Some Financial and Medico-Political Aspects of the New Zealand Medical Profession's Reaction to the Introduction of Social Security*

IN 1938 the New Zealand medical profession refused to accept the first Labour government's proposals for a scheme of medical social security covering general practice and maternity benefits. It has been suggested that this refusal amounted to a rejection of a substantial increase in income for most general practitioners, though little hard evidence has been adduced to demonstrate the truth of this contention.[1] As it is unusual for a professional group to refuse to advance its collective economic interests, it is of considerable interest to try to explain the refusal. It is, however, necessary first to demonstrate that the medical profession did in fact reject increased remuneration in 1938 before proceeding to examine the reasons, whether rational or irrational, for this rejection.

It is not easy to determine the income level of individual professional groups during the 1920s and 1930s. With some exceptions, the Department of Statistics did not begin to identify the incomes of specific professional groups in the abstracts of statistics until the period after World War II. The Department did, however, include questions regarding personal income for the first time in the 1926 census and did so again in the census of 1936 and in subsequent censuses. The relevant census question asked respondents to assess their personal income on a seven step scale with no subdivision of incomes in excess of £364 per annum. According to the returns, 746 of the 938 doctors completing the 1926 census (79.53%) were in receipt of an income in excess of $364 per annum; consequently, the census information is not particularly useful in arriving at an 'average' medical income for the period before the introduction of medical social security benefits.[2] A survey was, however, conducted in

*I am grateful for the constructive comments of Dr T. W. Brooking of Otago University and of Dr T. H. Beaglehole of Victoria University.

1 J. B. Lovell-Smith, *The New Zealand Doctor and the Welfare State,* Auckland, 1966, pp.53, 125.

2 Population Census 1926, XI, Incomes — N.Z. Department of Statistics.

1938 giving a detailed breakdown of the income of a wide variety of occupational groups, including doctors. This survey showed that in the immediate post-depression period surveyed 427 of the 959 medical practitioner respondents were in receipt of an income of £1,000–£2,000 per annum and only 247 were in receipt of an income of less than £500 per annum. These figures are of gross income.[3] Incomes at the £1,000–£2,000 level put the recipients into the top 2% of adult male income earners and thus clearly into New Zealand's 'Upper Class'. As separate registers of medical specialists and general practitioners were not maintained by the General Medical Council before World War II, it is not possible to state how many of these doctors were general practitioners and the information is thus not useful in distinguishing among the various groups of doctors. With such a paucity of official information the investigator is forced to search the medical and other literature for additional evidence regarding the income of general practitioners.

Medical fees had been standardized in New Zealand long before the 1930s. Although there was no formal arrangement for fixing fees, the British Medical Association (N.Z.) Branch [BMA] had from the early years of the century published a recommended schedule of fees and this schedule was followed by most doctors.[4] Over the first four decades of the century the fees of general practitioners had become so uniform that in 1941 Peter Fraser, the Minister of Health, could say to the doctors' representatives that the standard fee at that time was 10/6d per consultation. The medical profession denied that there was any uniformity in fees but the evidence for standardization is overwhelming.[5] During the depression members of the medical profession came under pressure, particularly in rural areas, to reduce either their fees or their mileage charges. While these requests were resisted at both national and local level by the doctors, it is certain that the pressure had some effect and that medical incomes fell at this time.[6] There is some further evidence of a fall in income in the census figures. A comparison of income returns in the 1926 and 1936 censuses shows that the numbers of medical practitioners classified as being in receipt of an income in excess of £364 per

3 *Statistics of Employment and Income 1937-38*, Wellington, 1938.

4 See, for example, *New Zealand Medical Journal* [NZMedJ], II, 4 (April 1901), p.265; II, 5 (June 1901), p.67; III, 10 (April 1903), p.108; XI, 42 (May 1912), pp.131-34; XX, 98 (August 1921), p.254. These articles and editorials give details of the Association's fee-fixing mechanisms and recommendations for changes in fees over the years. It should be emphasized that, although these fees were widely followed, they were a recommended scale and by no means binding upon members of the profession. The rate of remuneration received for attendance upon Lodge patients was of course lower.

