

1948
NEW ZEALAND

REPORT OF THE MEDICAL SERVICES COMMITTEE

SUBMITTED TO THE HONOURABLE MINISTER OF HEALTH

Presented to Both Houses of the General Assembly by Leave

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The Honourable M. B. Howard,
Minister of Health, Wellington.

11th June, 1948.

DEAR MADAM,—

As the Medical Services Committee set up in October, 1947, we have the honour to submit our report. A summary of the Committee's recommendations is given in paragraph 65.

PERSONNEL OF COMMITTEE AND ORDER OF REFERENCE

2. The Committee as originally appointed consisted of—

Mr. T. P. Cleary, Barrister and Solicitor (Chairman).

Dr. W. F. Buist

Dr. E. D. Pullon

Dr. D. S. Wylie

Dr. D. Cook

Dr. L. C. McNickle

Mr. A. V. Keisenberg

} Representatives of the New Zealand Branch of the British
Medical Association.

} Representatives of the Department of Health.

Following the first series of meetings Dr. Buist had unfortunately, on account of illness, to relinquish duty until the final meetings of the Committee. His place on the Committee was taken by Dr. A. E. Park, and the final series of meetings was attended by both Dr. Buist and Dr. Park. Mr. A. R. Hutchings, of the Department of Health, and Mr. G. R. Lee, General Secretary of the British Medical Association (New Zealand Branch), were also in attendance throughout the Committee's sittings. Mr. I. K. McKenzie, of the Department of Health, acted as Secretary to the Committee.

3. The Committee's Order of Reference, as approved by Cabinet, was as follows :—

Generally to examine and confer upon the provisions of Part III of the Social Security Act, 1938, affecting the services of medical practitioners, and to examine and confer upon the administration of those provisions, and to advise as to what alterations are necessary to give effect to the Government's policy of making available adequate and proper medical services (general and specialist) free or substantially free of cost; and, in particular, to make recommendations as to—

- (a) The methods by which medical practitioners should be remunerated, directly or indirectly, out of the Social Security Fund or other Government funds :
- (b) The scales or rates of such remuneration and the procedure for determining and altering such scales or rates :
- (c) The manner in which appointments to salaried posts should be made :
- (d) The qualifications and experience which should be taken into consideration in the recognition of specialists :
- (e) Arrangements for ensuring an adequate distribution of medical practitioners throughout the Dominion :
- (f) Any other relevant matters.

4. When notified of its order of reference the Committee was given an extensive list of questions compiled partly by the Department and partly by representatives of the New Zealand Branch of the British Medical Association. The Committee was informed that some of these questions might not be within the scope of the Committee's consultations, but that determinations on this point were left to the Committee.

PROCEDURE

5. The Committee met in the board room of the Department of Health, Wellington, on the 20th and 21st and on 24th to 28th November, 1947, and again on 12th to 16th January, 1948, and finally on 20th and 21st May, 1948.

6. Officers of the Department submitted to the Committee several statements dealing with the operation of the existing benefits and the expenditure thereon. The Association's representatives supplied copies of the reports of the Association's Medical Planning Committee, together with considered statements in writing on particular

questions before us. The Committee also visited the Department's Wellington district office and was shown the office procedures involved in dealing with claims under the General Medical Services Scheme and in the pricing of prescriptions in connection with pharmaceutical benefits. Except as just indicated, the proceedings took the form of discussions.

GENERAL OUTLINE OF COMMITTEE'S APPROACH

7. The Committee considered that its principal function was to explore the measure of agreement to be reached on various problems relating to medical services between the representatives of the two bodies immediately concerned with the difficulties occasioned by those problems—namely, the medical profession and the Department. As was to be expected, the representatives met each other with fairly well-established but divergent views on some issues, but each group of representatives was actuated by a sincere desire to appreciate and weigh the objections and difficulties on any point felt by the other group. Much of the discussion that took place was exploratory of these differing views in an endeavour to reach agreement.

The result was that on a number of matters, some of great importance, the Committee's recommendations were arrived at by concessions being made by one body or the other in order to reach a basis that afforded some reasonable hope of general acceptance and satisfactory operation. On many points, therefore, the recommendations made do not necessarily conform to the opinions of individual members of the Committee.

