

The “Ugly Sister of Welfare”

**The idea of health care ‘rationing’ in New Zealand
1968-c.1980**

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Abstract

This thesis explores the influence of healthcare 'rationing' in New Zealand from 1968 to c.1980. Rationing is a term and concept drawn from health economics and the history of the idea will be traced as well as its influence. The influence of rationing will primarily be explored through case studies: the supply of specialist staff to New Zealand's public hospitals, the building of hospitals (and specialist units in particular) and the supply of medical technology.

This era has been selected for historical examination because of the limited attention paid to it in studies of the health service, and more generally, welfare histories of New Zealand. Often in these studies the 1970s is overshadowed by the period health of reform in the 1980s and 1990s.

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Acronyms

AHB: Area Health Board

AJHR: *Appendix to the Journals of the House of Representatives*

CAT or CT Scanner: Computerised Axial Tomography Scanner

CSC: Central Specialists Committee

HAC: Hospital Advisory Council

HBA: Hospital Boards Association

HMOAC: Hospital Medical Officers Advisory Committee

MANZ: Medical Association of New Zealand

MSRU: Management Services and Research Unit (Department of Health)

NA: Archives New Zealand

NAC: National Allocations Committee

NZIER: New Zealand Institute of Economic Research

NZMA: New Zealand Medical Association

SACHSO: Special Advisory Committee on Health Services Organisation

WHO: World Health Organisation

WTSMOA: Whole-time Senior Medical Officers Association

Introduction

Alan Danks, chair of the National Government's Special Advisory Committee on Health Services Organisation (SACHSO), provided a vivid description of the consequences of rationing; rationing, Danks stated, is "the Ugly Sister of Welfare".¹ Whilst acknowledging that health care has always been rationed, this thesis seeks to historicise the late 20th century acceptance of this process, tracing the emergence of the idea from the 1967-1968 financial year, when capped budgets for hospital boards were introduced, through to the late 1970s. This is not to say that rationing had not existed up until this point, but until the mid 1970s those involved in health administration did not openly advocate explicit rationing; since the advent of the welfare state in 1938 an optimistic belief in expenditure overrode most awareness and acceptance of explicit rationing.

Rationing

The term rationing, as used within this thesis, encompasses the idea that society's health care needs could never actually be satisfied, leading to the strategic allocation of funding to certain areas, and therefore restricting funding to others. This definition draws upon the ideas of health economics generally, and for the New Zealand context draws specifically on the work of health economist Michael Cooper. Cooper was Professor of Economics at Otago University in the 1970s and worked on projects within the Department of Health's Management Services and Research Unit (MSRU).

The context of this argument is that from 1938 until the late 1960s and 1970s a certain optimism dominated the public provision of health care: it was generally believed that if enough staff, hospitals and resources could be provided then ill health could in a sense be

¹ Lynette A. Motte-Harrison, *Service Planning in New Zealand*, July 1980, The Special Advisory Committee on Health Services Organisation, Wellington, p. i.

eradicated.² The idea was fuelled by ‘advances’ in medicine and technology and led to the optimistic provision of those advances and the building of hospitals, as well as a general faith in doctors.³ In New Zealand the ‘crisis’ period for health is said to begin during the early 1980s and more specifically following the election of the Fourth Labour Government in 1984. But this thesis shows that even before the accepted ‘crisis period’ health administrators were facing a dilemma about the nature of ‘health’ and the priorities that should be assigned to health care generally and sophisticated specialist care in particular. Furthermore, from the mid-1970s a tightening economic situation meant that these philosophical issues were developed in a receptive fiscal environment.

The historical timing of these ideas is important in that, even within a recent work on medical specialisation, it was reported that various national health systems were in ‘crisis’, the implication of this statement being that the reason those systems were in such a state was because of a lack of finance.⁴ The idea of a health system in crisis as a recent trend is however somewhat misleading when taking into account the long standing discussion of health care rationing (both implicitly and explicitly). Even before the 1970s the public provision of health meant that finance was always strategically allocated, therefore indicating that funding was always in short supply to certain health services; in this situation rationing was implicit.

² Michael Cooper interview, 14 June 2008; George Salmond interview, 2 May 2008; George Salmond & John Martin, ‘Policy Making: The ‘Messy Reality’’ in Peter Davis & Toni Ashton, *Health and Public Policy in New Zealand*, Oxford University Press, Auckland, 2001, p. 46.

³ Although, it should be noted that even during a time of enthusiasm for medical advance dissent was voiced, even amongst the medical profession, but this did not contribute in any obvious way towards curbing expenditure.

⁴ George Weisz, *Divide and Conquer: A Comparative History of Medical Specialization*, Oxford University Press, Oxford & New York, 2006, pp. 233, 237-39.

Outline of findings

It can be argued that health care has always been rationed.⁵ However, without wishing to contradict this statement, a historical examination of the 1970s reveals that the idea of rationing medical care resources emerged more explicitly around the mid-1970s, with health care administrators in particular. Previously the desire to *provide* resources had taken precedence. This time period has been isolated because perceived shortages in health resources (in particular hospital buildings and adequate staffing levels) during the late 1960s and early 1970s combined with enthusiasm for medical advance producing a climate in which most health administrators were seeking to meet public demand, however that might express itself. The focus shifted around 1976 from seeking to overcome shortages of health resources towards *controlling* a seemingly limitless demand. This was fuelled in part by tightening public expenditure and also by a new awareness amongst health administrators that public demand could not be satisfied by an adequate supply of health resources. The idea of ‘rationing’ came into use at this time.

The ‘road to rationing’, the route of which took in successive efforts to control spending on health, will be examined in Chapter Two. An overview of the major reviews of the health service will also be provided in that chapter. It is in those reviews that an ‘alternative’ to rationing also begins to emerge: a renewed enthusiasm for community and preventive care, which had waned during the late 1960s and early 1970s due to specialist medical advance. This enthusiasm is evident in the Labour Government’s 1974 White Paper and in the National Government’s SACHSO. Whilst not the subject of detailed enquiry in this thesis, the policy of preventive care is a theme that runs alongside discussions of health care rationing.

⁵ Robert H. Blank, *New Zealand Health Policy: A Comparative Study*, Oxford University Press, Auckland, p. 89.

The influence of rationing ideas will then be explored in a series of case studies. The case studies are: an analysis of the debates surrounding the introduction of cardiac units into New Zealand (Chapter Three); the discussions stemming from pay negotiations for full time public hospital specialists (Chapter Four); and the funding of public hospital buildings, with the acquisition of CAT scanners being a particular focus (Chapter Five). Each case study reveals details of how ideas of rationing impacted upon the provision of specialist interventionist (read high-cost) medical techniques, technology and the specialist physicians who administered them.

The development of specialist care and its impact upon the allocation of health funding will be explored in Chapter Three. The focus in particular upon public hospital and highly specialised cardiac care is justified by the fact that from the mid twentieth century onwards the development of specialised medicine characterised medical care.⁶ In New Zealand this trend was slightly delayed with preventive and community medicine remaining the focus throughout the 1950s and early 1960s; specialist medicine only came to the fore in the later 1960s.⁷

In Chapter Four the shift in focus from supplying medical resources to controlling the demand for those resources can be seen in the debates over hospital specialist pay negotiations. In the early 1970s the shortage of medical staff dominated pay discussions, and attempts were made to make full time hospital work more attractive to specialists. The public hospital system was experiencing shortages, with many specialists working within public hospitals only part-time alongside their private practices. However, once the supply issue of medical graduates had been at least partly resolved in the later 1970s, attention shifted from the availability of doctors to the role that doctors played within the public hospital service. It

⁶ Roy Porter, *The Greatest Benefit to Mankind: A Medical History of Humanity from Antiquity to the present*, Harper Collins, London, 1997, pp. 11-12.

⁷ Annual Report, Department of Health, *Appendices to the Journal of the House of Representatives (AJHR)*, 1968, H.31, pp. 6-7

was no longer presumed that an adequate supply of doctors would lead to a reduction in levels of disease and illness amongst the population.⁸

Chapter Five includes two case studies of capital expenditure: the public hospital building program and the introduction of the CAT scanner, both of which generated public lobbying. The provision of hospital buildings reveals a different trajectory to that of the medical specialist; the building program itself remained fairly constant throughout the 1970s, only declining in any obvious way in the early 1980s. However the commitment to, and discussion, around hospital projects is different. Only until 1976 was there a significant commitment to the forward planning and building of hospitals; until then there appears to have been a general belief that the demand for hospitals, often discussed in terms of demand for hospital beds, was far in excess of what was being provided. Both the case studies of the medical specialist and hospital building reveal that in New Zealand, the late 1960s and early 1970s was an era in which the provision of physical resources and curative care were the most important components of New Zealand's public health service.

The case of the CAT scanner again provides a different 'rationing' story. Even though the medical benefits of the scanners were in little doubt, their considerable cost meant that they were placed under close scrutiny prior to their introduction to New Zealand. But the scanners were also the subject of much public attention, and attempts to stagger their introduction over four to five years were hampered by public pressure. So whilst the general influence of rationing can still be located within this case study in the mid 1970s, overall it was not significant enough for health administrators to succeed in controlling the introduction of the scanners.

⁸ Advisory Committee on Medical Manpower, *Report to the Minister of Health on Medical Manpower Requirements*, May 1979, pp. 4-5.

Individuals and groups

A variety of groups and individuals were involved in deciding upon and competing for health finance and resources during the 1970s. Within the Department of Health itself most of the analysis of health funding was done within the Management Services and Research Unit (in operation since 1962 as the Health Planning and Research Unit) which undertook a number of reviews into health finance. Much of the debate over the level of finance took place between Treasury and the Department of Health, with both departments producing reports advising the Minister of Finance and Minister of Health. When commenting on Department of Health reports Treasury was in most instances keen to reduce spending, but also compromised on their 'bottom line' on various occasions. Once a figure had been approved the National Allocations Committee (NAC)⁹ decided where the money should be spent and allocated it to boards accordingly. This was a general allocation, the boards themselves were still required to decide which health services would receive funds. A closer study of hospital boards through the lens of health care rationing would reveal further insights into the 'rationing story' but is beyond the scope of this thesis.¹⁰

As previously discussed the term 'rationing' came from within health economics, and it follows that the role of economists is significant in the health debates covered in this thesis. In fact it is not correct to discuss economists as a group; rather, a number of individuals featured prominently.

Michael Cooper has already been mentioned. Frank Holmes was another economist who commented upon the issue of health. Holmes was an Economics Professor from Victoria University, a public commentator on policy issues and the chair of several advisory agencies

⁹ NAC was established in 1968 and made up of one member of the Hospital Boards Association, four members from the Hospital Officers Association, two members from the Medical Superintendents Association and five Department of Health employees.

¹⁰ Hospital Board Financing of Operating Costs 1886-1973, Draft Report, pp. 4-5 & 8-9, Management Services and Research-Hospital Finance-Allocation and Finance-General, 1973, Archives New Zealand (NA), ABQU, 632, W4415, Box 596, Record 342/4/1.

for both the Labour and National governments.¹¹ Holmes was also close to Henry Lang, the Secretary for the Treasury from 1968-1977, who himself developed a special interest in health economics, at one time chairing a review of cardiac surgery.¹²

Alan Danks is the third economist notable in this thesis. Danks was very involved in health reviews during the 1970s. He chaired the Royal Commission on Social Security in 1972 and headed SACHSO from 1976. As already mentioned, it is from Danks that the description of rationing as “the Ugly Sister of Welfare” has been drawn. Danks endorsed the use of explicit rationing; he accepted that health should (and must be) rationed; in 1972 as chair of the Royal Commission Danks was posing possible ‘rationing scenarios’ to submitters.

The medical associations also feature prominently in this thesis. The association with the longest lineage was the Medical Association of New Zealand (MANZ). MANZ had historical links with the British Medical Association and had been politically active in New Zealand for some time. Notably, its resistance to the introduction of the 1938 Social Security Act meant the continuation of a fee for service for General Practitioner visits.¹³ This strong tradition of lobbying is evident throughout the period under review in this thesis; MANZ was active and vocal on all major government inquiries into the health service during the 1970s. There was also a second medical association active at this time. The New Zealand Medical Association (NZMA) emerged in the 1960s and was led by Dr Erich Geiringer. NZMA was not officially registered as an association, although it publicly used the name. Geiringer himself was a figure of some prominence; he had been ‘blackballed’ from membership of MANZ because of his political activism and because he had managed to alienate much of the

¹¹ Frank Holmes, ‘Three Labour Leaders: Their Economic and Educational Policies’ in Clark, Margaret, ed., *Three Labour Leaders: Nordmeyer, Kirk, Rowling*, Dunmore Press Limited, Palmerston North, 2001, p. 201.

¹² Malcolm McKinnon, *Treasury: The New Zealand Treasury 1840-2000*, Auckland University Press, Auckland, 2003, p. 230; J. R. Martin, ‘Lang, Henry George 1919 - 1997’. *Dictionary of New Zealand Biography*, updated 22 June 2007, URL: <http://www.dnzb.govt.nz/>

¹³ R.E. Wright-St Clair, *A History of the New Zealand Medical Association: the first 100 years*, Butterworths, Wellington, 1987, pp. 184-190.

medical community in Dunedin as a member of Otago University's Department of Medicine from 1959.¹⁴ In 1964 he married Carol Shand, National Member of Parliament Tom Shand's daughter, and although Tom gave his consent to the marriage Tom's friends were critical of the match, labelling Geiringer, as Carol would later recall, "most unsuitable". As it turned out Geiringer's 1969 book *If Doctors Grew on Trees* in which he criticised both Labour and National for their medical manpower policies, caused a family rift.¹⁵ NZMA was dissolved by 1974 and MANZ took the title NZMA in 1977.¹⁶

Alongside the two main associations there were also various derivatives and sub-committees who contributed to the debate over the health service. The Central Specialists Committee (CSC) of MANZ was involved in the first negotiations for specialist salaries in public hospitals with the Hospital Medical Officers Advisory Committee (HMOAC) in 1967.¹⁷ HMOAC was a crucial institution in wage negotiations; it was made up of a member of the State Services Commission, two members from the Department of Health, two members from the Hospital Boards Association and several members of MANZ themselves.¹⁸

Other smaller associations were also vocal during this time period; they often acted on their own behalf but also at times in conjunction with MANZ. A submission to be put forward to HMOAC in 1979 is illustrative of the number of smaller associations active during the 1970s. The submission from the Central Specialists Committee of NZMA was to be prepared in conjunction with the Whole-time Senior Medical Officers' Association of New Zealand (WTSMOA), New Zealand Association of Part-time Hospital Staff, New Zealand

¹⁴ Bevan Burgess, 'Erich Geiringer' in James Bade, ed., *Out of the Shadow of War: The German Connection with New Zealand in the Twentieth Century*, Oxford University Press, Auckland, 1998, pp. 209-210.

¹⁵ Margaret Clark, *Holyoake's Lieutenants*, Dunmore Press, Palmerston North, 2003, pp. 53-4.

¹⁶ R.E. Wright-St Clair, 1987, pp. 184-190.

¹⁷ The HMOAC began in 1966 and had its first meeting on 23 February 1967. For further background information on the development of the HMOAC see Pay Rates-Outside the Public Service-Hospital Boards Staff/Hospital Medical Officers Advisory Committee, NA, AEKO, 19171, SSC1, W2505, 33/7/9, Part 6.

¹⁸ See Hospital Boards-Hospital Medical Officers Advisory Committee, 1973-1974, NA, AAFH, 632, W4672 Box 12, Record 54-11-42.

Resident Medical Officers' Association and Medical Superintendents' Association of New Zealand.¹⁹ WTSMOA in particular was a significant player during the wage negotiations with HMOAC in the early 1970s.

The fact that the medical profession enjoyed high status was also significant, enabling members of the medical profession, often through MANZ or NZMA, but also as individuals in their own right, to command considerable media and political attention. George Weisz outlines this trend in the international setting. He argues that the 1950s and 1960s were the time in which the "social status and power of doctors" was at its height.²⁰ This was an era when doctors were pioneers of medical advance. Conditions that had previously been untreatable were more effectively treated or in some cases cured. The era was one of 'technological and medical innovation'. A study published in West Germany in 1970 predicted that by the 1990s organ transplantation would be so advanced that the body would not reject the transplanted organs, harmless mood-altering drugs would replace alcohol consumption, the common cold would be eradicated through the use of injections and 70% of all cancer cases would be controllable.²¹ As a result of this 'medical pioneering' doctors were in some cases afforded heroic or celebrity status. This is evident in the case of Dr Christiaan Barnard, who performed the first heart transplant in Cape Town in 1967. Even eight years after his successful operation he was a notable international figure; at an international film festival in 1976 it was reported that "the super-surgeon seemed to steal the show from the super-stars."²²

A useful assessment of the social influence of the medical doctor in New Zealand was captured in 1970 by the president of the New Zealand Registered Nurses' Association. Mrs E Holdgate described the social position of the doctor as being "set apart" from the rest

¹⁹ See Meeting Central Specialists Committee 18 October 1979, Minutes, New Zealand Medical Association Collection, MS-Group-1276, MSY-5833, Alexander Turnbull Library (ATL), pp. 2-3.

²⁰ Weisz, p. 233.

²¹ *The Evening Post*, January 8, 1970, p. 6.

²² *Economic and Political Weekly*, Vol. 11, No. 4, January, 1976, pp. 87-88.

of society by his knowledge and authority. (When doctors were described they were most often referred to as men, this was particularly noticeable when the shortage of doctors was analysed: the shortage was considered to be a lack of medical *manpower*).²³ The doctor's "aura" of social influence was accentuated by his wealth, which contributed to the power he was able to claim within society. While Holdgate conceded that the picture she had created may have been slightly overstated, she argued the image was one that was shared by much of New Zealand society.²⁴

The individual featuring in this thesis who best exemplifies this argument is Brian Barrett-Boyes. Barrett-Boyes was head of the Cardiac Unit at Green Lane Hospital in Auckland and was outspoken at various times about the Unit's lack of finance, staff, buildings and equipment. Barratt-Boyes encapsulates the image of the 'heroic doctor' in the New Zealand setting. During the 1970s he was seeking more funds for coronary artery bypass surgery, a relatively new procedure, performed first in the United States in 1969 and involving the replacement of a diseased coronary artery with a healthy vein from the patient's body. Originally sceptical of the long term benefits of the procedure, by 1975 Barratt-Boyes seems to have had a change of heart (in more ways than one; following angina attacks he underwent the procedure himself in August 1974²⁵). Barrett-Boyes was the successor to Dr Douglas Robb at Green Lane, who was also an active lobbyist for the public health service. Later described as "outstanding surgeons", Barrett-Boyes and Robb have been credited with the national and international acclaim accorded to the Unit.²⁶

Whilst it is important to keep in mind the power of the doctor, the 1970s has also been described as an era where their authority and influence was shaken, led in part by 'second-

²³ The supply of doctors will be discussed in Chapter Four.

²⁴ *The Dominion*, April 19, 1970, p. 17.

²⁵ *The New Zealand Herald*, June 28 1975, p. 1; *The New Zealand Herald*, July 1 1975, p. 3.

²⁶ B.R. Hutchinson, ed., *Green Lane Hospital: The First Hundred Years*, Green Lane Hospital Centennial Committee, Auckland, 1990, p. 18. Robb's opinions about the shortages in medical specialists contribute to the discussion in Chapter Four.

wave feminism' which challenged masculine authority over women's bodies, particularly in relation to access to contraception and abortion.²⁷ This challenge was also accompanied by a certain amount of contemporary scepticism about the claimed benefits of medical science. Where the image of the authoritative doctor was built up in the media during the 1950s & 1960s, as the 1970s progressed that image began to be undermined. The challenge to the social influence of doctors has indeed been reflected in the historiography. Michael Belgrave argues that doctors had previously been responsible for most medical history but more recent medical histories have challenged doctor's "right to dominate the past". As a result "[t]he scientific pretensions of nineteenth-century doctors have been stripped away to reveal a profession that grossly overstated its ability to cure".²⁸

Exclusions and explanations of terminology

As indicated by the previous discussion doctors feature prominently within this thesis, creating as they do a particular picture of the development of medical care rationing. The focus upon doctors means that other important figures involved in the delivery of health care are marginalised in this study, most notably nurses. This is particularly obvious in Chapter Three where the supply of medical graduates is discussed. Nurses were also in short supply during this time period but a discussion of this difficulty is beyond the scope of this thesis. Furthermore, as the study of health is such a broad subject, it has also been necessary use case studies, each revealing their own nuanced 'rationing story'. The selection of further case studies would necessarily bring other aspects of New Zealand's health service to the fore and reveal slightly different 'rationing stories'.

²⁷ Phillida Bunkle, 'Women, health, and politics: divisions and connections', in Rosemary Du Plessis & Alice Lynne, *Feminist Thought in Aotearoa New Zealand: Connections and Differences*, Oxford University Press, Auckland, 1998, pp. 240-41.

²⁸ Michael Belgrave, 'Medicine and the Rise of the Health Professions in New Zealand, 1860-1939' in Linda Bryder, ed., *A Healthy Country: Essays on the social history of medicine in New Zealand*, Bridget Williams Books, Wellington, 1991, p. 9.

The selection of these case studies has also been informed by trends in medical care itself. As discussed above the development of specialist medicine dominated medical care in New Zealand from the late 1960s; this trend was accompanied by a growth in expenditure on public hospitals. Although public hospitals have always offered a number of welfare services, and continued to do so throughout this time period, the significant growth in expenditure upon public hospitals was due to the corresponding development in high-cost specialist treatment.

Within this thesis the descriptive terms ‘sophisticated’, ‘advanced’ and ‘specialist’ medical treatment will be used to describe the nature of highly technologically dependent curative care during this time. The use of these terms can be justified by their liberal and interchangeable use within the primary sources informing this thesis, although Roy Porter’s extensive work on the history of medical care *The Greatest Benefit to Mankind: A Medical History of Humanity from Antiquity to the present* cautions about the use of such terms. Porter emphasises that, whilst it is not easy to move away from describing medical developments as ‘advances’, he is mindful that written in such a way medical histories could be criticised for being ‘Whiggish’ in nature.²⁹ Porter’s concern is also relevant to this thesis as it can be difficult to avoid describing developments in medical techniques and the introduction of new medical technology as anything other than ‘advances’ upon what had previously been available.

Literature review

A study of health care rationing can be located within works done on health policy in New Zealand, which for the most part incorporate historical studies, whilst often making their main focus the reform period of the 1980s and 1990s. Robert Blank argues in *New Zealand*

²⁹ Porter, p. 8. Porter’s work also investigates the tension between claims of medical advance and the actual results that were produced.

Health Policy: A Comparative Study that New Zealand's introduction of free health care, as part of the 1938 Social Security Act, was based upon the idea that all individuals had a right to health care. But the ability to provide those services became a problem, as the public placed greater demands upon the public health care system and new and expensive technology became available. The solution to the problem came in the form of the 1983 initiative, placing a cap upon public hospital funding with population based funding formulas. Blank argues that the population based funding formula was a "major turning point" in New Zealand's health policy as it ended the system of unlimited funding that had characterised, in particular, the public hospital sector. Blank claims that up until the 1970s New Zealand had a reasonably robust health care system, with only minor changes made mid-decade, in response to an economic downturn.³⁰

Miriam Laugesen, using the hospital board as the central focus in her thesis, has analysed the interaction between hospital boards and government reform efforts. She identifies the goals of reform as the regionalisation of medical services and the changing of hospital board representation, both of which enhanced central government control. Laugesen argues that, for the most part, attempts at reform failed from the 1930s through to the late 1980s, largely due to the effective opposition of hospital boards throughout the country.³¹ If both Blank's and Laugesen's approaches are combined, a relatively static, or at least stable, image of the health sector is created, either due to economic buoyancy or through the continued deadlock between government reform efforts and hospital board resistance.³²

This thesis does not seek to contradict the argument for relative stasis, particularly as it seems that major reform efforts (for Blank this period begins in the early 1980s, for

³⁰ Blank, pp. 48, 124.

³¹ Miriam Laugesen, 'The politics of hospital reforms in New Zealand, 1935-1995', PhD thesis, University of Melbourne, Australia, 2000, pp. 1-2, 22.

³² See also Robin Gauld, *Revolving Doors: New Zealand's Health Reforms*, Institute of Policy Studies and Health Services Research Centre, Victoria University, Wellington, 2001, p. 22.

Laugesen in the late 1980s) were for the most part successfully resisted. Despite this, the period prior to the health reforms warrants historical study.³³

A further justification for historical study of this era can be found in another public policy work. Toni Ashton states that expenditure upon health (inflation adjusted) increased significantly during the 1970s and 1980s. Ashton states that the response to this large increase was to fix budgets for hospital boards – although Blank argues that the 1983 cap upon funding was significant, fixed budgets were first introduced in 1968. Ashton goes on to argue that the cap placed upon budgets meant that health resources were effectively controlled through supply initiatives, a form of health care rationing.³⁴

This thesis in part takes a lead from revisionist works on studies of the welfare state seeking to deconstruct the idea that the system that existed before the 1980 reforms was a benign construction, built upon stable foundations. Work on the British welfare state by Anne Digby, John Stewart and Jane Lewis emphasises that a progression from individualism to collectivism is too simple.³⁵ In fact, Digby and Stewart believe that Britain was a “‘late’ and rather reluctant welfare state”.³⁶ Using the concept of a ‘mixed economy of welfare’ they draw attention to the idea that voluntary and private vehicles of welfare were maintained even after the formation of a centralised welfare state, cracking the facade of a comprehensive system of welfare provision.³⁷

³³ Michael Belgrave also makes a case for more historiographical attention to be paid to the 1970s whilst simultaneously upholding the 1980s as an era of “revolutionary” reform. See Michael Belgrave, ‘Needs and the State: Evolving social policy in New Zealand history’ in Bronwyn Dalley & Margaret Tennant, *Past Judgement: Social Policy in New Zealand History*, University of Otago Press, Dunedin, 2004, p. 24. For further discussion of the ‘revolutionary’ nature of changes to social policy in the 1980s, and the relatively stable system of welfare provision prior to this period see Geoffrey W. Rice, ‘A Revolution in Social Policy 1981-1991’ in Geoffrey Rice, ed., *The Oxford History of New Zealand*, 2nd edn., Oxford University Press, Auckland 1992, pp. 482-498.

³⁴ Toni Ashton, ‘The Influence of Economic Theory’ in Peter Davis, & Toni Ashton, *Health and Public Policy in New Zealand*, Oxford University Press, Auckland, 2001, pp. 107-127, pp. 108-09.