5 Lovell-Smith, p.143.

6 NZMedJ, XXX, 160 (October 1931), p.319; XXXII, 167 (February 1933), p.40; XXXII, 168 (April 1933), p.97; XXXII, 171, (October 1933), p.285. These pages record the decisions of the Council of the Association in regard to requests from various interest groups that medical fees be reduced. All were rejected on the grounds that doctors had already voluntarily reduced fees in individual cases.

annum fell from 79.5% of all practitioners in 1926 to 72% in 1936.[7]

In 1933 the salary scales of senior government servants ranged from the £728 per annum paid to the Secretary to Labour, to the £1,142 per annum salary of the Secretary to the Treasury.[8] In 1935 a provincial general practitioner estimated that the income of many practitioners was in the region of £1,000 to £1,250 per annum.[9] As the degree of inflation in the two years between the samples was negligible, it seems that general practitioners' incomes were on a par with those of the country's four top civil servants. Another indication of the position of medical practitioners on the social scale is to be found by comparing their salary level with the average annual wage in 1935 for skilled and unskilled male workers: this was £208.[10] If the liberal estimate of 50% of gross salary expended as practice expenses is made, the practitioner earning £1,500 was in receipt of a net income of over three times that of male non-professional workers.[11] Further indications of the high level of doctors' incomes can be found in the levy system , introduced by the BMA in 1939, to supplement the pay of medical officers serving overseas. As an example, the Council of the BMA decided to supplement the £638.15.0. per annum paid to an R.N.Z.A.M.C. captain by £4 per week in order to bring the salary to a figure of £737.5.0. per annum. In deciding upon this level of subsidy the BMA Council explicitly stated that it was not possible to provide a supplement which would guarantee serving officers against all financial loss.[12] This statement makes it reasonable to assume that the figure of £737.5.0. was below the normal income of a young general practitioner who had fairly recently entered practice.[13]

Confirmation of the level of doctors' incomes can be found in the records of the BMA. In his submission to the Parliamentary Select Committee on National Health and Insurance in 1938, Dr J. P. S. Jamieson, the Secretary of the BMA's National Insurance Committee, objected to an actuarial recommendation that the capitation fee should be 15 shillings inclusive of mileage. This figure he considered to be insufficient.[14] The level of captitation fee would have provided a doctor having a panel of 1,500 patients with an income of £1,125. A month earlier Jamieson

7 Population Census 1926; Population Census 1936, XII, Incomes.

8 *Appendices to the Journals of the House of Representatives* [AJHR], 1933, H-14.

9 Dr E. S. Stubbs, letter, NZMedJ, XXXV, 187 (June 1936), p.190.

10 W. B. Sutch, *The Responsible Society in New Zealand*, Wellington, 1971, p.47.

11 A rough indication of the possible level of expenses can be gained from the practice expenses for British doctors in 1936–1938 — these averaged between 20%–40%. A. Bradford Hill, 'The Doctor's Day and Pay', *Journal of the Royal Statistical Society*, CXIV, I (1951), p.3.

12 NZMedJ, XXXIX, 212 (August 1940), p.218.

13 H. E. Holland, speaking in the debate on the Social Security Amendment Bill, said that he knew a doctor who had sacrificed £600 per year to go overseas with the armed forces, *New Zealand Parliamentary Debates* [NZPD], 260, p.615.

14 Jamieson to Secretary, Committee of the House of Representatives on National Superannuation and Health Insurance, 19 April 1938, Jamieson Papers, NHI General Record 1935–39 File, New Zealand Medical Association, Head Office, Wellington, pp.7–8.

had informed his own Committee that their proposal for a capitation fee of 25 shillings would yield a gross average annual income of £3,000 for general practitioners and £4,000 for specialists and that they should be prepared to revise this demand downward.[15] It may be concluded that the average level of remuneration for all doctors (specialists and general practitioners) probably fell somewhere between the doctors' and the government's estimates and would thus have lain in the range of £1,250 to £2,000. The income range of most general practitioners was probably in the lower half of this range.

The income figures quoted above are mainly from the depression and the immediate post-depression period. There was, during the depression, a considerable volume of complaint to the effect that the incomes of many doctors had suffered a drastic decline. One complaint by the editor of the *New Zealand Medical Journal* alleged that by 1934 only 10% of patients were paying full fees, as compared to 80% in pre-depression days.[16] Similarly, in 1932 the Council of the BMA refused to entertain the request of the Dominion Secretary of the Farmers' Union that it lower its recommended scale of fees in view of the severe economic conditions. The grounds for this refusal were that 'there had been a voluntary reduction in the scale of fees greater in proportion than the reduction of income of other sections of the community'.[17] Despite these complaints there is little hard evidence that, during this period of severe deflation, the fall in medical incomes was proportionately greater than that of other groups.

