
It is only by allowing representatives from other health-related occupations, from health agencies, and from the wider publics of patients and citizens - bearing different types of expertise and allegiances - to help make determinations on clinical appropriateness, that peer review mechanisms can become more vigilant in protecting the public interest from the impact of overservicing under Medicare.

There has been some notable success in reducing the volume of pathology services under Medicare by making providers aware of the direct cost implications of their clinical decisions. The effect is most pronounced where doctors have the cost data available to them at the time of ordering, and where they can see how their patterns of ordering compare with those of their peers. For example, the provision of such information by the HIC to medical practitioners ordering high volumes of pathology services was associated with significant decreases in both the number of episodes in which pathology services were ordered, and the number of services per episode.23

However, the effect of such a tactic is limited in that only those practitioners with some level of commitment to aggregate cost restraint will voluntarily and conscientiously minimise the number of unnecessary pathology services they order. Those practitioners who place a higher priority on personal income maximisation can continue to provide significant numbers of services which are not medically necessary or which have only marginal clinical effect.

23. Deeble, J. and Lewis-Hughes, P. (1991), Directions For Pathology, National Health Strategy, Background Paper No. 6, July, Melbourne: NHS, Chapter 4. For claims that cost data and comparison letters sent by the HIC have reduced the total volume of tests ordered by GPs, see Australian Doctor, 12 March 1993:4.
In the short term, income-maximising practitioners are protected by the traditional reluctance of their medical colleagues to testify against them, as well as the legal and administrative burdens which prevent the MSCIs from processing all but a very small portion of potential overservicing cases. In the long term, they are protected by the medical profession retaining monopoly rights on defining and identifying cases of overservicing, so that all other non-medical staff are excluded from the process of making them more directly accountable for their medical decisions and patterns of practice.

Moreover, the cost-awareness tactic may inflate provider fears about the prospect of an overservicing investigation by the HIC, so that GPs who are relatively high level orderers may be "scared" into "reducing orders of necessary pathology tests."\(^{24}\) Alternatively, it could "frighten some GPs into treating problems they were not trained to handle instead of referring them to specialists".\(^{25}\) As a Melbourne pathologist suggested of the volume reductions associated with letters sent by the HIC to GPs about the cost of their pathology services in 1991 and 1992, "it is yet to be proven that the [reduction in ordering] effect was on the good guys or the bad guys".\(^{26}\)

Cost awareness is also ultimately limited in its impact on the conscientious practitioners who presumably make up the bulk of the profession. As the shock effect or novelty value of the cost-awareness letters wears thinner with each successive reminder - especially where

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unchanged practice patterns fail to trigger overservicing investigations - decisions about the necessity of tests are going to be less informed by their implications for government health budgets and more informed by their implications for personal income.

This is not to suggest there will be a wholesale shift within the profession from conscientious practitioners to income maximisers. Rather, it is suggesting that if a gap - perceived or otherwise - develops between the level of income received by practitioners and that at which due recognition of cost implications can be comfortably afforded, then more practitioners will have to make an either/or choice between their own financial interests and those of the community at large which pays for pathology services through Medicare. Under such conditions, and in the context of static health budgets, it can not be reasonably expected that cost-awareness approaches, by themselves, will significantly constrain volume and cost aggregates for pathology services in the long term.

The core of the overservicing problem is that it is the providers themselves who exclusively determine what overservicing is, whether or not it has occurred in particular circumstances, and, if it has occurred, to what extent. In the area of overservicing then, the perpetrators, the police, the jury and the lawmakers are all drawn from the same professional group. It is only by admitting other forms of knowledge from groups outside the medical profession into the process of actually defining overservicing that it can be monitored without conceding overall primacy to medical interests.
As implied by the discussion of the GP fees case study earlier in this chapter, the proposed Independent Peer Review Organisation (IPRO) is quite closely aligned to the reconstituted model of peer review advocated here. Under this model, the use of the fee descriptors by GPs to categorise the medical services they provide would be subject to review by a committee consisting not only of medical peers, but also of representatives of other health worker groups and community interests, and staff from state health agencies, such as the HIC.