³⁵ Anne Digby & John Stewart, ‘Welfare in Context’ in Anne Digby & John Stewart, eds., *Gender, Health and Welfare*, Routledge, London & New York, 1996, pp. 2, 22; Jane Lewis, ‘Welfare State or Mixed Economy of Welfare?’ in *History Today*, Vol.45(2), February 1995, pp. 4-6, p. 4. Lewis states that Thatcherism has prompted a ‘re-think’ of the periodisation of the ‘classic Welfare State’.

³⁶ Digby & Stewart, p. 7

³⁷ Digby & Stewart, p. 2. See also Lewis, p. 4. For the use of the concept of ‘mixed economy of welfare’ in the New Zealand setting see Bronwyn Labrum, ‘Family needs and family desires: discretionary state welfare in

This concept has been applied to a number of studies in New Zealand. David Thomson argues that the history of welfare provision should not be written as an evolutionary narrative and that New Zealand's history is characterised more by the constant challenging and renegotiation of social policies.³⁸ Furthermore, Thomson comments on the predominantly left-wing bias of studies of the welfare state, leading to an oversight of the possibility that conservative governments might have been more active in relation to welfare provision than has previously been acknowledged.³⁹ Linda Bryder argues, somewhat expanding but also qualifying Thomson's argument, that the influence of conservative ideology cannot be overlooked. Bryder describes New Zealand as “a socially conservative rather than a 'socially progressive' society”.⁴⁰

A more recent work incorporating this focus is Margaret Tennant's *The Fabric of Welfare*. Tennant argues that in the 1960s and 1970s expressions of disillusionment and overt challenges were made to the ideals that had underpinned the establishment of the welfare state in the 1930s and 1940s, whilst simultaneously emphasising that those ideals were firmly focussed upon the support of the family, and therefore discriminatory to those who did not fall into this category, for example the elderly.⁴¹ Of particular importance to the focus of this

New Zealand', PhD Thesis, Victoria University Wellington, 2000, p. 9; Margaret Tennant, 'History and Social Policy, Perspectives from the Past' in Bronwyn Dalley & Margaret Tennant, *Past Judgement: Social Policy in New Zealand History*, University of Otago Press, Dunedin, 2004.

³⁸ David Thomson, 'Society and Social Welfare' in Colin Davis & Peter Lineham, ed., *The Future of the Past*, Massey University, Palmerston North, 1991, pp. 105-7, 111.

³⁹ Thomson, p. 101. Although not specifically revisionist, other writers have also drawn similar conclusions. See Brian Easton, *Pragmatism and Progress: social security in the seventies*, University of Canterbury, Christchurch, 1981, pp. 18, 54, Easton argues that the Labour party did not have a “monopoly” on social spending, due particularly to the 1970s, a “sort of parity” in spending was obtained by National. See also Laurie Barber, 'The welfare state in the Muldoon years' in R.E. Wright-St Clair, ed., *Proceedings of the First New Zealand Conference on the History of New Zealand and Australian Medicine*, The Waikato Postgraduate Medical Society Inc., Waikato Hospital, Hamilton, 1987, p. 56 & Michael Bassett, *The State in New Zealand, 1840-1984: socialism without doctrines?*, Auckland University Press, Auckland, 1998, p. 14. Bassett argues that neither Labour nor National were guided in any significant way by ideology. Like Thomson and Easton, Bassett states that both major parties used state intervention in similar ways.

⁴⁰ Linda Bryder, “A Social Laboratory?” New Zealand and Social Welfare, 1840-1990', *British Review of New Zealand Studies*, vol. 4, November, 1991, p. 37. See also Michael Belgrave, 'New Welfare Histories Reviewed', *People's History*, 29, December, 1998, p. 6.

⁴¹ Margaret Tennant, *The Fabric of Welfare. Voluntary organisations, government and welfare in New Zealand, 1840-2005*, Bridget Williams Books, Wellington, 2007, pp. 123, 126.

thesis is Tennant's assertion in her earlier work, *Paupers and Providers*, that the 1960s and 1970s was the era in which increasing expenditure on welfare prompted criticism. Questions were raised as to whether "more money necessarily meant more welfare".⁴² These revisionist explorations all have a bearing on the period prior to the 1980s reforms of the New Zealand health service. The 'rationing' case studies in this thesis add breadth and depth to that revision: by the mid 1970s health administrators were aware that 'more money did not mean more health care'.

An important theme in health policy literature is the interaction between the public and private sector. Robin Gauld's and Iain Hay's works on New Zealand health policy both argue that the public hospital system 'failed' against the more effective private hospital and insurance system, and that government support to bolster the private system, starting first with the National Government in the 1950s, ultimately led to the deterioration of the public hospital system.⁴³ The emergence of a more robust private hospital system would undoubtedly influence the public system, but this thesis will also be investigating the ways in which medical developments may have influenced funding and allocation decisions. Policy studies tend to emphasise that demand in the public hospital system was *created* by the divergence of funds from the public to the private system, whilst also giving some credence to the fact that medical technology and techniques were being provided and developed at a rate that may have inspired this demand. The latter issue is, however, given much less consideration, with the strategic decisions of policy makers granted much more space in analyses of the health care system. In doing so, these works tend to consider that the 1938 system (in its conceptual form) was the ideal, with all adjustments made to this ideal as negative influences. But the enormous optimism surrounding medical science, and the faith

⁴² Margaret Tennant, *Paupers and Providers: Charitable aid in New Zealand*, Allen & Unwin/Historical Branch of Department of Internal Affairs, Wellington, 1989, pp. 6-7.

⁴³ Gauld, pp. 24-25; Iain Hay, *The Caring Commodity: The provision of health care in New Zealand*, Oxford University Press, Auckland, 1989, pp. 130-31.

that was placed in medical developments was a distinctive facet of the post World War Two era.⁴⁴ Robert Bud's work on public responses to antibiotic resistance in Britain highlights this. Bud argues that although there was evidence of antibiotic resistant infections during the 1950s they did not gain significant press, public, or government attention due to faith both in the antibiotics themselves and in the medical professionals who administered them.⁴⁵ This faith in medical advance transferred in most instances into an optimistic belief in public expenditure on health, with the belief that more expenditure would translate to better health care, and therefore a healthier population.⁴⁶

In downplaying the centrality of the division between public and private in the hospital system this thesis also takes its cue from the work of Rosemary Stevens. Using the American model of health care as the most obvious, and extreme example, Stevens states that “the essential tension” within health care systems is not that between the external relations of public and private, but rather the *internal* tension between elements of the service itself: the business model of health care, where the imperative is the production of the latest health care developments on demand, co-exists with the ideal of the hospital as an altruistic space, providing care for the sick.⁴⁷ Similarly, a recent work on the history of medical technology delves into related territory, outlining the co-existence of seemingly contradictory ideals in health care systems. The editors state that the general public no longer accept that ‘advances’ in medical care will necessarily translate to health benefits for society yet medical research still elicits optimism. And whilst many people dislike assigning costs to medical services,

⁴⁴ Porter, pp. 648, 652.

⁴⁵ Robert Bud, ‘From Epidemic to Scandal: the Politicization of Antibiotic Resistance, 1957-1969’ in Timmerman, Carsten and Anderson, Julie, eds., *Devices and Designs, Medical Technologies in Historical Perspective*, Palgrave Macmillan, Hampshire and New York, 2006, pp. 200-201.

⁴⁶ Jane Hall & Rosalie Viney, ‘The Political Economy of Health Sector Reform’ in Abby L. Bloom, ed., *Health Reform in Australia and New Zealand*, Oxford University Press, Melbourne, 2000, pp. 50-1. See also Porter, p. 648.

⁴⁷ Rosemary Stevens, *In Sickness and in Wealth: American Hospitals in the Twentieth Century*, Basic Books, USA, 1989, pp. 6-7.

rationing is for the most part accepted as part of health care systems.⁴⁸ Such paradoxes, and how they shifted throughout the 1970s, are at the heart of the discussions in this thesis.

⁴⁸ 'Introduction' in Carsten Timmerman & Julie Anderson, eds., *Devices and Designs, Medical Technologies in Historical Perspective*, Palgrave Macmillan, Hampshire and New York, 2006, p. 12.

Chapter Two: The road to rationing

A growing awareness of conflicting pressures upon health funding decisions is the central theme of this chapter. On the one hand it was felt that health, being ‘special’, should not be subject to resource constraints; rather, resource constraints should be overcome, in the interests of better health outcomes. Other analyses saw health caught between limited resources and potentially unlimited demand; from this perspective there was merit in making explicit the rationing inherent in working within those limits. It is the emergence of these latter ideas that characterises the 1970s.

The idea that health was special had been the predominant belief since the introduction of state funded health care in the 1930s, and from approximately the late 1940s there had been overwhelming enthusiasm for the possibilities of what medical science might be able to achieve.⁴⁹ In 1968, the Minister of Finance, Robert Muldoon, discussed concerns over cost within the health service, but nonetheless underlined the special status of health. He told the New Zealand Ethical Pharmaceuticals Association that “[i]t is the public’s insatiable desire for medicine which differentiates man from the lower animals”.⁵⁰

It was during the 1970s health care administrators in particular began to accept more readily that health had the potential to be a ‘bottomless funding pit’. One way to overcome that was to be more explicit about the need to ration the provision of health services.

An example can be taken from 1971. A comment was made in the Annual Report of Wellington Hospital Board for that year about the cyclical relationship between the provision of doctors and other resources, and limitless demand. Whilst mentioning that many departments were still struggling to fill staff vacancies, it was noted that even those departments which had managed to acquire additional staff were still reporting shortages.

⁴⁹Salmond & Martin, ‘Policy Making: The ‘Messy Reality’’, p. 46.

⁵⁰ Robert Muldoon, ‘The Cost of New Zealand’s Health Services in Relation to Current Economic Conditions’, *New Zealand Hospital: The Official Journal of the New Zealand Hospital Boards and Hospital Officers Association*, March, 1968, p. 12. Muldoon’s quote was attributed to an un-named source.

Awareness of this trend prompted the authors of the Report to question why, “when available beds for patients have remained fairly constant...staff numbers should continue to increase year after year and more and more be demanded still”. However, significantly, this trend was not analysed within the report, its authors noting that any comment could only be regarded as “superficial” in nature.⁵¹ In the next few years the outlook would change.

The influence of economists

In March 1976 Sir Frank Holmes delivered a lecture to the International Conference of Voluntary Health Service Funds. During this lecture Holmes cautioned his audience that they might face public disdain by inviting an economist (someone he claimed was “once defined as a man who would marry Elizabeth Taylor for her money”) to speak. Holmes stated that the reason for this was because many people felt uncomfortable when connections were made between health and economics due to the fact that health was often described as “a basic human right”. Despite this ideal, Holmes argued that the reality of providing a comprehensive health service for all members of society had repeatedly failed. He claimed that such a failure, despite the continued increase in expenditure upon health services in the public, private and charitable sectors had been due to a corresponding growth in both “needs and demands” from the general public. To compound this continued disappointment the funds provided had not resulted in an overall reduction in illness, as had originally been anticipated.⁵² In attempting to explain this seemingly limitless demand, Holmes drew heavily upon the work of Michael Cooper, a British specialist on health economics who had recently arrived to take up the post of Professor of Economics at the University of Otago and was the author of the 1975 book *Rationing Health Care*.

⁵¹ Wellington Hospital Board, *Reports of the Secretary and the Treasurer on the Receipts and Payments for the year ended the 31st March 1971 and the Allocations for the year ended 31st March 1972*, p. 1.

⁵² Sir Frank Holmes, ‘The Role of the Public and Private Sectors in Financing Tomorrow’s Health Services. The Sir Ronald Grieve Lecture 1976’, *New Zealand Medical Journal (NZMJ)*, vol. 83, no. 563, May 12 1976, pp. 326-28.

Cooper's work on supply and demand within the health service illustrated that when costs were covered then demand for the service "is capable of expanding at a rate which is impossible to meet". In such a situation, Cooper argued, the 'rationing' of resources was carried out in practice by medical workers in surgeries and hospitals. It is the interplay between need and demand during this process that is crucial. In *Rationing Health Care* Cooper outlined that demand is largely the result of an individual's self assessment before presenting themselves to a medical professional; a highly subjective process. However, crucially Cooper also argued that the evaluation of need was itself a highly subjective process controlled by doctors. In Cooper's opinion the demand for more resources was not directly due to demand from the general public. Instead Cooper argued that doctors were *creating* the continued problems by their subjective assessments of need; this, he claimed, was the cause of continued waiting lists for admission despite the allocation of additional resources. Cooper argued that a doctor's assessment of relative need grew alongside the provision of resources.⁵³

Health economics itself was a sub-discipline of relatively recent origin. In 1973 Cooper and Anthony Culyer had edited a book entitled *Health Economics* in which they described the area of study as an adolescent; all of the reprinted articles in the volume had been produced in the 1960s or early 1970s, with the earliest published in 1962. At this stage, the editors acknowledged, health economists were often producing more questions than answers; although this was not solely due to the infancy of the subject matter, but also to the differences between health care and other subjects more obviously used in economic analysis. Cooper and Culyer were reluctant to place health care alongside more 'traditional' subjects for economic study. The relationship between patient and doctor, the doctor's "special status" in society, and the emotion that the subject of a person's health (or ill health) inspired all

⁵³ Michael H. Cooper, *Rationing Health Care*, Croom Helm, London, 1975, p. 22.

contributed to the idea, they argued, that “[h]ealth is ‘special’” and cannot be compared in any kind of straightforward way with other subjects that might more easily fit into the category of economic commodity.⁵⁴

Capped budgets

Holmes’s address came at a time of financial stringency but an earlier episode in the later 1960s had foreshadowed it: the introduction of capped budgets in the wake of years of steadily increasing claims on central government health spending. An increase in demands from hospital boards as well as inflationary costs during and directly following World War Two led to the abolition of local contributions to hospital funding. The 1951 Hospitals Amendment Act ensured that all funding was now central government’s responsibility.⁵⁵ The Act proved to be the precursor to a further increase in demands from hospital boards for more resources.⁵⁶ The National Government’s (1949-1957) encouragement of the private hospital sector was one way in which escalating costs were countered.⁵⁷ But it was in 1967 that a further remedy was put forth in the National Government’s budget, with limits placed on allocations and a requirement that hospital boards adhere to them.⁵⁸ The cap upon grants was part of Muldoon’s first budget as Minister of Finance, one notable for its stringent approach

⁵⁴ Michael H. Cooper & Anthony J. Culyer, ‘Introduction’ in *Health Economics*, Penguin Books, Middlesex, 1973, p. 7.

⁵⁵ Derek Dow, *Safeguarding the Public Health: A History of the New Zealand Department of Health*, Victoria University Press, in association with the Ministry of Health and with assistance of the Historical Branch, Department of Internal Affairs, Wellington, 1995, p. 174. See also Gauld, pp. 23-24.

⁵⁶ Hospital Board Financing of Operating Costs 1886-1973, Draft Report, pp. 1-2, NA, ABQU, 632, W4415, Box 596, Record 342/4/1. See also Gauld, p. 24; Dow, pp. 175, 186. Dow states that the cost per person grew significantly during the post war years.

⁵⁷ Gauld, p. 25.

⁵⁸ Hospital Board Financing of Operating Costs 1886-1973, Draft Report, pp. 1-2, NA, ABQU, 632, W4415, Box 596, Record 342/4/1. See also Salmond & Martin, ‘Policy Making: The ‘Messy Reality’’, p. 47; Annual Report, Department of Health, *AJHR*, 1971, H. 31, p. 58.

to all government spending, part of his attempt to deal with the fall in the terms of trade brought about by a drop in the price of wool in late 1966.⁵⁹

Thus the impetus behind capped budgets was brought about partly by factors within the economy, but also by trends specific to the health service. In 1969, Director-General of Health Douglas Kennedy emphasised the considerable cost of the New Zealand health service in his foreword to the Department of Health's *Review of Hospital and Related Services in New Zealand*. Because of this cost, Kennedy argued that those involved in health administration generally, and hospital administration in particular, needed to be increasingly vigilant to “ensure that they are obtaining the maximum benefit for expenditure in men, money and materials.”⁶⁰ Muldoon had made earlier comments outlining more specific reasons behind the attempted controls in hospital spending. Soon after the introduction of capped budgets he claimed that hospital board spending had been “[t]he largest single factor in health expenditure”. Muldoon argued that the main driver behind this increase in expenditure was the complexity of medicine: “more things are possible today, and this is reflected in demands for more highly skilled staff and for more expensive equipment and facilities.”⁶¹

In order to establish limits upon funding the Department of Health went about obtaining the *actual* amounts spent by boards in the previous financial year; interest paid on loans was not included in the figures and deductions were made for money allocated but not spent upon wages and salaries. Following this, an assessment was made as to whether a board

⁵⁹ Brian Easton, ‘Two Economic Lieutenants’ in Margaret Clark, ed., *Holyoake’s Lieutenants*, Dunmore Press, Palmerston North, 2003, pp. 68-9; Barry Gustafson, *His Way: a biography of Robert Muldoon*, Auckland University Press, Auckland, 2000, p. 94.

⁶⁰ Department of Health, *A Review of Hospital and Related Services in New Zealand*, Department of Health, Wellington, September 1969, p. 3. The figures include those in the hospital service as well as those employed within the Department of Health. The total estimated cost for the financial year 1969/70 was estimated at two hundred million, over 16% of the expenditure of the Consolidated Revenue Account.

⁶¹ Robert Muldoon, *New Zealand Hospital*, March, 1968, p. 11. Muldoon’s assessment of the situation within the hospital service is a very succinct summary of the themes that will be explored throughout this thesis. The increasingly complex and specialist nature of medicine shaped the debates about hospital funding and the rationing of those funds. Issues relating to the supply of specialist staff, expensive technology and facilities form the case studies of this thesis.

was to be classed as high or low cost.⁶² If a board was judged high cost then funding was reduced, if low cost, additional funds were provided. More funding was also provided if a board was responsible for a population that had an expansion rate greater than the national average. There was also room for “special grants” to be made to cover the costs of new or extended facilities.⁶³ The level of allocations determined by this method then became the basis for grants made in 1968-69, allowing for wage and salary increases, new commissioning costs,⁶⁴ price stabilisation allowances and an individual growth rate for each board as determined by trends in inpatient and outpatient attendances.⁶⁵ Mr E.M. Connor of the Department’s Division of Hospitals attended the New Zealand Hospital Officers Association Annual Conference in November 1967 and replied to questioning regarding the ways in which allocations would be made in the coming years, Connor’s reply was tentative and open to suggestion from members of the Association about how grants might be allocated.⁶⁶ This consultative relationship between the Department, hospital officers and board members was made official in August 1968 following the establishment of the NAC.⁶⁷

Funding methods after the introduction of capped budgets

After the introduction of capped budgets a certain amount of trial and error took place in hospital grant funding. Various measures were initiated, adjusted, removed and in some cases reintroduced as the Health Department strove to find an adequate funding formula.

⁶² The distinction between a high and low cost board was arrived at by taking the operating expenditure, the private hospital operating expenditure, half the cost of private laboratory services, two thirds of the cost of private radiologists and the full cost of private physiotherapists. These figures were then added together and divided to get an average figure per head of population.

⁶³ Hospital Board Financing of Operating Costs 1886-1973, Draft Report, pp. 2-3, NA, ABQU, 632, W4415, Box 596, Record 342/4/1.

⁶⁴ New Commissioning costs were those involved in running a new facility, for example the service costs of running a new ward or clinical services block.

⁶⁵ Phillip Tatchell, Comments on the Press Editorial of February 28 1976, p. 1, NA, ABQU, 632, W4415, Box 596, Record 342/4/1.

⁶⁶ ‘Discussion Period: “Coping with the present economic restrictions”’, *New Zealand Hospital*, March 1968, p. 17.

⁶⁷ Hospital Board Financing of Operating Costs 1886-1973, Draft Report, pp. 4-5 & 8-9, NA, ABQU, 632, W4415, Box 596, Record 342/4/1.

Even in 1974 the actual base upon which growth rates were allocated was still being ascertained;⁶⁸ and again in 1976, Director General of Health John Hiddlestone⁶⁹ acknowledged that the scheme had been “evolving with refinements” each year. Grants were based upon past levels of funding plus allowances for growth and stabilisation funds.⁷⁰

Continued efforts by the Department and the NAC to establish an adequate funding formula indicate both that attempts were being made to standardise hospital board expenditure and the difficult nature of this process. Despite the fact that escalating costs had been of concern for a number of years no significant reduction of hospital board funding was made. The Wellington Hospital Board acknowledged in 1971 that substantial increases had been made to the block grants available to the Board, although they still felt they were restricted by the allocated funding, noting that it was only shortages in staff that had allowed them to remain within their grant. However, the Board concluded that the grant had not “proved sufficient to meet the requirements of new developments and techniques, new specialties and improved methods and services in addition to inflationary costs,” and for this reason, they claimed that the service they had provided would not meet the expectations of the New Zealand public.⁷¹ The response of the Wellington Hospital Board indicates the kinds of pressures and expectations placed upon hospital funding at this time and clearly illustrates the influence that medical developments were having upon pre-existing funding allocations.

A further pressure upon hospital board funding was shortages of staff and equipment.⁷² The pressures of medical advances on the one hand, and staff and equipment shortages on the other, combined and prompted the Department to *provide* finance,

⁶⁸ D.N.Ryan to the Chief Executives and Secretaries of all hospital boards, circular letter, 27 March 1974, p. 6, NA, ABQU, 632, W4415, Box 596, Record 342/4/1.

⁶⁹ John Hiddlestone was recruited to the Department in 1969 to become Director of the Hospitals Division. He was appointed Director General in 1973 following the death of Doug Kennedy and remained in the role until 1983. See Dow, pp. 188, 205-6.

⁷⁰ John Hiddlestone to the Cabinet Committee on Expenditure, Revision of Basis of Hospital Board Grants, Report, 1 December 1976, pp. 2, Appendix A, NA, ABQU, 632, W4415, Box 596, Record 342/4/1.

⁷¹ Wellington Hospital Board, *Reports of the Secretary and the Treasurer on the Receipts and Payments for the year ended the 31st March 1971 and the Allocations for the year ended 31st March 1972*, p. 1.

⁷² These pressures will be further analysed in chapters three and four.

overriding obvious concerns about costs within the sector and issues relating to need and demand. In the case of medical advancement the enthusiasm for such advances co-existed with concerns over cost; when it came to equipment and staff shortages it was hoped that finance would remedy pre-existing problems.

Labour Government 1972-1975

Reviews of hospital funding continued under the Labour Government. In November 1972 the NAC undertook a review of funding processes.⁷³ The criteria under which hospitals were allocated finance again came under scrutiny in 1973 from the MSRU. Following the lead of the National Health Service in Britain, MSRU instigated its own study into how hospital finance might be standardised and provided on a more equitable basis throughout New Zealand; the intention being that ultimately, over a ten year period the notion of funding according to the number of beds provided by a particular hospital board would be eliminated. Instead, the demographic characteristics of a population would be considered in funding decisions, as would the number of cases treated (adjusted for each medical specialty, according to an average cost). This method was intended to remedy the discrepancies in funding between boards where funding was allocated according to costs per patient per day. It was recognised that such a formula tended to favour long stay institutions, which came out of such assessments with low expenses, giving the appearance of economy of use, over those providing high-cost, acute specialty care.

A relatively new recruit to the Department of Health, George Salmond, produced a draft report outlining possible changes that could be made to funding methods, including a method to track the history of funding of specific diseases, by both hospital board and length of stay for each patient, in an attempt to assess any kinds of trends or patterns that may

⁷³ Hospital Board Financing of Operating Costs 1886-1973, Draft Report, pp. 4-5, 8-9, NA, ABQU, 632, W4415, Box 596, Record 342/4/1.

indicate where funding might be better placed in the future.⁷⁴ These methods of assessment were a relatively new approach to the health service. Salmond himself recalled that he had only been hired in 1970 because Doug Kennedy had been pestered by colleagues at a World Health Organisation conference to get involved in the “new trend” of collecting and evaluating information for planning purposes. Even then, Salmond found that his colleagues at the Department were reluctant to let him do work within their area of expertise, and were in fact rather suspicious about his role altogether.⁷⁵

Both Labour and National governments attempted to supply adequate funds to allow for medical advances and adequate staffing and equipment (despite National’s earlier introduction of capped budgets); although Labour was certainly beginning to explore the idea of preventive and community health, as we shall see from a later discussion of Labour’s 1974 White Paper. For the year 1974 financial year (April 1973 to March 1974) most hospital boards under spent their allocated funding for operating expenses; such under spending was again due mainly to shortages of supplies, materials and staff. The following year the Department approved a growth allowance of 4% in the continued hope that boards would be able to improve their medical services.⁷⁶ Treasury had originally recommended that a growth rate of 2.3% would be sufficient, but agreed to an additional 1.7% following the Department of Health’s advice that an increase would be required if the Government’s intention to reduce waiting times and increase staff numbers was to be achieved.⁷⁷ Growth funds were intended to cover a range of expansionary aspects of the service: the expansion of existing services in response to changing disease and injury patterns amongst the population, costs associated

⁷⁴ George Salmond, Hospital Board Finance, Notes as at 22 July 1973, pp. 1-3 & Appendix, NA, ABQU, 632, W4415, Box 596, Record 342/4/1.

⁷⁵ Interview, George Salmond, 2 May 2008.

⁷⁶ Annual Report, Department of Health, *AJHR*, 1974, E.10, p. 67. See also D.N. Ryan to the Chief Executives and Secretaries of all hospital boards, circular letter, 27 March 1974, p. 4, NA, ABQU, 632, W4415, Box 596, Record 342/4/1.

⁷⁷ Hospital Board Grants 1975/76-Advice of Basic Allocation from Treasury to Bill Rowling and Bob Tizard, 29 November 1974, Appendix, NA, ABQU, 632, W4415, Box 596, Record 342/4/1.

with more “sophisticated” medical techniques, increased expenditure due to staff promotions and also increase in staff volume.⁷⁸

There was however a hint at a change in attitude with the New Commissionings Grants provided to fund the first year of operation for a new facility. In March 1974, the Chief Executives and Secretaries of all the hospital boards received a letter from Desmond Ryan, the chairman of NAC, informing them of their financial allocations for the 1975 financial year. The grants for New Commissionings would be almost halved, based upon the difference between their own estimates for New Commissionings in 1973 and the actual amount used in 1974. The reduction in funding had unanimous support from Treasury and the Department of Health and was justified by the continuing shortages in supplies as well as the fact that levels of staffing were often below estimate for the first year of operation of new facilities. These factors convinced Treasury and the Department that under spending should be expected again in the coming year. The decision was made after the NAC weighed up the value of reducing the New Commissionings Grants proportionately, or a reduction in the growth allocation for each board, therefore allowing boards’ estimates for New Commissioning Grants to be provided in full. The decision to reduce the New Commissionings Grants was made because the allocations would mainly benefit a select number of boards, especially those with a substantial building program underway, whereas the growth allocations were distributed between all boards and were in recognition of existing circumstances.⁷⁹

⁷⁸ Department of Health to the Cabinet Committee on Expenditure, Report, 1 December 1976, NA, ABQU, 632, W4415, Box 596, Record 342/4/1. Growth rates did not include increased funds needed for new wage orders; these were additional to base and growth allocations and were often provided to boards retrospectively.

