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Public virtue, private ambition—Women owners of private hospitals in early twentieth-century New Zealand

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Abstract

New Zealand's early-twentieth-century health service was a two-tier system of state hospitals supported by an expanding network of over 300 private hospitals, almost exclusively owned by nurses and midwives. This article will show that this environment was created by a legislative framework introduced between 1901 and 1906, requiring nurses, midwives, and their private hospitals to be registered, licensed, and monitored. Stringent regulation could have stifled the industry. Instead, it provided fertile ground on which many women flourished as enterprising businesswomen who made significant contributions to their communities, breaking with traditional notions of nurses solely as carers and handmaidens to doctors.

KEYWORDS

midwives, New Zealand, nurses, nursing, private hospitals

JEL CLASSIFICATION

I10, N00, Z13

INTRODUCTION

In May 1929, registered midwife and private hospital owner Alice Clymo received a visit from a New Zealand Department of Health Nurse Inspector, Ruth Mirams. Miss Mirams' role was to assess the state of a private maternity hospital in the former gold rush town of Paeroa located in the eastern plains of the North Island province of Waikato. Her brief was to ensure that the Arohanui Private Hospital met the standards laid out in accordance with New Zealand's Private Hospitals Act (1906). In her report to head office in Wellington Miss Mirams expressed concern about the state of the hospital from its drab appearance and less-than-inviting décor to its dusty and ill-kept fitout including bed linen that was '... [a] bad colour and shabby' (Mirams, 1929). On the basis of this report alone, it might be concluded that Miss Clymo was a midwife more in line with Charles Dickens' Sairey Gamp—cheerful but down at heel and, in the case of Miss Clymo, barely keeping her business together (Dickens, 1906, p. 269). Instead, Miss Clymo was a highly-regarded member of her community who successfully kept her business going for 16 years in the small, low-income town that was badly hit by the depression. She served her community as a midwife with her hospital also licensed for minor surgeries such as tooth extractions and adenoid removals. An active member of the local bridge club, she hosted parties and community farewell events, and even judged baby competitions which were popular at the time ('Successful Fair and Paddy's Market' 1932, p. 2). In addition she provided employment and accommodation for herself and her sister's family at the hospital and when she retired she sold her business as a going concern to two nurses who had recently moved to the town ('Nursing Homes in Paeroa Area' 1968).

Alice Clymo's experience was not unique in New Zealand. In fact, she was one of several hundred nurses and midwives who owned and managed private hospitals around the country in the early twentieth century. The climate that facilitated the rapid expansion of this sector was based on legislation that professionalised nurses and midwives through national training and registration and regulated the hospitals they owned and/or licensed. The cumulative effect of these changes was the emergence of a sector that allowed entrepreneurial women to expand their vocation to incorporate business acumen and build a public profile under the banner of professionalism and feminine nursing skills.

The stories of nurses and midwives, such as Miss Clymo, and their private hospitals have not been a significant part of New Zealand's historiography. When mentioned it is usually a minor reference in the context of wider research about nursing and the country's healthcare systems (Dow, 1995; Sargison, 2001; Wood, 2022). One exception to this is an essay written by Colleen De Vore which focused on midwives as businesswomen suggesting that property ownership, business acumen, and access to capital were key factors to their success (De Vore, 1997). More detailed research has been done in Australia about private hospital ownership but in geographically specific areas rather than looking at the country as a whole (Kyle, 2017; Kyle, 2020). Hannah Forsyth has recently explored private hospital ownership as part of a wider examination of women's role in developing the Australian economy. She focused on the currency of virtue, which enabled female-dominated and middle-class professions such as nursing to thrive. Through this lens she posits that the moral ideals of nursing such as duty, purity, and courage when coupled with its technical aspects such as hygiene, neatness, and skill established professional competence reflecting Victorian gender norms (Forsyth, 2023). Perhaps more importantly they 'served explicit economic purposes' such as reassuring London investors that the colonials were fiscally sound and growing (Forsyth, 2023, p. 61).

In the United States of America (USA), entrepreneurial nurses stood out as owner-operators of private duty registries rather than private hospitals. These operated as bureaux for self-employed nurses in 'a critical historical illustration of the power nurses have held over their professional lives' (D'Antonio et al., 2010, p. 208). Expanding this notion of agency and control, J.C. Whelan suggested that this aspect of entrepreneurship has been little acknowledged but was the backbone of the early twentieth century American nursing workforce. An estimated 80 per cent of nurses worked as independent contractors through these registries and were responsible for their own employment (Whelan, 2012).