Clearly the doctors were a privileged group before the introduction of medical social security and it is interesting to consider whether they rejected the introduction of social security medicine because this would have worsened their financial position. Would the Labour government's first capitation offer have substantially raised or lowered the income of the average general practitioner? After all, if the effect of introducing the scheme would have been to lower medical incomes, then one need look no further for the doctors' opposition, as a threat to any occupational group's financial interest is usually remarkably effective in making that group a cohesive entity (despite the arguments of Mancur Olson to the contrary).[18]

The government's first formal capitation offer was for 15 shillings a head of insured population plus a mileage fee of 2 shillings per mile from three to thirty miles. Based upon a panel of 1,500 patients the average general practitioner would have received a salary of, from around £1,600

15 Memorandum to members of the NHI Committee, 13 March 1938. Jamieson papers, NHI General Record 1935–39 File, p.8.

16 Editorial, 'State Medicine', NZMedJ, XXXIII, 173 (February 1934), p.49.

17 Minutes of Meeting of the Council of the BMA, December 1932, NZMedJ, XXXII, 167 (February 1933), p.40.

18 Mancur Olson Jr., *The Logic of Collective Action: Public Goods and the Theory of Groups*, Harvard, 1965.

to around £1,900 per annum. In other words the average general practitioner could expect a rise in income by contracting into the Labour government scheme. Nevertheless the scheme was rejected, only 85 of 945 practising doctors accepting.

The reasons for the rejection of the scheme were complex. Some doctors were opposed to state medicine on principle and were prepared to make financial sacrifices in defence of that principle. These doctors — as shown by events in later years — were a minority. Some other members of the profession undoubtedly thought that by holding out they could obtain more advantageous terms — either a higher capitation fee or the establishment of remuneration on a fee for service basis. Once again this group was a minority, although it was probably a somewhat larger minority than those in the first group who rejected all government interference in medicine. Smaller minorities of the profession favoured either a capitation system on the British model or a salaried service.

A large group of doctors, possibly the majority of the profession, were open to persuasion — although anxious to retain their existing conditions of work. The attitude taken by these men was therefore critical in deciding the outcome of any negotiations, their support being essential to either the government — in supporting a state medical scheme — or to those of their colleagues who opposed a state scheme. In these circumstances the leaders of the medical profession — and in particular those members chosen to conduct negotiations with the government — were in a position of critical importance and the character and opinions of the men chosen for this role was of great significance.

The setting up of the BMA's National Health Insurance Committee antedated the Labour Party's election victory by some ten months and was in fact the result of an initiative of the Auckland Division in 1933. The Auckland Division had asked the Council of the Association to collect data and opinions and to formulate a policy to embody a general insurance to meet the cost of hospital and/or domiciliary medical treatment for the whole population.[19]

This initiative of the Auckland Division led the Branch Council to approach, in 1933, the Hospital Boards' Association — with which body the BMA had intermittently and unsuccessfully been discussing the reform of the hospital system since 1922 — with a proposal for an insurance scheme to cover the medical expenses, both hospital and domiciliary, of the lower socio-economic groups. The Hospital Boards' Association received the BMA's suggestions sympathetically and a joint sub-committee of the two bodies was set up to consider medical insurance. The representatives, both of the BMA and of the Hospital Boards' Association, were men of considerable distinction: Dr T. D. M. Stout, Dr D. MacDonald-Wilson, and Mr G. F. V. Anson for the BMA

19 C. E. Hercus, 'Health Insurance in New Zealand', NZMedJ, XXXIV, 180 (April 1935), p.88-97.

and W. Wallace, F. Castle and J. K. Hamilton for the Hospital Boards' Association.[20]

In the report of the combined sub-committee, published in 1934, it was proposed that a comprehensive scheme of medical insurance should be instituted for all those members of the community and their dependents whose income, after deducting £50 for each dependent, was below £260 per annum. The sub-committee estimated the cost involved in implementing the scheme at £1.75 million for comprehensive medical, hospital and dental cover for 800,000 people, approximately £2.2.0. per insured person per annum. While this estimate was approximate and the sub-committee stressed that the government should cost any scheme carefully, the estimate did give a useful pointer to the scale of expenditure required if a health scheme were to be implemented.[21] The proposals of the joint sub-committee were for a complete medical service for the group to be covered. This service included hospital and maternity benefits, general practitioner, specialist and dental benefits plus domiciliary nursing and other supporting and diagnostic services. It was the first proposal for a really comprehensive scheme for any section of the population and the first significant move away from the unproductive wrangling over hospital medicine which had dominated relations between the Medical Association and the Hospital Boards' Association over the previous decade.

In February 1935 the annual general meeting of the BMA considered the proposals of the joint sub-committee and accepted them as a basis for future policy. A series of resolutions concerning health insurance were approved by the meeting, including one stressing the Association's willingness to co-operate with the government in formulating a scheme of national health insurance and stating that the Association would in the meantime conduct its own examination of the question. From this it may be inferred that the members of the BMA saw their organization as having the leading and directing role in any reorganization of the nation's health services. In order to conduct its own investigation the Council of the Association, immediately following the 1935 annual general meeting, formally resolved to ask the divisions of the branch to appoint representatives to serve on a special committee which would conduct further enquiries into the question of national health insurance.