⁷⁹ D.N.Ryan to the Chief Executives and Secretaries of all hospital boards, circular letter, 27 March 1974, pp. 1-3, NA, ABQU, 632, W4415, Box 596, Record 342/4/1. Alan Wilson was the Treasury member of the Allocations Committee at this time. Wilson was later described by John Martin as a “no man” within Treasury. See Malcolm McKinnon, *Treasury: The New Zealand Treasury 1840-2000*, Auckland University Press, Auckland, 2003, p. 199.

NAC's decision reveals a bias towards the continued growth of the *total* public hospital service. Less optimism was however expressed that additional finance would alleviate shortages, and funding levels were set accordingly. Boards were also informed that if they were struggling to meet the costs of any new facilities they should explore the possibility of using their growth allocation before applying for any additional finance. The need to absorb the costs of any new projects was to be a stabilisation measure and co-operation was requested with this strategy to ensure controls on expenditure would be successful. Boards were also warned that supplementary funds were unlikely to be available during the year, and any overspending would not be compensated as it had been in the past. The warning suggests that although the block grant scheme had been intended to place limits on expenditure, it had not been strictly followed, and boards had applied for more funds as required.⁸⁰

Reductions to New Commissionings and warnings given to boards that they would not receive further funds are evidence of a harsher attitude from the NAC. This harsher attitude is understandable considering the economic context at the time (the economic situation was used by Treasury to justify the financial reductions to boards). New Zealand's terms of trade had declined significantly following of the 'oil shock' in 1973, and Britain's new membership of the European Economic Community added to New Zealand's economic insecurity.⁸¹ These restrictions did not in and of themselves involve making rationing explicit, and in practice, the combined growth amount and New Commissioning costs sought by the Department was more than double the Government's intention. The final amount allocated – 6.1% of total government spending – was considered a generous allocation under the

⁸⁰ D.N.Ryan to the Chief Executives and Secretaries of all hospital boards, circular letter, 27 March 1974, pp. 1-3, NA, ABQU, 632, W4415, Box 596, Record 342/4/1. The Department also made allowances for increased prices of supplies and expenses and for increases in wages and salaries. Although, the amount gained for inflationary costs in supplies and expenses was slightly less than the Department had originally requested; as a Hospital Price Index was under development.

⁸¹ James Belich, *Paradise Reforged: A history of New Zealanders from the 1880s to the year 2000*, Penguin Books, Auckland, 2001, pp. 396-97.

circumstances.⁸² Furthermore, hospital boards were not subject to a reduction in their operating grant, as was the case with other government departments.⁸³

Ideal and reality continued to clash for health administrators as they sought to control hospital board spending, and piecemeal changes were made to funding levels. For the 1975-76 financial year Minister of Finance Bob Tizard approved a growth allowance despite Treasury's hesitant advice regarding the economic situation throughout the country and their assessment that boards had received "over generous allocations" in the previous two years.⁸⁴ But boards also learnt that more changes could be expected. In 1973 the NAC had undertaken a study into the inequities in funding between boards. They looked into the actual workload each board undertook in comparison to the funding that the board received. The results of this study led the NAC to conclude that adjustments needed to be made over the next four years to rectify discrepancies in funding levels. The Minister accepted NAC's recommendations. Accordingly for 1975-76, boards that had received an imbalance in funds were informed that a 25% reduction in that imbalance would be made that financial year. Exceptions were made only if it was felt that the reduction would prove too severe for a particular board; several boards were allocated a reduction of 12.5% instead of the full 25%.⁸⁵ As had been the case in the previous year, a quarter of a percent was allocated as a flat growth allowance to all hospital boards and the rest was assigned according to weightings which were decided according to the type of care that a board provided; in this system inpatient and new day patients were given the greatest weight. Boards were also told to expect further reductions in the levels of funding they would receive; results emerging from

⁸² D.N.Ryan to the Chief Executives and Secretaries of all hospital boards, circular letter, 27 March 1974, pp. 1-3, NA, ABQU, 632, W4415, Box 596, Record 342/4/1.

⁸³ Hospital Board Grants 1975/76-Advice of Basic Allocation from Treasury to Bill Rowling and Bob Tizard, 29 November 1974, Appendix, NA, ABQU, 632, W4415, Box 596, Record 342/4/1.

⁸⁴ Hospital Board Grants 1975/76-Advice of Basic Allocation from Treasury to Bill Rowling and Bob Tizard, 29 November 1974, Appendix, NA, ABQU, 632, W4415, Box 596, Record 342/4/1.

⁸⁵ D.N.Ryan to the Chief Executives and Secretaries of all hospital boards, Circular Letter, 14 January 1975, p. 2, NA, ABQU, 632, W4415, Box 596, Record 342/4/1.

the Hospital Price Index (a project undertaken by the Department together with the Auckland Hospital Board and Treasury and supported by the Committee of Officials on Public Expenditure) indicated that previous funds for stabilisation had been excessive, and as such, boards were warned against planning for similar levels of stabilisation funding the following year.⁸⁶

National Government 1975

Muldoon, as Minister of Finance and Prime Minister, was responsible for economic policy following the re-election of the National Government in 1975. Muldoon's support of social spending is often highlighted, notably the introduction of universal superannuation. He has been described as a defender of the welfare state, retaining a "philosophical commitment" to it even though its sustainability was being questioned by growing political factions within both National and Labour. Their support for imposing 'the discipline of the market' on government expenditure would by the 1980s find them labelled the "New Right".⁸⁷

Muldoon made the economy a key issue in the 1975 election and campaigned upon his ability to restore it to a healthy status. To 'weather the storm' Muldoon set about encouraging farming exports to generate sufficient income to maintain levels of social support in benefits, education and health. But the immediate aim was to reduce government expenditure from 42% of Gross National Product (GNP) in 1975-76 to a proposed 36% for 1976-77.⁸⁸

⁸⁶ D.N.Ryan to the Chief Executives and Secretaries of all hospital boards, Circular Letter, 14 January 1975, pp. 1-2, NA, ABQU, 632, W4415, Box 596, Record 342/4/1; a flat growth rate of 0.25% was allocated to each board, specifically to ensure that the smaller boards could cope with the additional expenditure required to keep up with, and utilise, new innovations in health technology. See D.N.Ryan to the Chief Executives and Secretaries of all hospital boards, circular letter, 27 March 1974, p. 4, NA, ABQU, 632, W4415, Box 596, Record 342/4/1.

⁸⁷ Gustafson, p. 239.

⁸⁸ Gustafson, pp. 242, 245.

It is in this context that Frank Holmes's comments about the failure of the publicly funded health service can be placed. The tightening economic situation ensured that government expenditure upon social services was under great scrutiny. Hospital board grants did not escape. Government expenditure was reduced and boards were warned by the Department of Health that the National Government was alarmed about the economic situation and that this would mean that no further finance would be provided.⁸⁹ They were to consider the total grant allocated to be the upper limit of their expenditure.⁹⁰

In October 1976 the newly created Cabinet Committee on Expenditure requested reports from the Department of Health and Treasury outlining current hospital board funding mechanisms and their justification. In his report Hiddlestone argued that allocations for growth could be made to encourage boards to invest in extramural services, therefore aligning with the Government's policy direction for health. However he was reluctant to make any further suggestions to change other funding strategies; the base allocation for each year (consisting of the total allocation of the previous year) had not been altered since the introduction of the block grant scheme, and he argued that it could not be in the future without risking significant political repercussions.⁹¹ Despite his reluctance to alter the levels of block grants Hiddlestone was personally supportive of the Government's directional shift toward extramural services (community based health services); he considered the shift from curative to preventive health a positive trend.⁹² The subsequent report provided by the Department argued that committing to a consistent growth allocation would allow boards to plan more effectively, removing the "stop-go" policy in place when growth rates were

⁸⁹ McKinnon, p. 266.

⁹⁰ S.J.V. Wilson (for the Director, Division of Hospitals) to the Chief Executives and Secretaries of all hospital boards, Circular Letter, 9 April 1976, p. 3, NA, ABQU, 632, W4415, Box 596, Record 342/4/1.

⁹¹ John Hiddlestone to the Cabinet Committee on Expenditure, Report, 1 December 1976, p. 2, NA, ABQU, 632, W4415, Box 596, Record 342/4/1.

⁹² Interview with George Salmond, 2 May 2008. See also Dow, p. 228. Hiddlestone had made no secret of his dislike for the growth in lifestyle related diseases claiming that such a growth was due to a lack of responsibility amongst the general population. Hiddlestone enthusiastically welcomed Gill's introduction of additional duties upon alcohol and tobacco and the use of the generated funds for community health.

reconsidered annually.⁹³ Treasury's report was more critical of current funding levels and procedures and sought a review and reduction of hospital board allocations. It argued that their approach followed the precedent of studies undertaken internationally looking into curbing and controlling health expenditure and would follow "the Government's specific aim of shifting resources to export-based industry". In line with this focus they recommended that the growth allowance should not be increased at all to combat the funds expected to be required for New Commissionings and also to limit "inflationary expectations".⁹⁴

The 'Shadow' of Rationing

From the previous discussion it is clear that in the early to mid 1970s extended efforts were made to take control, standardise and in some cases limit hospital board expenditure. 'Rationing', as an explicit concept, was not influential in these practical decisions. However a close look at the two principal reviews undertaken during this period, and responses to them, reveals that ideas aligned to health care rationing were expressed on various occasions.

At the 1972 Royal Commission on Social Security, chair Alan Danks posed to Dr Erich Geiringer, president of the NZMA, a hypothetical 'rationing scenario'. He questioned him about how he would allocate money if he were given the total budget that was spent upon the General Medical Services, pharmaceutical and specialist benefits. Geiringer's reply? That resources should go to those who he felt were not getting their fair share; if pushed, he stated that the GMS benefit should be lowered in order to "slap the extra money on to the children and the aged". Geiringer seemed reluctant to engage in any kind of discussion about rationing, even hypothetically, scared perhaps that his answers might contradict the general

⁹³ Department of Health to the Cabinet Committee on Expenditure, Memorandum, no date, p. 2, NA, ABQU, 632, W4415, Box 596, Record 342/4/1.

⁹⁴ Secretary to the Treasury (Henry Lang) to the Deputy Minister of Finance, report, 10 December 1976, NA, ABQU, 632, W4415, Box 596, Record 342/4/1.

argument of NZMA's submission: more money needed to be dedicated to health care, in both the public and private sector.

Even the Labour Government's 1974 White Paper on health could not escape reference to health care rationing; this is significant because at first glance the White Paper appeared to be arguing that health was indeed a special case: the document was strongly influenced by the principles of the World Health Organisation's (WHO) constitution. The directives of the constitution selected to introduce the White Paper emphasised that health was the basis of any society and that governments had "a responsibility for the health of their people".⁹⁵ But as will be discussed later, the paper also included a discussion on 'service planning' that was more closely aligned to ideas of rationing.

The White Paper was the result of the Labour Government's Caucus Committee on Health (made up of Gerry Wall, Rufus Rogers, Russell Marshall, John Munro and Bob Tizard). The Committee heard submissions from interest groups and was presented with research from the Department. However because of the subsequent backlash, particularly from members of the medical community, against the proposals put forward, it is unclear as to who was responsible for the overall message within the White Paper. Michael Bassett has claimed that George Salmond was responsible for the "final shape" of the document.⁹⁶ But when questioned Salmond claimed that no one was willing to come forward and take responsibility for the authorship.⁹⁷ The unwillingness of those involved to take ownership of the document is understandable in light of the subsequent attack upon the ideas it put forward. Both MANZ and hospital board members came forward to publicly attack the ideas within the White Paper.

The authors of the White Paper used the values espoused in the WHO's constitution to argue for a "fundamental overhaul" of New Zealand's health service so that every citizen

⁹⁵ *A Health Service for New Zealand (White Paper)*, Government Printer, Wellington, 1974, p.5.

⁹⁶ Michael Bassett, *The Third Labour Government*, Dunmore Press, Palmerston North, 1976, p. 196.

⁹⁷ George Salmond, interview, 2 May 2008.

had access to health care on an equitable basis, irrespective of their ability to pay for individual services.⁹⁸ In particular, the White Paper was critical of the private sector which was subsidised by the state. They argued that if the private sector continued to expand it would be at the expense of the intended “comprehensive public sector”; *if* the private sector were to receive further funding then its impact on the public sector would need to be carefully assessed.⁹⁹ It was only within the public sector that New Zealand could acquire a health service most able to supply all members of the community with health care; the argument was that the public sector had “the resources and the commitment” towards this goal, the private sector did not.¹⁰⁰

The White Paper’s emphasis on bolstering the public service received sharp criticism from MANZ, claiming that the solution to the country’s health problems was a continuation of the dual system of care. They went as far as saying that New Zealand had one of the “best health services in the world”, specifically because of its dual system of care. The dual system allowed patients to select the service they wished, making contributions themselves if they chose, often by way of health insurance; these contributions, it was argued, lessened the “burden on the national finances”.¹⁰¹ MANZ claimed that further strengthening of the private sector was required in the form of increased benefits to general practitioners, specialists and private hospitals (including the continuance of additional benefits for the “disadvantaged”); these benefits would supplement the fee for service payments made by patients to general practitioners and specialists.¹⁰² Despite this quite fundamental disagreement about whether health care would best be delivered in the public or private sector, there was however a

⁹⁸*A Health Service for New Zealand*, p. 83.

⁹⁹*A Health Service for New Zealand*, pp. 75, 77-78.

¹⁰⁰ Michael Bassett, ‘Labour’s White Paper on Health-Some Reflections’ in Michael H. Cooper & Patrick T. Shannon, eds., *A New Health Service for New Zealand?*, Proceedings of a Symposium held 11-13 November 1977, University of Otago, Otago, 1978, pp. 58-65, p. 59.

¹⁰¹*An Improved Health Service for New Zealand: submissions by the Medical Association of New Zealand on the 1974 Government White Paper, “A Health Service for New Zealand”*, June 1975, pp. 3-4.

¹⁰²*An Improved Health Service for New Zealand*, pp. 6-7.

crucial similarity between MANZ and the White Paper: MANZ supported the view that health care was now a “right” for all citizens, and that social and economic circumstances should not be a barrier to accessing adequate health care. Their support for this view is perhaps understandable in that it would ensure that health care funding would continue to be a priority, therefore securing the value of their profession.

Yet interestingly MANZ’s justifications for funding to the private sector resemble those expressed in rationing arguments. They argued that the suggestion that the restructuring proposed would meet all of New Zealand’s *demands* as well as needs was simply unrealistic; quoting Dr David Owen, the United Kingdom’s Minister of State for Health MANZ argued that, “there will never be a Government or a country that has enough resources to meet all the demands any nation will make on a national health service”.¹⁰³ In fact, MANZ argued, a bolstering of the fee for service scheme would ensure that the *current* rationing climate could be alleviated. The logic behind this argument was that a system where health services are “free at the point of consumption” leads to an unnecessary demand upon those services, resulting in a “run-down” lower quality service, which in itself results in a form of rationing.¹⁰⁴ It is clear from the focus in the White Paper and in MANZ’s response that there was at least some agreement that the *supply* of more physical and financial resources would not in and of itself meet all the *demands* placed on the health service.

Service Planning

It is in the service planning section of the White Paper that ideas aligned to rationing were most strongly in evidence. Service planning in New Zealand had its early beginnings with the establishment of the Department of Health’s Planning and Research Unit in 1962 and was further developed in the 1970s. Several advisory planning groups were established

¹⁰³ H.H. Gilbert, ‘Presidential Address’, *NZMJ*, vol.83, no.561, April 14, 1976, p. 240.

¹⁰⁴ *An Improved Health Service for New Zealand*, p. 23.

by the North Canterbury Hospital Board, assisted by members of the medical profession and Dr Laurence Malcolm, the Principal Medical Officer (Research) of the Health Planning and Research Unit.¹⁰⁵

One of the proposed solutions put forward in the White Paper was that the use of existing resources would need to be analysed. Although the public might perceive that the problem was a *lack* of resources because of the shortage of doctors and the delays experienced in gaining treatment;¹⁰⁶ for the authors of the White Paper, assessment of whether the resources currently available were being used efficiently would need to be considered before the Government could respond to the “popular” resource solution: more hospital beds.¹⁰⁷ The implications of “inefficient resource use” (a conclusion that, it was acknowledged, could not be reached without an extensive collection of management data) was that limitations would be placed upon resources, at least until efficient use of those resources could be assured.

In the same year as the White Paper was released, David Morris, Deputy Director of MSRU, reinforced the importance of efficiency within the health sector, stating that as there could be little hope in the near future that the health sector would receive increased funding, then any progress made would have to come from increases in efficiency. Morris was aware of the possible implications of the term efficiency when applied to the health sector; he noted that many people felt uneasy with the term as it implied that the focus would simply be on economy of use, resulting in an impersonal, calculated approach to health services. Morris was aware that the pursuit of efficiency in health was especially difficult for many people to accept, given that healthcare – the “most personal and intimate of the public services” – was an area said to deserve the utmost care and compassion. Seeking to dispel these fears, Morris argued that this interpretation was only half of the picture; even when resources were *used*

¹⁰⁵ Motte-Harrison, pp. 1, 16.

¹⁰⁶ *A Health Service for New Zealand*, p. 75.

¹⁰⁷ *A Health Service for New Zealand*, p. 77.

efficiently, the *outcome* could be regarded as inefficient if the impact on patients was negative.¹⁰⁸

Crucially, like the 1969 *Review*, the White Paper outlined the distinction between need and demand as a significant factor to be considered in any service plan. Whilst accepting that obvious needs, such as delays in specialist services and waiting lists, should be given a high priority, it was also stated that any health plan could not conceivably deal with all needs as there were simply too many factors involved. With this in mind, service planners should establish “norms” to be achieved throughout all regions. The establishment of these norms would ensure that the available limit of “financial, manpower and material resources” could be evenly distributed throughout the country.¹⁰⁹

For the authors of the White Paper, effective management and service planning were interconnected. The focus upon service planning would be a new facet of New Zealand’s health sector, where, in the past the architectural design of hospitals had been given higher priority than consideration of the services they were designed to provide.¹¹⁰ However, although service planning was infused with ideas aligned to rationing, the weight of the White Paper was still on the fulfilment of WHO’s definition of health and wellbeing, ensuring that any notion of explicit rationing was concealed.

Little explanation as to how the proposed services would be assessed was put forward in the White Paper, except to say that there were few standards that could be used to effectively measure “health outcomes”, particularly when trying to assess patient care in quantitative terms.¹¹¹ Salmond, who was Director of MSRU at the time of the White Paper’s release, was not so reluctant in his description of the various ways in which the health

¹⁰⁸ David Morris, ‘The Efficient Use of Resources’ in D.W. Beaven & B.H. Easton, eds., *The Future of New Zealand Medicine: a progressive view*, N.M.Peryer Ltd, Christchurch, 1974, pp. 54-55. See also G.C. Salmond, ‘Health Care Evaluation’ in D.W. Beaven & B.H. Easton, eds., *The Future of New Zealand Medicine: a progressive view*, N.M.Peryer Ltd, Christchurch, 1974, pp. 60, 64.

¹⁰⁹ *A Health Service for New Zealand*, pp.100-102.

¹¹⁰ *A Health Service for New Zealand*, pp. 98-99.

¹¹¹ *A Health Service for New Zealand*, p. 102.

services could be assessed; this assessment, Salmond wrote, was the subject of increasing interest due to the similarly increasing levels of expenditure upon the health sector (both public and private). In turn these increases were driving initiatives to find reliable evaluation methods. Salmond argued that the “ill-defined, ill-structured, value-laden nature of health care problems makes evaluation an important part of health care administration”.¹¹²

The Special Advisory Committee on Health Services Organisation (SACHSO)

Following National’s re-election at the end of 1975 the White Paper was shelved. Some writers have since speculated that Labour’s defeat was due in part to the strong attack upon the White Paper.¹¹³ In 1976 the Special Advisory Committee on Health Services Organisation (SACHSO) was created. SACHSO was chaired by Alan Danks (who had previously headed the Royal Commission on Social Security) and was established by National’s new Minister of Health Frank Gill. Muldoon put Gill in charge of the Health portfolio specifically to construct an adequate alternative to the proposals in the White paper.¹¹⁴

SACHSO was intended as a way to involve all those sectors responsible for the delivery of health services, the majority of its members were drawn from the medical professions with only a minority from within the Department of Health. The transparency of SACHSO was the new National Government’s response to the sustained criticism that had been levelled at the White Paper and was aligned with MANZ’s request to Gill that all Consultative Committees set up to discuss the White Paper’s proposals be disbanded.¹¹⁵ Gill was keen to ensure that members of the medical profession were aligned with the

¹¹² Salmond, ‘Health care evaluation’, pp. 60-65.

¹¹³ See Gauld, p. 32. Gauld cites Michael Bassett, *The Third Labour Government*, when claiming that Labour’s defeat was due to the White Paper.

¹¹⁴ Gustafson, p. 175.

¹¹⁵ Dow, pp. 214-17. See also ‘The Medical Association of New Zealand, Proceedings of Council Meeting held on Wednesday, 10 December 1975’, *NZMJ*, vol. 83, no.556, January 28, 1976, p. 58.

Government's approach and attended the MANZ meeting in March 1976, promising that "over-centralised control of the Health Services" would not persist under a National Government; instead local involvement would potentially increase. In addition, Gill promised that hospital boards would not be abolished, but instead would be encouraged to amalgamate where appropriate.¹¹⁶ This attention to the concerns of the medical profession appears to have been successful. Gill was held in high regard by the Hospital Boards Association and by MANZ.¹¹⁷

In order to test the proposals developed by SACHSO two pilot schemes were established. In 1978 Northland was selected as the rural test case and in 1979 Wellington was selected as the urban environment for the scheme. Ultimately, those within the pilot schemes believed their work would lead to the construction of the Area Health Board (AHB) model of health care delivery. Within these schemes 'Shadow' service development groups were established, and the workings of these shadow advisory groups produced findings relevant to their particular region.¹¹⁸

The Area Health Board model for funding reinforced the value of community care. This model of health care delivery would mean that hospital boards became responsible not only for patients' institutional care, but also for community health care. The idea was part of a broader initiative to move the focus of health care solely from "illness indicators", as was likely the case if health planning dealt only with data resulting from hospital admissions and visits to the general practitioner, and to create health plans that included what were described as "wellness" indicators. The broader focus of the Area Health Board meant that information would now be needed to plan not only for the number of beds, buildings and equipment required for the population – a formidable task in itself – but also for the co-ordination of a

¹¹⁶ 'The Medical Association of New Zealand: proceedings of Council Meeting held 10 March 1976', *NZMJ*, vol.83, no.562, April 28, 1976, p. 290.

¹¹⁷ Dow, pp. 216-17.

¹¹⁸ For the development of service planning and the Area Health Board model of funding see, Motte-Harrison, pp. 1, 2, 5, 21. See also Gauld, pp. 34-35.

number of agencies and individuals in the community. In this way, AHB's might take on, and be accountable for, the health of the general population. Although the AHB model of health delivery would seemingly align SACHSO with the WHO model of health and wellbeing that had been influential to the White Paper, with Danks as SACHSO's chair the issue of rationing was never far from the agenda. In 1980 Alan Danks wrote of the problems that hospital planners faced when allocating resources with public funds. The demand for services would never be satisfied, "[r]ationing is the ugly sister of welfare".¹¹⁹

Voicing the need for rationing

Danks's acceptance of explicit rationing whilst chair of SACHSO was one product of the pressure on health funding during the 1970s. Such ideas were also expressed in the Department of Health and the Treasury. In 1979 Desmond Ryan, Deputy Director of Health (Administration)¹²⁰ wrote of the lack of adequate facts upon which health resources could be allocated; to remedy this, a recently released Department of Health special report collated and compiled available health statistics in order to analyse historical trends in health expenditure. Ryan felt this was a necessary exercise given that the "voracious appetite" for health resources was being scrutinised both within New Zealand and internationally. He wrote that the "halcyon period" of the late 1960s and early 1970s was over. The "infinite resources" of the earlier period were now finite. Although, what remained constant from this earlier period, according to Ryan, was the "unlimited demand" for those same resources; the collision of resource demand and supply constraint meant that "[u]npalatable decisions" were unavoidable.¹²¹

¹¹⁹ Motte-Harrison, p.i.

¹²⁰ Desmond Ryan became Deputy-Director General (Administration) in March 1975. See Dow, p. 213.

¹²¹ A.G. Smith & P. M. Tatchell, *Health Expenditure in New Zealand-Trends and Growth Patterns: special report series no.53, Management Services and Research Unit, Department of Health*, Govt Printer, Wellington, 1979, foreword.

Danks made a similar assessment of the health sector. According to Danks the context in which rationing took place had altered dramatically in the decades following World War Two. Once health services had in effect been rationed by a lack of “real resources”: shortages of trained staff, a lack of beds, buildings and equipment; but Danks believed that was now no longer the case. Like Ryan, Danks argued that the health sector had moved into something of a “static state” where resources were now available. He went on to argue that service planning would be the answer to the country's health resource problems; service planners would now be called upon to make deliberate decisions in order to ration resources. He noted that while resources were no longer in short supply, expenditure on welfare was “politically constrained” and as such must be divided up according to the decisions made by planners.¹²² The focus of service planners reflected many of the broader concerns about the allocation of health resources that had been gathering momentum throughout the 1970s. Service planners would have to set about identifying competing demands and assessing and deciding upon the resources that would be allocated to each area of priority, aware that this would necessarily mean that other areas would be negatively affected.¹²³

Despite this explicit use of rationing, the concept was still contentious. When Michael Cooper first released *Rationing Health Care* in 1975 his work received strong criticism in the United Kingdom for proposing that the provision of health should be limited in anyway.¹²⁴ This attitude was later evident in New Zealand; John Martin recalled how he came under strong attack from members of NZMA for using the term rationing during a meeting in the early 1980s.¹²⁵ Furthermore greater talk of rationing did not necessarily translate to acceptance even within the Health Department. Phillip Tatchell's interest in rationing was not

¹²² Motte-Harrison, p. i; *Report on a Workshop for Health Planners*, Lower Hutt 21-23 October 1985, A joint project of the Department of Health and the Hospital Boards Association of NZ (Inc), 1986, p. 2.

¹²³ Laurence Malcolm, 'Planning Strategies for policy development' in M. Cooper & P. Shannon, *A New Health Service for New Zealand: proceedings of a symposium held 11-13 November 1977*, University of Otago, Otago, 1978, p. 80.