Meanwhile in Britain, the evolution of the hospital network which would form the basis of the National Health Service (NHS) had little in common with what was happening either in the USA, Australia or New Zealand. The development of hospitals prior to the establishment of the NHS came from a combination of voluntary organisations and their subscribers, local authorities, and the poor law guardians (Doyle, 2014, pp. 53–54). Private hospital beds in England and Wales, for example, were unregulated and represented 9% of the total number of the 122,250 hospital beds in 1891, dropping to just 6% of the 210,494 in 1911 and increasing to 10% of the 254,722 in 1921 (Abel-Smith, 1964, p. 189; Gorsky, 2020, p. 184). Brian Abel-Smith's research in this area noted that while both patients and physicians increasingly believed that treatment and recovery were better served in a hospital environment, it was not until the Nursing Homes Registration Act 1927 that private hospitals became fully regulated and required to have at least some qualified nursing staff (Abel-Smith, 1964, p. 342).

The situation in New Zealand was quite different. This article will argue that the legislative framework introduced by New Zealand's Liberal Government between 1901 and 1906—the Nurses Registration Act 1901, the Midwives Act (1904), and the Private Hospitals Act (1906)—created an environment where this complementary two-tiered health system worked together to create a safer, nation-wide hospital network (Midwives Act, 1904; Private Hospitals Act, 1906; The Nurses Registration Act, 1901). There was also an element of self-determination with what has been described as 'the monopoly that women had achieved as nurses' (Rodgers, 1985, p. 21). Their control was strengthened through the development of training credentials and a central nursing body, and their position elevated by excluding untrained and unregistered nurses (Rodgers, 1985, p. 21). In addition, the nurses and midwives who owned their private hospitals thrived, carving out a distinct space in the public sphere of commerce and business.

THE FLORENCE NIGHTINGALE EFFECT

During the late nineteenth century, nursing had transformed to an almost exclusively female domain, and was revered as a wholesome and appropriate womanly career choice (Sargison, 2001, pp. 15–16). This was largely due to Florence Nightingale's influence and the type of women she deemed desirable to become nurses (Sargison, 2001, p. 16). Nightingale nurse training had arrived in New Zealand around 1886 and by the turn of the century was a foundation for the formalised nurse training implemented under the Nurses Registration Act 1901. Nightingale expected nurses to be women of good character who prioritised service and sacrifice rather than chasing a career as a means of becoming independent (Dunsford, 1994, p. 36). The government reinforced this view, with New Zealand's Premier Richard Seddon proclaiming that the skills nurses and midwives acquired during their training would be put to good use in their families once they returned to the home when married (Midwives bill, 1904, p. 71).

This deification of nursing as vocational and service driven viewed nursing through a narrow lens that did not include, much less embrace, the commercial aspects of running a business.

Grace Neill, Assistant Inspector to the Department of Hospitals, Asylums and Charitable Institutions of New Zealand, had a more pragmatic view however, and recognised that financial benefits were vital in order to attract the 'right kind' of young women to the profession (Dunsford, 1994, p. 26). Neill's view reflected her own experience as a trained nurse, a public servant, a factory inspector, and staunch advocate for women's and workers' rights (Tennant, 1991, pp. 467–71). As a key figure in drafting the Nurses Registration Act 1901 and Midwives Act (1904), it was in her interests, as well as the country's, to attract the right calibre of capable, intelligent young women to the profession. Part of this was creating an environment where it was safe and socially acceptable for these single young women to work. Hospitals provided chaperoned accommodation, which satisfied the social mores of the educated middle-classes whom the hospitals wanted to employ, while at the same time it served to keep the nurses close at hand for the long days and nights they were required to work (Toynbee, 1995, p. 98).

The New Zealand Trained Nurses Association (NZTNA) actively promoted this aspirational view of nursing candidates. Hester Maclean succeeded Grace Neill as the Assistant Inspector of Hospitals in 1906 and encouraged the regional nursing organisations to come together as the national NZTNA in 1909, representing both public and private nurses. She was also strident in her views about the calibre of association members. In a review of the NZTNA national meeting in 1910, she described the Association as being 'more of the nature of a private club, and the personnel and the social attributes of members can be taken into consideration [when considering membership]' (Maclean, 1910, p. 49). Class did not prevent them from securing state registration but 'so many registered nurses would not be desirable as members of a club though professionally nothing can be said against them' (Maclean, 1910, p. 49). So while the government aspired to a uniform approach for training and registration for all, the nurses' professional body was hanging on to the remnants of a class structure harking back to 'Home' and the vestiges of the Nightingale ethos of nurse training.

PROFESSIONALISING NEW ZEALAND'S NURSES AND MIDWIVES

The nationwide regulation of New Zealand's nurses and midwives was a world first imposing national uniformity and regulation around training and work-place practices while improving outcomes for patients, particularly mothers and babies. It reflected the Liberal government's wellbeing agenda of legislation during its 21-year reign between 1891 and 1912. This included, amongst other things, the Electoral Act 1893 which gave women the vote, the Old-age Pension Act 1898 which gave a small, means-tested pension to men and women over 65 who were sober and of good moral character, an industrial arbitration court for dispute resolution in 1894 and new laws protecting women and children in the work place under the Factories Act 1894, requiring all factories to be registered and subject to regular inspections (Electoral Act 1893; Old-Age Pensions Act 1898; Industrial Conciliation and Arbitration Act 1894; Factories Act, 1894).