It is thus apparent that the BMA's National Health Insurance [NHI] Committee was not specifically created to oppose the Labour Party's proposals; it was a response to the interest in national health insurance being shown by all political parties. This interest had culminated in the Coalition government's decision to set up a departmental committee to investigate the need for, and the scope of, a national health insurance scheme. The second major reason for setting up the BMA committee was the pressure

20 J. P. S. Jamieson, 'The New Zealand Hospital System', Part II, NZMedJ, XXXIII, 178 (December 1934), p.365.

21 Lovell-Smith, pp.20–24.

inside the profession from certain general practitioners for some form of health insurance. The Chairman of the NHI Committee, Dr Jamieson, appears to have been of the opinion that metropolitan practitioners favoured insurance and he was at pains to stress this to rural practitioners.[22] In view of this and of the later, intensive propaganda campaign to convince doctors to follow the NHI Committee's approach, it appears to be likely that medical opinion was either in favour of some limited form of insurance, or at least fairly evenly divided on the question.

While, as has been demonstrated above, the income of most general practitioners remained more than adequate, the income of some metropolitan doctors had been badly affected by the depression. The largely working class clientele of these doctors was being reduced to penury and was increasingly unable to pay for medical attention.[23] Additionally, many of their club patients had been unable to keep up payments to their lodges and had been suspended from membership. As a consequence the basic income of these doctors had fallen drastically. As has been mentioned above the members of the Auckland Division were the most vociferous advocates of some form of health insurance.

At the meeting of the BMA Council held following the 1935 annual general meeting of the Branch, it was shown that there was a reluctant acceptance by the majority of council members that, in the near future, the introduction of some form of health insurance was inevitable. In view of this and of the resolution of the annual general meeting the Council set up a National Health Insurance Committee to investigate the introduction of some form of health insurance, at the same time announcing the Association's readiness to co-operate with the government and/or the hospital boards in any enquiry to consider the matter of health insurance.

While the NHI Committee had been set up before the Labour election victory, its work assumed urgency only in 1936 when the new government began serious work on its medical plans. The terms of reference of the NHI Committee were broad and non-specific, consisting only of the resolution of Council setting it up. This resolved 'that divisions be asked to appoint a representative to serve on a special committee to conduct further investigations on the question of National Health Insurance'.[24] The Committee interpreted this as constituting its 'order of reference' and stated 'it must be clearly understood that the Committee cannot enter into its work with any "a priori" bias towards advocating or initiating a scheme of National Health Insurance. Its conclusions may be

22 Report of a meeting held at the Masterton Hospital on 13 October 1936 to consider the National Health Insurance Scheme. Jamieson Papers, NHI General Record file 1935-39, p.7. See also 'State Medicine', p.50.

23 ibid.

24 Minutes of a meeting of the Council of the BMA, 28 February/1 March 1935, NZMedJ, XXXIV, 180 (April 1935), p.131.

favourable or otherwise but its business is investigation'.[25] While the statement would on the face of it imply an attitude of open-mindedness, it was in some respects a retreat from the position adopted by the Council in February. At that time Council was clearly of the opinion that some form of national health insurance was inevitable.[26] The suspicion that the Committee was dominated from its inception by doctors opposed to the introduction of national health insurance finds confirmation in the later revelations of two senior members of the medical profession. P. P. Lynch, a member of the Committee from its inception and the Honorary Secretary of the Association during the critical years 1935–9, averred that although the Committee was ostensibly set up to negotiate with the government, its main purpose was in fact obstructive. Lynch admitted that he had kept silent until 1944, as he did not wish to divide the profession.[27] The Wellington obstetrician, T. F. Corkill, Chairman of the Council in 1934 and 1935 and a member of the Council Executive until 1938, also submitted a paper to the *New Zealand Medical Journal* in 1944, in which he attacked the NHI Committee in scathing terms. 'On more than one occasion I have been utterly ashamed of the selfish, ignorant, laissez-faire attitude expressed in our discussions by men who see no fault in the past system, who appear to be unaware of the world-wide changing outlook regarding health services and whose main hope is to postpone the evil day of change as long as possible.'[28] It thus appears that the members of the NHI Committee had failed to accept the inevitability of some form of health insurance despite the promise of the provision of such insurance as a plank in the platform of both political parties. It seems that this Committee was dominated from the outset by doctors opposed to any state insurance scheme, although when setting it up, the Council of the BMA had indicated willingness to co-operate. The attitude of the Committee thus augured ill for the rapid success of negotiations with any government committed to introducing a national health insurance scheme.

The composition of the Committee closely paralleled that of the Council of the BMA. This is not surprising as the meetings of the Committee were normally held in Wellington on the same day as the Council meeting, the Committee meeting in the morning, the Council meeting following in the afternoon. This being the case, most divisions nominated as delegate to the Committee one of their delegates to Coun-

25 'The National Health Insurance Committee: Explanation of its Work', NZMedJ, XXXIV, 182 (August 1935), p.19.