¹²⁴ Interview, Michael Cooper, 14 June 2008.

¹²⁵ Interview, John Martin, 22 April 2008.

wholly supported within MSRU, the concept was still regarded as slightly on the ‘fringe’ of what health planners should be discussing (although Cooper himself assisted with studies done within the Department in the later 1970s)¹²⁶ It seems then that although the concept was in use, particularly in government reviews of the health service, the idea that resources should be found to overcome constraints faced by the health services thrived alongside arguments for the explicit rationing of those same services.

¹²⁶ Interview, George Salmond, 2 May 2008.

Chapter Three: Rationing and Specialist Treatment

Health care rationing debates were influenced by the need for ‘advancing technology’ and specialist treatment, due in part to the development of that same technology and also to increases in degenerative diseases.¹²⁷ Increasing rates of, in particular, coronary disease and most types of cancer were challenging for health administrators. As outlined in Chapter Two, specialist and highly technologically-dependent medicine became a crucial element of medical care, particularly from the 1960s. The high cost of the procedures associated with this type of medicine placed pressure upon a health service in which health administrators and successive governments were already concerned with the cost of existing services. MANZ argued that the shift from communicable diseases to what could now be described as “lifestyle diseases” was not being adequately dealt with in the public health system. It argued that the unwillingness to shift focus meant that innovation in medical care did not take place, and that the public had a health system intent on fixing the problems of the past.¹²⁸

The number of patients treated in public hospitals for coronary heart disease and some types of cancer increased markedly from the 1940s to the 1970s. The number of cases of coronary disease for every one hundred thousand members of the population nearly tripled between 1940 and 1950 and then more than doubled between 1950 and 1960. This number then steadily increased throughout the 1960s. Cancers of the trachea, bronchus, lung and the breast displayed similar trajectories; the increases in cancers of the stomach and cervix were not as dramatic, reaching peak rates by the 1960s and then for the most part levelling off.¹²⁹

An example of this type of issue and debate emerged in 1970 when two professors from Auckland’s post graduate school of obstetrics and gynaecology criticised the amount of

¹²⁷Gauld, pp. 23-24. The issues surrounding the provision of new medical technology will be dealt with in greater detail in Chapter Five.

¹²⁸*The New Zealand Herald*, May 19, 1970, p. 5.

¹²⁹National Health Statistics Centre, Department of Health, *New Zealand Health Statistics Report: Hospital and Selected Morbidity Data 1971*, Department of Health, Wellington, 1971, p. 19.

money spent upon cancer research. Professor Green claimed that the money spent on such research over the previous twenty years had produced very few advances in the actual treatment of the patient. Dr Stephens, himself a specialist in malignant diseases and a former research fellow of the Institute of Cancer Research in London supported this stance, claiming that New Zealand could only justify the cost of one cancer research unit. There were however two such units already in New Zealand, with planning underway for a third. Stephens stated that although research into the treatment of cancer had value, at least in principle, he also felt that “sooner or later we have to ask: Is it worth it?”¹³⁰

In fact, new and expensive technologies and procedures raised complicated issues which had to be taken into account in the allocation of health resources. Michael Cooper touched upon the challenges that new medical technology was creating for the allocation of health resources in his work on rationing. Cooper argued that it was not possible for any country to provide all the treatment that is “technically feasible”.¹³¹ Furthermore, Cooper argued “that much medical treatment is inappropriate, unproven or even unsound”, giving patients hope and comfort, but not effective treatment or cure. Cooper carefully noted the value of such hope and comfort, but questioned whether the allocation of resources could be justified to meet only those ends.¹³²

¹³⁰*The Evening Post*, 20 January, 1970, p. 22. For the President of the Cancer Society’s rebuttal see *The Evening Post*, January 22, 1970, p. 23.

¹³¹Cooper, *Rationing Health Care*, p. 46.

¹³²Cooper, *Rationing Health Care*, p. 58.

Medical Specialisation

Medical specialisation began in the nineteenth century.¹³³ Although originally inferior to generalist physicians who were able to gain posts at hospitals because of their social standing, gradually the specialist physician became important.¹³⁴ Lindsay Granshaw argues that in Britain, at least, the building of the specialist hospital, as distinct from a general institution, pre-dated the establishment of specialist physicians as an organised group, with specialists using the establishment of (at first) small specialist hospitals to legitimise their role in medicine. Specialisation's impact upon the way in which medicine was practiced accelerated during the twentieth century; by mid-century specialisation dominated medical practice.¹³⁵ George Weisz's recent work on medical specialisation argues that the era following World War II can best be described as an era of "high technology 'bio-medicine' practised in hospitals"; the accompanying division of physicians into various specialties and sub-specialties was an important part of this process.¹³⁶

The path that specialisation took in New Zealand is illustrated by Dr C.B.Sherer's winning entry to an essay competition run by the New Zealand Council of the College of General Practitioners in 1959. In his essay Dr Sherer discussed the role of the general practitioner and how that role was changing in relation to the medical specialist and the practice of medicine. Sherer argued that the role of the "traditional family doctor" was now redundant. The family doctor, who in the past was responsible for the overall care of patients, was now replaced by the general practitioner who had become the coordinator of an "army of

¹³³ Porter, pp. 525-27.

¹³⁴ Lindsay Granshaw, 'Fame and fortune by means of bricks and mortar': the medical profession and specialist hospitals in Britain, 1800-1948' in Roy Granshaw and Lindsay Granshaw, *The Hospital in History*, Routledge, London, 1989, pp. 200, 202.

¹³⁵ Porter, pp. 11-12.

¹³⁶ Weisz, pp. x, xvi, 231.

specialists”.¹³⁷ Increasing specialisation meant that patients were viewed through the narrow lens of the particular specialty to which the doctor belonged.¹³⁸

The growing importance of specialist medicine to health care can also be seen in the increased demand for specialist services, particularly following the introduction of the Social Security Act in 1938. Initially specialist services under the Act were available only to inpatients in public hospitals, although this changed fairly soon and several benefits were introduced which allowed outpatients access to more advanced treatment. Thus the x-ray diagnostic services benefit began on the 11 August 1941 and the laboratory diagnostic services benefit commenced on 1 April 1946. By 1950, the uptake of the benefits had placed considerable pressure upon laboratory services, the majority of which were attached to public hospitals. In 1950 the Department of Health’s Annual Report noted that the demand for services following the introduction of the benefits was still exceeding the “capacity of many of the departments concerned”.¹³⁹

‘Early’ rationing

Long before Cooper made his 1975 observation that not all “technically feasible” care could be provided to the public, indicating that specialist care should be explicitly rationed, specialist care was in fact subject to de facto rationing by the market. An extension of outpatient services had caused an increased demand for specialist treatment. The growth of

¹³⁷ C.B. Sherer, 'The Correlation of the Work of the General Practitioner with the work of fellow practitioners and specialists and with public hospital practice', *NZMJ*, vol.58, no.324, April 1959, pp. 199-209, p. 201.

¹³⁸ For a discussion of medical developments (particularly the technological developments that went alongside medical innovation) see Joseph D. Bronzion, Vincent H. Smith & Maurice L. Wade, *Medical Technology and Society: An Interdisciplinary Perspective*, MIT Press, Massachusetts, 1990, p. 13. Bronzion, Smith and Wade also argue for the timeline described by Sherer, with the ‘modern hospital’ emerging from the beginning of the twentieth century; a trend that accelerated following World War Two. See also Sir Kempson Maddox & James M. Gardiner & John B. Hickie, 'The History of the Cardiac Society of Australia and New Zealand' in Josephine C. Wiseman, ed., *To Follow Knowledge: A history of examinations, continuing education and specialist affiliations of The Royal Australasian College of Physicians*, The Royal, Australasian College of Physicians, Sydney, 1988, p. 21 for a discussion of the division of medical specialties, particularly following the Second World War.

¹³⁹ *AJHR*, 1950, H.31, p. 40. For further description of the growth in demand for medical care following the introduction of the Social Security Act see Hay, pp. 129-30.

patients and overall attendances at outpatient departments during the 1940s was caused by a corresponding growth in the number of specialist clinics; there had been such considerable growth during the decade that several specialist clinics struggled to keep pace with the increased demand for outpatient treatments, a situation not helped by the number of specialists (in particular radiologists and pathologists) who were moving into private practice.¹⁴⁰ As well as private specialist care, the National Government (in particular) utilised private hospitals to take pressure off public hospital facilities.¹⁴¹ The Government's policy was supported within the Department. Director General of Health Harold Turbott described private hospital beds as a "supplement" to public hospital beds.¹⁴² By the 1950s the Government was rationing specialist services in a number of ways: by price (treatment by private specialists was not covered at all), by attempts to limit specialist treatment through measures to control the number of inpatients treated, or through the active diversion of patients to the private system.

Change of attitude towards specialist care in the late 1960s

By the later 1960s attitudes in New Zealand towards the provision of specialist treatment had changed. In a recent work upon health sector reform, Jane Hall and Rosalie Viney argue that by that time optimism and faith in scientific medical advance had translated into hope that such advances would lead to the removal of illness from society.¹⁴³ Individuals previously involved in health administration in New Zealand, such as George Salmond and John Martin, concur with this argument.¹⁴⁴

The public hospital was crucial to the endeavour. The "cost and complexity" of specialist diagnosis and treatments meant that some procedures could only practicably be

¹⁴⁰ *AJHR*, 1950, H.31, pp. 40-41.

¹⁴¹ Hay, pp. 134-5; Gauld, p. 19.

¹⁴² *AJHR*, 1960, H. 31, p. 9.

¹⁴³ Jane Hall & Rosalie Viney, 'The Political Economy of Health Sector Reform', pp. 50-51.

¹⁴⁴ Salmond & Martin, 'Policy Making: The 'Messy Reality'', p. 46.

provided in public hospitals.¹⁴⁵ The expense of specialist treatment had implications for both patients and for specialists themselves; certain specialisations were not commercially viable due to the expense of the equipment; this made them reliant on the public hospital.¹⁴⁶

Because of the considerable cost in providing specialist services, both in equipment and in the number of staff required, the dependence of specialist medicine on the public hospital system intensified from the late 1960s. Specialist services also tended to develop within the public hospital sector because of their interdependence, for example cardiology and cardiothoracic surgery. They also relied upon specialised diagnostic procedures and equipment supplied by radiology and laboratory services. In the Wellington region this meant that specialist services developed at Wellington hospital; the costs of replicating services in surrounding hospitals was prohibitive.¹⁴⁷

A look into trends in health expenditure also reveals a move towards expenditure on hospital based (read specialist) medicine from the mid 1950s. By the 1960s the majority of increased funds available under Vote Health went towards the public hospital service; in contrast, community and public health care both maintained steady percentages throughout the period.¹⁴⁸

The significance of the hospital is further reinforced by the title of the major review carried out during this time. Entitled *A Review of Hospital and Related Services in New Zealand* the focus of this 1969 report clearly indicates the centrality of the hospital to New Zealand's health service; the hospital is the central point around which all other services

¹⁴⁵ Sherer, pp. 199.

¹⁴⁶ Submission of the Central Specialists Committee (Christchurch Working Party) (Submission 249) to the Royal Commission on Social Security, Benefits-Qualifications and coverage-Specialist Benefits, NA, ADQU, 19492 Com 7, Box 33, Record, 30/3.

¹⁴⁷ Wellington Hospital Board, *Clinical Services Review, General Medicine and Medical Sub-specialties*, Fourth Draft, August 1984, pp. 1, 32-33.

¹⁴⁸ Peter Davis, *Health and Health Care in New Zealand*, Longman Paul, Auckland, 1981, p. 6. Davis has figures of overall public expenditure in constant prices showing a large increase in expenditure on health between the 1930s and the 1970s. In particular he shows an increase in expenditure upon hospitals in contrast to other health services. Davis takes his data from J. McKinlay, 'Evaluating medical technology in the context of a fiscal crisis: the case of New Zealand', *Milbank Memorial Fund Quarterly (Health and Society)*, no. 58, 1980, pp. 217-67.

cluster. (The significance of the hospital during the 1950s and, in particular, the 1960s, is compounded by the fact that by the mid-1970s the emphasis had shifted away from the hospital to the health service as a whole. Again this shift was appropriately captured by the title of the 1974 White Paper: *A Health Service for New Zealand*. The shift would have implications for specialists, with hospital care only one of a number of services, and health endeavours spread more evenly between preventive and curative care.¹⁴⁹)

By the late 1960s the Health Department had embraced specialist care as part of the health services. In 1968 Director General Douglas Kennedy acknowledged the greater role that specialist services now played in health care, driven in large part by technological advance over the previous decade.¹⁵⁰ The Department outlined this trend in the 1969 *Review*. Drawing on that year's August issue of the WHO magazine, the *Review* outlined the "double revolution" over the past twenty years, referring for the most part to technological advances in medicine, and claiming that the public's expectations of that same technology had grown in tandem.¹⁵¹

The greater acceptance of the hospital, technological development, and the growth of specialist care within New Zealand's health service meant that the concerns over cost visible in health administration had, by the later 1960s, taken a particular shape. In some cases the discussion of specialist services was focused on tactics to allow the equitable distribution of specialist services throughout the population, and therefore giving the greatest number of people access to medical advance.¹⁵² A study published in 1970 described the growth in specialist medicine as being subject to public demand: as cures, or more effective treatments, were discovered for previously incurable conditions, then the public would demand greater

¹⁴⁹ I am indebted to George Salmond for drawing my attention to this point. George Salmond interview, 2 May 2008.

¹⁵⁰ *AJHR*, 1968, H.31, pp. 6-7

¹⁵¹ *A Review of Hospital and Related Services in New Zealand*, p. 59.

¹⁵² *AJHR*, 1968, H.31, pp. 6-7

access to those treatments. And as per capita income increased, so too would demands upon specialist services.¹⁵³

Although there was considerable enthusiasm for specialist medical advances, there lingered under the surface, even in the medical community, a certain degree of scepticism about their possible benefits. The advent of new medical procedures led to some philosophical questioning about the value of medical care itself. In his 1968 inaugural address to MANZ, Dr W.J. Hutchison seemed in two minds about scientific and medical advance. On the one hand he was critical of the Government for the lack of resources available to perform operations such as kidney and heart transplants, but at the same time he appeared mindful of the tremendous cost of those same procedures. Strikingly, Hutchison also inadvertently questioned whether those same procedures could be justified by the actual results that were produced: “Scientific changes in medicine would dictate the future but it was impossible to tell to what extent man's knowledge of such diseases as cancer would reach”.¹⁵⁴ Whilst it may be presumed that as a doctor, Hutchison was not against scientific advance in medicine per se, his address questioned whether the existing health care system was adequately dealing with the “revolution” in medical care.¹⁵⁵

More obvious philosophical questioning occurred at the Health Administration Convention held in Hamilton in May 1968. Dr W.E Henley's (Superintendent in Chief of Auckland Hospital Board) question: “What of what can be done, should be done to any particular patient?” epitomised the problem tackled by health administrators. Expanding upon this line of inquiry, Richard Latimer, the Operational Research Officer of MSRU, noted that the reason health resource decisions needed to be considered in such a way was driven in part

¹⁵³ Joint Committee on Medical Graduate Needs, *Report on Medical Graduate Needs in New Zealand for the years 1968-2000*, Department of Health for the Committee, Wellington, May 1970, pp. 16, 21. The committee was chaired by Dr Morvyn Williams of The Royal Australasian College of Physicians and made up of members of the medical community (MANZ liaised with the committee), and was assisted by the MSRU.

¹⁵⁴ *The Dominion*, 14 March 1968, no page number, Social Welfare Department Regulations and Monetary Benefits, 1968-1975, NA, ABRR, 7273, Acc W4744, Box 40, Record, 139/3.

¹⁵⁵ *The Evening Post*, 14 March 1968, p. 10, NA, ABRR, 7273, Acc W4744, Box 40, Record, 139/3.

by the advent of procedures such as heart transplant operations. Although Latimer argued these issues had wider implications for the allocation of health resources, “ground-breaking” procedures were simply the most recent and visible element of health resource allocation.¹⁵⁶

Thus although there was considerable enthusiasm for advances in medical care, the increasing cost of advancing technology and treatment also prompted the Department's attempts to justify possible rationing decisions on an ideological basis: how could expensive resources be divided in order to ensure “the greatest good for the greatest number”? In real terms this meant they were mindful of the fact that an expensive but potentially life-saving procedure for one patient could mean that many others would be denied treatment; a dilemma aptly described in the 1969 *Review* as “the routine *versus* the dramatic; the individual against the group”.¹⁵⁷

Although the best way of remedying this problem was still up for contention, Latimer was not so reluctant in his assessment, claiming that in any health care system, “the sky is not the limit” in availability of care. Latimer argued that little headway could be made in health resource discussions without the general acceptance that there was a limited amount of finance available, and that priorities must be established in order to use that finance “to best advantage”.¹⁵⁸

Latimer’s assessment was a harsher approach than that expressed by Director General Douglas Kennedy, although the sentiment was similar. Kennedy outlined in the 1968 Annual Report his own admiration for advances in medicine which, he wrote was “deeply in debt to technological advances for its own progress”. But like Latimer, he cautioned that such

¹⁵⁶ R.J. Latimer, ‘Introduction’ in R.J. Latimer, ed., *Health Administration in New Zealand*, New Zealand Institute of Public Administration, Wellington, 1969, pp. 7-8.

¹⁵⁷ *A Review of Hospital and Related Services in New Zealand*, p. 60.

¹⁵⁸ Latimer, p. 12.

medical advances would mean that the control of health resources would need to be monitored much more carefully.¹⁵⁹

Arguments and debates over the provision of specialist treatment persisted throughout the 1970s. President of MANZ H.H. Gilbert claimed in his presidential address to its March 1976 meeting that scientific medical advances were the cause of increased demand for treatment. Gilbert went on to say that many medical advances had not been effectively evaluated; he even went so far as to argue for a moratorium on further research until the benefits of current advances were known.¹⁶⁰

Gilbert's line of argument was again discussed at a symposium hosted by the University of Otago in November 1977. Several of the addresses were concerned with social influences upon health, and moved away from, and criticised, the continued allocation of funds "for ever more sophisticated investigation of the human organism".¹⁶¹ Sir Randall Elliot, the then president of MANZ, wrote of the advances made in medical science, but noted that declines in mortality rates had not followed.¹⁶² Professor G.L. Brinkman, Dean of the University's Medical School, also commented on the same trend, singling out the very expensive CAT scanners to illustrate his point.¹⁶³ Despite costing one million dollars, with ongoing costs of half a million per year, Brinkman argued that the scanners, and other similar technology, would not alter the relative "plateau" achieved in life expectancy. Quoting Dr

¹⁵⁹ *AJHR*, 1968, H.31, pp. 6-7.

¹⁶⁰ H.H. Gilbert, 'Presidential Address', *NZMJ*, vol. 83, no. 561, April 14 1976, p. 240.

¹⁶¹ Patrick T. Shannon, 'An Ounce of Prevention...An Overview of the Symposium' in Michael H. Cooper & Patrick T. Shannon, eds., *A New Health Service for New Zealand?*, Proceedings of a Symposium held 11-13 November 1977, University of Otago, Dunedin, 1978, p. 1.

¹⁶² Sir Randall Elliot, 'Health and Humanity' in Michael H. Cooper & Patrick T. Shannon, eds., *A New Health Service for New Zealand?*, Proceedings of a Symposium held 11-13 November 1977, University of Otago, Dunedin, 1978, pp. 8-11.

¹⁶³ For more detailed discussion of the introduction of CAT scanners into New Zealand see Chapter 4.

Archie Cochrane, Brinkman noted that “modern medicine” had made more of a contribution to the “comfort of living” than to life expectancy.¹⁶⁴

Minister of Health Gill touched upon another dimension inherent in discussions of resource allocation in his address to the NZMA (formerly MANZ) Biennial Conference in February 1977. The public had often been characterised in previous discussions regarding health resources as the source of insatiable demand; Gill argued that a new trend was emerging, where the public were also becoming critical of the benefits of medical advance. Gill argued it was no longer accepted that the goal of the medical profession to preserve life was “a simple and infallible binding rule” to be followed in all clinical situations.¹⁶⁵ The above discussion serves to show that during the 1970s scientific medical advances that had been greeted with optimism early in the decade were questioned by health administrators, politicians, and even by members of NZMA. In many cases the questions raised outlined the ‘rationing dilemma’ without actually naming it.

Philosophical questioning in action: Green Lane Cardiac Unit

These abstract discussions of specialist care also became public issues. One instance was the future of Auckland Hospital’s Green Lane Cardio-thoracic Unit. Drawing attention to the fact that three patients had died waiting for surgery in the first half of 1975, Dr Brian Barratt-Boyes claimed that unless the Government provided additional finance more patients would die awaiting surgery. Barratt-Boyes claimed that the lack of finance was indicative of the situation in the wider public hospital system, and went on to say that if additional finance was not forthcoming, the Unit would not be able to respond to public demand. Barratt-Boyes argued that the Government was “bound” to supply additional finance as per request so that

¹⁶⁴ G.L., Brinkman, ‘A Medical Perspective’ in Michael H. Cooper, & Patrick T. Shannon, eds., *A New Health Service for New Zealand?*, Proceedings of a Symposium held 11-13 November 1977, University of Otago, Dunedin, 1978, pp. 12-22, pp. 12-13.

¹⁶⁵ T.F. Gill, ‘An Address’, *NZMJ*, vol.85, no.583, 1977, pp. 194-95.

the number of surgical procedures could be increased from twelve to fifteen a week and eventually to twenty-five. Barrett-Boyes issued a veiled threat to the Government: if it could not provide the finance then “it should tell us, and we will tell the patients we cannot operate on them.”¹⁶⁶

Barratt-Boyes argued that in order to satisfy demand, more equipment would be required as well as beds and staff.¹⁶⁷ The situation was, according to Dr Frank Rutter (chairman of the Auckland Hospital Board), the combined result of Barratt-Boyes’ team’s increased skill and expertise in what was considered a very complicated procedure; the enlargement of the Intensive Care Unit at Green Lane Hospital; and an increase in public demand. The public were now aware of the benefits that could be gained; a sardonic observation had it that whereas in the early 1970s people were dying from coronaries, now, due to the increase in the waiting list, people were dying due to excess demand.¹⁶⁸

Barratt-Boyes outlined that he was continually considering issues of explicit rationing every week; the choice between urgent and very urgent was a weekly dilemma, with seemingly no prospect that the situation would remedy without expanded facilities and additional funds. He claimed that even when three or four very urgent cases could be taken from the top of the list, ten to fifteen more were added to the bottom. And, in case the public was still uncertain of the value of the procedure, Barratt-Boyes stressed what he considered to be the societal importance of those awaiting treatment; coronary heart disease “mainly affected the middle-aged executive type of man – people under stress and valuable members of the community”.¹⁶⁹

Barratt-Boyes’ claims were challenged by some members of the medical community who were seeking to ensure that preventive and community care did not suffer from the

¹⁶⁶*The Evening Post*, June 27, 1975, p. 19; *The Dominion*, July 1, 1975, p. 1.

¹⁶⁷*The Evening Post*, June 27, 1975, p. 19

¹⁶⁸*The New Zealand Herald*, June 28 1975, p. 1; *The New Zealand Herald*, July 1 1975, p. 3.

¹⁶⁹*The New Zealand Herald*, June 30, 1975, p. 1.

growth of specialist treatment. Professor Randall Elliot, Head of Paediatrics at Auckland's Medical School, and his colleague Professor Veale of the Human Genetics and Community Health Department, publicly questioned whether responding to Barratt-Boyes' claims would be the wisest use of money. The annual sum of one hundred thousand dollars needed to fulfil the Unit's aims of fifteen operations per week, would, Elliot argued "go a long way" if allocated to other sectors of the health care community. He conceded that he himself would probably act in a similar manner if he were in Barratt-Boyes' position but ultimately, he argued, if there was a shortage of funds it should not automatically be presumed that heart surgery was where the money was best spent. If that were the case, he claimed, it would simply be that funding would go to "those who clamour loudest".

Professor Veale held similar views. He too stated that priorities within the health sector needed to be carefully considered, particularly as "[t]he financial barrel is not bottomless".¹⁷⁰ Veale believed that, despite this, Barratt-Boyes would be likely to get his additional funding. But the fact that the procedure was in the early stages of development, was expensive, and because the condition for which it was performed was relatively common, he cautioned that if not considered carefully cardio-thoracic surgery could swallow "absolutely all" the available funding for health care.¹⁷¹

Rutter too made similar comments, stating that he was not totally convinced that if the Board were to be given additional funding that the money should automatically go to increase the number of coronary bypass operations. He knew of other areas for which the Board was responsible where demand for additional funding was as great.¹⁷² Using the publicity from Barratt-Boyes' press release, Rutter claimed that all specialties at all Auckland Hospitals would suffer without additional finance.¹⁷³

¹⁷⁰*The Dominion*, July 1, 1975, p. 1.

¹⁷¹*The New Zealand Herald*, July 1, 1975, p. 1.

¹⁷²*The New Zealand Herald*, July 1, 1975, p. 3.

¹⁷³*The New Zealand Herald*, June 30, 1975, p. 1.

Barratt-Boyes' claim that the allocation of additional finance was ultimately the Government's responsibility was in response to having been told by the Board that this was the only way in which the Unit would gain additional money.¹⁷⁴ As chairman of the Board, Rutter had met with Minister of Health Tom McGuigan on June 17, 1975 to discuss the fact that Barratt-Boyes was making "loud noises about people dying" on the waiting list. McGuigan had been responsive to Rutter's request, and promised to contact the Department of Health. But Rutter stated that within three days there was a "pretty blunt" telephone call from the Department informing him that there were no additional funds available for Auckland, or for any other hospital board.¹⁷⁵

McGuigan and Rutter continued to argue through the media about how long each had been aware of the problem, and, therefore, who was most responsible for the deterioration in service. Rutter stated that the Government had already been told that additional finances would be required due to the fact that in the preceding five to ten years medical care had become more "sophisticated" and "expensive"; and, in particular, Rutter stated the Board had informed the Government that cardio-thoracic surgery was one of the areas that would warrant additional finance.¹⁷⁶

Despite his bickering with Rutter, McGuigan responded almost apologetically to Barratt-Boyes' press release, most likely aware of the political fallout if he did not sympathize with the emotional appeal. McGuigan claimed that adequate treatment of patients must never be compromised "under any circumstances-financial or otherwise". But he did not take total responsibility. He argued firmly that the Hospital Board was responsible for *allowing* the deterioration of the Unit's service, and for leaving it too long before drawing the Government's attention to its problems (although Rutter had stated that the Board had itself only been informed in the week preceding the Rutter-McGuigan meeting). McGuigan argued

¹⁷⁴*The Evening Post*, June 27, 1975, p. 19.