Assessing the degree of congruence between the presenting symptoms of a GP’s client, the content of the service provided, and the category of fee claimed for that service, is not innately beyond the cognitive abilities of such non-medical peers. This is not to suggest that all such peers need to acquire medical training in order to understand the content of individual medical services provided by GPs and the rationale for providing them. Rather, it is to suggest that there exists no wholly objective, incontrovertible knowledge informing clinical decisions about treatment or the categorisation of the content of specific services. The very wide variations in practice patterns amongst doctors is testimony to the inexactness of their cognitive base, as is the notion, discussed in Chapter Two, of clinical medicine as both art and science. Individual GPs routinely respond to the same presenting symptoms with different types of treatment and management plans, falling under different descriptor categories. Given the limitations of medical knowledge in this regard, it is clear that the medical peer review system of accountability cannot be relied on to produce wholly impartial determinations, informed by technical expertise.
Nor can review systems based on other forms of knowledge be relied on to produce impartial assessments. If it is accepted that all knowledge is in some ways conventional and interpretive, then no combination of medical and non-medical knowledges, regardless of their scope and variety, can produce entirely neutral determinations. The involvement of non-medical knowledge in reviewing the use of GP fee descriptors is not aimed at bringing medical assessments closer towards an ideal of objective, non-partisan measurement. Rather, it is aimed both at openly recognising the value-laden nature of medical expertise, and at extending the types of values implicit in the review process beyond those solely representative of medical interests. Thus the reconstituted peer review mechanism suggested above would base its determinations on the knowledge and experience of the non-medical health workers, the health agencies and the client groups, not because they can improve on the objectivity of medical determinations, but because of broader, more democratic range of community interests they represent.

We might expect some resistance from the medical profession to such proposals to reconstitute peer review, since they represent a significant potential decline in the traditionally high level of autonomy over the content of work enjoyed by the profession, and thereby over the level of income derived from fee-for-service practice under Medicare. This is especially so in light of the reluctance of some sectors of the profession to implement formal procedures for peer review in even the more restricted sense of in-house quality control over practice standards. For example, it was not until late 1993 that the Royal Australasian College of Surgeons (RASC), acknowledging the increasing "community pressure for more accountability", first moved
towards a formal auditing procedure of its members' practice skills and continuing education standards.\textsuperscript{27} If such "community pressure"\textsuperscript{28} can produce only a gradual and reluctant acceptance of review by medical peers, then it cannot be expected that the profession would actively encourage or embrace the development of review by outsiders.

There may well be strong support for the profession's position from sections of the community at large. As noted in Chapter Two, the notion of non-medical personnel making assessments about what are widely perceived to be wholly medical decisions and judgements is, to a large extent, counter-intuitive. It goes some way beyond our normal understandings of what is medical and what is not, and proposes instead the application of "outside" knowledge to decisions based on "inside" medical knowledge. The notion of a reconstituted peer review process brings into the medical realm that which customarily resides outside it. It rests on the plausibility of the proposal that people without formal medical training have the cognitive capacity to get "inside" medical knowledge, and to assess the appropriateness of decisions made by practitioners on the basis of expertise derived from that knowledge. It exposes medical knowledge and expertise to non-medical scrutiny and assessment.

While fierce resistance from the medical profession to such lay scrutiny is almost inevitable, given its potential impact on work autonomy and control over income levels, the level of resistance from other sectors of the community is far less certain in both scope and

\textsuperscript{27} *Advertiser*, 30 November 1993:3.

\textsuperscript{28} *Ibid.*
intensity. Indeed, given the potential cost savings associated with reconstituted peer review, it seems more likely in the long run to attract considerable community support. On the other hand, the scope of the political support for the profession's opposition to the proposed reforms is directly dependent on the capacities of the profession to define the issues around the scrutiny and accountability of doctors as essentially medical in nature, and so ultimately dependent on medical expertise for its operation. It is also dependent on the willingness of the community to generally accept a counter-intuitive definition of peer review. Because we so widely and uncritically accept science-based knowledge as objective facts, it requires something of a leap in logic to accommodate the notion of subjective non-scientists critically reviewing both the content and the application of such "facts".