26 Minutes of a meeting of the Council of the BMA, 28 February/1 March 1935, p.131.

27 Typed statement to Medical Planning Committee (of BMA) dated 1.2.1944 by P. P. Lynch, Jamieson Papers, Medical Planning Committee File.

28 Galley proofs of paper by T. F. Corkill, 'Conditions of Medical Service in New Zealand' (no date, but its position in the file indicates that it was probably written about the same time as Lynch's statement). Interestingly this paper was not published. Jamieson papers, Medical Planning Committee File.

cil. The NHI Committee thus represented a cross section of the leadership of the organized medical profession in New Zealand, being a miniature of the Council of the Branch and, one can assume, representative of those doctors attending the meetings of the Divisional Councils.

An analysis of the composition of the Committee between 1935 and 1939 shows that it consisted of up to 18 members, including one representative from each of the 14 divisions, the editor of the *New Zealand Medical Journal*, and on occasion the Chairman of the Branch Council and the Honorary General Secretary. The Secretary of the Association, Dr G. W. Hogg, also attended these meetings, but appears to have acted only as Minute Secretary. Typically, 12–16 members attended any meeting, the West Coast being the division most frequently unrepresented. The members of the Committee (as also the members of the Branch Council) were hardly typical of the New Zealand medical profession as a whole. The members most frequently attending the meetings of the Committee during the period 1935–40 included nine specialists, six general practitioners/surgeons (who could be considered specialists as they possessed higher qualifications and came from areas which lacked the work to support full-time specialists), and only five general practitioners. In view of the fact that most of the conflict with the government was to centre around general medical benefit, it is surprising that only 25% of the members of the Committee were general practitioners and thus directly involved and representative of the 62% of the profession in general practice.[29]

There is also some evidence of conflict between the specialists dominating the leadership of the profession and the rank and file general practitioner members of some divisions. The first representative of the Auckland Division was a Dr S. L. Ludbrook who, like Jamieson and most other members, was at best lukewarm toward national health insurance. In Auckland a considerable number of general practitioners were advocating some form of compulsory health insurance during the early 1930s.[30] It is significant that in 1938, when it appeared that the

29 Figures showing the proportions of general practitioners to specialists and doctors in other employment were published by Professor C. Hercus and H. P. Purves in NZMedJ, XXXXII, 229 (June 1943), p.340. The members of the NHI Committee were unrepresentative of doctors as a whole in several ways. While their median age at the time that they were active in Association affairs (45 years) was not dissimilar to that of the profession as a whole, 65% of the members of the committee had higher qualifications compared to 11% of the profession as a whole. 71% of the committee had received their medical training overseas, most of them in the United Kingdom, as compared to 29% of the profession generally. 41% of the membership of the committee had emigrated to New Zealand. The 20 members most frequently attending meetings of the committee during its active life were Drs J. P. S. Jamieson, J. O. Mercer, G. F. V. Anson, F. Kahlenberg, J. P. Duncan, S. D. Rhind, W. P. P. Gordon, L. G. Drury, F. A. Scannell, A. Wilson, A. D. S. Whyte, L. A. Bennett, N. L. Speight, W. F. Buist, T. D. M. Stout, H. K. Pacey, T. F. Corkill, J. C. McKenzie, D. D. McKenzie, P. P. Lynch.

30 Hercus, 'Health Insurance in New Zealand', pp.87–88.

leadership of the Association had closed the door to further negotiation with the government, Ludbrook was replaced as the representative of the Auckland Division on the NHI Committee by Dr L. G. Drury, a general practitioner. Drury was a leading advocate of national health insurance, but on a fee for service rather than a capitation basis. He was to be an influential figure after 1941. Another of the general practitioner members of the Committee, Dr W. P. P. Gordon, was also to repudiate, in the middle 1940s, the Committee's attitude to the Labour government's proposals and was to attempt to reach an accommodation with the government.[31]

The members of the Committee would seem to have been the representative of the elite group of specialists and part-time specialists which dominated the medical professional organization during the inter-war years. Most of these men had received their education in the United Kingdom and many of them were emigrants from that country.[32] It seems likely that many had come to New Zealand because they were dissatisfied with the type of contract practice introduced into the United Kingdom by the 1911 National Health Insurance Act. In the main the members of the Committee were men of considerable ability who had made major contributions to the development of medical services in New Zealand. The contributions of Corkill in obstetrics, Lynch and J. O. Mercer in pathology, and Anson in anaesthetics, are outstanding examples but are far from being an exhaustive catalogue of the achievements of Committee members. While all these doctors were more than competent in their own spheres and most were articulate men, all, without exception, even when they disagreed with the policy he was following, were dominated and overshadowed by the Chairman of the Committee, a general practitioner surgeon from Nelson, Dr Jamieson.