8. From the commencement of its deliberations the Committee recognized that any recommendations made by it must be governed by the wording of the order of reference which required it to "advise as to what alterations are necessary to give effect to the Government's policy of making available adequate and proper medical services (general and specialist) free or substantially free of cost."

9. The requirement, as a matter of Government policy, that medical services should be free or substantially free of cost to the patient relieved the Committee from the necessity of considering any suggestions that did not satisfy this requirement. In effect this meant that the Committee was to commence its investigations with the consideration of the best means of remunerating medical practitioners from the Social Security Fund for services that should be free or substantially free to the public. This brought the Committee at an early stage to a consideration of the method of dealing with the most important aspect of medical services—the General Medical Services Scheme.

10. The information supplied to the Committee as to the payments made from the Fund under the General Medical Services Scheme disclosed cases where general practitioners were receiving annual sums much in excess of what could be regarded as reasonable and proper remuneration. The Committee was unanimous in its desire to devise a system and methods to guard against excessive payments and to eliminate abuses. To achieve this end under such new system the Committee recommends that steps be taken to place upon the profession itself as a body a large degree of responsibility for the ethical behaviour of its members and for the general quality of all medical services afforded in relation to benefits. This report, therefore, includes recommendations for giving responsibility of this nature to the New Zealand Branch of the British Medical Association through advisory and disciplinary committees to be set up as hereinafter suggested.

11. The next major question with which the Committee was faced was that under the present arrangements many specialist services afforded under conditions of private practice are not as yet the subject of adequate benefits, and, therefore, to a large number of patients constitute a considerable financial burden. The making of recommendations whereby specialist services as well as general medical services should be available free or substantially free of cost to the patient involved the examination of many aspects of specialism, and the Committee's recommendations in this respect are set out in detail in later portions of the report.

The Committee recognized that the extension of the present system of health benefits which these recommendations project, so as to cover the complete range of medical services, must necessarily involve further heavy charges on the Fund, but it assumed that this was contemplated when the Committee was asked to make recommendations whereby adequate specialist medical services should be available free or substantially free of cost to the patient.

GENERAL PRACTITIONER SERVICES: METHOD OF REMUNERATION

12. The Committee reviewed the several existing methods by which medical practitioners are remunerated directly or indirectly out of the Social Security Fund.

CAPITATION SYSTEM

13. The advantages and disadvantages of a general capitation system on the lines of that already operating by virtue of sections 13 and 14 of the Finance Act (No. 4), 1940, having been considered, it was agreed that at the present time and under the existing circumstances in this country a renewed attempt to introduce such a system generally could not succeed. The Committee recognized that the capitation system has certain obvious advantages to recommend it, including the very important advantage of budgetary control, and this report is not to be understood as a condemnation of the system. The Committee likewise recognized that the profession has consistently maintained that the system tends to a decline in the high standard of practice, and the fact remains that it at no time attained a measure of popularity with the profession. At most fifty-one doctors entered into agreement to provide medical services under this scheme, and the number has dwindled until at present there are only twenty-three operating under it, most of this number also practising under the general medical services scheme at the same time.

14. The Committee recommends that no practitioner should be permitted to practice under both the capitation system and the fee-for-service system at the same time, but should be required to elect between them. The Committee also considered the administrative difficulties and expense arising from some practitioners practising under the capitation system and others in the same area practising under a fee-for-service system, but does not desire to make any recommendation on this point.

SALARIED SYSTEM

15. A suggestion to adopt a general salaried system of service affords no solution as it does not appear practicable to devise a general system of this kind that is administratively possible and also acceptable to the body of the profession. The Committee agreed that in remote areas remuneration by salary might be the only practical means of securing a medical practitioner's services, giving as it does an assured income from the outset of practice. It appears desirable, however, that as far as possible there should be one uniform system of remuneration from the Fund for general practitioner services, and that when circumstances permit the system of remuneration on a fee-for-service basis recommended by the Committee in this report (para. 19) should replace remuneration by salary.

16. The Committee recommends that the Association be consulted on the setting-up of any special area which it appears must be served by a salaried medical officer. The Association would be expected to give advice as to remuneration and other conditions and generally to assist in obtaining a medical officer for the area.

17. Consideration was given to the possibility of a system combining a basic salary with additional payments according to services rendered and also to a scheme under which a global sum would be allocated to District Medical Committees, who would

apportion it among medical practitioners of their district on a basis decided by the majority. Owing to the absence of sufficient information as to the working of any such systems, the Committee considered it was not in a position to make any recommendation.