The level of initial community acceptance for these changes to peer review may well be quite low for two reasons. Firstly, knowledge based on rational science is to a large extent privileged within Western societies. This is reflected especially by its elevation as technical expertise which is above the crassness and uncertainties of interest group politics. The increasing frequency with which social policy issues in Western societies are transformed into technical issues is what Offe and Habermas refer to as the "scientization of politics". 29

The second reason is the reinforcing lobbying capacities of the medical profession. Historically, the various medical interest groups have

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mobilised very vigorously against any attempts - real or otherwise - to reduce the level of professional autonomy in medical practice. Given that the proposal for reconstituted peer review goes to the very core of that autonomy, we can expect all sectors of the profession to unite very strongly and very actively against it. Such a campaign of resistance by the profession, against a proposal which implies extensive changes to the traditional structure of the health system, may well gain strong support among the non-government political parties and their constituents. Such support places limits not only on the capacity of any government to legislate for the changes, but also on the level of community acceptance of the notion of lay review of medical practice.

On the other hand, the very process of debating health policy in these terms could dramatically increase the frequency with which we critically question our traditional presumptions about the neutrality of science and medical knowledge. Such a process of exposure could thereby provide the momentum for a gradual shift towards accepting the notion of reconstituted peer review as the legitimate authority over medical decisions. As the level of general acceptance increases, the self-interest behind the profession's organised campaign would tend to be exposed to the same extent, thereby imposing limits on its potential base of political support.

Within this scenario lies the greatest potential for the extensive erosion of medical dominance, and the general democratisation of health policy's review procedures. Medical peer review is essentially anti-democratic. Those most effected by medical decisions are excluded from the process of evaluating those decisions. For example,
peer review provides no direct means for individuals to claim compensation for the personal costs of unnecessary services or procedures performed on them. Similarly, it precludes compensation for the social costs of directing health resources into unnecessary services rather than public health programs. Under medical peer review, the process of assessing medical services is restricted to those with medical training. The community which largely funds the supply of those services (and, indeed, the provision of that training) ultimately has no say in assessing their relative social worth.

Medical peer review not only locks out large sections of the community from direct participation in the evaluation of health policy, but also affords no opportunity for the state to intervene on the community’s behalf. Medical peer review locks out the community’s elected representatives, and members of the state health agencies on who they rely for policy advice and administration, from a direct role in the monitoring and review of medical decisions. It also necessarily excludes them from controlling the content and overall direction of all health policies dependent on the cooperation of the medical profession. The overall effect is that in all of those policy areas where peer review is the ultimate review authority - and I would argue that this covers the core of the health portfolio - wider political values such as equity of access and social justice have no means of direct entry into the policy process.

As a result, these values are not necessarily reflected in health policy objectives or outcomes. Where they are reflected in its outcomes, it is not because of the design of the accountability structure, but despite it. Such outcomes are directly dependent on the discretionary largesse
of the medical profession, and on the coincidence of community interests with medical interests. It also means that the more narrowly defined interests and values of the medical profession are much more likely to permeate both the evaluation of existing health policies, and the development of new policies based on the conclusions of such evaluation.

The problems with medical peer review identified here do not apply only to those instances with significant cost implications. Even within its own terms of reference, where the overall clinical benefit to the patient is used as the prime criterion, medical peer review has a very poor record of achievement. Melvin Konner, for example, has compiled a substantial list of procedures which were largely left to medical peer review for assessment and evaluation, were widely adopted by the medical profession - more so in some regions than in others - and which turned out to be ineffective, unproven, vastly expensive or even harmful to the patient. These include tonsillectomy, artificial hearts ("an expensive, unsupervised experiment", according to one US cardiologist), hysterectomy, frontal lobotomy (for which Egas Moniz shared the Nobel Prize in medicine in 1949), and carotid artery surgery.30

All of these procedures were routinely performed by medical practitioners on the principle of what other colleagues and peers working in the field were doing at the time. Unlike new pharmaceuticals, new medical procedures are not subject to government evaluation and regulation. Their assessment is left

entirely within the hands of the medical profession through a fragmented peer review process which varies enormously in intensity, design and criteria from one hospital or country to another.