Jamieson dominated the Committee from its foundation until its demise. Professor C. Hercus, appointed as Chairman of the Committee when it was set up, stood down at the first meeting on the grounds that his duties as Dean of the Medical School would prevent him giving adequate time to the matter. He also considered that an academic was an inappropriate person to head such a committee, which he felt should be chaired by a general practitioner. Hercus proposed that Jamieson be appointed and he was duly elected.[33] The reasons for selecting Jamieson appear to have been threefold: his strong qualities of leadership, his

31 Drury is considered to have been instrumental in persuading the government to offer a fee for service system of remuneration in place of the unsuccessful capitation offer. Gordon was active in promoting the North Taranaki Clinical Society's scheme in 1944–5.

32 Seven of the members of the NHI Committee were born and educated outside New Zealand. Twelve members had received their medical education in the United Kingdom and qualified there. All of the 13 members having higher qualifications had spent some time undertaking post-graduate studies in the United Kingdom. Only one of the 20 members had not had some experience of medical practice in the United Kingdom.

33 Minutes of the Inaugural meeting of the National Health Insurance Committee, NZMedJ, XXIV, 182 (August 1935), p.7.

dominant personality, and the fact that he had in the recent past written critically and at some length on the deficiencies of the New Zealand hospital service.[34] He was, however, hardly a typical general practitioner, having the postgraduate qualification of M.D. together with a higher surgical qualification. The fact that Jamieson was deeply opposed to change in the existing arrangements for medical practice and would act as a counter to any divisional representative anxious to see some form of health insurance introduced, was also important.

To understand why the BMA proved so intransigent in its struggle with the Labour Party it is important to obtain some impression of the character of this complex man. Statements from both those who supported and those who opposed him help to build such a picture. In 1935, he was in his early fifties and had practised in New Zealand for some 27 years, for most of that time in the Nelson district. He was basically a general practitioner but, in common with other doctors with higher surgical qualifications working in provincial towns, he practised surgery. During his chairmanship of the Committee, Jamieson was also at various times President of the New Zealand Branch of the Association and Chairman of the BMA Council. He has been described by a medically qualified commentator on the history of the negotiations as one of a distinguished medical family and himself a highly respected practitioner.

> He was a man of considerable personality, a natural leader with the gift of eloquence and sardonic wit. He had a remarkable ability to write good English and proved to be remarkably cool headed in the various crises which beset the profession in the ensuing years. Politicians found him a formidable antagonist. He was not a man to be awed by threats and was rock fast on matters of principle. He came to embody the conscience of the profession in New Zealand, and under his leadership medical men were united as never before or since.[35]

Another doctor, and a personal friend of Jamieson, has stated that:

> He was a most impressive speaker and he held and persuaded, or maybe led, his audience by his own special charisma and influence.
>
> Because of his great ability as a speaker, he was always in great demand and one was so impressed, at all times, by the clarity of his thought process. He was a most determined Scot, a dour fighter and one who usually succeeded by a vastly superior knowledge of subject.[36]

The remarkable powers given to the NHI Committee during the period of its existence are a mute testimony to the power of Jamieson's personality, as is the high level of support for (or at least acquiescence in) the Committee's policies manifested by the profession during the years 1935 to 1940. Needless to say those who held views differing from

35 Lovell-Smith, p.26.

34 J. P. S. Jamieson, 'The New Zealand Hospital System; A Review of the History of its Development, and a Summary of Discussion on Hospital Policy', Part I, NZMedJ, XXXIII, 177 (October 1934), pp.283-7. Part II, NZMedJ, XXXIII, 178 (December 1934), pp.354-65. Part III, NZMedJ, XXXIV, 179 (February 1935), pp.7-14.

36 Dr M. N. Oliver of Nelson, personal communication, 5 July 1977.

Jamieson and, in particular, those members of the Labour government who had to negotiate with him, had a rather different view of Jamieson's personality, although perhaps not of his influence on the profession.

Sir Arnold Nordmeyer, who, as Minister of Health, had extensive dealings with Jamieson, has characterized him as 'dominant and dominating'.[37] Recalling interviews between himself, as Minister of Health, and the Committee, Nordmeyer stated that 'Jamieson was so visibly the leader that the other British Medical Association delegates almost ceased to have any significance'.[38] It was Jamieson who did all the talking at these meetings and he frowned upon any delegate who interrupted. Nordmeyer attributes this to Jamieson's conviction that 'he was the leader and he alone could save the profession from "socialism"'.[39] Nordmeyer further remarked that Jamieson was dominating a group of men whom he (Nordmeyer) knew to be both articulate and capable but that when Jamieson was present it was very much a one-man show.[40] Unlike the medical men cited above, Nordmeyer did not consider Jamieson a persuasive speaker. He recalled him as a 'cunning, dour Scot with the analytical mind which is characteristic of some Scots'.[41] He conceded that Jamieson could 'put up a very good case, the fallacies of which were not always immediately obvious, but which appeared to be convincing to those who did not analyse what he said carefully'.[42] In other words, Nordmeyer confirms indirectly what Jamieson's sympathizers have also claimed, that he was a persuasive platform speaker although, as Nordmeyer adds, his arguments often could not withstand close analysis.