The Liberals' focus on social and economic issues has been described as 'pragmatic interventionism' but also criticised for affording only a limited level of power to women who were, in theory, emancipated but also controlled within increasingly regulated workplaces

(Hamer, 1997, pp. 126–30; Dalziel, 2000, pp. 88). For example, legislation that regulated women's roles as workers did so paternalistically, reflecting more about attitudes towards women's perceived fragility and femininity than it did about the desire to create opportunities and equitable workspaces. The Nurses Registration Act (1901), the Midwives Act (1904), and the Private Hospitals Act (1906) could potentially have fallen into the same category given the gender-specific nature of nursing and midwifery. In contrast, their professionalisation placed nurses and midwives into a fierce competitive commercial environment where both professional skill and business nous were required.

Hannah Forsyth has suggested that while international scholarship views professionalism as 'a highly gendered perhaps even patriarchal process, systematically excluding women' her Australian-focused research in this area revealed a more layered interpretation (Forsyth, 2019, p. 56). At its centre is the notion that traditional 'women's work' such as nursing and teaching, was appropriated from the home into hospitals and schools 'which helped industrial capitalism develop' (Forsyth, 2019, p. 76). Women were central to this process rather than simply being bystanders. This experience can be seen also in New Zealand where the professionalisation of nursing and midwifery created opportunities for women to operate independently and beyond the home while maintaining the moral authority associated with their work.

The Nurses Registration Act, 1901 required that all new probationer nurses were trained under one system within the country's state hospitals and were then eligible for registration after 3 years. Theoretical and practical nurse training was delivered by the medical officer and matron of a hospital with the probationer nurses required to have at least a basic competency in reading, writing, and comprehension (*The Nurses Registration Act*, 1901, s4(1)). Nurses who had trained in other countries could apply for registration as long as their training was at a recognised institution, while nurses who had worked for at least 4 years in a New Zealand hospital prior to the Act could also apply for registration in recognition of their experience and service. As there were a limited number of state hospitals around the country, the private hospital network became increasingly important both in terms of providing a critical service to smaller, often rural towns, as well as employment opportunities for the growing number of nurses whose names appeared on the government register.

The Act made no specific requirement for working nurses to be registered; rather, in the early years, it simply recommended that state hospitals give preference to registered nurses but with no penalty for employing unregistered nurses (*The Nurses Registration Act*, 1901, s9). Pay rates varied from region to region, with pay and conditions determined by hospital boards or by the licensee/business-owner of a private hospital ('Salaries of nurses' 1919, p. 119). The register of qualified nurses was published annually and showed where each nurse had trained and the hospitals and/or private nursing in which they had been employed. The decision of whom to employ—whether registered or not—remained with the hospital boards for the state hospitals and the owner/licensees of private hospitals. It was not until the Nurses and Midwives Registration Act (1925) that it became compulsory for hospitals to employ only registered nurses (Nurses and Midwives Registration Act, 1925, s8).

While the Nurses Registration Act 1901 set the benchmark for nursing reform, in many ways the Midwives Act (1904) was even more significant in New Zealand as there were far more women working in the traditionally female practice of midwifery. When the Nurses Registration Act 1901 was enforced in 1902 there were just 297 names on the register while the midwives' register showed 730 names in its first year and almost 900 names in the 1907 register (Nurses and Midwives Board, 1922; Valintine, 1907). Unlike the nurses' register, the Register of Midwives had two classes of qualification. Class A midwives held the new Certificate of

Training in Midwifery approved by the Registrar, while Class B midwives were deemed to have 'satisfied the Registrar' that they had at least 3 years in bona fide practice as midwives and that they were women of good character (Valintine, 1907). Just 75 of the women appearing on the first register were Class A midwives while the rest were Class B. The Midwives Act (1904) made it compulsory for midwives to be registered to practice lawfully. Anyone working as a midwife without registration was subject to a fine of up to £20, regardless of their track record or length of service, and false documentation and advertising claims could also lead to a 12-month prison sentence (Midwives Act, 1904, s16).

New Zealand's dwindling birth rate and high infant mortality had in part fuelled the compulsory training and employment of registered midwives. The country's Premier Richard Seddon cited the 15,767 children under 1 year old who had died between 1894 and 1903 as a motivation for the Midwives Act (Midwives Bill, 2). Improving the safety of women and their babies during childbirth was addressed in two main strands within the Act—the formal instruction of midwives in their craft and the creation of a network of state maternity hospitals where the midwives would train. The intention was to create a safe hospital space where working class women, less likely to be able to afford medical assistance in their homes, could give birth. The first St Helen's hospital opened in Wellington in May 1905 with hospitals in Dunedin, Auckland, and Christchurch opening over the next 2 years followed by Gisborne in 1915, Invercargill in 1917, and finally Wanganui in 1921. These specialist hospitals promoted a medical environment for childbirth which became increasingly widely accepted and expected. All midwives had to be formally trained and registered, so as more women sought a medicalised birth, those without access to a St Helen's hospital were able to make use of the numerous private maternity hospitals around the country.