¹⁷⁵*The New Zealand Herald*, June 28, 1975, p. 1.

¹⁷⁶*The Evening Post*, June 27, 1975, p. 19.

that the Government could do little when the Green Lane Hospital Planning Committee had itself deferred a proposal for the expansion of services within the Unit. And furthermore, in the previous year, when Barratt-Boyes had submitted his report, the Board had under-spent its grant.

Rutter countered that the level of under-spending was approximately one tenth of the Board's daily expenditure; he claimed the Board was still seriously lacking in growth funds. McGuigan's response was to commission an immediate and full inquiry into the Board's finances.¹⁷⁷ Rutter welcomed this step. Maybe then, he stated, the Department of Health might realise that the continuing growth of Auckland's population and the "increasing sophistication of medical services" was a very real challenge for the Board, and provide the additional money required.¹⁷⁸

The media attention to the situation at the Unit prompted several responses in the press in support of increased funding. A Hamilton man, whose daughter had been on the waiting list for nine months, implied that the withholding of funds was unnecessary and illogical; if the Government itself required additional finance there would be no question that this would be given the utmost priority.¹⁷⁹ A Mt Eden specialist wrote in arguing that the Government was placing the Hospital Board in an impossible position, on the one hand demanding that waiting lists be cut, and on the other, not providing the funding to hire staff to work in the already more than adequate facilities.¹⁸⁰ An editorial in the *New Zealand Herald* expressed strong support for Barratt-Boyes' request to be fulfilled: there were undoubtedly other priorities, but these could be dealt with in due course, whereas there was an immediate need for funding to the Unit, funding that could potentially save 150 lives per year. The

¹⁷⁷*The New Zealand Herald*, June 27, 1975, p. 1; *The New Zealand Herald*, June 30, 1975, p. 1. See also *The New Zealand Herald*, July 1, 1975, p. 3 where it is claimed that the Board was aware of a proposal to increase the number of surgeries as early as November 1973, when they were first informed that patients were dying on the waiting list for the operation.

¹⁷⁸*The New Zealand Herald*, June 28, 1975, p. 1.

¹⁷⁹*The New Zealand Herald*, June 30, 1975, p. 6.

¹⁸⁰*The New Zealand Herald*, July 18, 1975, p. 6.

editorial argued that such a request should not be overlooked due to bickering between the Government, the Department of Health and the Hospital Board over who was responsible for the situation. The facilities were in place, the writer claimed, and failing to adequately fund them would be a great waste. Others were prompted by the situation at the Unit to comment on the waiting lists for other procedures. Both a general practitioner and a “concerned daughter” wrote about the delay in gaining access to x-ray facilities at public hospitals.¹⁸¹ One contributor suggested that the funding problem could be fixed by drawing a lottery, a measure that was, he claimed, successful in other countries.¹⁸²

The exchange between McGuigan, Rutter and Barrett-Boyes, and the subsequent editorial responses, highlight the various issues raised by specialist treatment and the implications these issues had for rationing health resources. The continued public support and enthusiasm for the benefits of specialist medical advance is expressed strongly in the editorial responses; whilst the ways in which resources and funding were rationed comes through in the exchange between McGuigan and Rutter. McGuigan was careful to protect himself politically and so responded sympathetically to Barrett-Boyes, but at the same time he remained unmoved in relation to Rutter’s claims that the Board was struggling to cope with the costs of “sophisticated” medical services. McGuigan’s attitude in this case would undoubtedly result in the implicit rationing of specialist services, given his unwillingness to increase finance.

Barrett-Boyes’ claims went to the NAC but in April 1976 it rejected his proposal, on the grounds that it would disrupt the funding mechanisms already in place, and open the way for specialists to have “direct access to the Government”.¹⁸³ The Hospital Advisory Council

¹⁸¹*The New Zealand Herald*, July 3, 1975, p. 6.

¹⁸²*The New Zealand Herald*, June 30, 1975, p. 6

¹⁸³Direct funding of cardiac surgery units, no date, pp. 1-2, Hospital Advisory Council, Agenda and Minutes, 1974-76, NA, AALR, 873, W5427, Box 636, Record 40/56/4, Part 8.

(HAC)¹⁸⁴ supported and reinforced NAC's position; although it agreed with Barratt-Boyes that the demand for treatment at the Unit was considerable, its funding was to remain a hospital board, not a government decision. In its report HAC concluded that "with the rapid expansion of medical knowledge and specialties, there is no limit nowadays to the money which could be spent on specialist medical treatment"; in light of this, it argued, it was crucial that specialists were required to submit their claims to their respective boards, so that priorities could be decided between competing specialties.

The HAC also expressed a certain degree of scepticism about the value of devoting disproportionately large sums to cardiac units. It accepted that coronary artery disease was certainly on the increase, but the value of operations to relieve the symptoms of the disease were not assured; pain was relieved but there was no clear evidence that treatment increased life expectancy. Considering this, it expressed alarm that cardiac units had "captured" public imagination and concern, prompted by, they argued, press releases from cardiac surgeons (no names were mentioned) about the numbers of people dying on waiting lists.¹⁸⁵

HAC however altered its position a few months later in light of the fact that the problem had become a national one. In June 1976 it recommended that a special "tagged" grant be made to the Green Lane Unit so that it could increase its operations from twelve to fifteen per week. (Significantly, Rutter suggested that the grant should be tagged to stop his own board from using the grant for "other pressing demands").¹⁸⁶ The new Minister of Health, Frank Gill, supported the decision but Treasury opposed HAC's new justification for the tagged grant, arguing that cardiac units, and other specialist units like them, had always been national in scope. They were designed to cater for the New Zealand, not just the local

¹⁸⁴ HAC was made up of members of the Department, Treasury and hospital board members. Hiddlestone and Rutter were both members of HAC.

¹⁸⁵ Report of the Hospital Advisory Council on Cardiac Surgery, presented to the HAC meeting 11 June 1976, pp. 1-2, NA, AALR, 873, W5427, Box 636, Record 40/56/4, Part 8.

¹⁸⁶ Hospital Advisory Council Meeting, Minutes, 11 June 1976, pp. 3-4, NA, AALR, 873, W5427, Box 636, Record 40/56/4, Part 8.

population, receiving additional funding to cope with this role.¹⁸⁷ Treasury advised Cabinet not to approve HAC's recommendation as it would do nothing to remedy the situation, arguing that "[t]he money is there – the responsibility is not".¹⁸⁸ Cabinet disagreed; a note scribbled by a member of the Treasury on the memo detailing the resulting decision summed it up, stating simply: "we lost".¹⁸⁹

Cardiac Unit in Christchurch

The issue of cardio-thoracic surgery was also on the political agenda for the people of Christchurch. After the change of government in late 1975, HAC arranged an urgent meeting at Ministerial request in April 1976 to again discuss the proposals for a fourth Unit, following rumours in the press that the Unit would cost close to two million dollars; a significant escalation from the original estimate of a half million dollars. Despite receiving a more recent estimate from the Board of just over seven hundred thousand dollars, Gill had still been made uneasy by the rumours and requested that HAC consider the proposals for the Unit again.¹⁹⁰ In June 1976 Gill, on the recommendations of HAC, stated that the planned Cardiac Unit at Princess Margaret Hospital was to be delayed due to the increased cost of the proposed building. Further provision for increased numbers of cardiac surgery, in the short term, would be through the expansion of existing facilities at Green Lane and through more effective use of the units at Wellington and Dunedin hospitals (both of which, unlike Green Lane, were not being used to their full capacity).

¹⁸⁷ Secretary to the Cabinet to Robert Muldoon, Memo on New Policy 1976/77, 12 August 1976, Hospital Advisory Council, Agenda and Minutes, 1976-77, NA, AALR, 873, W5427, Box 637, Record 40/56/4, Part 9.

¹⁸⁸ Treasury Report to Robert Muldoon, 4 August 1976, p. 2, NA, AALR, 873, W5427, Box 637, Record 40/56/4, Part 9.

¹⁸⁹ Secretary to the Cabinet to Secretary to the Treasury, Memorandum on Cabinet meeting 16 August 1976, NA, AALR, 873, W5427, Box 637, Record 40/56/4, Part 9.

¹⁹⁰ Report to HAC, Open Heart Surgery Unit, North Canterbury Hospital Board, 8 April 1976, p. 2, NA, AALR, 873, W5427, Box 636, Record 40/56/4, Part 8.

Gill justified this decision upon the basis that expanding existing services would mean that more patients could be treated in a timely manner, as the Christchurch Unit would not be functional before 1978. The Labour Opposition saw it differently. The member for Sydenham, John Kirk, argued that the decision reflected the Government's priorities: finance first, the lives of Christchurch citizens second. Kirk challenged the plans further, stating that the lack of a Unit at Christchurch would mean that patients would be reliant upon adequate transport and flying conditions, factors which, Kirk claimed, would undoubtedly mean delays; delays which would in turn, cost lives. Gill responded by saying that the issue of getting patients to surgeons in adequate time was not reserved solely for patients coming from remote locations, and that deaths had, and would occur due to impracticalities. In an ideal situation, Gill stated, cardiac units would be built in all centres throughout New Zealand with sufficient population density.¹⁹¹

The escalation in building costs was undoubtedly a factor in the postponement of the Christchurch Unit, but so also was the sequence of events which had led to Dunedin being the site of the South Island's first cardiac unit. Cabinet originally decided, in late 1971, that two units would be built in the South Island, one in Dunedin, the other in Christchurch. The decision was short-lived; following a year of intense debate, significantly involving the personal input of Barratt-Boyes, and the endorsement of Professor P.J.Molloy, the Cardiac Surgeon at Victoria Hospital in Belfast in the UK (who had been brought to New Zealand by the University of Otago and the Otago Hospital Board to make an assessment as to whether there was enough workload to justify the establishment of a third unit), the North Canterbury Hospital Board was told that plans for the Unit were to be shelved indefinitely. HAC did prefer Christchurch over Dunedin for the Unit, but the financial investment already made in establishing a Unit in Dunedin was such that ultimately the Cabinet decided in its favour.

¹⁹¹*New Zealand Parliamentary Debates, (NZPD)*, 403 (1976), pp. 630-32.

Furthermore, the post-op longevity of coronary surgery patients had not been conclusively established, and for these reasons, HAC recommended proceeding with caution when considering the establishment of further units.¹⁹²

National's Health Minister at this time, Lance Adams-Schneider, offered a concession to the North Canterbury Hospital Board: once the Dunedin Unit had been operating for two years the Board could re-submit its plans if it considered that there was still need for a Unit in Christchurch. Barratt-Boyes, so active on behalf of Auckland's cardiac unit, was dismissive of this offer, stating that it would be at least ten years before New Zealand's cardiac surgery caseload could justify the building of another unit.¹⁹³ It also seems likely however that *planning* for a fourth unit was not totally abandoned, so as to avoid public controversy. The Minister's press statement announcing Cabinet's decision made no mention of any hesitations that HAC had in regards to the long term value of the surgery. The press release reinforced that ultimately four cardiac units would be established in New Zealand, allowing New Zealanders "the full benefits of the recent dramatic changes in coronary artery surgery overseas" and "providing complete coverage of cardiac facilities throughout New Zealand".¹⁹⁴

The Dunedin Unit became operational in June 1973. In line with earlier promises, the North Canterbury Hospital Board's Open Heart Surgery Committee submitted its report to HAC in August 1975 on the situation in Christchurch; reaffirming the Board's earlier position, the Committee argued that Christchurch needed a Cardiac Unit.¹⁹⁵ The Committee emphasised in its Report that Christchurch patients were facing significant obstacles gaining

¹⁹² Hospitals Division, Report to the Hospitals Advisory Council, 8 September 1971, NA, AALR, 873, W5427, Box 636, Record 40/56/4, Part 8.

¹⁹³ Open Heart Surgery Committee, *Development of Open Heart Surgery in Christchurch*, November 1974, report, p. 1, NA, AALR, 873, W5427, Box 636, Record 40/56/4, Part 8.

¹⁹⁴ Hospitals Division, Report to the Hospitals Advisory Council, 11 August 1975, pp. 1-2, NA, AALR, 873, W5427, Box 636, Record 40/56/4, Part 8.

¹⁹⁵ Open Heart Surgery Committee, *Development of Open Heart Surgery in Christchurch*, November 1974, report, p. 1; Report to HAC, Open Heart Surgery Unit, North Canterbury Hospital Board, 8 April 1976, p. 1, NA, AALR, 873, W5427, Box 636, Record 40/56/4, Part 8.

access to cardiac surgery. There had already been an official request from the Department of Health that no more cases should be referred to the Green Lane Unit as they were struggling to cope with their existing workload. Similarly, the Dunedin Unit was not dealing with a substantial number of referrals due to the smaller size of the Unit. This left Wellington as the crucial Unit for referrals, but the Committee claimed that only half of the Christchurch referrals received the surgery, due to staffing shortages and “conservative” cardiologists in Wellington. In light of this fact the Committee concluded that Christchurch patients would be at even more risk in the near future due to their predictions that demand for cardiac surgery was steadily increasing.¹⁹⁶ HAC agreed with the Committee and recommended to the Minister that approval be given for a Unit in Christchurch, to be established at Princess Margaret Hospital in 1977. The Labour Government approved the recommendation in September 1975.¹⁹⁷

This brings us back to the deferral announced by Gill in 1976. This was a political decision. HAC recommended deferral to Gill, whilst recording that it had originally favoured a unit in Christchurch, not Dunedin, claiming that Dunedin had been chosen solely on account of a promise to that city made in 1963 by then Prime Minister Keith Holyoake. HAC agreed that the reasons for the establishment of a Unit at Christchurch had not altered, and in fact, for the most part they were in favour of it. However, aligning himself directly with Barratt-Boyes, the Treasury member of HAC, Alan Wilson, raised concerns that if the Christchurch Unit were to be established this would likely render the Dunedin Unit

¹⁹⁶ Open Heart Surgery Committee, *Development of Open Heart Surgery in Christchurch*, November 1974, report, pp. 2- 3, NA, AALR, 873, W5427, Box 636, Record 40/56/4, Part 8. Their claim that the demand for coronary surgery was, and would continue to grow, was supported by trends observed in both the United States and the United Kingdom, See Beaven, D.W. ‘Report of a meeting held under the auspices of the Royal Society of Medicine entitled Coronary Surgery a critical appraisal and measurement’.

¹⁹⁷ Report to HAC, Open Heart Surgery Unit, North Canterbury Hospital Board, 8 April 1976, p. 2, NA, AALR, 873, W5427, Box 636, Record 40/56/4, Part 8.

uneconomical.¹⁹⁸ All other members of HAC, however, were of the opinion that demand for cardiac surgery would increase, likely justifying a second unit in the South Island.

An overseas expert was to be consulted however, because of the “super specialty” status of cardiac surgery. J.Keith Ross, the Consultant Cardiac Surgeon from Southampton Western Hospital in England was selected for this role.¹⁹⁹ Treasury initially expressed its firm opposition to any assessment of a Unit in Christchurch, largely because Wilson had raised concerns that the decision by HAC was based upon a desire to restate its earlier position in favour of a South Island Unit at Christchurch.²⁰⁰ Ultimately however, Treasury approved of Ross’s study, as his inquiry was to include an assessment of current and proposed facilities, including an economic assessment.²⁰¹

Ross’s 1977 report to HAC was in favour of the Christchurch Unit, and more generally for the continued development of cardiac surgery in New Zealand. He not only decided that the Christchurch Unit should go ahead but he also supported the further development of facilities at Green Lane, Wellington, Hamilton and Dunedin, concluding that the Christchurch Unit would, if properly managed, have no significant effect upon Dunedin.²⁰²

The discussion over the Christchurch Cardiac Unit revealed the ‘muddiness’ of planning around specialty services. Hesitation was expressed about the continued financial commitment towards the construction of a new unit, and alongside this, a limited amount of caution was voiced about the value of the procedure itself. But overwhelmingly the discussion was about how best to provide cardiac treatment which, crucially, translated to

¹⁹⁸ Hospital Advisory Council Meeting, Minutes, 11 June 1976, p. 2; Alan Wilson, notes on cardiac surgery, no date, NA, AALR, 873, W5427, Box 636, Record 40/56/4, Part 8.

¹⁹⁹ Memorandum for Members of Cabinet, 21 October 1976, NA, AALR, 873, W5427, Box 637, Record 40/56/4, Part 9.

²⁰⁰ Treasury Report to Robert Muldoon, 4 August 1976, p. 2, NA, AALR, 873, W5427, Box 637, Record 40/56/4, Part 9.

²⁰¹ Treasury Report to Robert Muldoon, 28 October 1976, p. 1, NA, AALR, 873, W5427, Box 637, Record 40/56/4, Part 9.

²⁰² J.Keith Ross to the Hospital Advisory Council, Report, 19 February 1977, Hospital Advisory Council, Agenda and Minutes, 1977-78, NA, AALR, 873, W5427, Box 637, Record 40/56/4, Part 11.

press releases detailing four Units would be built. And despite the ‘tussle’ over the proposed Unit during 1976, in September 1977, when opening a new Clinical Services block in Christchurch, Muldoon announced that upon the advice of Ross’s report and the recommendation of HAC, a Cardiac Unit would be built in Christchurch.²⁰³

In both episodes involving the cardiac care units it is possible to see the dual pressures upon funding decisions: resource considerations ensured that arguments aligned to rationing ideas were put forward, but the underlying belief that health could not be subject to such disciplines, that it was ‘special’, existed alongside it. Significantly this latter sentiment was also expressed within HAC, where decisions were made that ultimately overrode Treasury recommendations; Treasury being the most likely agency to favour explicit rationing.

²⁰³ Hospital Advisory Council Meeting, Minutes, 3 November 1977, p. 1, NA, AALR, 873, W5427, Box 637, Record 40/56/4, Part 11.

Chapter 4: Specialist ‘Manpower’

An awareness that medical care resources *should* be explicitly rationed was an idea that emerged and gained more acceptance with health care administrators (and perhaps also, although reluctantly, with health care professionals and hospital boards) around the mid-1970s; up to that point, the desire to *provide* resources took precedence over issues relating to any form of explicit rationing. The influence of rationing can be seen in the shift in focus in the debates over hospital specialists’ pay negotiations. Initially the shortage of medical staff dominated pay discussions and although the negotiators on the HMOAC would not agree to wage relativity with Australia, there was a certain amount of sympathy expressed towards specialists’ claims and attempts continued to be made to make full time hospital work more attractive to specialists.

However, although the shortage of medical graduates eased in the later 1970s, the abundant supply did not, as health administrators had anticipated, solve the country’s health resource problems. In discussions of staffing, attention firmly shifted within the Department of Health (particularly within MSRU) from the availability of doctors to the role that doctors played within the public hospital service; it was no longer presumed that an adequate supply of doctors – along with advances in medical science – would lead to a reduction in levels of disease and illness amongst the population.²⁰⁴ The shift in focus illustrates a more willing acceptance of explicit rationing within health administrative circles.

Drawing on studies done during the period on what, at the time, was referred to as ‘manpower’ (in practice the supply of medical graduates), this chapter will examine doctors as a health resource. Along with the growing significance of the hospital and highly technologically dependant curative care discussed in Chapter Two, the medical specialist became an important health resource in New Zealand.

²⁰⁴ Advisory Committee on Medical Manpower, pp. 4-5.

At Wellington Hospital in 1982, for example, the number of whole time equivalent medical staff employed within specialty services was 34.8, totalling 72% of all medical staff. The disproportionate number of staff required for specialist medicine was further reinforced by the fact that those staff cared for patients in only 40% of the total medical beds available.²⁰⁵ More generally, the importance (and dominance) of specialists throughout the medical service was an established trend; in 1974 75% of medical professionals worked in specialties.²⁰⁶ By the 1970s the medical specialist was an important health resource within New Zealand.

Supply of Medical Graduates

Although scientific and medical advance had prompted some philosophical reflection as to the value of the new and expensive procedures, when it came to the supply of medical graduates, ‘more’ was the dominant outlook in the late 1960s and early 1970s. A study published in 1970 by the Joint Committee on Medical Graduate Needs (made up of members of the Royal Colleges and endorsed by the Department of Health) described the growth in specialist medicine as being subject to public demand. The Committee stated that as cures, or more effective treatments, were discovered for previously incurable conditions then the public would demand greater access to those treatments.²⁰⁷ The Committee went on to argue that public demand should be met with an adequate supply of medical graduates; although the Department *was* aware that the supply would need to be carefully channelled in order to meet the greatest number of demands for “[a]dvances in medicine”.

Taking into account the relatively short-term requirements for additional doctors and the number required in order to achieve “the ideal establishment” in the future, the overall

²⁰⁵ Wellington Hospital Board, *Clinical Services Review, General Medicine and Medical Sub-specialties*, Fourth Draft, August 1984, p.1.

²⁰⁶ Davis, p. 6.

²⁰⁷ Joint Committee on Medical Graduate Needs, pp. 16, 21; *AJHR*, 1970, H.31, p. 7.

total shortage was assessed at 554. Of this number over half were specialists, with the balance made up of general practitioners and health administrators.²⁰⁸ The Committee also took into account growth in “preventive and social medicine” but the rest of their report was concerned with the provision of doctors to meet public demand for treatments that, in some cases, had not been discovered. The Committee placed a great deal of emphasis on the changing shape of medical care led by continuing research and the development of medical technology.²⁰⁹

‘Catch-up’ was also an element in the calculation of the 1970 Committee: shortages in medical graduates during the 1960s had arisen from what was later considered a significant underestimation of manpower requirements made by the Special Committee on the Availability and Distribution of Medical Practitioners, set up in the late 1950s and early 1960s. In 1979 an Advisory Committee on Medical Manpower argued that the earlier Special Committee had failed to take into account that “economic prosperity, rapid population growth and expanding medical technology” would lead to a considerable increase in demand for medical care throughout the 1960s.²¹⁰

Initially, many specialists worked within public hospitals only part-time. Market forces were responsible for this trend in some areas of specialist medicine, in which working privately was more financially viable; in others the limited number of vacant full time appointments established in the public system dictated the number of specialists required. In 1958, in an article published in the *New Zealand Medical Journal*, Douglas Robb outlined his concerns about the development of outpatient services in public hospitals. Robb was an outspoken commentator and would-be ‘reformer’ of the New Zealand health service who was unpopular with MANZ on account of his support for a salaried medical service. As a leading

²⁰⁸ Joint Committee on Medical Graduate Needs, pp. 7-8, 14, 21. The assessed shortages were 286 for specialists and 286 for General Practitioners and Health Administrators.

²⁰⁹ Joint Committee on Medical Graduate Needs, pp. 9, 16.

²¹⁰ Advisory Committee on Medical Manpower, pp. 4-5.

figure in Green Lane Hospital's thoracic team since 1942, and later a founder of the Cardio-thoracic Unit, he was well versed in the problems facing public hospitals.²¹¹

Robb argued that the lack of outpatient services was a strategic decision, aiding the government in dealing with the "sea of rising costs" associated with medical care, in other words a form of rationing (although Robb did not use that term). Robb stated that for many specialists the introduction of the Social Security Act had made little difference to their methods of practice; there had been few full-time appointments created and many specialists worked in private practice.²¹² His charges were well founded. In 1960 the number of part time physicians, surgeons and anaesthetists in the public hospital system far outweighed the number of whole time appointments.²¹³

It is, however, difficult to assess whether staffing shortages in outpatient departments were deliberate as Robb was suggesting. The shortages could be explained by the fact that there was a strong emphasis at this time on preventive health care, which would somewhat skew resource allocation away from curative hospital services (although in the 1960 Annual Report Director-General Harold Turbott did hint at a change in attitude towards specialist care in acknowledging the "widening" role of the curative aspects of the health care system.²¹⁴)

Turbott's attitude towards specialist services was a precursor of the later enthusiasm in the late 1960s and early 1970s for specialist care, and also foreshadows the focus on resource allocation before the mid 1970s, when government policy took a turn back towards

²¹¹ Derek A. Dow 'Robb, George Douglas 1899 - 1974'. *Dictionary of New Zealand Biography*, updated 22 June 2007 ,URL: <http://www.dnzb.govt.nz/>; See also Wright-St Clair, pp. 177-78; Hutchinson, p. 18.

²¹² Douglas Robb, 'Outpatients: The proper scope and development of Hospital Out-Patient services in relation to other health services in the community', *NZMJ*, August 1958, v.57, no.320, pp. 346-47.

²¹³ *AJHR*, 1960, H. 31, p. 51. The number of part-time appointments for general surgeons was 96 and whole-time appointments was 20; for anaesthetists the number of part-time appointments was 136 and whole-time appointments totalled 23.

²¹⁴ *AJHR*, 1960, H. 31, p. 5.

preventive and community health. Specialist services required more physical resources in the form of staffing, buildings and equipment than preventive care.

The findings of the 1968 Committee on medical graduate needs led to an increased intake of students to the Otago University School of Medicine, and to the first intake of sixty students at the University of Auckland School of Medicine. The report also prompted discussions as to whether a third medical school should be established in Wellington.²¹⁵

Despite these initiatives, members of the medical profession were still dissatisfied with the recommendations in the report. Members of MANZ attended the Committee as observers, but their counterparts in NZMA made a more impassioned critique of the shortcomings within the health service. President Dr Erich Geiringer wrote that the health service was in danger of being “shipwrecked” if the current trend in management continued. Geiringer did not spare his colleagues in the attack, labelling the advisors to government as “half-decayed medico[s]”. If drastic measures were not taken, Geiringer argued, the shortages of doctors would only get worse.²¹⁶

The issue was also on the political agenda. In 1970 Health Minister Don McKay frequently answered questions in parliament about the National Government’s plans to relieve the doctor shortage. Ron Bailey, Labour’s member for Heretaunga and Junior Opposition Whip was insistent that delay in moving forward on the building of a third medical school was a sign that National was reneging upon an election promise. Citing the possible collapse of clinical services at Auckland Hospital Board and the closure of Hutt Hospital’s Ear, Nose and Throat section as evidence of this impending collapse, Bailey labelled the delay in the decision making process as “criminal”.²¹⁷

²¹⁵ Advisory Committee on Medical Manpower, pp. 4-5; *Report on Medical Education in New Zealand and the need for a third Medical School*, October 1970, Commissioned by a Joint Committee of the Victoria University of Wellington and the Wellington Hospital, p. 1.

²¹⁶ Erich Geiringer, *If doctors grew on trees....a look at the doctor shortage in New Zealand today*, John McIndoe Limited, Dunedin, 1969, pp. 6, 9.

²¹⁷ *NZPD*, 365 (1970), p. 177.

The most relentless questioning about medical staff shortages came from Norman King, Labour's health spokesperson and Dr Gerard Wall, member for Porirua. Despite persistent questioning and a seemingly extensive list of examples of "medical degradation", the Minister's reply was consistent: the doctor shortage was an international problem.