From these sometimes conflicting opinions, one may build up at least a partial picture of Jamieson. He was a leader and a gifted speaker and writer who possessed the ability to argue logically from doubtful premises and had the gift of making such premises appear plausible.[43] He had also a conservative view of the desirability of 'evolutionary rather than revolutionary change' as the route by which any reform of the system of providing medical services should be brought about. Jamieson also had an almost mystical conception of the nature of the medical profession which he saw as embodying a collective wisdom, which could express itself otherwise than through its official representative body.[44] As

37 Personal interview with Sir Arnold Nordmeyer, 12 October 1977.
38 ibid.
39 ibid.
40 ibid.
41 ibid.
42 ibid.
43 As shown for example in some of his writings. See 'The New Zealand Hospital System', Part III, pp.7–8.
44 ibid., p.8, where Jamieson, reviewing the somewhat tardy progress of hospital reform in New Zealand asks: 'Is there any need for pressing to an early conclusion? The controversy seems long; but what are a dozen years in the development of such a matter? Departments or Boards — and the British Medical Association too — are ephemeral things

an individual Jamieson appears to have been a well-regarded member of his community, an erudite and cultured gentleman; as the leader of the medical profession's fight against the Labour government, Jamieson was indeed 'dominant and dominating'.

The clear impression that the policy of the Committee was largely Jamieson's is strengthened if consideration is given to the number of distinguished members of the profession (including members of the Committee) who later criticized the policy. As the formulation of the Committee's policy was directed by Jamieson, by implication they criticized Jamieson himself, and also their own lack of courage in not opposing what they knew to be mistaken policies. The criticisms of Lynch and Corkill have already been remarked upon. W. P. P. Gordon, also a foundation member of the NHI Committee, commented that the doctors were completely out of tune with public opinion and demonstrated this by their own proposals for an insurance scheme.[45]

The policies followed by Jamieson seem not to have been universally admired within the medical profession during the period of his greatest influence, from 1935 to 1940, and in view of this it is a matter of some surprise that the New Zealand doctors' initial opposition to the Labour government's scheme was as total and that their resistance lasted as long as it did. W. B. Sutch suggested that the opposition was based primarily on economic grounds.[46] However, as has been shown above, this explanation is untenable. Nordmeyer suggested that a reason for the profession's support of Jamieson could have been that the profession, having elected him as their leader, felt that they had to support him despite misgivings over the policies he was pursuing.[47] Such an explanation is also hardly adequate. E. Hanson has argued that the explanation can be found in 'an inherent and deep conservatism on the part of the profession'.[48] This explanation is partially correct: it appears that a majority, but by no means all, of the medical practitioners active in BMA politics at branch and divisional level, could be characterized in the manner Hanson suggests, but that the majority, or at least a large body, of doctors appear to have been more open-minded and open to persuasion in either direction. It seems likely that Jamieson's strong influence was based upon the fact that he was representative of the group of specialists and semi-specialists who assumed control of New Zealand medicine during the 1930s and this, combined with his qualities of leadership and his active campaign to gain the support of country doctors, was sufficient to

in comparison to the profession, which is stable enough and venerable enough to proceed with the caution of maturity rather than the impetuousness of youth'. For further evidence of Jamieson's conservatism, see Jamieson to Fraser, 7 February 1939, NHI General Record, 1935-39 File.

45 Tape recording made by Dr W. P. P. Gordon in March 1977, held in the National Office of the NZMA.

46 Sutch, ch.viii.

47 Nordmeyer interview.

48 E. Hanson, *The Politics of Social Security*, Auckland, 1980, p.103.

dominate the small-scale and scattered social group which comprised the New Zealand medical profession of the period. It must be conceded that Jamieson's views were more extreme than the views of the group he represented (the other members of the Committee) and that many in the group may have had misgivings regarding the course taken by Jamieson. In the main these men wanted a very limited scheme and they wanted any benefits extended to include specialists. In other words they wanted a bad debt insurance scheme. This would ensure that doctors received some remuneration for attendance upon the poorer members of society while leaving them free to charge their more affluent patients whatever the market would bear. While the introduction of such a scheme would benefit all doctors it would be of greatest benefit to those doctors having a majority of patients in the higher income brackets.