An unexpected consequence of the Midwives Act (1904) was the competitive environment it created between midwives and doctors. In the two-tier classification system, Class B midwives tended to be older women who had practiced over a number of years and were well-schooled in the tradition of medical hierarchy. While they were 'allowed' under the terms of their registration to attend births on their own, the more common practice was to call the doctor in towards the end of the first stage of labour, which also ensured the doctor could claim his fee (Smith, 1986, p. 16). In difficult cases Philippa Mein Smith suggested that it was not uncommon for doctors to shift the blame to these lesser qualified women when things went wrong as they were less likely to speak out because of their reliance on the doctor for work (Smith, 1986, p. 17). Class A midwives, on the other hand, were less likely to succumb to this kind of intimidation. As the numbers of Class A midwives grew, many opted to establish private hospitals working without direct input from the doctors. This undermined the doctor's monopoly in this space, creating fierce competition and a shift in the balance of power between them (Smith, 1986, p. 18). Doctors continued to work in both the state and private maternity hospitals but for patients with limited means, small private maternity hospitals with a trained midwife offered a safer, affordable hospital option without necessarily incurring the cost of a doctor unless required. This tripartite of regulation, professionalism, and the private hospital facilitated the advance of early twentieth century entrepreneurial businesswomen.

THE RISE OF THE PRIVATE HOSPITAL

In the early twentieth century, attitudes were also changing towards treatment in medical and surgical hospitals. Historically, medical ailments had been treated in the home with state

hospitals a place of last resort. As with private treatment at home, both private and public hospital patients were also expected to pay for their treatment. Increasingly, however, the social stigma of hospitals diminished as more sophisticated medical and surgical techniques became impossible to be performed at home (Minister of Health, 1974, p. 39). As early as 1912 the Inspector-General of Hospitals and Chief Health Officer Dr. Thomas Valintine noted in his annual report that there was 'no longer that repugnance, either on account of fear, ignorance, or pride, to enter a public hospital that was so noticeable a decade ago' (p. 11). The government's attitude towards private hospitals and their nursing staff reflected these changes in attitudes. It wanted a safe, robust, and uniform system throughout the country, but could not fund a network with a state hospital in every town. As a result, private hospitals became a necessary adjunct to the state system. The financial investment and risk were with the hospital licensee/owner but through the private hospitals' legislation, the government achieved central control with the regulations laying out standards for the management, training, staffing, sanitation, hygiene, and record-keeping of each establishment.

The first full nation-wide analysis of private hospitals in 1909 showed that at the start of that year there were 191 which by the end of the year had increased to 205 (Inspector-General of Hospitals and Charitable Institutions and Chief Health Officer 1909, p. 14). Of the 58 general medical and surgical hospitals licensed during that year, only 'two or three' were established by doctors, the rest were '...owned and conducted by well-qualified nurses' (Inspector-General of Hospitals and Charitable Institutions and Chief Health Officer 1909, 14). The remainder were maternity hospitals, 11 of which were operated by fully trained and qualified midwives and 136 owned by midwives who were already practicing when the Midwives Act (1904) was passed (Inspector-General of Hospitals and Charitable Institutions and Chief Health Officer 1909, p. 14). Some of these would have been Class A midwives who had been formally trained overseas but the majority were Class B midwives whose classification was based on their work experience rather than formal training. During the early years of the legislation as the department transitioned to its new system, the so-called 'old-time trained midwives' were closely monitored and found in some instances to be wanting. However, this was deemed to be due to their unwillingness or inability to 'read or understand regulations' rather than willful disobedience (Inspector-General of Hospitals and Charitable Institutions and Chief Health Officer 1910, p. 14). Ultimately the number of private hospitals had stabilised by 1912 at 198 and then steadily increased to 327 in 1929 before the slump of the depression saw 53 private hospitals close in just 3 years (Inspector-General of Hospitals and Charitable Institutions and Chief Health Officer 1912, p. 22; Inspector-General of Hospitals and Charitable Institutions and Chief Health Officer 1929, p. 39; Wright, 2009, p. 43) (Figure 1).