FEE-FOR-SERVICE SYSTEM

18. Particular attention was necessarily directed to the existing General Medical Service Scheme introduced under sections 2 to 11 of the Social Security Amendment Act, 1941, which provide two alternative methods of payment from the Fund—namely, a direct payment to the doctor or a refund to the patient. Reviewing the administrative procedures involved in these two methods, the Committee came to a general agreement that there should be one method only of claiming against the Fund.

19. The Committee recommends that in lieu of the present alternative fee-for-service methods of payment from the Fund (namely, (i) direct payment, and (ii) refund) there be adopted only one method (namely, one by which the medical practitioner shall be required to claim on the Fund on behalf of the patient the appropriate amount payable from the Fund for the service and apply that amount in full or part settlement of his charge for the service).

The recommendation that the claim be made in this manner—*i.e.*, on behalf of the patient—rather than directly as is at present provided by section 4 of the Social Security Amendment Act, 1941, is made to meet the desire of the profession to preserve the doctor-patient relationship to the fullest extent. It is a matter of common knowledge that, on account of the widely held view that a direct claim by the practitioner on the Fund infringed this principle, a large number of practitioners have declined to make direct claims upon the Fund.

20. A suggested form of claim was discussed and while the Committee recognized that the actual detail and form of the claim would be a matter for further discussion and settlement, a draft of the form considered by the Committee forms an appendix to this report as an indication of what is considered necessary.

21. *Verification of Claims.*—It was agreed that the present invariable practice of obtaining a certificate from the patient, parent, or guardian as to the dates, &c., of attendance has only limited value. With the adoption of the system recommended in paragraph 19 it is recommended that certification by patients, &c., be discontinued.

It was recognized, however, that with the discontinuance of certification by patients some alternative method for checking the claims made by practitioners would be necessary. It is accordingly suggested that the Department devise a system of verification of service as an alternative to the patients' certification, as, for example, postal inquiry from a proportion of the patients of each practitioner. In addition, it is recommended that all practitioners be required to maintain adequate medical records of their patients in support of all claims made and that these records and daily diary sheets be subject to inspection by medical practitioners duly appointed for that purpose.

22. *Amount of Payment from Fund.*—The Committee recommends the following scale of payment from the Fund in respect of general practitioner services:—

- (a) For an attendance at the doctor's place of residence or surgery or at a private hospital, up to 7s. 6d. :
- (b) For an attendance elsewhere than at the doctor's place of residence or surgery or at a private hospital, up to 10s. :
- (c) For an attendance between 9 p.m. and 7 a.m. or on a Sunday or on a public holiday in response to an urgent request at those times, 12s. 6d. :
- (d) Where any attendance extends beyond a half-hour, 5s. for every additional quarter-hour :
- (e) For telephone consultations in certain rural areas approved by the Medical Officer of Health, up to 5s.

It was agreed that no payment should be made either from the Fund or by a patient where the only service was to repeat a prescription.

23. *Mileage.*—The Committee recommends that consideration should be given to the question of some increase in the present ordinary mileage payment from the Fund of 1s. 3d. per mile (fixed by section 5 of the Social Security Amendment Act, 1941), with the general intention that the amount paid from the Fund will be accepted in full satisfaction of the doctor's charge by way of mileage. The Committee felt that this question should be the subject of further discussions between the Association and the Department. The Committee recognized that the complete abolition of mileage charges to patients calls for some other deterrent against unnecessary and time-consuming visits to distant places.

24. *Increase in Payment for Domiciliary Attendance.*—The scale of payments from the Fund recommended in paragraph 22 is substantially as at present, except that the Committee suggests an increase of 2s. 6d. for an attendance at the patient's home. Since the General Medical Services Scheme was inaugurated in 1941 a uniform fee of 7s. 6d. has been paid from the Fund for an ordinary attendance in the doctor's surgery or a visit to a patient's home or elsewhere. The Committee appreciated that the fee had been made a uniform one on the assumption that the ratio of attendances in the surgery to visits would be much the same for all general practitioners in urban areas and that, so far as practitioners in rural areas were concerned, the mileage payments would adjust matters. It has, however, continued to be the regular custom for many practitioners to charge a higher fee for a visit than for an attendance in the surgery. The ratio of attendances to visits undoubtedly varies a good deal among practitioners. The present uniform payment encourages those individuals who are inclined to deal with unduly large numbers of patients in their surgeries. They, of course, are able to claim the same fee for every attendance no matter how little time is involved.