Analysis of the composition of the NHI Committee has demonstrated that it was largely composed of men who were middle-aged, English or English-educated and conservative — conservatism meaning, in this case, that the doctor was opposed to any form of medical remuneration, either in hospital or general practice, other than the traditional form of direct fee payment by the patient to his doctor for services rendered. Doctors holding this attitude saw provision for those unable to pay for medical services being provided, as a charitable service. Jamieson was the natural leader, given his background and his well-known conservatism. This conservatism had been made widely known to the profession by his several critical articles on medico-political subjects in the *New Zealand Medical Journal* and elsewhere. The fact that a majority of doctors with interests dissimilar to Jamieson and his friends followed the Committee's lead can probably be explained by the tendency to follow the leadership's line which typifies the rank and file of such organizations. This tendency was compounded by the isolation of many country doctors, which made it difficult for them to attend meetings or to discuss the problem of national health insurance with colleagues. They had perforce to gain their information from the pages of the *New Zealand Medical Journal* and its supplements, together with the propaganda placed by the Committee in the New Zealand press.

The steps taken by the Committee to publicize its views were a new departure in medical politics; besides the establishment of a special National Health Insurance Supplement to the *New Zealand Medical Journal*, which bombarded doctors with a continuous stream of material regarding health insurance, the Committee (or rather its Chairman) took many other active steps to ensure that the doctors presented a united front to the government. Among these steps were the preparation of standard answers for doctors to use in reply to government questionnaires[49] and personal visits by Jamieson to speak to doctors in centres

49 National Health Insurance Committee, 'Report presented to the Annual Meeting of the Branch held at Wellington, 26 February 1937', NZMedJ, XXXVI, 192 (April 1937), p.83.

both large and small throughout the dominion.[50]

With a committee led by Jamieson, the doctors were directed by a man devoted to halting, or at least delaying, the introduction of medical insurance. This alone would probably have been insufficient to sway the bulk of the profession. However, Jamieson's campaign was assisted by a large minority of doctors who had their own reasons for opposing the introduction of medical social security, despite the fact that such a scheme would be to their financial advantage. These reasons can be found in the conditions of practice in New Zealand. For those general practitioners not practising in the working class areas of the main centres, these conditions were extremely pleasant by contrast to those in the United Kingdom. The New Zealand practitioner did about half the work of his British equivalent and was remunerated at least as well.[51] The British authority on health insurance, Sir Henry Brackenbury, who had been brought to New Zealand in 1938 to advise both Government and the BMA, had noted this during his visit and had remarked that the average New Zealand doctor charged twice as much as his British counterpart and that the British profession worked 'ever so much harder than the profession in New Zealand'. The average number of patients seen by New Zealand general practitioners was 10 or 12 per day as compared to the 30 or 40 seen by British doctors. The counter-argument produced by Dr Hunter, a member of the BMA Council, that the New Zealand public was more demanding than that of the United Kingdom appears very weak.[52] A large number of New Zealand doctors had worked at some stage of their career in the United Kingdom and were thus only too familiar with the more arduous conditions in that country: this could well have stiffened their resolve to resist the introduction of insurance medicine on a capitation basis as in the British system. The majority of doctors had no experience of medical practice in the United Kingdom and many of them were confused as to the points at issue. Their confusion was understandable given the conflicting opinion to which they were exposed. This welter of opinion varied from Jamieson and his supporters' urgings that the introduction of any national health insurance scheme should be resisted (Jamieson had travelled widely late in 1937, visiting many provincial towns in order to get his message through to the rural general practitioners). They were also subject to the propaganda of those within the profession who were not opposed to a universal insurance scheme, provided such a scheme were on a 'fee for service' and

50 Report of a meeting held at Masterton Hospital, pp.7–8; also Report of a Meeting held at Napier Hospital, 16 October 1936. Jamieson Papers, NHI General Record 1935–39 File.

51 See Bradford-Hill, 'The Doctor's Day and Pay', passim.

52 Report of the Select Committee on National Superannuation, Health and Unemployment Insurance. Text of Sir Henry Brackenbury's second address and answers to questions at a meeting of the Committee held in Parliament Buildings, Wellington, on 11 October 1937, p.12. Jamieson Papers, Sir Henry Brackenbury's meeting, 1937 File.

not on a capitation basis. Finally they were subject to persuasion by the government's propagandists. In this babel of conflicting voices it would be a wonder if many doctors did not wish to cling to the status quo. Besides this skilful propaganda campaign by the NHI Committee the inept handling of the medical profession by the government assisted in forging professional solidarity.

The reason for the doctors' opposition to social security when acceptance would have been to their financial advantage now becomes clearer: the desire to maintain a much more agreeable life style with a lighter workload than was the case in the United Kingdom. This desire was combined with a resentment of lay interference, fomented by a concentrated and clever progaganda campaign organized by a small group of doctrinaire anti-socialist doctors at the head of the profession. These men in turn were led by a gifted leader and orator in the person of J. P. Jamieson. These factors make the profession's opposition to the government's scheme understandable.

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