Financial training and business management were not part of the nurse training curriculum which meant that most nurse licensees were self-taught or, if they were lucky, had skills acquired from other work experience prior to their nursing careers. Catherine Bishop's *Women Mean Business* argued that 'despite the rhetoric of female domesticity, running a business was neither unusual nor unacceptable for most women' in colonial New Zealand (Bishop, 2019, p. 12). Some 50 years later, while the opportunities may have changed, an emerging regulatory environment and healthcare landscape created space for these women to succeed. As some of the larger state training hospitals extended to a 4 year programme, ward administration was added to the final year's nursing curriculum, providing useful insight into the economics and financial modelling of the public hospital environment but this was not universal and was a far cry from the varying size and scope of many of the private hospitals ('Training of Nurses' 1912, p. 19). In smaller rural towns there were different kinds of commercial challenges such as

Year	Surgical/Medical	Maternity/Medical Surgical	Maternity	Total
1908	-	-	-	191
1909	58	-	-	205
1910	70	-	132	202
1911	52	31	135	218
1912	43	38	117	198
1913	-	-	-	227
1914	51	60	138	249
1917	-	-	165	260
1922	-	-	-	282
1924	-	-	-	295
1926	100	213	-	313
1927	-	-	-	222
1928	63	48	216	327*
1929	93	45	167	305
1930	89	40	146	275
1931	-	-	-	274**
1932	-	-	-	282**
1933	94	-	189	283**
1934	101	-	190	291
1935	99	-	194	293

FIGURE 1 Private hospital numbers in New Zealand between 1908 and 1935 based on the New Zealand Official Year Book data and annual Appendix to the Journals of the House of Representative (AJHR) reports. Inconsistencies in the way and frequency the data was reported have created an incomplete data set. Where there is no data entry reflects the non-specific way in which data was recorded for that year. * Peaked in 1928 at 327 private hospitals. **Peak depression years (*Source:* Wright, 'Mordacious years', 43). *Source:* AJHR Health reports 1908–1935; New Zealand Official Year Book 1908–1937.

attracting and retaining staff and securing a broad enough client base to ensure the hospital's viability. By keeping nurse training within the state system, however, the department effectively shaped the knowledge and skills of the nurses. Similarly, by regulating the private hospital industry, where significant numbers of nurses moved to work, there was a measure of control and uniformity over how the hospitals operated.

MONITORING AND INSPECTIONS

The business framework for private hospitals was dictated by the legislation and regulations which governed them. Every aspect of the business had to be kept to the exacting standards of the department and was subject to at least annual and usually twice-yearly inspections checking competency and compliance. The private hospital licensee was required to be an excellent nurse and/or midwife with the added skills of understanding building and sanitation regulations,

being an employer, and having the financial expertise to run her business. Her relationship with the District Health Officer was key, as was her relationship with the Assistant Inspector of Hospitals and the small team of Nurse Inspectors who visited the hospitals. The licence application form supplied by the Department required a scaled floor plan of the hospital with each room being numbered and its purpose identified along with dimensions, window size, and proposed number of patients (Private Hospitals, 1916). This included private rooms where the family and/or staff lived, how the rooms were accessed, and whether any potential cross-over might occur that could increase the risk of contamination. A separate bathroom/toilet for family members and staff was required, meaning that in most instances an additional lavatory had to be built to specific requirements. Once a licence had been approved, any changes to a room, whether structural or in how it was used, had to be pre-approved by the hospital inspectorate.

The financial onus to meet these standards sat firmly with the licensees. This was challenging for some and identified by Miss Maclean in 1917 as a major obstacle for some hospitals in their startup phase (Public Health and Hospitals and Charitable Aid: Report thereon by the Inspector-General of Hospitals and Charitable Institutions and Chief Health Officer, 1917, p. 7). She stated that the capital outlay for premises and equipment was very high, and the Government should be prepared to provide subsidies to help with this (Public Health and Hospitals and Charitable Aid, 1917, p. 8). There was no immediate response to her proposal but it indicated a realistic level of understanding about what it was like for the licensees, particularly in more remote areas. Failure to adhere to the new regulations also presented the department with an issue of how to ensure there was an appropriate balance between compliance by the hospital and the practicality of providing a much-needed service to communities, particularly of midwifery services in rural areas.

Challenges for maternity hospital owners also came from within the sector, with sole-operator midwives working in direct competition to them. A midwife taking on one maternity patient at a time, either in her own home or in the patient's home, did not have the same overheads as a hospital, however small, and was a cheaper option for patients. Under the Private Hospitals Act (1906) a hospital was defined as where two or more people are treated within the course of a month (Private Hospitals Act, 1906 s14, p. 45). The independent operators taking one patient at a time were within the law but acting outside the remit and intent of the Act. Perhaps surprisingly, the Department's ongoing nervousness about unregulated women proffering their services was as much about the commercial threat to private maternity hospitals as it was about the obvious safety concerns (Public Health and Hospitals and Charitable Aid, 1917, p. 8). Mindful of the impact on small registered private hospitals, the Department's annual report to the Minister of Health in 1917 suggested a way of addressing this would be to make the regulations tougher for sole operators (Public Health and Hospitals and Charitable Aid, 1917, p. 8). Paradoxically, this suggests that these sole operators who were also entrepreneurial women were being sidelined by the institutionalisation of their practice.