The Committee feels, therefore, that a distinction should be made as regards the fee for an attendance in the surgery and an attendance in the patient's home. That this should be done by increasing the payment in respect of a domiciliary visit is conditional upon measures being taken, as recommended elsewhere in this report, to control the amounts paid to practitioners generally.

25. The Committee contemplates that the amounts payable from the Fund will in many cases be accepted in full satisfaction for the services rendered. Indeed, the Committee expects that there will be a proportion of cases, varying with the different types of practice, where less than the amounts set out in paragraph 22 will be accepted as a sufficient charge in the particular circumstances. At the same time the Committee recognizes that there will be cases where the amounts recommended in paragraph 22 will be insufficient to provide an adequate fee to the practitioner, and this aspect has caused the Committee to consider the question of the right of practitioners to recover fees from patients.

26. *Fees Payable by Patients.*—Under section 8 of the Social Security Amendment Act, 1941, a practitioner is prohibited from recovering at law a charge in respect of a general medical service above the fee payable from the Fund for that service. In fact, almost all practitioners operating under the "refund" system and a number of those operating under the "direct payment" system regularly make additional charges, which are, as a rule, readily paid by patients. Although, therefore, the provision mentioned is not very effective, it is nevertheless a source of dissatisfaction, if not resentment, on the part of a considerable number of the profession.

There was general agreement that every general medical practitioner should have the right to charge and recover a fee additional to that payable from the Fund wherever circumstances, in his opinion, warranted it.

27. The Committee accordingly recommends that section 8 of the Social Security Amendment Act, 1941, be replaced by a provision that no medical practitioner shall be entitled to recover fees (whether in respect of general medical services or any

specialist services for the time being subject to benefit from the Fund) until after the expiration of one month from the delivery of a detailed account to the patient. During the month the patient would be at liberty to refer the account to a Local Investigating Committee (referred to elsewhere in the report), which would have power, conferred by regulations, to say whether the charges were fair and reasonable having regard to the general practice of the profession and the circumstances of the case, and if excessive, to what amount they should be reduced. There should be a further provision enabling a Court to refer proceedings, pending before it for the recovery of medical charges, to the appropriate Local Investigating Committee for its views.

28. *Limitation of Number of Attendances.*—The Committee discussed the practicability of prescribing limits to the number of patients to be seen daily or, alternatively, of prescribing a limit to the amount payable from the Fund to an individual practitioner. It considered that, in view of the wide variation in local conditions, types of patients, and the capacity of practitioners, no fixed or arbitrary limits could be prescribed. Nevertheless, there are substantial grounds for believing that an average of, say, thirty attendances daily is the maximum number practicable for an efficient and conscientious practitioner, and the Committee considers that Local Investigating Committees should be vigilant to investigate cases which habitually exceed the figure mentioned. The Committee was informed that it was the intention of the Association to address its divisions throughout the country on these general lines.

29. *Transitional Provisions.*—The system of remuneration for general practitioner services now recommended is intended to be universally applied except in approved special areas where the practitioner is remunerated on a salary basis and except where the practitioner confines his practice to the capitation system. The suggestion has been made, however, that a number of medical practitioners might be reluctant to agree to operate under the system recommended in this report and that some special transitional provision be made for these cases. The Committee recommends that the Minister should have power to allow the present refund system for doctors who elect to operate thereunder if such doctors have in fact wholly operated under the present refund system since its inception in 1941. The Committee believes that there are very few practitioners who might want to take advantage of that special provision and that those few belong to the older generation of practitioners.

SPECIALIST MEDICAL SERVICES

30. *Range of Services.*—The Committee discussed at length methods by which benefits might be made available in respect of all specialist medical services not already the subject of benefit.