Shortages in the early 1970s

Staff shortages remained a high profile issue during the early 1970s and most commentators held the belief that medical care could be improved if an adequate supply of doctors was achieved. The *Dominion* columnist Lorna Rowland claimed to have evidence from an authoritative source that due to shortages, Wellington Hospital had even been unable to use one of two kidneys that became available for transplant and the unused kidney was thrown away. She argued that although hospital boards and the Department of Health maintained that the best possible service was being provided despite these shortages, the thought that they were getting the best possible care available was of little comfort to those waiting for life saving operations.²¹⁸

Rowland's column came directly after a week in which much media attention had already been given to staffing shortages. Brian Barratt-Boyes had outlined his concerns in a speech to the 1971 biennial conference of the Hospital Boards Association (HBA). It was not the lack of facilities that was the problem; Barratt-Boyes argued that the building and facilities of the Cardio-thoracic Unit were "the finest of its type in the world" and well-equipped too. But the lack of staff meant that the work achieved in the grand surroundings was little better than had been achieved in the old buildings. To remedy the situation Barratt-Boyes urged HBA to be more active in lobbying the government for a change in the pay structures for specialist and technical staff, as the doctors themselves were achieving little on

²¹⁸*The Dominion*, March 13, 1971, p. 10

this front. Barratt-Boyes stated that he could not in good conscience recommend to young graduates that they stay in New Zealand, claiming he himself stayed *despite* the pay and working conditions. He said he remained in New Zealand for “a love of his own country, the golden opportunity at Green Lane and a certain stubbornness and the hope that perhaps he could help his associates”.²¹⁹

Barrett-Boyes’ comments received much editorial support.²²⁰ They followed on from the attention given to staffing shortages through 1970; the impending (or in some opinions continued) ‘degradation’ of the New Zealand hospital system was a pressing issue for both MANZ and NZMA, fuelling intense pay negotiations with HMOAC, during which both organisations argued for increases in salary levels to attract more specialists to full time hospital work.²²¹

On this issue the two main medical associations also had support from the Whole Time Senior Medical Officers’ Association. WTSMOA argued that conditions in New Zealand hospitals were producing dissatisfaction amongst workers because staffing levels were inadequate.²²² President of WTSMOA, Dr J.B.Mackay, argued that the lack of specialist staff in New Zealand’s hospitals was due to the opening negotiations between the Central Specialist’s Committee (CSC) of MANZ and HMOAC. Mackay stated that because of the “economic situation” at the time CSC had accepted lower salary scales than would have been ideal under the assumption that this would be remedied in the next review. According to Mackay, this had not happened.²²³

²¹⁹*The New Zealand Herald*, March 4, 1971, pp. 3, 6; *The Dominion*, March 5 1971, p. 7. See also *The Dominion*, March 8, 1971, p. 10.

²²⁰*The New Zealand Herald*, March 6, 1971, p. 7.

²²¹ Despite the comments of Dr J.B. Mackay of WTSMOA, for some members of the medical profession the earlier negotiations were apparently more acceptable. Lindsay Brown delivered an inadvertent compliment to HMOAC when he was asked in April 1971 of his opinion of the recent negotiations: “At no time has the official side of H.M.O.A.C shown sufficient knowledge to have achieved anything like the acceptability of the 1967 review which involved completely new definitions, classifications as well as new scales.” NA, AEKO, 19171, SSC1, W2505, Record 33/7/9, Part 6.

²²²*The Otago Daily Times*, December 16 1970, p. 5.

²²³*The Evening Post*, December 15 1970, p. 32.

Of the two main associations, MANZ was most involved in wage negotiations as a member of HMOAC, but the two maintained similarly disgruntled attitudes in regards to the pay negotiations. NZMA publicly supported Dr Lindsay Brown's (MANZ President) statement that the Department of Health was proving to be "hopelessly out of date and inflexible".²²⁴ The consensus expressed on this issue was rather unusual, as there was little love lost between the two associations; MANZ did not appreciate the rather antagonistic way in which Dr Geiringer went about drawing attention to issues within the health service.

Geiringer's own approach can be seen from an extract of NZMA news in which he printed a torn letter apparently salvaged from a rubbish bin in Montreal in which Director-General of Health Douglas Kennedy appeared to be trying to boost the numbers on the New Zealand Medical Register by asking New Zealand doctors overseas to remain registered even if they had emigrated.²²⁵

An editorial in the *NZMJ*, printed in December 1970, at the end of a frustrating year of failed negotiations, claimed that the hospital system the country had enjoyed in the preceding few decades was in crisis, threatening the end of a system that "while not perfect, has been one of which we can be proud". The crux of the pay negotiations was that MANZ was seeking international relativity, specifically with Australia. MANZ claimed that relativity was required in order to put a stop to the number of specialists emigrating to take up more financially rewarding positions overseas, and in order to encourage immigrant specialists to New Zealand hospital posts to alleviate staff shortages. These shortages, they argued, were in some areas already hampering the provision of adequate hospital services.²²⁶

The offered increase of 25% (on 1967 pay rates) was rejected by MANZ members of HMOAC, but the Cabinet Committee on State Services, supported by the "official side" of

²²⁴*The Otago Daily Times*, December 11 1970, p. 4.

²²⁵*NZMA News*, Vol.1, no. 8, 5 June, 1970, p.1.

²²⁶ Letter from MANZ to HMOAC 23 October 1970; MANZ, *News & Views*, December 15 1970, no. 143, Pay Rates-Outside the Public Service-Hospital Boards/Staff/Hospital Medical Officers Advisory Committee, 1970-1971, NA, AEKO 19171, SSC1, W2505, Record 33/7/9, Part 5.

HMOAC (made up of representatives from the Hospital Boards Association, State Services Commission and the Department of Health), would not agree to wage relativity with Australia, stating that it could not consider the wages of medical officers in isolation from other New Zealand wage rates.²²⁷

In a letter to the chair of HMOAC, Ian Lythgoe, Lindsay Brown outlined that although he had enjoyed “sparring” with Lythgoe during HMOAC negotiations (and acknowledged that “the ‘man from SSC & Treasury’ had always done his homework”) he also felt that it was the State Services Commission and Treasury who drove the decision not to grant international wage relativity. Brown went on to say that the State Services Commission and Treasury dominance was evident within the ‘official side’ of HMOAC; he claimed that although the HBA and the Department of Health were the employers of staff they “contributed the least” to HMOAC negotiations. Furthermore he argued that HMOAC was no longer acting in an advisory capacity to the Minister, as it had originally been in 1967; he stated that even by Lythgoe’s own admission HMOAC now took a “conciliatory” approach to negotiations, implying that it was more likely to appease the medical community through half measures than by any significant change.²²⁸

Senior medical staff at Waikato Hospital Board also weighed into the debate over HMOAC negotiations. They accused the Government of dominating the two year negotiations with hospital specialists, and in the end, taking only the recommendations of the ‘official side’ of HMOAC and ignoring the opinions of MANZ representatives. The decision, the medical staff argued, would lead to further staff shortages (particularly in specialist positions) making it virtually impossible to fill the basic minimum numbers of staff required. They claimed it would exacerbate an already difficult situation, one that had persisted even

²²⁷ HMOAC report to Minister of Health 4 November 1970, NA, AEKO 19171, SSC1, W2505, Record 33/7/9, Part 5.

²²⁸ Lindsay Brown to Ian Lythgoe, Letter, 20 April 1971, NA, AEKO 19171, SSC 1, W2505, Record 33/7/9, Part 6.

when “a substantial pay increase” was expected. The Cabinet Committee's rejection of wage relativity with Australia had, the Waikato staff argued, condemned the New Zealand public to become the recipients of a “third-rate hospital service”, well below par compared with what other countries were able to provide. In particular, the senior medical staff stressed that the main shortages were in full-time or near full-time specialist positions, a trend they noted throughout New Zealand, not just within the Waikato.²²⁹

MANZ considered the working conditions in public hospitals so grave that, following the failed negotiations, its Council felt justified in threatening to issue a 'warning' to doctors overseas about their likely fate in the New Zealand hospital system. Support for the warning was not unanimous throughout the profession however. The Wellington Division of MANZ opposed the decision.²³⁰ Opposition also came from other doctors. Dr H. Selwyn Kenrick, formerly the superintendent-in-chief of Auckland Hospital Board also expressed his concerns that the opinions of the MANZ council were not held by the majority of medical practitioners. Citing his own conversations with colleagues as evidence of his position (only one out of eight colleagues that Kenrick had spoken to were in favour of MANZ's stance), Kenrick argued that “[o]verseas doctors are certainly entitled to be advised of New Zealand hospital salary scales, but they should then be left to make their own individual decisions without any gratuitous advice from the M.A.N.Z Council”.²³¹

Evidence of more widespread opposition can be found from an editorial in *NZMJ*; it appears that some members of the profession felt the intended warning was counterproductive and MANZ was editorialising in its own defence.²³² Director General of

²²⁹ D.H.Friedlander (Secretary, Senior Medical Staff) to the Hon. Mr.B.E.Talboys (Chairman, State Services Commission), Letter, 14 December 1970, NA, AEKO 19171, SSC1, W2505, Record 33/7/9, Part 5.

²³⁰ Letter, D.P.Kennedy to unknown recipient, 22 January 1971, NA, AEKO 19171, SSC1, W2505, Record 33/7/9, Part 5.

²³¹ Selwyn H. Kenrick editorial to unknown newspaper, 15 December, 1970, NA, AEKO 19171, SSC1, W2505, Record 33/7/9, Part 5.

²³² Editorial, *NZMJ*, January 1971, NA, AEKO 19171, SSC1, W2505, Record 33/7/9, Part 5.

Health Doug Kennedy was so alarmed at MANZ's stance on the matter that he declared that if they followed through with their plans he would resign from MANZ.

The president of the HBA, Sir Edwin Bate, called the threat a militant action, a sentiment echoed by an editorial in *The Otago Daily Times (ODT)*, which also included its own warning to those doctors involved; their professional status within the community would decline should they proceed, and furthermore, they should expect to be met with "a specific as well as a general reaction" from both the Department and the community as a whole.²³³ There was considerable public opposition to MANZ's intended tactics; all major newspapers published articles and letters condemning the actions they proposed.²³⁴ A letter to the editor of the *ODT* claimed that the doctors involved were ungrateful for the education they had received at the expense of the New Zealand public, stopping only very short of stating that the threat involved an element of treachery to New Zealanders as a whole.²³⁵

Whilst Dr Brown conceded that MANZ's stance had undoubtedly upset the public, this was, he stated, necessary to draw attention to MANZ's concerns. And furthermore, whilst public interpretation of the tactic was unfavourable, he claimed that MANZ's intention was never to dissuade doctors from returning to New Zealand; their objective was to ensure that pay scales would be improved so that doctors would want to return. They would not come back, he argued, if specialists continued to be paid at rates equivalent to the crew working week about shifts on the Interisland Ferry, and New Zealand society continued to be governed by "the sour egalitarianism" he felt predominated at present.²³⁶

Despite public opposition and divisions amongst the profession itself, MANZ went ahead with its plans, and Dr Kennedy resigned from the Association (a decision he took no

²³³*The Otago Daily Times*, Friday December 11 1970, pp. 3-4.

²³⁴ Digest of Public Opinion for the week ended 18 December 1970, Reference Officer, Information and Press Section, Tourist and Publicity Department, NA, AEKO 19171, SSC1, W2505, Record 33/7/9, Part 5.

²³⁵*The Otago Daily Times*, December 15 1970, p. 4.

²³⁶*The Evening Post*, December 15 1970, p. 7.

joy in making as it ended a thirty year membership).²³⁷ In 1971 a notice was placed in the advertisements section of the *NZMJ*, the *British Medical Journal* and the *Medical Journal of Australia* asking all applicants applying for public hospital posts to first contact Dr J.B. Lovell-Smith (Medical Secretary, MANZ) “in order that they may be acquainted with the terms and conditions of service in New Zealand hospitals”.²³⁸ By August 1971 ten enquirers had received letters regarding employment conditions in New Zealand; including details of starting salaries, overseas and study leave, superannuation and a brief overview of the housing market and finance conditions.²³⁹

Whilst the issue of the warning caused disagreement between the negotiating parties, the goal of those involved remained the same: to increase the supply of medical specialists to New Zealand’s public hospitals. Although MANZ used ‘shock tactics’ in this case, their underlying concern was to induce HMOAC, the Department of Health and the Government to increase the salary scales of hospital specialists, thus making the hospital service more appealing and therefore increasing the supply of staff.

HMOAC was also keenly focused on the supply of staff and the issue of the warning did not stall negotiations in 1971 and further financial incentives were offered to full time medical staff in public hospitals. As of the 1 January 1972 an additional duties supplement was granted to those officers who, because of staffing shortages were consistently performing in excess of their paid duties. Whereas part-time staff could be compensated if they were called upon to provide additional services, up until 1972 there was no such provision for whole- time staff. This problem was compounded by the fact that in comparison to part-time staff, whole-time staff were often conveniently available to perform additional duties. The initiative was also intended to stem the flow of whole-time staff to part-time appointments, a

²³⁷ *The Otago Daily Times*, December 16 1970, p. 5. For Dr AF Ferguson’s (Chairman of the Central Specialists Committee of MANZ) support of MANZ’s stance see *The Evening Post*, Wednesday December 9, 1970, p. 12.

²³⁸ *NZMJ*, March 1971, p. 188, NA, AEKO 19171, SSC1, W2505, Record 33/7/9, Part 5.

²³⁹ MANZ to Dr D.P.Kennedy (Director-General of Health), letter, 25 August 1971, NA, AEKO 19171, SSC1, W2505, Record 33/7/9, Part 5.

trend that had been evident in preceding years.²⁴⁰ However, its introduction was not a wholly satisfactory solution. Applications for the supplement were finally approved in July 1972, but MANZ and WTSMOA argued that the terms of the supplement were unreasonable; in some instances it was possible for a specialist to work over 100 hours a week without qualifying for the supplement. The limits for qualification were only altered following protests from the associations and even then, the award of one tenth of an overall salary was still regarded as unsatisfactory. WTSMOA argued that the amount should be doubled, and furthermore, the granting of a supplement should require hospital board approval only, and not also the Department of Health, in order to remedy “the slow and ponderous nature of medical administration”.²⁴¹

The Royal Commission on Social Security 1972

The 1972 Royal Commission on Social Security provided a further avenue for comment upon the supply of specialist staff to New Zealand’s public hospitals. Dr Geiringer used the opportunity to repeat his arguments from his 1969 book *If doctors grew on trees....a look at the doctor shortage in New Zealand today*. In his submission he stated that New Zealand was on the verge of having one of the worst medical services in the world due to a lack of investment in medical education to keep pace with growing demands for treatment. For its part, NZMA proposed a radical extension of the dual system as a remedy to the problems it had identified: a fee for service should operate in public hospitals. Such a system, they claimed, was working effectively in private hospitals and in hospitals overseas. A fee for service would, according to NZMA “deprive the Health Department of its power to artificially starve our public hospitals of medical staff, it would restore a proper doctor/patient

²⁴⁰ HMOAC to The Minister of Health, no date; Cabinet Committee on State Services, Minutes of meeting, 9 November 1971, NA, AEKO 19171, SSC1, W2505, Record 33/7/9, Part 5.

²⁴¹ Submission of Whole-Time Senior Medical Officers Association of New Zealand to the Caucus Committee on Health, 17 May 1974, NA, AAFH, 632, W4672 Box 12, Record 54-11-42.

relationship for hospital patients and it would, at last, get rid of the invidious distinction between standards of private medical care and of public hospital medical care”.²⁴²

The need to ration health care would effectively be removed as the supply of staff in this case, according to NZMA, would *meet* demand because every patient would be provided with a doctor they had selected thus removing the Health Department’s role as “salary provider” (although presumably the Department would have to meet the costs of the service provided).²⁴³ NZMA’s suggestions would allow specialists to work privately whilst utilising the facilities provided by public hospitals, illustrating that even those most in favour of private specialist treatment acknowledged the role of the public hospital.²⁴⁴ The proposal was also in the best interests of the medical profession as it allowed them to rely on the public system to provide the up-to-date facilities and equipment that specialist care required without having to finance the capital outlay themselves.

The ‘Shadow’ of Rationing

The Royal Commission did lead to some initiatives in relation to the supply of medical graduates. A manpower planning division was set up within MSRU.²⁴⁵ The need for such a division was justified by the fact that manpower was still the most costly resource within the health sector; the Department estimated that the amount spent on wages and salaries was five times the total cost of buildings, equipment and drugs. In addition (and somewhat in line with NZMA’s submission) a lack of manpower and resources was said to be the biggest obstacle to the adequate provision of health care services.

²⁴² See also Geiringer, p. 20.

²⁴³ The submission was not conclusive about who would be expected to pay for each service but Geiringer made an analogy to the maternity service so it may be assumed that government would be expected to meet specialists’ service fees.

²⁴⁴ Submission from NZMA to the Royal Commission (submission 259), NA, ADQU, 19492 Com 7, Box 33, Record 30/3.

²⁴⁵ *AJHR*, 1974, E.10, p. 17.

However, a shift is evident in regards to the focus of the manpower division as opposed to the previous official reports undertaken on the subject of medical manpower. Despite the fact that shortages were of concern, MSRU was not simply trying to ascertain how more workers could be provided; it was also trying to assess how current levels of staff were being utilised. MSRU was very aware that if asked for their solution, “groups of health workers” would always claim that additional manpower was required, but it was the *existing* levels of staff and their efficient use that was also of concern.²⁴⁶

MSRU’s focus foreshadowed later attempts to move beyond the idea that the ‘problems’ in the health service could be remedied with an increased supply of medical staff. Although this cannot be described as rationing, in that the underlying focus was still to meet public demand through effective planning, their reluctance to provide continually increasing staff levels would later form part of the argument for explicit rationing.

Economic Situation Impacts

In November 1973 the Labour Government’s Caucus Committee on Health recommended that a financial supplement should be paid to all full time specialist staff in public hospitals.²⁴⁷ The recommendations were stalled however, because of the Economic Stabilisation Regulations, in force until 1 July 1974, which sought to deter wage and price increases. A request to begin negotiations so that the supplement (or other agreed incentive) could be introduced as soon as the Regulations were lifted was rejected by Prime Minister Norman Kirk; in a letter to the Combined State Services Organisations Kirk stated that any negotiations beginning before July 1974 could jeopardise any improvement in economic conditions. That the Department and Caucus Committee were both sympathetic to the awarding of a financial supplement and willing to take “quite radical steps” to ensure that

²⁴⁶ *AJHR*, 1977, E. 10, pp. 7-8.

²⁴⁷ As previously discussed in Chapter Two the Caucus Committee was a crucial figure in the development of the White Paper on Health.

more specialists engaged in full time appointments in the public sector illustrates the difficulty that public hospitals were having in maintaining adequate specialist staff levels.²⁴⁸

Specialists continued to press their case that the public hospital sector was seriously understaffed. WTSMOA wrote to the Caucus Committee in May 1974 arguing that official figures from the Medical Superintendent's report had underestimated the staffing crisis in New Zealand hospitals, particularly in whole-time specialist posts (although WTSMOA also felt that shortages in many areas throughout the hospital were also in need of urgent action). WTSMOA was complimentary about the role that part-time specialists played within public hospitals, it was however, they argued, the services of whole-time specialists that were most crucial, as it was they who oversaw the administration of departments, ensured that twenty-four hour care was coordinated, supervised extended treatment programs involving "complex technology" and supervised the training of junior staff.²⁴⁹

WTSMOA's 1974 submission highlights the stalemate reached in the early 1970s in regards to the pay and working conditions of specialists within public hospitals; many of its recommendations were in line with those made by MANZ to HMOAC in 1972. Like MANZ, WTSMOA argued that wage relativity and adequate finance for conference leave were crucial to stop the "major exodus" of staff to Australia. WTSMOA also argued that the automatic grading scale was a crucial component of any initiative to remedy the staffing shortage. In Australia the highest level in the grading system could be reached within five years. Specialists wanted to keep the number of years required to reach maximum earning potential as few as possible, because, as it was, their extra years of post graduate study put them at a financial disadvantage to non-specialists.

²⁴⁸ Letter from EA Kennedy to the Minister of State Services, date 6 December 1973, NA, AAFH, 632, W4672, Box 12, Record 54-11-42. The memo from Kirk was not specifically in reference to medical specialists, but to any wage negotiations.

²⁴⁹ Submission of Whole-Time Senior Medical Officers Association of New Zealand to the Caucus Committee on Health, 17 May 1974, NA, AAFH, 632, W4672, Box 12 Record 54-11-42

Dr Stephen Clark, a pathologist from Nelson Hospital, emphasised how crucial this factor was in the retention of full time specialists. Dr Clark argued that it was often the case that specialists would return to New Zealand after undertaking additional post graduate training overseas at around thirty-four years of age, entering the public hospital system on the “‘bottom rung’” of the grading system, on a salary that, he argued, was one of the lowest medical salaries in the country. In short, Dr Clark felt that specialists were penalised for their additional years of study, particularly in contrast to general practitioners, who, by the time specialists had completed their training would already have been practicing for six or seven years.²⁵⁰

The 1974 White Paper and after

Despite the gulf between government and specialists over salary levels the adequate supply of medical graduates as a resource for New Zealand’s health service was still an important issue. The Labour Government hoped to remedy the doctor shortage by increasing the number of medical students accepted to New Zealand’s medical schools.²⁵¹ Efforts to remedy the shortage also ensured that a degree of sympathy was expressed towards specialists, although their demands in pay negotiations were never totally met. The Government was still very concerned with remedying the shortages and therefore satisfying public demand for medical care through the supply of graduates rather than controlling demand through rationing.

However, a certain change in attitude from the Labour Government was evident upon the release of the White Paper. As already discussed in Chapter Two, the overwhelming message within the White Paper was that the public hospital sector should be strengthened via the integration of all services through the creation of cohesive service planning ‘norms’;

²⁵⁰ Dr Stephen Clark to JH Hiddlestone Department of Health, Letter, 5 Nov 1974, NA, AAFH, 632 W4672, Box 12, Record 54-11-42.

²⁵¹ Bassett, ‘Labour’s White Paper on Health-Some Reflections’, pp. 59-60.

the plans would be created by a centrally located authority and administered regionally, thus introducing a version of ‘rationing’.²⁵²

MANZ interpreted the White Paper as a threat to specialist treatment, presumably because the White Paper also hinted that the problems might not be fixed through the supply of more doctors.²⁵³ In their response to it, MANZ acknowledged that strong public demand for specialist consultation was causing a “bottleneck” at some outpatient clinics, which was “undoubtedly a major cause of public dissatisfaction”. Their solutions were however, more in line with previous attempts to remedy the problems in the public hospital service. Their favoured remedy was “to produce more specialists” with the immediate problems alleviated by diverting public demand towards the private sector. This could be done by increasing the level of specialist benefit, with additional supplements given to “disadvantaged groups”: minors, pensioners and the chronically ill.²⁵⁴

MANZ’s argument for an increase in the level of the specialist benefit was a reiteration of that proposed to the Royal Commission on Social Security in 1972. The Taranaki Division of MANZ argued that the subsidy should be raised so that elderly patients would not have to struggle to meet the costs of treatment and so that the “form of Robin Hooding” that was occurring within specialist practice could be stopped (the term “Robin Hooding” referred to the reduction of fees for those patients who could not afford to pay for treatment).²⁵⁵ Yet a submission by Mrs Amos of Levin highlighted that even when subsidies were increased this had not benefited patients, noting that an increase in government subsidy to specialists in May 1970 was not passed on to patients.²⁵⁶ MANZ’s solutions amounted to

²⁵² For further information regarding the White Paper refer to Chapter Two.

²⁵³ *A Health Service for New Zealand*, p. 77.

²⁵⁴ *An Improved Health Service for New Zealand*, pp. 16-21. See also, H.H. Gilbert, ‘Presidential Address’ *NZMJ*, vol. 83, no. 561, April 14, 1976, pp.238-39.

²⁵⁵ Submission 249 from the Taranki Division of MANZ to the Royal Commission on Social Security, NA, ADQU, 19492 Com 7, Box 33, Record, 30/3.

²⁵⁶ Submission 254 from Mrs KL Amos to the Royal Commission on Social Security, NA, ADQU, 19492 Com 7, Box 33, Record, 30/3. Mrs Amos's submission also dealt more broadly with charges for all medical services.

investment in doctors as a resource either by bolstering medical education or by making private practice more lucrative.

MANZ continued to cling to the idea that problems in the health service would be fixed through an adequate supply of specialists; but within the Department of Health a shift away from spending money on the supply of staff became clearer at the beginning of 1974, indicated most obviously at this time by the White Paper. This change in attitude was also aided by the fact that the supply of staff *was* beginning to increase. The Department's Annual Report outlined that staffing levels were improving, and a "greater stability" in the number of medical staff employed in public hospitals was observed from 1972 to 1974.²⁵⁷ This prompted the Division of Hospitals to warn boards that, whilst they might be eager to remedy shortages, they were obliged to stay within their financial allocations; "the disturbing trend" of the past year to allow growth in staffing without consideration to budgetary constraint would not be considered in a favourable light; any financial problems they had as a result of their actions were to be considered "entirely of their own making". Furthermore, it was judged that overall allocations in previous years had been too generous, considering the lack of available staff.²⁵⁸

The more restrictive attitude towards staffing costs continued under the National Government. The Cabinet Committee on Expenditure instructed the Department of Health to discuss with HBA about the ways in which control of expenditure on staffing might be achieved. The matter was crucial because staffing costs constituted close to 80% of hospital board expenditure. It was eventually decided that for the 1976 financial year boards would have their operating grants divided into categories for staffing and other operating costs. If savings were made on staffing costs they could be utilised elsewhere but the situation could

²⁵⁷ *AJHR*, 1974, E.10, pp. 60-1. In 1972 the number employed was 1478, in 1973 this had increased to 1662, and then further still in 1974 to 1765.

²⁵⁸ J.J.V. Wilson for the Director Division of Hospitals to all Chief Executives and Secretaries of Hospital Boards, Circular Letter, 11 April 1975, pp. 1- 2, NA, ABQU, 632, W4415, Box 596, Record 342/4/1.

not be reversed. The measure was deemed effective and the Department sought support from HBA to make the scheme permanent.²⁵⁹

Nonetheless some of the initiatives to make hospital based specialist medicine appealing were still promoted. Early in 1976 the automatic scale was reduced from ten steps to nine, and the years of qualification to be recognised as a specialist were reduced from eight to seven.²⁶⁰ The new salary scales were not wholly satisfactory to CSC, although there was a certain air of resignation in regards to fighting for further advances. It reported to MANZ Council that there was little prospect of “major adjustments” in scales as salary levels were kept in line with the Director General of Health and University salary scales; although it was hoped that advances would be made in the areas of “fringe benefits” and employment conditions.²⁶¹

Supply of Doctors Resolving

The supply of doctors *was* beginning to resolve by the later 1970s.²⁶² As already discussed, the supply of medical graduates stabilised during 1972-1974 and, in fact, by 1979 even CSC were endorsing a 25% reduction in the number of admissions to medical school.²⁶³ Indeed the knee-jerk increase in medical graduate numbers in the early 1970s had resulted in an ‘oversupply’ of graduates a few years later.