PREMISES

The nurses identified in this research used every available option with which to secure their premises, whether through leasing, renting, purchasing, and in some cases, commissioning purpose-built premises. Often, in the initial stages, hospitals were established in a licence-holder's home. Others, such as Jean Foote's Rawlingstone Private Hospital in New Zealand's largest city Auckland, were purpose built (Haigh, 1991, p. 151). Rawlingstone opened its doors

in 1902 as a medical and surgical hospital that would become one of Auckland's leading private hospitals ('Miscellaneous' 1902, p. 1). Family archives suggested that Miss Foote commissioned the building of Rawlingstone having purchased some land (Haigh, 1991, p. 151). It is not clear how this was funded—whether her father's success in business extended to helping his daughter start her business or whether she was able to secure a loan through her own devices. Whatever her initial source of capital, until her death in 1916, Miss Foote 'successfully managed her well-known and popular hospital' at 127 Grafton Road which also hosted meetings of the Trained Nurses' Association, of which she had been President ('Obituary' 1917, p. 65).

Access to finance to complete modifications or to purchase a property could be secured through the State Advances Corporation of New Zealand. Established in 1903, the corporation's remit was to provide cheap loans to farmers, settlers, and workers. The use of private homes as hospital premises was common and access to a loan to complete modifications or to buy a property outright gave women the opportunity to start out on their own. The loan structure allowed for a timeframe that was substantial enough to buy a suitable property and, with a repayment schedule as long as thirty-six-and-a-half-years, it was manageable for the scale of a small business (Government advances to settlers act, 1894). For every £100 borrowed, a £3 repayment was required every 6 months over the period of the loan. To put that into context, in 1913 an 11-roomed house in Auckland on three quarters of an acre advertised as 'suitable for a private hospital or convalescent home' was for sale for £1900, including a £100 deposit ('Remuera' 1913, p. 2). A maximum of three fifths of the value of a property could be loaned so repayments for the £1140 amount available for loan would be just over £34 every 6 months, or just under £6 per month, over the 36.5 year term (State Advances Act, 1913, p. 219). The balance was payable at any stage during the loan period with interest calculated at the date of settlement.

In the absence of a central archive of private hospital transactions, details of hospital sales are sketchy, but examples of outright purchase can be gleaned through newspapers, council records, and the occasional reference to loan status within individual hospital files ('Resignations, appointments, etc.' 1921, pp. 49–53; Clymo, 1937; Auckland City Council 'Wakefield Street' 1912b; Auckland City Council 'Grafton Road' 1912a). In terms of income, the average weekly rate in a medical, surgical or maternity hospital between 1910 and 1935 was between £4 and £6.[1] Doctor's fees were extra and paid to the doctor. In 1926 Braemar Hospital, a medical and surgical hospital in the small North Island town of Wanganui owned by Sisters Chambers and Livingstone, was licensed for 10 patients indicating they could expect fees of around £2600 per annum (Broad, 1927).[2] They employed one probationer nurse and three domestic staff who would have been paid between £1 and £2 per week each at an estimated total cost of between £300 and £400 per year (Broad, 1927).[3] A small maternity hospital licensed for four patients in the South Island town of Timaru in 1926 had 89 women through the door over the course of that year for their two-week confinements generating an income of around £890. The registered midwife licensee employed just one domestic staff at an estimated cost of between £50 and 60 (Dawson, 1926). Hospital provisions, some surgical and dispensary costs, hospital improvements, and food for patients and staff had to be met from this income showing the complex and often challenging financial conditions for many of the licensee/owners.

[1]Sourced from a range of newspapers between 1913 and 1938.

[2]Calculation based on £5 per week for 52 weeks.

[3]Estimates of wages based on a survey of newspaper advertising.

While renting was common and, in some cases, the only option for a hospital licensee, it was also potentially precarious. The tension between meeting the department's requirements and getting the property owner to at least agree to, or preferably pay for, modifications was not guaranteed. Before Sister Edith Hayward built her new hospital in the central North Island agricultural township of Te Awamutu in 1935, she rented a house for her Te Whare Ora Private Hospital but was unable to get the owner to make the necessary improvements without a protracted battle (Paget, 1931). Ultimately, the department allowed Sister Hayward some flexibility to keep the hospital open, but the situation exposed the precarious position renters were in. Generally, the rental market was fairly stable and the 1937 government house rental index showed that the general level of rent increases was comparatively slow between 1926 and 1935 (Government Statistician, 1937). This was in part driven by the depression but also by 'infrequent changes of residence and the difficulty of departing from customary rents' (Government Statistician, 1937). This indicated that while finding appropriate premises might have been challenging initially, once they were found consistent rent prices without major increases could be expected, resulting in longer term tenancies.