The full range of classes of specialists which the Committee had under consideration was as follows :—

- | | |
|------------------------------------|----------------------------|
| (1) Medicine— | (3) Obstetrics. |
| General. | (4) Eye. |
| Pediatrics. | (5) Ear, nose, and throat. |
| Dermatology. | (6) Pathology. |
| Tuberculosis. | (7) Anæsthetics. |
| Psychiatry. | (8) Radiology. |
| Physical medicine. | |
| (2) Surgery— | |
| General. | |
| Urology. | |
| Orthopædic. | |
| Gynæcology. | |
| Plastic or reconstructive surgery. | |
| Neuro-surgery. | |

31. The Committee appreciated that all of the classes of specialist services listed above are the subject of full benefit when provided by specialist staffs of Hospital Boards and all are the subject of the provisions made in section 12 of the Finance Act (No. 2), 1942, whereby a person paying fees for specialist services may obtain from the Fund a refund of 7s. 6d. for every occasion on which the services have been provided. So far as private specialist services are concerned, substantial benefits have thus far been provided only in respect of radiology and pathology under the Social Security (X-ray Diagnostic) Regulations 1941 and the Social Security (Laboratory Diagnostic Services) Regulations 1946 respectively. Further brief reference is made to these two classes of services in paragraph 45. Reference is also made to obstetric specialist services in paragraph 42 under the heading of "maternity benefits."

32. *Payment of Benefits.*—For those private specialist services not already the subject of substantial benefit the Committee agreed that the method which was likely to receive the most general approval would be one by which the specialist should be required to claim on the Fund on behalf of the patient the appropriate amount payable from the Fund for the service and apply that amount in full or part settlement of his charge for the service, with the right to recover any balance from the patient in the manner suggested in respect of General Medical Services.

33. *Recognition of Specialists.*—The Committee considered that, in general, the requirements for recognition as a specialist would be—

- (1) An adequate training in the specialty under recognized teachers ;
- (2) The possession of a higher qualification (if such exists) in that specialty ;
- (3) The holding of or having held hospital or other public appointment in the specialty ; and
- (4) A general recognition by the applicant's colleagues of his special skill and experience.

Some specialists might be recognized as such under more than one of the classes listed in paragraph 30.

34. The Committee did not consider that, under the conditions governing practice in New Zealand at the present time, there should, or ordinarily could be, a requirement that the specialist devote his practice exclusively to his specialty. This requirement could at the best be fulfilled only in certain specialties, but more often conditions will dictate that a practitioner should practise his specialty along with the general practice of medicine or surgery. The Committee considered, however, that there should be no differentiation in the requirements for recognition as between the full-time specialist and the part-time specialist.

35. In order to provide machinery for the recognition of specialists the Committee contemplates legislation modelled upon section 14 of the Social Security Amendment Act, 1939, which would incorporate the requirements set out in paragraph 33 above. No doubt the Association would set up a special committee which would report and make recommendations to the Minister in respect of every application for recognition as a specialist referred to the Association under a provision corresponding to section 14 (3) of the Social Security Amendment Act, 1939.

36. It should be made clear that the recognition or non-recognition of practitioners as specialists would in no way affect the right of the particular practitioner to practise a specialty, but would merely affect the right of the practitioner to receive the specialist benefits from the Fund on behalf of his patients. Moreover, special provision would require to be made enabling recognition to be afforded, pursuant to the provisions suggested in the preceding paragraph, in the case of those practitioners already practising a specialty at the time of the initiation of the specialist benefits who do not hold a higher academic qualification, but otherwise possess the necessary qualifications. Further, provision should be made for the discretionary allowance of specialist benefits in respect of specialist services rendered in an emergency or under like exceptional circumstances.

37. *Quantum of Specialist Benefits.*—A number of scales of benefits for the various specialist services will require to be settled, but it was quite impracticable for the Committee to deal with this difficult and technical matter other than in a general way. Section 12 of the Social Security Amendment Act, 1939, provides machinery which has worked well in practice in the settlement of the fees payable for medical services in relation to maternity benefits. The Committee contemplates that provision would be made so that the benefits in respect of specialist services would be fixed by agreement between the Minister and the Association in much the same way as the section just referred to provides for the fixation of fees in relation to maternity benefits. It is to be remembered, however, that those fees are (except in the case of obstetric specialists) accepted in full satisfaction of the practitioner's charges. The section is therefore not altogether apt, and regulations would be necessary to prescribe, with respect to the different specialist services, the methods of fixing the scales of benefits which would not necessarily be accepted by the practitioner in full satisfaction of his charges.