²⁵⁹ Department of Health to the Cabinet Committee on Expenditure, Memorandum, 1976, p. 4, NA, ABQU, 632, W4415, Box 596, Record 342/4/1.

²⁶⁰ ‘New Conditions and Salaries for Hospital Medical Officers’ *NZMJ*, vol. 83, no.559, March 10 1976, p. 163.

²⁶¹ ‘The Medical Association of New Zealand: proceedings of Council Meeting 10 March 1976’ *NZMJ*, vol.83, no.562, April 28 1976, p. 291.

²⁶² Meeting Central Specialists Committee Wednesday 22 June 1977, Minutes, Collection NZMA MS-Group-1276, MSY-5833, p. 3; Meeting Central Specialists Committee Wednesday 28 September 1977, Minutes, NZMA Collection, ATL, MS-Group-1276, MSY-5833, p. 1.

²⁶³ Meeting Central Specialists Committee 12 July 1979, Minutes, NZMA Collection, ATL, MS-Group-1276, MSY-5833, p. 2

In addition, the economic climate and lack of expected population growth compounded concerns of “oversupply”.²⁶⁴ In the past a medical degree had “been a passport to international mobility” as most countries were experiencing a shortage of doctors, but in 1977 the United States moved to significantly reduce the numbers of foreign doctors practising. In Britain also, medical schools were producing more doctors, so there was less need for the shortfall to be made up from international recruits. A similar pattern was evident closer to home; it was anticipated that both Australia and New Zealand would become self-sufficient in doctors in the near future.²⁶⁵ The more restricted economic climate had combined with an increased supply of graduates to make hospital specialists a less ‘sought after’ health resource.

In addition, the move towards community care had implications for attitudes towards the claims of specialists. The Department of Health’s 1977 Annual Report commented on the high cost and “manpower intensity of advanced specialty medical care”.²⁶⁶ The 1978 Report contained an element of regret that in New Zealand “medical care has become virtually synonymous with health care”, with the health system considered successful if it equated to the supply of additional beds and doctors. Such a trend was, the Department claimed, due in large part to the “growing sophistication of medical technology and the dramatic nature of some modern medical intervention”. The shift towards community care, it was claimed, was developed in response to the “world-wide emphasis” on the “effectiveness, and economy of overall health care systems”, and as a result the hospital, and the emphasis on adequate staffing and beds, would be removed from the agenda.²⁶⁷

²⁶⁴ Advisory Committee on Medical Manpower, p. 5. See also Alan McRobie, ‘The Politics of Volatility, 1972-1991’, in Geoffrey W. Rice, ed., *The Oxford History of New Zealand*, 2nd edn., Oxford University Press, Auckland, 1992, pp. 393-395.

²⁶⁵ ‘Migration and Doctors’, *NZMJ*, vol.85, no.585, April 13 1977, pp. 283-4.

²⁶⁶ *AJHR*, 1977, E.10, p. 6.

²⁶⁷ *AJHR*, 1978, E.10, p.8.

CSC nonetheless continued to push for the fulfilment of the “ideal hospital establishment” (whilst also acknowledging that an establishment such as this could never *actually* exist). It lobbied on behalf of all specialists with the aim of making full time hospital work more attractive via increased salaries.

But it was now very unlikely that the Government would respond to their concerns, a marked contrast with the early 1970s. When George Salmond met with CSC in October 1978 to inform it that MSRU was going to undertake a survey of medical manpower, members expressed concern that “a survey of *actual* numbers of Specialists employed [would] not represent the ideal number of posts or even the number of vacant established posts”. Salmond’s reply was that given the general economic situation (and with health expenditure consuming just under 7% of the GNP), New Zealand could not afford the ideal establishment; a growth rate of 1% or 2% was all that was possible. The survey’s purpose was to assess (and then hopefully solve) the problem of distribution, with the aim, Salmond argued, of avoiding “an across the board cut of, say 10 percent”.²⁶⁸

CSC was dissatisfied with the focus of the survey and it wrote to the Medical Manpower Committee of the Medical Council arguing that the survey would not reveal the current shortages throughout New Zealand. They felt that such a survey should be designed “to survey real needs for specialists within each hospital board” and “although it was not necessarily possible to fulfil these needs they should be evaluated and recorded”.²⁶⁹

The change in attitude towards specialists was reflected within wage and salary discussions. It seems that by the later 1970s sights had been lowered somewhat by NZMA in its discussions with HMOAC. Instead of relativity with Australia, it was now felt that hospital medical officers were losing relativity within New Zealand in relation to other professions.

²⁶⁸ Meeting Central Specialists Committee 12 October 1978, Minutes, NZMA Collection, ATL, MS-Group-1276, MSY-5833, p. 3

²⁶⁹ Meeting Central Specialists Committee 1 March 1979, p. 1; 19 April 1979, p. 3, Minutes, NZMA Collection, ATL, MS-Group-1276, MSY-5833.

The next triennial review, to take place in 1981, was therefore crucial to any further advances. It was felt that an even more comprehensive submission would be required in light of the fact that the “manpower question and economic circumstances likely to prevail in 1981 will require a well documented and substantiated case to be prepared”.

The anticipation of a tougher fight for any further advances is clear. CSC was looking to hire an economist to help prepare its submissions to HMOAC, a strategy that had also been used in 1974.²⁷⁰ It seems that the leverage NZMA had held in the early 1970s was eroding as the Government was less willing to provide finance to increase the supply of hospital specialists.

While the immediate responses of government were shaped by fiscal constraints, we can also see recognition that fixing the medical graduate shortage would not solve the country’s health resource problems (as had been anticipated in the early 1970s) and a shift in attention to the role that doctors played within the health service. The comments made in the Health Department’s annual reports for 1977 and 1978 were demonstrative of this. It was now no longer taken for granted that an adequate supply of doctors (along with advances in medical science) would ensure that “disease could be conquered”; in fact, studies were revealing that an increase in doctor numbers did not correlate with improved public health.²⁷¹ The questions raised in relation to the relative *worth* of doctors within the health service reflected broader discussions that had been taking place in health economics for a number of years.

²⁷⁰ Meeting Central Specialists Committee 18 October 1979, Minutes, NZMA Collection, ATL, MS-Group-1276, MSY-5833, pp. 2-3.

²⁷¹ Advisory Committee on Medical Manpower, pp. 4-5.

Chapter Five: Buildings and Technology

This chapter explores the ways in which rationing influenced decisions relating to capital expenditure; both hospital buildings and expenditure upon medical technology. The provision of hospital buildings reveals that there was certainly increased scrutiny from at least 1976 onwards with the Local Authorities Loans Board placing restraints upon expenditure.²⁷² However the actual building program remained relatively constant throughout the 1970s, reaching its peak in 1979;²⁷³ evidence of restrictions became more obvious only in the early 1980s. If looked at through the perspective of rationing it seems that the building programme in the early 1970s was justified as a response to both a need and demands from the public for hospital facilities, and was often described as a demand for beds. It seems likely then that any awareness of the limitless potential for health care spending was masked by a belief that facilities were being provided to cope with population growth.

The lagging building schedule of projects already underway added a sense of urgency to these discussions; this argument was certainly made in relation to Auckland Hospital Board which frequently featured in headlines relating to shortages in hospital facilities.²⁷⁴ Following on from this, it was only once hospital facilities were in – or close to being in – place that the demand which, it was presumed, would be satisfied, revealed itself as something continuing and therefore in need of more careful management in the form of restrictions and stricter justifications for planned projects. It is however difficult to disentangle this awareness from the mid-decade economic tightening occurring across much social spending.²⁷⁵

Following a more general discussion of trends in hospital building and planning, this chapter goes on to discuss the introduction of CAT (computerised axial tomography)

²⁷² *AJHR*, 1976, E. 10, p. 65.

²⁷³ *AJHR*, 1980, E.10, pp. 35-36.

²⁷⁴ *The New Zealand Herald*, May 18 1970, p. 16.

²⁷⁵ Refer to Chapter Two for more detailed discussion of economic tightening, particularly from 1976.

scanners to the public hospital system in the later 1970s. Their introduction reveals the influence of health care rationing ideas, as well as persisting beliefs in the value of health care for all members of society. In some ways, in the case of CAT scanners, it is possible to argue that their introduction into New Zealand represents the most overt attempt at rationing health care during this period. Scanners were subject to extensive investigation and assessment as to their medical and economic value, and it was intended that they would be exclusively central government projects. The fact that these efforts failed due to public pressure and fundraising efforts is also an excellent example of the internal tension inherent in rationing health care resources: faith in scientific and medical advance existed alongside efforts to control and manage those same advances.

Demand in the early 1970s inspires a rush to provide facilities

By the early 1970s there was significant growth in hospital building programmes. This growth is evidence of a general shift away from community care in conjunction with a move towards the provision of advanced medical care in hospitals throughout the 1960s. In 1960 the Department of Health was claiming the merits of community services. By 1965 the tone of discussion had changed and the Department was focused upon the need to *respond* to the changing requirements of medicine in hospital design.²⁷⁶ The Department reported in the 1971 Annual Report that there had been a “substantial increase” in the number of building projects for which hospital boards had accepted tenders. The approved projects, as well as those already under construction, included plans for “modern clinical and outpatient facilities, including diagnostic x-ray pathology services, physiotherapy and occupational therapy departments”. An additional 1,900 beds would also be provided over the coming five

²⁷⁶ *AJHR*, 1965, H. 31, p. 32. For further discussion of the shift away from community care and towards the hospital sector see Chapter Two.

years.²⁷⁷ Although there was a clear increase in the number of planned building projects, the Department was insistent that this was due to the timing at which tenders were accepted and final approval given; actual expenditure was not increasing as dramatically as the figures suggested and predictions for expenditure over the coming five years remained constant at close to thirty million dollars per year.²⁷⁸

The larger centres featured prominently in building programmes. Waikato, Palmerston North, Wellington, North Canterbury and Otago Hospital Boards all had extensive projects either planned or underway. And Auckland Hospital Board was assigned an ample portion of the available finance for a number of years. The Board was in the process of developing three new hospitals at North Shore, Manukau and Waitakere. They also had Auckland Hospital Acute Block and developments at Green Lane Hospital near completion.²⁷⁹ The scale of hospital building in the context of other local building projects is evident from the building projects underway in Palmerston North. Its Hospital Board had a building programme costing an estimated nine million dollars, a figure dwarfing the local council's most expensive building project at the time, a new Civic Centre costing a comparatively small two and a half million dollars.²⁸⁰

The building programme was visible enough as to attract significant criticism from the Labour Party, particularly in a time where staffing shortages were already a highly charged issue.²⁸¹ Opposition member Norman King claimed that "palatial buildings" were being built at the expense of adequate salaries for staff, leading to a declining level of service.²⁸² Dr Gerard Wall, himself a doctor before entering into politics, argued that too much was being spent upon buildings and not enough upon staff. Wall believed that the cost

²⁷⁷ *AJHR* 1971, H. 31, p. 5.

²⁷⁸ *AJHR*, 1971, H. 31, p. 88. The estimates only refer to expenditure on projects over twenty thousand dollars.

²⁷⁹ *AJHR*, 1971, H. 31, p. 54.

²⁸⁰ *The Dominion*, May 26, 1970, p. 12.

²⁸¹ See Chapter Three for more discussion of staffing shortages during the early 1970s.

²⁸² *NZPD*, 371 (1971), p. 251.

of buildings added considerably to the cost of the sector as a whole, leaving few funds available to provide for the staff needed to service those buildings. Wall claimed to have witnessed this trend first hand on a visit to the Clinical Services Block of Hamilton Hospital. On one floor, of the six available suites only one was occupied, a further 24 rooms were also empty due to a lack of staff.²⁸³

NZMA and MANZ also expressed concern at what they saw as the disproportionate emphasis upon the building of hospital facilities at the expense of adequate staffing levels. Geiringer, of NZMA, had argued in an earlier attack upon the state of the health system that most hospitals were built for political purposes. Singling out the Labour Party for particular criticism, Geiringer noted the “built in tendency in Labour thinking to pay for hospitals rather than for doctors”.²⁸⁴ MANZ reiterated Geiringer’s argument a few years later. MANZ’s chairman, Dr Lindsay Brown, told HMOAC that desperate shortages of staff would continue if priority was continually given to building enormous base hospitals beyond the scope of the available “men, money and materials (including nurses)”.²⁸⁵ Health Minister McKay, although admitting that the building of base hospitals inevitably led to a concentration of specialists where there were adequate equipment and facilities, did not concede that the costs of building were diverting money from salary funds, and were therefore *leading* to shortages; instead McKay used the trend towards specialist concentration to argue for the reorganisation of hospital districts.²⁸⁶

The increase in planned building projects was justified by boards in the main urban centres which claimed they had a shortage of available beds.²⁸⁷ Auckland Hospital had problems providing adequate accommodation and treatment facilities. The average number of

²⁸³ NZPD, 373 (1971), pp.1758-59. For further comments about excessive government spending on equipment and buildings see *The Evening Post*, Friday March 12, 1971, p. 3.

²⁸⁴ Geiringer, p. 13.

²⁸⁵ Lindsay Brown to Ian Lythgoe, letter, 20 April 1971, NA, AEKO, 19171, SSC1, W2505, 33/7/9, Part 6.

²⁸⁶ *The New Zealand Herald*, March 4 1971, p. 4.

²⁸⁷ Refer to Appendices for bed availability and use.

beds per-capita in the Auckland region was three quarters of the national average. To cope with the demand for treatment W.E Henley (Medical Superintendent of Auckland Hospital Board) stated extramural services were being more readily used. But even with a significant number of people treated extramurally, the demand for hospital beds was still beyond what the Board was able to provide. Henley said that they were trying to keep momentum up on their “forward building” programme but the capital fund was limited to a fixed amount each year, and delays increased building costs. (The cap on the budget was not the crucial factor in the lagging schedule; the Board was finding it difficult to spend all of its capital funds, suggesting that delays were due more to problems in the building industry). The use of extramural and outpatient services had helped to ease demand for the available beds as they contributed, along with new medical techniques, to shorter inpatient stay times. Despite these factors, Henley argued that the speed at which buildings could be finished was trailing well behind population increases.²⁸⁸

Demand being immeasurable it remains open to speculation as to whether the impetus to provide facilities was in response to a real or perceived demand. A rush to provide additional beds amidst claims of excess demand is certainly not borne out by the available figures. The number of additional beds provided during the years 1970 to 1975 grew by just over 1,200, nearly half of which were added in 1973 (although a possible explanation for the misperception was that 1,900 beds were originally planned for construction during this time period).²⁸⁹ Despite these additions the number of beds only kept pace with New Zealand’s population growth; for the years 1970-76 on average, five beds were available per thousand of New Zealand’s population. For the same period, on average, close to four beds were occupied per day for every thousand of the population. The under use of beds could be explained by the fact that shortages of staff led to a restriction upon the numbers of patients

²⁸⁸*The New Zealand Herald*, May 18 1970, p. 16.

²⁸⁹*AJHR* 1971, H. 31, p. 5.

treated at any one time, despite the fact that bed provision was keeping pace with population growth and the beds available continued to be underused. Under use may also be explained by board policies to utilise outpatient and extra-mural services to a greater extent, as is suggested by Henley's comment above. The true cause of underutilisation of beds despite claims of continuing demand is difficult to ascertain. It should also be noted that whilst the desire to provide additional facilities can be described as response to demand, it is more likely that the building programme was in response to a perceived need, or at the very least legitimate, and not needlessly excessive demand. This is particularly evident in that building programmes were said to be in response to pre-existing shortages and population growth.

The impetus to provide hospital facilities may also be explained by the local significance attached to public hospitals and their prominent place within communities. In a rather emotive appeal for public finance and public sympathy, Wellington Hospital Board's advertisements in *The Dominion* during 1970 featured a team of surgeons; but instead of the patient lying on the operating table, potential public investors were encouraged to view the Hospital itself as the sickly invalid in need of urgent repair. Rather than the usual heart attacks, traffic accidents and acute surgery typically associated with emergency medicine, the hospital, it was claimed, was the "new emergency". Furthermore, investors were asked to consider their finance as a form of insurance. The advertisement implied their investment would guarantee that when they were in need of care, they would be sure to get the attention they required. An investment in loan finance would, the advertisement claimed, provide a kind of peace of mind for the individual.²⁹⁰

Public appeals for loan finance continued to feature in *The Dominion* the following year although the advertisements did not tug so obviously at the heart strings of potential investors. They again pictured a team of surgeons, but appeal was made to the gains of

²⁹⁰*The Dominion*, May 20, 1970, p. 12; May 26, 1970, p. 17.

financial investment rather than to the public's conscience or fear of potential medical emergency.²⁹¹ The connection of adequate medical care with the modern hospital building clearly indicates the local significance of the public hospital.

The local significance of hospitals is further reinforced by the way in which a public appeal was made to rally local support if facilities were considered inadequate. The Ear Nose and Throat clinic at Hutt Hospital had temporarily closed due to the departure of the specialist in charge of the department. June Kennedy-Good, a Hutt Valley member of Wellington Hospital Board, argued that the hospital's ability to attract a replacement specialist to fill the position was hindered by the lack of facilities available. In an area where there were specialist shortages, Kennedy-Good wrote, employees will be inclined to take positions where "the physical environment is pleasant, the equipment excellent and ancillary personnel is available". This was not the case at Hutt Hospital, and she felt this would not be remedied until the new clinical services block was built, adding that a similar situation existed in the outpatient department, where she described the facilities as "quite primitive". Kennedy-Good concluded that the Hospital was in desperate need of a new clinical services block to ensure that the Hutt area could be provided with acceptable levels of specialist care.²⁹² The emotive public appeal made by Kennedy-Good clearly connected the provision of physical buildings and facilities with the provision of adequate medical treatment, providing a sense of urgency and a possible 'rallying point' for local support.

A change of attitude: 1976

The need to attract public loan finance for hospital works programmes was still an issue for hospital boards in 1976, but the surrounding discussion in relation to loans for capital works reveals much about the change in tone in relation to hospital board expenditure

²⁹¹*The Dominion*, March 10, 1971, p. 14.

²⁹²*The Dominion*, April 20, 1970, p. 10.

upon buildings. In May of that year, as Minister of Finance, Robert Muldoon approved in principle the allocation of twenty million dollars from the Public Account.²⁹³ Treasury had made a recommendation that the funds would go some way to mending the gap between what was required by hospital boards and what appeared to be available through public finance. Muldoon's support for the hospitals works programme is significant considering the National Government was looking into ways to curb government expenditure.

The advice given to Muldoon would appear to sanction the hospital works programme, but a recommendation made alongside this indicated that Treasury was also looking into ways to gain control of the approval and planning process of hospital building. Alarm was raised within Treasury by observations that the works programme had "considerable forward momentum" due to the inadequacy of past planning and approval procedures. As a result, the Minister was informed, for the year ending March 1976 there had been a significant increase in requests for hospital loan money (accompanied by a similar trend in operating costs); the figure requested, totalling sixty million dollars, was nearly double what had been requested in the previous year; although both the Treasury and the Ministry of Works considered the estimate excessive, and were looking to reduce the sum by close to thirteen million dollars.²⁹⁴ They were also careful to note that the huge escalation should not be read as an increase in health "needs" as opposed to the previous year.²⁹⁵

The Treasury report went on to detail the weaknesses identified in the current hospital works programme, as well as possible remedies that might halt, or at least exert some kind of control over the forward momentum in hospital expenditure. It argued that decisions relating to the programming of new hospital buildings were made without consideration as to whether the resources were (or would be) available to finance the project, staff the new facility and

²⁹³ The allocated sum would be approximately \$150,000,000 in 2009.

²⁹⁴ Treasury Proposal to Robert Muldoon, Proposal on Hospital Board Financing, 26 May 1976, pp. 1-2, NA, ABQU, 632, W4415, Box 596, Record 342/4/1.

²⁹⁵ Treasury to Robert Muldoon and Frank Gill, Hospital Board New Commissioning Grants 1976/77, Memorandum, 11 May 1976, p. 1, NA, ABQU, 632, W4415, Box 596, Record 342/4/1.

provide ongoing maintenance costs. There were, they went on, no clear guidelines for capital expenditure (here they used the example of bed guidelines), stating that those in place were “permissive” and failed “in determining ‘need’ or assigning priorities”. Upon the completion of the building, the operating costs were effectively guaranteed. Therefore, the report argued, a crucial driving force behind increasing costs were the decisions made, often several years in advance, to provide more hospital buildings. Treasury claimed that the problem lay with the fact that no committee had overall responsibility for the approval and co-ordination of capital expenditure. The Hospital Works Committee and NAC operated separately and the HAC advised on priorities within the hospital service generally, but ultimately, HAC was not responsible for “limitations of finance and resources”.

The proposal put forward by the Treasury, to remedy the problem in the shorter term at least, was discussed at the Cabinet Committee on Expenditure in June 1976. Treasury wanted to encourage boards to consider growth allowances and new commissioning grants together and, more importantly, to encourage boards to use growth funds for the commissioning of new buildings. In effect, if the new commissioning grants were removed totally it would place a cap upon expenditure for new services. Long term, Treasury wanted boards to provide more extensive and robust arguments for new capital works and also wanted consideration to be given to future operating costs of the new building within applications for capital expenditure, suggesting perhaps that this might be an area of consideration for the newly established SACHSO.²⁹⁶

Treasury’s approach to the problem of new commissioning and capital expenditure was stern in comparison to the Department of Health. Although the Department also argued that capital expenditure was somewhat out of control it felt that a grant of eight and a half million dollars (as Treasury suggested) would attract too much public and press criticism,

²⁹⁶ Treasury Proposal to Robert Muldoon, Proposal on Hospital Board Financing, 26 May 1976, pp. 2-4, NA, ABQU, 632, W4415, Box 596, Record 342/4/1.

favouring instead an eleven million dollar allocation. Treasury's proposal would mean an increase of 5% on the previous year, the Department of Health's 5.9%. Treasury acknowledged that the lower sum would mean that boards would need to reconsider their expenditure plans, but felt that the figure was still generous considering the economic situation.²⁹⁷

The Department of Health's attitude appears to have changed somewhat by 1977 with its Annual Report publicly declaring the Government's intention to reduce loan money available for building projects as well as increased scrutiny upon requests for additional beds. An additional justification was also given alongside the argument for fiscal restraint: preventive and community medicine were to be made imperatives over curative care.²⁹⁸ As public hospitals were the sites at which the most advanced care took place, the Government's intentions to reduce expenditure and bolster community care would have consequences for the building of public hospitals.

There was however, considerable forward momentum in hospital building programmes already approved and underway, so despite intentions to reduce capital expenditure, it was not until the end of the 1970s that hospital building programmes began to slow down.²⁹⁹ It was over this 'forward momentum' that Treasury and the Department of Health still differed. The Department exhibited a great deal more tolerance towards the provision of New Commissioning funds, accepting that there was "no change that could assist in the immediate future in re-directing this expenditure". It was content with the fact that boards were making more requests for New Commissioning funds for services associated with community care, and thereby conforming to the Department's intention to reduce

²⁹⁷ Treasury to Robert Muldoon and Frank Gill, Hospital Board New Commissioning Grants 1976/77, Memorandum, 11 May 1976, pp. 2-3, NA, ABQU, 632, W4415, Box 596, Record 342/4/1.

²⁹⁸ *AJHR*, 1977, E. 10, pp. 6, 24, 34.

²⁹⁹ *AJHR*, 1978, E. 10, pp. 31-32.

emphasis on the building of more hospital beds.³⁰⁰ In contrast Treasury did not want additional claims to be made under the New Commissioning scheme, even to bolster community services. It argued instead that all new service proposals should go through the new policy process so that Government could decide upon the ones it wished to finance.³⁰¹

The influence of emerging ‘rationing ideas’ within service plans and increasing scrutiny of expenditure upon hospital building programmes due in part to financial crisis and in part to an increased emphasis upon community over institutional care, could have led to a severe restriction upon hospital building. This was not the case. Hospital building remained constant throughout the 1970s. The building of treatment facilities went forward at a steady pace, only dropping away in the early 1980s.

Ward and Clinical Services Blocks were the facilities to which the Boards were making the greatest commitment in their building programmes. This commitment remained fairly consistent throughout the 1970s, before declining markedly between 1980 and 1983. At the peak in 1971 and 1972, eleven Ward Blocks were either completed or under construction, falling to a low of two in 1982. Similarly, commitment to building Clinical Services Blocks peaked in 1972, with nine blocks underway or completed; again showing a steady decline from 1980 to a low of two in 1982.

The number of theatre suites built was fairly low throughout the early to mid 1970s; by the early 1980s all construction on theatre suites had stopped. Hospital construction itself, including the building of new hospitals and redevelopments, remained fairly constant throughout the entire period. In 1973 and 1974, five projects were underway; and again in 1979 five projects were under construction. There was however a sharper decline from 1980 to 1981, falling from four to two projects within a year, and remaining at this figure for 1982.

³⁰⁰ Department of Health to the Cabinet Committee on Expenditure for the 1977/78 financial year, Report, 1 December 1976, Appendix A, pp. 2 & 4, NA, ABQU, 632, W4415, Box 596, Record 342/4/1.

³⁰¹ Department of Health to the Cabinet Committee on Expenditure, Memorandum, no date [1976], p. 4, NA, ABQU, 632, W4415, Box 596, Record 342/4/1.

There also seems to have been a fairly constant commitment to the provision of other facilities, such as geriatric accommodation, teaching facilities and other services (including administration blocks, kitchen and laundry facilities).³⁰²

The local significance of the hospital as well as the forward momentum in building programmes has been offered within this chapter as a possible explanation for the continuation of large scale hospital building and the provision of treatment facilities. The following discussion also explores the local element of hospital provision through a more specific investigation of the introduction of CAT scanners into New Zealand. Investigating the nuances of this example allows a more detailed explanation to be offered as to why large scale hospital building continued unabated throughout the 1970s, and why, for the most part ‘rationing ideas’ were ineffective in this area: medical ‘advance’ provided a further local rallying point.