ADVERTISING

As an independent businesswoman a nurse licensee had her own standing within a community which came with respect and acknowledgement, often reflected in the ways hospitals were referred to. For example, whatever the official given name of a hospital, it was also common for it to be referred to by the name of the nurse or matron ('Lost' 1917, p. 1).[4] As the public face of a private hospital the licensee was afforded this status even if the establishment was owned by another investor or with a silent partner ('Maternity care in Nelson—Te Rangi' 2014). One of Auckland's largest private hospitals, Rawlingstone Private Hospital, was also widely known as 'Miss Foote's hospital' in recognition of the profile she had in the community and the reputation of her hospital ('Local and general' 1906, p. 4). In birth notices as well, it was common to refer to the birth taking place '...at Nurse—hospital' ('Birth' 1919, p. 4). Leveraging this, many licensees also invested in newspaper advertising as a means of promoting their businesses.

An example of a prolific advertiser was Nurse Bamforth, a registered Class B midwife who ran her premises in Hastings, on the east coast of the North Island. Between March 1915 and September 1920 Nurse Bamforth placed over 1000 advertisements promoting her business.[5] Given advertising costs in comparable newspapers could be as much as five shillings per column inch it represented a significant financial investment, ('Advertising

[4]Te Rangi Private Hospital was owned by a group of doctors who appointed Nurse Gosling, also a shareholder, as the manager. Despite this the hospital was known locally as "Nurse Gosling's". "Lost," *Nelson Evening Mail* (Nelson), 15 February 1917, 1, https://paperspast.natlib.govt.nz/newspapers/NEM19170215.2.7.6; "Personal," *Colonist* (Nelson), 7 April 1917, 4, https://paperspast.natlib.govt.nz/newspapers/TC19170407.2.27.

[5]Search: "Nurse Bamforth," in *Papers Past Newspapers* (1916–1919). https://paperspast.natlib.govt.nz/newspapers?end_date=31-12-1940&items_per_page=100&phrase=2&query=Registered+Maternity+Home&snippet=true&sort_by=byDA.rev&start_date=01-01-1910&title=BA%2cDTN%2cHAST%2cHBH%2cHBT%2cHBTRIB%2cHBWT%2cWAIPM&type=ADVERTISEMENT.

rates 1925, p. 1; 'Note to advertisers' 1920, p. 9) but in a region that had at least 17 private hospitals operating between 1910 and 1940, competition was fierce.[6] Most were maternity hospitals, with five offering medical and surgical services alongside the three public hospitals in the wider region. Nurse Bamforth's modest advertisement simply stated her address and her nursing registration with no other fanfare, but it was an investment she clearly deemed to be worthwhile. The interconnectedness of community life meant that as a vital part of her community a hospital licensee might also be involved in a range of events such as hosting farewells, weddings or local club events, as well as becoming a community leader in times of crisis such as the 1918 influenza epidemic ('Farewelling a clever nurse' 1908, p. 7; 'A unique wedding on hospital balcony' 1926, p. 10). It is difficult to assess whether these activities were a deliberate strategy to boost business or simply the actions of women invested in their communities. Either way, based on the reporting of these many and varied events in local newspapers over time, they served to elevate their standing and reputation.

SHIFTING TRADITIONAL POWER DYNAMICS BETWEEN DOCTORS AND NURSES

In some ways the predominance of women at the helm of private hospitals should not have been surprising. Doctors in New Zealand during this period were required to have not only hospital and university appointments but also a successful private practice (Belgrave, 1988, p. 50). A successful private practice relied on having a hospital in which to treat patients. The private hospital regulations stipulated, however, that a licensee had to be resident at the hospital, which did not necessarily suit a doctor's breadth of work commitments. The financial investment in a hospital, when weighed against the time they were required to be there, may have discouraged them, leaving the door open for nurses and midwives to take the lead. In smaller towns without a state hospital, private hospitals assumed even greater importance as part of the fabric of the community. This afforded the risk-taking nurses and midwives a business opportunity while allowing the doctors to remain independent of the rigours of running a hospital. This mutually beneficial scenario relied on nurse licensees building a business based on their nursing practice and providing premises for doctors to treat their patients—a subtly different scenario from the state hospital environment where the doctor held the balance of power.

In Te Awamutu, Sister Edith Hayward had built a good reputation as the owner and licensee of the Te Whare Ora Private Hospital. A registered nurse, her business had been successfully operating for 3 years but during a dispute with one of the local doctors in 1932, her reputation came under close and uncomfortable scrutiny. This dispute revealed a new power dynamic between doctor and nurse that was not generally seen in the public hospital environment.

Tensions between the two had been growing over several months but the incident that appeared to trigger the conflict was Sister Hayward's alleged refusal to pass the doctor a gown or gloves.[7] This seemingly minor spat resulted in Sister Hayward banishing the doctor from her

[6]Search: "Private Hospitals Hawke's Bay," in *Papers Past Newspapers* (1910–1940). https://paperspast.natlib.govt.nz/newspapers?phrase=2&sort_by=byDA&items_per_page=100&snippet=true&title=BA%2CDTN%2CHAST%2CHBH%2CHBT%2CHBTRIB%2CHBWT%2CWAIPM&query=private+hospitals+&start_date=01-01-1910&end_date=31-12-1940&type=ADVERTISEMENT.