38. For the better appreciation of the problems involved in determining scales of specialist benefits the Committee gave some consideration to the amount of benefit that might be payable in respect of specialist consultations. Its discussions centred around the following points:—

(a) Should the amount of the benefits in relation to specialist consultations bear the same proportion to the fees for consultation customarily charged as the amount of the General Medical Services benefit of 7s. 6d. bore to the fee of 10s. 6d. which had been the prevailing charge for an ordinary general practitioner consultation?

For most classes of specialists the prevailing consultation fees (which have remained unaltered over a period of years) are £2 2s. for an initial consultation and £1 1s. for a subsequent consultation. The amount of benefit from the Social Security Fund will require to be settled in accordance with two principles, that of making the service substantially free on the one hand and that of providing some deterrent against excessive demands on the specialists on the other hand. In the Committee's view the sums payable from the Fund in respect of the specialist consultations referred to should not exceed 30s. and 15s. respectively for an "initial" and a "subsequent" consultation.

(b) Should the benefit in relation to specialist consultations be limited to one or more of the cases where:—

- (i) The patient is referred to the specialist by a general practitioner:
- (ii) The specialist is a full-time specialist:
- (iii) The specialist certifies that the service given is in fact of a genuinely specialist nature?

(c) Should there be special provision for a weekly benefit in respect of attendances on patients in private hospitals, where no operation is involved?

(d) Should there be a differentiation as to the specialist benefit between services rendered by a full-time specialist on the one hand, and those rendered by a part-time specialist on the other hand?

On all these questions the Committee found need for close investigation and consideration, which could be best undertaken in detail in the negotiations that will be necessary for the settlement of the scales of benefits.

39. As has been mentioned in paragraph 11, the Committee is conscious that the provision of adequate specialist medical services free or substantially free of cost will involve the Fund in further heavy commitments. The Committee had not the information which would enable it to estimate the amount likely to be required, nor indeed could any estimate be attempted until the scales of fees referred to in paragraph 37 have been settled. The Committee recognized that any decision as to the introduction of benefits in respect of specialist services must take seriously into account the financial obligations involved.

40. *Shortage of Specialists.*—Evidence was furnished to the Committee showing that at present the requirements of the various hospital districts call for a further fifty specialists, and serious hardship is being caused to the public by their absence. In particular, there is an urgent shortage of radiologists; eye, ear, nose and throat specialists; and (perhaps to a less degree) orthopædic specialists.

The only possibility of early relief is to attract specialists from overseas. This, however, is unlikely to provide more than a small proportion of our needs, and the long-term view should be to encourage the growth of specialism amongst our own graduates. Measures which the Committee consider should be undertaken in this direction are:—

- (i) The “open hospital” system should as far as possible be put into operation. This is the system whereby visiting medical staff are obtained by selection from doctors practising in the district—as contrasted with a “closed hospital” where the medical staff is entirely internal:
- (ii) The encouragement of the full and satisfactory use, on staffs of hospitals generally, of young practitioners with some of the chief specialists’ qualifications is very desirable. Many of these practitioners after their entrance to private practice find it difficult to procure part-time hospital appointments and the accompanying practical experience, without which their development as specialists is at present in many cases very definitely delayed:
- (iii) Additional specialist registrarships in the larger hospitals should be established:
- (iv) Bursaries should be given to encourage selected men to obtain specialist qualifications, and positions should be assured to them upon qualifying.
- (v) The Association might devote further consideration to the ways in which it could assist to find a solution to the problem.

MATERNITY BENEFITS

41. The Committee found general satisfaction experienced in the operation of these benefits as affecting medical services, and there was a notable absence of complaints to the Department except in one respect mentioned in the next paragraph. Machinery already exists in section 12 of the Social Security Amendment Act, 1939, for dealing with any revision required from time to time in the amounts of the benefits, and the Committee understands that this machinery has functioned satisfactorily.

42. There have been complaints from time to time as to the amount of the fees charged by some of the recognized obstetric specialists to their patients over and above the amount paid from the Fund. For this reason the Committee has suggested in paragraph 27 a procedure whereby the fees claimed by all medical practitioners, whether specialists or general practitioners, should be subject to review by a Local Investigating Committee. It was felt that this machinery, if adopted, should remove any justified complaints of over-charge whether by obstetric specialists or other practitioners.

43. The Committee considered that the defects pointed out in the report of the committee set up by the New Zealand Obstetrical and Gynæcological Society in 1946 under the chairmanship of Dr. T. F. Corkill have been adequately dealt with in the subsequent report of the executive of the Society, and understands that the main recommendations of the Society have been, or are being, given effect to.