Technology

A significant influence on capital expenditure during the 1970s was the wish to provide for new medical technology. Recent work on the history of medical technology has emphasised that the 1960s and 1970s was an era in which medical technology became a feature of medical care. This era has been referred to as the time at which “‘medical-industrial complex’” developed; also described as the “‘medical arms race’” the emergence of expensive medical technology was identified by several economists as a crucial factor in the escalating costs of medical care.³⁰³ Alongside this assessment, other writers have asserted that optimism and faith in advancing technology to rid the population of ill health began to

³⁰² See Appendices for figures relating to hospital building and development.

³⁰³ Thomas P. Hughes, ‘Foreword’ in Carsten Timmerman and Julie Anderson, eds., *Devices and Designs, Medical Technologies in Historical Perspective*, Palgrave Macmillan, Hampshire and New York, 2006, p. viii. Hughes sites Arnold Relman, the editor of the *New England Journal of Medicine* as the person who first coined the term ‘medical-industrial complex’ in 1980.

fade in the 1970s because although health care expenditure had markedly increased, health status had not improved, as judged by indicators such as overall mortality rates.³⁰⁴

In 1976 the Hospital Works Committee discussed ways in which greater control over the system through which hospital boards applied for permission to purchase equipment could be achieved. Much like arguments relating to capital expenditure in general, the need to outline and instigate a clear programme of expenditure for equipment was intended to gain some measure of influence over the driving forces believed to lie behind escalating capital expenditure. At this time, boards were able to apply for funds for equipment as part of new commissioning grants upon the completion of a new building; they were also allocated money within a minor capital grant and they also had the ability to raise loan money. In May 1976 the Hospital Works Committee advised the Cabinet Works Committee about the possibility of introducing a Hospital Plant and Equipment Programme, which would instigate an approval process ensuring that spending on equipment would be brought into line with instructions from Treasury regarding the Government Works Programme.³⁰⁵

Despite this shift towards greater control over medical technology, when the introduction of the CAT scanner is examined it is revealed that although there was significant assessment of the value of the machines themselves, public pressure and enthusiasm for the machines meant that efforts to control the pace of installation were hampered.

The introduction of CAT Scanners to New Zealand was first put on the agenda in June 1976. HAC noted that there was “some agitation in Dunedin” and a fund had been established to acquire a scanner for the area.³⁰⁶ In response the Council set up a sub-

³⁰⁴ Hall & Viney, pp. 50-51.

³⁰⁵ Treasury Proposal to Robert Muldoon, Proposal on Hospital Board Financing, 26 May 1976, p. 3, NA, ABQU, 632, W4415, Box 596, Record 342/4/1.

³⁰⁶ Hospital Advisory Council Meeting, Minutes, 11 June 1976, p.5, Hospital Advisory Council, Agenda and Minutes, 1974-76, NA, AALR, 873, W5427, Box 636, Record 40/56/4, Part 8.

committee designed to assess and report upon the need for the scanners in New Zealand.³⁰⁷

CAT Scanners were a recent development; Allan M. Cormack had begun to develop the theory behind the new medical imaging procedure in the mid-1950s; but it was not until the late 1960s that the EMI Corporation in Britain began work on production of a machine, producing the first prototype in 1971. The scanner was available commercially in 1972 and the first two were installed in January 1973 in the United States.³⁰⁸

The sub-committee chaired by Dr Randall Elliot (a former member of Auckland Hospital Board) included, among others, a researcher from the New Zealand Institute of Economic Research (NZIER), a Neurologist and a General Practitioner. The inclusion of committee members other than medical practitioners was done following a specific request from Elliot. He argued that as the medical benefit of CAT scanners would be relatively easy to establish, and considering many of the medical members had a vested interest in the introduction of the scanners to their respective hospitals, it was appropriate to balance such representation with members who would be better equipped to assess the scanners using a business or economic perspective.³⁰⁹ The committee was to report on the diagnostic and economic benefits of the scans in comparison to other similar techniques, as well as their likely impact upon patient treatment and wellbeing. The sub-committee was also to supply a plan for their introduction into the country, including the type that should be purchased, the hospitals they would be placed in, and the structure for deciding which patients would be granted access to the scans.³¹⁰

³⁰⁷ Press Release, no date, Hospital Board-Hospital Advisory Council-E.M.I Scanner-Committee on computerised axial tomography, NA, AAFB, 632, W4914, Box 127, Record 53/57/3.

³⁰⁸ John Webster, ed., *Encyclopedia of Medical Devices and Instrumentation, Volume 2*, John Wiley & Sons, New York, 1988, p. 826. The development of computed tomography made a dramatic impact on the diagnosis of some neurological conditions, eliminating, in some instances the need for invasive diagnostic procedures. The developers, Allan Cormack and Godfrey Hounsfield (who headed the team at EMI for the commercial production of the machine) received the Nobel Prize in 1978 in honour of their work on the scanners.

³⁰⁹ Minutes of the Hospital Advisory Council, 20 July 1976, p. 3, Hospital Advisory Council, Agenda and Minutes, 1976-77, NA, AALR, 873, W5427, Box 637, Record 40/56/4, Part 9.

³¹⁰ Hospitals Advisory Council, *Report of the Sub-Committee of the Hospitals Advisory Council on Computerised Axial Tomography*, date unknown, pp. 1-2.

The sub-committee was unable to draw any conclusions about the possible costs or savings that might be made following the introduction of the scanners because the figures, they claimed, demonstrated “large inexplicable variations between comparable hospitals”. It was however noted that the scanners would be a considerable expense, not only due to the initial outlay in capital expenditure but also due to the high upgrading, operating and maintenance costs of the equipment.

Despite the cost, the committee argued that New Zealand, as an “advanced Western country” should introduce CAT Scanners, not only because they were considered to be superior in their diagnostic potential, but also to ensure that medical staff stayed in New Zealand, and did not emigrate to other countries where the new technology was available. In considering where the scanners should be placed the committee decided that population density, equitable geographical placement throughout the country, the location of neurosurgical departments (to ensure that no departments were rendered unviable due to a *lack* of the new technology) and the location of medical schools would all be considered. The rapid rate at which the technology had developed in the preceding two to three years, particularly in regards to full body scanners (the technological development of head scanners was already fairly advanced, so they would not be easily superseded by a newer model), meant that the committee was reluctant to recommend any large initial purchase in case New Zealand became “locked into” a certain type of CAT machine.

Ultimately, the committee recommended that the introduction of CAT scanners to New Zealand should be done in three phases: the first being the purchase of a head scanner for Auckland and full body scanners for Wellington and Dunedin respectively; the second phase should begin six to twelve months after the completion of phase one, involving the purchase of full body scanners for Auckland and Christchurch. After adequate assessment of

phases one and two, phase three would entail the possible relocation of the first scanners to other regions, and the replacement of those machines with new ones for the main centres.³¹¹

Following on from the recommendations, Dr T.M. Peters and C.J. Alexander were sent to the United States and Britain to undertake an evaluation of the scanners, chiefly with the purpose of deciding which model should be purchased. Cabinet decided that such an investigation was required before a definite commitment was made to purchase the machines.³¹²

The recommendations made in the report did prompt criticism from some sectors of the medical community. Dr Frank Rutter, a member of HAC himself, and chairman of the Auckland Hospital Board, came forward publicly to assert that in his opinion, the value of CAT scanners was not assured, and also noted that the report itself was far from conclusive about the merits of their introduction. As it was the Auckland Hospital Board that was first in line to receive a scanner, Rutter was very conscious about the possible implications any decisions made would have upon the Board, leading him to question whether the scanners were a wise use of money. Even though the funds for the scanners were to be drawn directly from central government, Rutter argued that their purchase would inevitably influence the total allocations available under Vote Health, diverting funds from other possible health initiatives; Rutter mentioned in particular community health services and suggested that a cost benefit analysis should be done before a decision was made.³¹³

Perhaps not surprisingly, Dr Ian Scott of the Department of Community Health at Auckland Medical School also came forward to criticise the report. He argued there was an

³¹¹ Hospitals Advisory Council, *Report of the Sub-Committee of the Hospitals Advisory Council on Computerised Axial Tomography*, 1979, pp. 3-4, 5-7, Appendix C.

³¹² Secretary of the Cabinet, Memorandum of the Cabinet meeting, 8 November 1976, NA, AALR, 873, W5427, Box 637, Record 40/56/4, Part 9.

³¹³ 'The high cost of CAT', *NZ Listener*, January 15, 1977, pp.10-11.

ethical issue enmeshed in decisions relating to CAT Scanners: should funds be provided for “better diagnosis of diseases for which there is no effective treatment”?³¹⁴

These criticisms were rebuffed by Dr Graeme Bydder of Dunedin Hospital who claimed that such remarks could be summed up as “GOAT Gripe (Gormless Opposition to Advances in Technology)”, the acronym was in response to public suggestions that Dr Bydder (and others like him in favour of introducing the scans) were themselves gripped by “CAT fever”.³¹⁵

Attention had already been drawn to the dangers of an overzealous approach to new medical technology when Professor Kerr White, Head of Medical Care at John Hopkins University in the United States had been brought to New Zealand following a joint initiative by the World Health Organisation and the Government. (White met with Gill, addressed community health authorities, gave a lecture to a meeting of general practitioners and spoke at two medical conferences). White argued for a “hard nosed” approach to CAT scans. Whilst he was certain of the scanners’ medical value as a diagnostic tool, he also warned against introducing them under the guise of “technology in search of use, instead of careful allocation of resources”.³¹⁶ However the tough approach that White favoured may have been made impossible by the fact that there was already significant public support for the introduction of the scanners in all the main centres.³¹⁷

Treasury advocated a thorough economic assessment of the scanners before the programme of introduction. When commenting on the proposed overseas trip of Professor Alexander (Professor of Radiology at Auckland University) and Dr Peters (technical expert at

³¹⁴ ‘The high cost of CAT’, *NZ Listener*, January 15, 1977, pp.10-11.

³¹⁵ *NZ Listener*, February 5, 1977, p. 26. The reporter of the *Listener* article in which Rutter and Scott’s comments appeared drew upon an issue of the *New England Journal of Medicine* in which the term “CAT fever” was used to describe the exuberance for CAT scanners. For a discussion of the swift impact of CAT scanners and “scanning fever” see Bronzion, Smith & Wade, pp. 30-33.

³¹⁶ *The Dominion*, 2 September 1976, no page number, NA, AALR, 873, W5427, Box 637, Record 40/56/4, Part 9.

³¹⁷ Office of the Minister of Health to Members of Cabinet, Memorandum, 3 November 1976, p. 2, NA, AALR, 873, W5427, Box 637, Record 40/56/4, Part 9.

the Medical Physics Department of Christchurch Hospital) to make an assessment of the machines, Treasury argued that the HAC sub-committee's report on the scanners had not taken into account the economic implications of the machines. To remedy this they recommended that either Professor Alexander or Dr Peters should be replaced with an economist.³¹⁸ Treasury's suggestions were however ignored; Cabinet approved the trip.³¹⁹

In January 1977 the sub-committee met to discuss Professor Alexander and Dr Peter's report, deciding that the Delta scanner was to be purchased in preference to the EMI scanner.³²⁰ Subsequently Gill recommended to Cabinet that three scanners should be purchased, the first for Auckland, and, a year later, the second and third for Wellington and Dunedin. Gill argued that as "most advanced Western countries now have C.A.T scanners" New Zealand must also have them, or risk the consequences of a "second rate" health service.³²¹

Treasury officials remained much more cautious. They were sceptical about a large initial purchase of the machines in light of the fact that the technology for the machines was still developing at a rapid pace. Significantly they were also mindful both of whether either the demand or the need for the machines was great enough to warrant installation in the proposed hospitals. *And*, if need or demand was not sufficient, whether (as they perceived the case to be overseas) demand for the machines would be created by "relatively unnecessary

³¹⁸ Treasury to Robert Muldoon (as Minister of Finance), Recommendation to Cabinet, 5 November 1976, p. 2, NA, AALR, 873, W5427, Box 637, Record 40/56/4, Part 9.

³¹⁹ Secretary of the Cabinet to Frank Gill, Memorandum, 10 November 1976, NA, AALR, 873, W5427, Box 637, Record 40/56/4, Part 9.

³²⁰ The Computerised Axial Tomography Sub-committee, Minutes of Meeting, 26 January 1977, p. 2, NA, AALR, 873, W5427, Box 637, Record 40/56/4, Part 9. The "cost-effective" element of the report was in reference to a choice between the two machines, rather than assessment of the cost-effectiveness of the treatment itself.

³²¹ Frank Gill to Cabinet, Memorandum, no date, p. 1, NA, AALR, 873, W5427, Box 637, Record 40/56/4, Part 9.

usage”. Treasury recommended that a single scanner be purchased for Auckland which would undergo economic and medical assessment before further purchases were made.³²²

Cabinet agreed with Treasury. In March 1977 it was decided that one scanner would be purchased, to be located in Auckland.³²³ However, perhaps in anticipation of protests from Wellington and Otago hospital boards, it was also announced that any further machines purchased would be placed with those two boards (and with the North Canterbury – Christchurch – board in four to five years).³²⁴ Director General of Health John Hiddlestone, was in agreement with the Cabinet’s decision, stating that considering the economic climate, the decision to purchase and assess only one scanner was wise.³²⁵

Once the programme of introduction had commenced an economic assessment was done by J.A. Ellis of NZIER, but the economic benefits of the machines were not obvious. There appeared to be some savings in bed use and in the reduction of other exploratory techniques, but the report was not conclusive; in fact HAC requested that the paragraphs relating to the economic benefits of the scanners be removed as they appeared to be unsupported by adequate evidence.³²⁶

The decision to set an initial limit upon the number of scanners was not popular, notably with those in the South Island, and in particular, with members of the Dunedin public. Richard Walls, the Member of Parliament for Dunedin North, wrote to Minister of Health Gill, with his concerns regarding a recent article in a local newspaper. Walls wanted an assurance from Gill that a scanner would be provided for the Dunedin region (and also that

³²² Treasury to Robert Muldoon, Report on C.A.T Scanners, 25 February 1977, pp. 2-4, NA, AALR, 873, W5427, Box 637, Record 40/56/4, Part 9.

³²³ Press Release, no date, NA, AAFB, 632, W4914, Box 127, Record 53/57/3.

³²⁴ Secretary of the Cabinet to Ministers of Health and Finance, Notice of Cabinet meeting, 1977, NA, AALR, 873, W5427, Box 637, Record 40/56/4, Part 9.

³²⁵ John Hiddlestone, report on Hospital Advisory Council Meeting, NA, AAFB, 632, W4914, Box 127, Record 53/57/3.

³²⁶ J.A. Ellis, *Computed Axial Tomography and other Diagnostic Techniques: A Cost Comparison*, Report to the Department of Health (presented to HAC 15 June 1978); Minutes of the Hospital Advisory Council, 15 June 1978, p. 3, Hospital Advisory Council, Agenda and Minutes, 1977-79, NA, AALR, 873, W5427, Box 637, Record 40/56/4, Part 12.

it would be paid for from government, and not *local* government, funds). He stressed that considering the tone of the article, it was crucial that the matter of the scanner should be handled sensitively, as he felt that the issue was becoming one of considerable importance to the community. Two letters from Dunedin locals illustrate the concerns that were alarming Wall. Helen Richardson wrote to Prime Minister Muldoon (after receiving what she claimed was “verbose parliamentarianism” from Gill in response to her previous letters) wondering whether it was he, as Minister of Finance, who was halting the funds needed for a scanner for Dunedin. Richardson claimed that “the people want a scanner”. David Proctor of Dunedin also wrote to Gill expressing similar opinions:

“This body scanner joke has already gone too far. If my country is so poor that it can’t afford three or four of these machines @ \$600,000 each then let me know. I think we could raise the money for one down here and lend it to the Government to help it out.”³²⁷

The actual funding of the scanners was, in contrast to other resource allocation, to remain solely in the control of the government. A supplementary grant allowed the purchase of the scanner for Auckland, alterations made to the hospital to house it, maintenance and upgrading costs. Whilst hospital boards had largely been in control of where money would be allocated and spent within their realm of responsibility, the planning and funding of the Scanners was not to be included in that domain.³²⁸ The initial report of the sub-committee on CAT Scanners was at pains to emphasise the fact that because these machines were to be funded directly from government funds there should be “sufficient control to avoid improper, trivial or unnecessary examinations”; the possible unintended implication in this statement (unintended because the chairman of the sub-committee, Dr Elliot, had been chairman of Auckland Hospital Board) being that hospital boards were capable of such mismanagement.³²⁹

³²⁷ David Proctor to Frank Gill, letter, 1 June 1977, NA, AAFB, 632, W4914, Box 127, Record 53/57/3.

³²⁸ Frank Gill to Richard Walls, letter, 14 June 1977, NA, AAFB, 632, W4914, Box 127, Record 53/57/3.

³²⁹ Hospitals Advisory Council, *Report of the Sub-Committee of the Hospitals Advisory Council on Computerised Axial Tomography*, 1979, p. 5.

Although there was careful scrutiny about the value and cost of CAT scanners, and a strong *intention* for government to keep control of the scanners, the public support indicated in the letters from members of the Dunedin public was a hint of further things to come. David Proctor's idea to raise money for scanners was apparently also on the minds of other New Zealanders. In the coming years fundraising efforts to purchase scanners went ahead throughout the country, effectively removing the introduction of the scanners from government control. Furthermore, once the scanners were installed the government was required to provide funds for their maintenance; a decision not to do so would have been politically disastrous.³³⁰

³³⁰ John Martin interview, 22 April 2008; George Salmond interview, 2 May 2008.

Conclusion

The late 1960s and early 1970s was a germination period for the formulation of explicit ideas for health care rationing. Chapter Two of this thesis outlined the emergence of health care rationing as a concept, led for the most part by health administrators (particularly within MSRU), economists and Treasury officials. Explicit rationing was also influenced by the economic situation during the 1970s and it is difficult to disentangle the influence of rationing as a concept from the financial stringency applied to all government spending upon the election of the National Government in late 1975, even though the two imperatives were somewhat different. In all the case studies in this thesis, a turning point occurred in 1976, allowing, if not specific action to be taken to influence health funding decisions, then at least pointed questioning. The economic difficulties did not lead to health care rationing but did produce a heightened awareness about possible ways to manage health spending. It was at this point that the desire to provide resources took a backseat to controlling (public) demand for those same resources, and alongside this, those involved in health administration were more aware that demand could never be satisfied.

Explicit recourse to ideas of health care rationing was also prompted by the advent and growth of specialist care. As described in Chapter Three, the concerns of health administrators, economists and politicians about the escalating costs in the health service were influenced by the development of high cost specialist services. In some cases enthusiasm was expressed about the possibilities of specialist curative care, at other times ideological reflection revealed the possible pitfalls of providing such care at the expense of other health services; these two strands of thought were occurring at the same time, and in the later 1960s and early 1970s enthusiasm for medical advance took precedence. The interplay between these ideas comes through clearly in the discussion in Chapter Three of the Cardiac Unit at Green Lane and in the fight for such a Unit in Christchurch. Whilst reservations about

providing additional finance were put forward by Treasury officials and by some members of the medical community (notably the Chairman of Auckland Hospital Board, Frank Rutter) the Green Lane Unit was still able to gain additional funding and the Christchurch Unit was approved.

The acceptance of explicit rationing of curative specialist services did not take place during the earlier 1970s because the focus of health administrators and politicians (fuelled by claims from hospital boards for more beds and staff to meet public demand) was about remedying previous shortages; they believed that the problems in the health service would be solved by an adequate supply of 'real resources'; any ideological reflection upon the value of such services was secondary. In the discussion in Chapter Four we saw that the rush to provide physical resources in the form of full-time hospital specialist staff reduced around the mid-1970s as staff became more readily available. That should have solved the problem as continuing public demand for specialist care had been blamed upon lack of staff when specialists were in short supply. But even after staffing levels improved, the public's thirst for specialist treatment remained, prompting the belief amongst health administrators that public demand could never be satisfied. It was an idea which health economists had long since accepted.

In Chapter Five the timeline outlined above is evident in health administrators' desire to respond to hospital boards' claims for more facilities, often expressed in requests for beds. During the early 1970s there was a large scale hospital building programme underway, often in the main urban centres. On the surface it appears that rationing ideas did not have any influence upon hospital building as the level of building did not abate during the 1970s, however the discussion behind the programme certainly reveals the influence of rationing ideas. Treasury officials in particular were most concerned with the number of projects under

construction and were even more alarmed at the lack of planning for the financial management of the proposed new facilities.

In both the cases of specialist staff and hospital building, the growing sense that public demand could never be satisfied came up against the earlier desire to overcome shortages; the case of the CAT scanner in Chapter Five was slightly different as talk of their introduction came around the mid 1970s by which time explicit rationing was more widely accepted. In that instance Government had the opportunity to study the economic benefits and pitfalls of the equipment in an attempt to carefully control their introduction and it is in this case study that attempts at explicit rationing were most evident. However, although both Government and health administrators attempted to control the introduction of CAT scanners, the public still displayed continued enthusiasm for medical advance, lobbying for their introduction, and in some cases fundraising for the purchase of the equipment. Much like the hospital building programme the equipment provided a rally point for public protest. Accordingly, although those involved in health administration had resolved their earlier philosophical questioning in favour of explicit rationing the public's actions tipped the balance towards investment in high cost medical technology, ensuring health remained a 'special case' for funding.

Rationing debates over curative care combined with the less tolerant economic environment and gave further impetus to the policy shift towards community care; providing an alternative to spending upon high cost curative care. This certainly seems to have been the official attitude by the mid 1970s, with the shift towards preventive care arguably beginning with the Labour Government's 1974 White Paper. Government policy emphasised preventive over curative care because it would reduce the need for beds, buildings and equipment (although not necessarily for staff). Although the severe reaction from the medical community in particular ensured that the White Paper itself was 'shelved' once National

came back into power in late 1975, the impetus towards preventive and community care survived in the form of SACHSO. Whilst this shift cannot itself be described as rationing, it certainly seemed to provide an alternative to expenditure upon high cost specialist care. If preventive care was effective then the debates over curative care, and the rationing required to manage it, would be muted.

It is possible therefore to see the way in which this mid-decade change in focus provided enough momentum to drive the preventive health care model of delivery through SACHSO towards the Area Health Board model of delivery which, although it took a number of years to implement, signalled a shift away from institution based health delivery to preventive and public health programmes.³³¹

However, as the CAT scanner case study makes clear, the situation was never as straightforward or as clear cut as a shift in focus from curative to preventive care. Even though health administrators at many levels were more willing to scrutinise and control the introduction of the new technology the public held onto its enthusiasm for medical advance. But it is possible to trace a renewal of emphasis upon preventive care, particularly as part of official government policy. From 1983 the Area Health Board Act was gradually implemented over the ensuing decade. Although the hospital was still a crucial factor in funding and delivery within the health service, Director General Ron Barker believed that Act and its population based funding formula would encourage boards to expand their views of health service delivery.³³²

This thesis has examined the emergence of health care rationing in New Zealand at a time of specialist medical advance. During the late 1960s and early 1970s questions about the value of specialist care were for the most part suppressed by enthusiasm for those same

³³¹ Gauld, p. 36.

³³² Dow, pp. 220-21.

advances. Also influential at this time was a desire by health administrators (at the request of hospital boards) to provide 'real resources' in the form of buildings, specialist doctors and equipment in order to remedy pre-existing shortages. By the mid 1970s a change had occurred. The change was influenced in part by a stricter economic policy but also by a growing awareness amongst health administrators that even though physical resources were now more in place public demand was still not being met; this awareness could aptly be summarised as 'increased supply would lead to increased demand'. As it was now accepted that demand would grow to meet supply it was also more readily accepted that health care rationing would be necessary to control that same demand. The 1970s was a turning point in thinking about health spending, and the insights that emerged during this period shaped health policy in the 1980s.

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Beds in public hospitals*	<u>1970-71</u>	<u>1971-72</u>	<u>1972-73</u>	<u>1973-74</u>	<u>1974-75</u>	<u>1975-76</u>
General Beds	11, 794	11,846	11,901	12,145	14,869	15,034
In other institutions**	2004	2,022	2,144	2,125	n/a	n/a
Total	13,798	13,868	14,045	14,270	14,869	15,034
Per thousand population	4.9	4.9	4.8	4.8	4.9	4.8
Average number occupied per day per thousand population	4	3.9	3.8	3.8	3.9	3.9

*All figures taken from the Department of Health's Annual Reports in the *AJHR*'s.³³³ There are no comparable bed statistics available beyond 1976. The lack of statistics can be explained by a general policy shift towards community and preventive care and away from the provision of additional beds.³³⁴ "[P]rogress in the delivery of health care" was no longer measured in bed numbers.³³⁵

**Figures include beds in hospitals that are also aged persons' homes, special hospitals and general beds in maternity hospitals.

³³³ *AJHR*, 1971, H. 31, p. 55; *AJHR*, 1972, H. 31, pp. 61-62; *AJHR*, 1973, E.10, p. 75; *AJHR*, 1974, E. 10, pp. 65-66; *AJHR*, 1975, E. 10, pp. 66-67; *AJHR*, 1976, E. 10, p. 66.

³³⁴ *AJHR*, 1977, E.10, p. 34

³³⁵ *AJHR*, 1979, E.10, pp. 39 & 52.

Large building projects completed or under construction*

	1970-1971	1971-1972	1972-1973	1973-1974	1974-1975	1975-1976**	1979-1980	1980-1981	1981-1982	1982-1983
Hospitals (includes redevelopments)	n/a	3	4	5	5	3	5	4	2	2
Clinical Services blocks	6	8	9	8	8	7	5	4	3	2
Theatre blocks or suites	3	3	3	1	2	2	0	0	0	0
Ward blocks	7	11	11	8	9	8	4	5	2	2
Acute blocks	1	1	1	1	1	0	0	0	0	0

*Explanation of method: all figures are taken from the Department of Health's Annual Reports in the *AJHRs*. The figures are intended to indicate the scale of the overall hospital building program going on throughout the country and therefore, if for example a theatre suite took two years to complete then it will be included in the figures for both years of construction. Also, if the building was for more than one purpose (a joint Ward and Clinical Services Block for instance) then it has been counted twice.³³⁶

** No comparable figures exist for the years 1976-1979, however, as the discussion in Chapter Five has shown from approximately 1976 onwards the archival evidence allows us to speculate about the building program during this period: much effort was exerted (particularly by Treasury officials) to slow the hospital building program down; this effort resulted in the reduction in figures for 1979-1983.

³³⁶ *AJHR*, 1971, H. 31, pp. 54- 55; *AJHR*, 1972, H. 31, pp. 60-61; *AJHR*, 1973, E.10, p. 74; *AJHR*, 1974, E. 10, p. 64; *AJHR*, 1975, E. 10, p. 65; *AJHR*, 1976, E. 10, p. 65; *AJHR*, 1980, E. 10, p. 36; *AJHR*, 1981, E. 10, p. 41; *AJHR*, 1982, E. 10, p. 37; *AJHR*, 1983, E. 10, p. 36.