[7]L.S. Rogers, "The Inspector General of Hospital. (sic)," in *R20963123 Private Hospitals—Miss E.M. Hayward—Te Awamutu* (Wellington: Archives New Zealand, 28 February 1933).; This statement was subsequently found to be inaccurate in the investigation and that Sister Hayward had in fact supplied him with the sterile gown and gloves as demanded; Inspector of Private Hospitals T.L. Paget, "Memorandum for the Medical Officer of Health, Auckland," in *R20963123 Private Hospitals—Miss E.M. Hayward—Te Awamutu* (Wellington: Archives New Zealand, 29 March 1933).

hospital with the instruction 'that unless he was polite to me in my theatre and hospital he could not bring his patients to me' (Hayward, 1933, p. 3). This meant he would have to make a 70-kilometre round trip to Hamilton, the nearest major town, in order to perform surgeries as there were no other private or state hospitals in Te Awamutu at that time. The disclosure of her refusal to work with him illustrated the unquestioned authority she held in her hospital and, perhaps even more interestingly, that she was prepared to use it. Frustrated by this, the irate doctor wrote to the Inspector of Private Hospitals, Dr. Tom Paget, accusing Sister Hayward of 'acting in a most unprofessional manner towards my patients and towards [another doctor's] patients' and that she had allegedly advised their patients to change their medical adviser while also grossly overcharging them (Rogers, 1933). The result of his allegations was a full departmental enquiry that would see Dr. Paget interviewing patients, nursing staff, and the doctors to assess the voracity of the claims as well as attempting to mediate between all the parties involved.

Ultimately, Sister Hayward was exonerated with Dr. Paget stating that 'there was a want of frankness amounting to suppression of essential facts in favour of Sister Hayward' and that none of Dr. Paget's findings into the complaints 'would in any way justify me in recommending the Hon. The Minister to revoke the license' (Paget, 1933). His view that the doctor's statements were 'lacking in correctness ...[and] are to be deplored as being largely unjustifiable attacks upon a nurse with whom they have had a personal quarrel' put an end to the matter (Paget, 1933). What potentially could have been disastrous for her appeared to do little to curb her enthusiasm for her chosen vocation, however, and just 2 years later she commissioned a 14-room purpose-built hospital at a cost of £2230 ('Local and general' 1935). At its official opening the local Member of Parliament Mr. W. J. Broadfoot commended Sister Hayward 'for her enterprise in providing a distinct service for Te Awamutu...[and hoped] she would meet with a maximum of success and a minimum of worry' ('Local and general' 1935, p. 6).

CONCLUSION

Between the Private Hospitals Act, 1906 and the advent of the groundbreaking Social Security Act 1938 which introduced free healthcare for all New Zealanders, women dominated the private hospital sector as licensees, property owners, employers, and colleagues of the licensed male and female doctors across New Zealand. The nurse licensees provided the premises, fielded the rigorous inspection processes, invested in all medical, sanitary, and building requirements, took the financial risk and, to a greater and lesser extent, reaped the financial rewards of their endeavours. In doing so they created a unique sector that was almost entirely their own.

Private hospital ownership and/or management found different business models from families to friendships, sole operators, and occasionally partnerships with doctors, each with different backgrounds and, presumably, each with different reasons for entering into such a venture. Women could call on their family members to be part of their workforce and scale a business up or down to meet the needs of their local communities balanced with their own family commitments. The licensees' preparedness to take the financial risks to build their businesses was mutually beneficial for doctors wishing to focus their energies on building their private medical practices supported by honoraria and academic appointments, and without the day-to-day grind of running a business. Along with the licensee's responsibility for meeting the exacting standards set out in the regulations came agency and an independence from the traditional nurse/doctor hierarchy. Building a good working relationship between doctors and the licensees of

private hospitals, however, ensured doctors had premises in which to perform their surgeries as medical advances and the preference for treatment in hospital became more common.

For women like Sister Hayward and Miss Clymo, service was clearly at the heart of their nursing vocation but a desire to succeed in business must also have been a driving force. In Sister Hayward's case, she went on to open her own purpose-built hospital, while Miss Clymo's hospital provided ongoing employment for her and her sister's family as well as accommodation for them all and presumably a level of financial reward when she finally sold her business. Whether their respective motivations were rooted in financial independence, professional agency, or social standing cannot be determined from this distance, but the ownership and/or management of a private hospital certainly provided the opportunity for them to develop all three. The strong legislative framework introduced between 1901 and 1906 requiring nurses, midwives, and their hospitals to be registered and regularly monitored could have put a straitjacket around the industry. Instead, it created an opportunity for many women prepared to take on the responsibility of running their own business, assisted by the Department of Health, which adopted a practical and collaborative approach that enabled licensees to not only survive but thrive.

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Some data that support the findings of this study are available from the Ministry of Health. Restrictions apply to the availability of these data, which were used under license for this study. Other data is available in the public domain.

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