In Australia, the history of medical peer review provides a similarly disturbing picture. Chapter Two discussed the adoption of Magnetic Resonance Imaging (MRI) and foetal heart monitoring before they had been systematically assessed.\textsuperscript{31} Glennys Bell refers to the wide acceptance of procedures and therapies under less than rigorous medical peer review as "medical fashions", or "MediFads", to which both health consumers and doctors are susceptible.\textsuperscript{32} In the 1960s these fashions included thyroid, barbiturates and amphetamines, circumcision and ulcers; in the 1970s, vitamins C and B12, tranquillisers, spastic colon and diverticulitis; and in the 1980s, Epstein-Barr virus, endoscopy, cholesterol and coronary bypass.\textsuperscript{33} Despite the high costs and risks involved, none of these procedures and treatments were systematically assessed by the existing peer review mechanisms before their widespread use in the field, and some continue to be used even when research strongly suggests that their clinical utility is marginal or negative.

Perhaps the most notable - and certainly one of the longest - lapse in evaluation by medical peer review in Australia occurred in the case of


\textsuperscript{33} Ibid., p51.
the deep sleep therapy conducted at the Chelmsford Private Hospital in Sydney. Between 1962 and 1979, 24 people died during or after such therapy. Despite the many concerns raised by family and friends of Chelmsford patients, formal complaints made to the NSW Health Department, and a coronial inquiry, no medical practitioner aware of the treatment was willing to provide evidence against the director, Dr. Harry Bailey, or his partners. Moreover, the medical bureaucrats in the NSW Health Department at the time were extremely reluctant to take any action against Dr. Bailey because they did not wish to interfere with his clinical autonomy.34 The fads approach to new medical procedures adds considerable weight to the argument that the profession often finds it difficult to separate clinical matters from professional and financial matters, and widely uses peer review to effectively further its own interests.

**Conclusion: challenging medical dominance**

There are areas other than aged care and birthing where "medical dominance" is limited and challenged by other non-medical forms of knowledge and expertise. For example, since the 1970s we have seen the re-emergence of a broader, social definition of dying in place of a narrow, almost wholly medical one. We no longer leave it entirely to doctors to decide, on the basis of their specialist medical science knowledge, when to cease attempts at cure and leave the terminally ill patient to die with some control over the timing and circumstances.

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Backed up by specific legislation in several States, decisions about dying are not subject to a purely medical peer review mechanism which can exclude all non-medical knowledges and experience. As with the aged care and birthing cases, this reflects a social assessment of dying as something extending beyond the confines of the merely medical, embracing a cluster of human, cultural, political and religious values. Accordingly, health policy in this area is subject to development and evaluation by a broad range of groups and interests representing non-medical knowledges and experiences, including legal, bureaucratic, nursing, clerical, ethical and those of the dying themselves.

Other significant areas of health policy which are currently being demedicalised, or are showing signs of resistance to the process of medicalisation, include alcohol and drug addiction, human nutrition, IVF and fertility experimentation, genetic manipulation, and mental illness. Like aged care, birthing and dying, all of these policy areas have in common the inclusion of non-medical expertise in the making and/or evaluation of treatment decisions. There is no exclusively medical peer review mechanism forming the core of the accountability provisions in these areas. The establishment or maintenance of medical dominance here is limited to the relative capacities of the

profession's organised pressure groups to direct health policies towards a narrow range of medical interests, and away from those of competing groups in the wider community. Without medical peer review, those lobbying capacities to protect medical interests cannot be reinforced by the selective application of medical expertise. Without medical peer review, the profession's interest group power cannot be complemented by self-assessments infused with medical interests, masquerading as technical determinations. Without medical peer review, both the content and the evaluation of policies in these areas can be ultimately guided not by medical interests, but by overarching public interests such as social justice and equity in health.

Within our legal system, we are prepared to accept both the practice and the authority of lay juries evaluating evidence which is based on forensic science. We do not expect such juries to hold recognised qualifications in forensic science; nor do we regard the specialist knowledge of forensic science as entirely beyond the cognitive capacities of jury members. Similarly, juries are routinely authorised to assess the relative merits of evidence provided by expert witnesses from a wide range of specialist fields of knowledge, including medicine. We entrust juries with the task of determining guilt or innocence not because of their formal knowledge of science, but because of the cross-section of community interests and values they represent beyond the realm of science.

Such evaluations are not without their administrative problems, and there have been a number of trials where jury confusion over expert scientific evidence have led to unsatisfactory or contestable verdicts. Perhaps the most notorious of these is the Lindy Chamberlain case,
where the conviction for murder, and subsequent retrial and acquittal, rested largely on differing interpretations of what is routinely presented as objective forensic evidence.\textsuperscript{36} However, these problems are not the product of some intrinsic opaqueness of science-based knowledge which precludes access to the lay person. They reflect more the adversarial structure of the legal system, and the selective, confusing presentation of evidence it encourages on the part of both the defence and the prosecution.\textsuperscript{37}

Like the jury system of the law, reconstituted peer review in the health system acknowledges the social construction of knowledge and undermines the modern illusion of the neutrality of science. Peer review which defers to the authority of broad-based, non-medical forms of knowledge implies that people other than doctors are capable of meaningfully scrutinising the decisions of doctors in order to recommend improvements and reforms in health policy. As the case studies have strongly suggested, other groups of health workers, patients and policy bureaucrats can make as valid an assessment of clinical practices as the medical profession. They can assess the medical necessity of a pathology test or the relative work-value of a GP service - not more objectively, but more democratically. The scope of this form of scrutiny of clinical decisions is not confined by narrow medical interests and values. Rather, it is guided by the broader interests and values of the social context in which those decisions were made.

\textsuperscript{36} For a brief review of some of the problems of expert evidence and their impact on jury deliberations, see Fife-Yeomans, J. (1993), "Experts on stand-by", \textit{Australian}, 30 November, p7.

\textsuperscript{37} \textit{Ibid.}
For example, the members of a wholly medical peer review committee might be inclined to conclude that, if a very expensive testing procedure detected the presence of a serious secondary condition in 2% of patients with a particular presenting condition, then the procedure was well worth the costs involved. Presented with the committee’s conclusion in this way, health ministers and health agencies would find it difficult to make a strong case against funding the procedure, even if it ultimately meant a corresponding reduction in other areas of the health budget.

However, a reconstituted peer review committee might begin further back in the process of knowledge production, and review the scientific literature on which the 2% success rate was based. Given the interpretive nature of scientific knowledge, and the variety of methods used amongst different researchers and clinicians, their assessments of the procedure’s accuracy can be expected to cover a range of success rates. If this range is considerable, or if the reliability of the figures is quite low, or if the results are subject to several different interpretations, then this type of review committee, more aware of the opportunity costs arising from competing needs within (and beyond) the health system, might postpone the funding of the procedure until more convincing evidence is available, and effectively redirect the funds to other areas. Unlike the medical members, non-medical members have no direct professional or financial investment in pushing for funding for the latest technological developments or "magic bullets".

The essential point here is that clinical decisions are social decisions. Their effect is not confined to individual doctor and patient within the
clinic, for they collectively involve the allocation of resources in the wider community. Specialist knowledge and expertise is an integral component of many other policy areas, such as economics, the environment, education and social welfare. However, in these areas, it is not the specialists but the political community which controls decisions about the allocation of resources. Such decisions are ultimately made on the basis of perceived social and economic priorities. The central question which this research raises is whether or not health policy, currently characterised by medical dominance, should be so qualitatively different from other policy areas, especially given the considerable proportion of public resources and expenditures it represents.

It also raises the related question about what sort of groups should be conducting research into health policy. While there has clearly been significant benefits gained from the analysis of health policy through the perspectives of health economists, administrators, historians, sociologists, anthropologists and medical and other health occupations, there are also high potential benefits from such analysis through the perspective of political science. For the analysis and resolution of issues about who gets what, when and how in health has equally significant implications for the wider community outside the clinic, as they have for the individual clients within.

****OOO****
Table 3. Proposed MBS Time-based and Content/Time-based fees for GPs, 11 May 1989.

<table>
<thead>
<tr>
<th>Item</th>
<th>Definition</th>
<th>MBS Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Brief, less than 5 mins</td>
<td>$13.20</td>
</tr>
<tr>
<td>5</td>
<td>Standard, 5 to 25 mins</td>
<td>$18.60</td>
</tr>
<tr>
<td>7</td>
<td>Long, 25 to 45 mins</td>
<td>$33.50</td>
</tr>
<tr>
<td>9</td>
<td>Prolonged, more than 45 mins</td>
<td>$53.00</td>
</tr>
</tbody>
</table>

**TIME CONTENT BASED FEES**

<table>
<thead>
<tr>
<th>Level</th>
<th>Definition</th>
<th>MBS Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>A^1</td>
<td>Straightforward, no time limit</td>
<td>$10.00</td>
</tr>
<tr>
<td>B^2</td>
<td>Complex, less than 20 mins</td>
<td>$20.50</td>
</tr>
<tr>
<td>C^3</td>
<td>Detailed, 20 to 40 mins</td>
<td>$36.50</td>
</tr>
<tr>
<td>D^4</td>
<td>Comprehensive, more than 40 mins</td>
<td>$54.00</td>
</tr>
</tbody>
</table>

Notes:
1. Level A: Service for a straightforward problem that requires a short patient history and, if required, limited examination and management.
2. Level B: Service including a selective patient history, examination and management of a problem; or a visit of less than 20 minutes.
3. Level C: Service involving a detailed history, a thorough examination and management; or a visit of between 20 and 40 minutes.
4. Level D: Service involving an exhaustive history, a comprehensive examination, management plan of a complex problem and arrangement of necessary tests; or a visit lasting more than 40 minutes.

Table 4. MBS GP Fee Structure Effective 1 December 1989.

<table>
<thead>
<tr>
<th>Consultation</th>
<th>Time</th>
<th>AMA Fee</th>
<th>MBS Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>TIME-BASED:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinic Brief</td>
<td>&lt; 5 mins</td>
<td>----</td>
<td>$13.20</td>
</tr>
<tr>
<td>Clinic Standard</td>
<td>5-25 mins</td>
<td>----</td>
<td>$19.60</td>
</tr>
<tr>
<td>Clinic Long</td>
<td>25-45 mins</td>
<td>----</td>
<td>$35.00</td>
</tr>
<tr>
<td>Clinic Prolonged</td>
<td>&gt; 45 mins</td>
<td>----</td>
<td>$56.00</td>
</tr>
<tr>
<td><strong>TIME-CONTENT:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A(^1) Obvious Problem</td>
<td>N/A</td>
<td>$13.00</td>
<td>$10.30</td>
</tr>
<tr>
<td>B(^2) Selective Hx, Ex</td>
<td>&lt; 20 mins</td>
<td>$27.00</td>
<td>$21.00</td>
</tr>
<tr>
<td>C(^3) Detailed Hx, Ex</td>
<td>20-40 mins</td>
<td>$50.00</td>
<td>$38.00</td>
</tr>
<tr>
<td>D(^4) Exhaust Hx, Ex</td>
<td>&gt; 40 mins</td>
<td>$73.00</td>
<td>$56.00</td>
</tr>
</tbody>
</table>

**Notes:**

1. Level A: Professional attendance by a vocationally trained GP for an obvious problem characterised by the straightforward nature of the task that requires a short patient history and, if required, limited examination and management. Relative value 10 units.

2. Level B: Professional attendance by a vocationally trained GP involving taking a selective history, examination of the patient with implementation of a management plan in relation to one or more problems, OR a professional attendance of less than 20 minutes duration involving components of an attendance of the type otherwise covered by Item C or D. Relative value 21 units.

3. Level C: Professional attendance by a vocationally trained GP involving taking a detailed history, an examination of multiple systems, arranging any necessary investigations and implementing a management plan in relation to one or more problems, and lasting at least 20 minutes, OR a professional attendance of less than 40 minutes duration involving components of an attendance of the type covered by Item D. Relative value 38 units.

4. Level D: Professional attendance by a vocationally trained GP involving taking an exhaustive history, a comprehensive examination of multiple systems arranging any necessary investigations and implementing a management plan in relation to one or more complex problems and lasting at least 40 minutes, OR a professional attendance of at least 40 minutes duration for implementation of a management plan. Relative value 56 units.

**Sources:** Derived from RACGP/Federal Government, "Announcing the arrival of a new idea in family medicine", n.d. (leaflet distributed to all GPs towards December 1989); Commonwealth Serum Laboratories (1989), "General Practitioner Fee Schedule Summary", Melbourne: CSL; and Australian Dr Wkly, 20 October 1989:1,2 and 17 November 1989:1,3.
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