44. The Committee approved the general principle that, except so far as it is necessary to allocate a minimum number of beds for the training of medical students and midwives and for post-graduate training in obstetrics, every patient should have the right to be attended by the doctor of her choice. It was considered that the opening of the new St. Helens Hospitals was too far in the future for a precise recommendation to be made as to the allocation of their beds. The principle that private maternity hospitals should be maintained and encouraged was approved.

RADIOLOGICAL AND PATHOLOGICAL SERVICES

45. The Committee did not enter into any detailed examination of the operation of these services. If the General Advisory Committee referred to in paragraph 52 of this report is set up, the Committee considered that this Committee should review the operation of these services after obtaining full information from the specialists concerned.

PHARMACEUTICAL

46. The principal factors which in the opinion of the Committee have caused the heavy annual increase in the cost to the Fund of these benefits may be summarized as follows :—

- (i) The general medical services benefits have encouraged the public to resort to doctors for trivial complaints, with the result that there has arisen a “patient-pressure” on the doctor which can only too easily be satisfied by prescribing medicine, towards the cost of which neither the patient nor the doctor contributes. This financial irresponsibility in the seeking of medical advice and the obtaining of prescriptions has undoubtedly led to a large measure of unnecessary and over prescribing :
- (ii) In recent years the use of new and expensive drugs has become much more general.
- (iii) There have been many instances of the unnecessary selection by doctors of the more expensive forms of medication, and there have likewise been instances of irresponsibility on the part of some practitioners in prescribing excessive quantities of drugs :
- (iv) There has been much unnecessary waste of medicine through loose methods of sanctioning repeats of prescriptions :
- (v) The wholesale cost of drugs has increased, and the greater duty and sales tax payable have resulted in proportionately increased prescription prices. In addition, the rate of sales tax has itself been increased :
- (vi) Many items previously bought over the counter from chemists are now prescribed.

47. It is apparent from the foregoing that a number of the factors contributing to the increased claims on the Fund for these benefits are matters in respect of which the medical profession can exercise no control. Apart from such factors, however, there remain a number of features leading to unnecessary or over prescribing in which both the public and the profession take some part. The Committee accordingly considered what recommendations it could make to act as a deterrent against unnecessary or over prescribing.

48. So far as the public is concerned, the Committee could see no method whereby the position could be improved other than the adoption of the principle of part payment by the patient of the cost of prescriptions. It is accordingly strongly recommended that, subject to exceptions in specific cases—*e.g.*, the supply of insulin to a diabetic—the principle of part payment by the patient be adopted as the most effective measure to check the present trend.

49. So far as the profession is concerned, the Association recently drew the attention of all its members to the care which should be exercised in prescribing new and expensive drugs and the need generally for economy in prescribing. The Committee recommends :—

- (a) The revision and extension of the present Formulary issued by the Department with a view to its general adoption as a pattern for economy in prescribing. That would both lessen administrative costs and be an educative factor in diminishing costly prescribing.

- (b) That the machinery for the prevention of abuses contained in the Social Security (Pharmaceutical Supplies) Regulations, Amendment No. 2, should be invoked in all cases where there appears to be reasonable evidence of unnecessary or over prescription. It is suggested that cases calling for investigation should be referred to the appropriate Local Investigating Committee (referred to in paragraph 56 hereof) for investigation, and that the necessary powers be conferred upon these Committees to enable them to investigate and deal with complaints.

GROUP SERVICES

50. The Department intimated that it had in course of preparation Group Service Regulations to provide services for groups of individuals in factories, boarding school, &c. The services provided would be preventive or curative, or both. It is proposed that the method of remuneration in each particular case be the subject of arrangement between the Department and the Association, and it is recommended that the draft regulations be submitted to the Association for their consideration.

HEALTH CENTRES

51. A matter discussed at length was the possibility of initiating in a newly-settled housing area a combined health and medical centre, concentrating therein both preventive and curative services. The development of health centres should, in the Committee's view, be encouraged, but it is recommended that before their establishment full agreement should be reached through the British Medical Association with the medical practitioners in areas concerned regarding methods of administration, types of work and working conditions, and methods of remuneration.

GENERAL ADVISORY COMMITTEE

52. The Committee recommends that there should be a General Advisory Committee constituted of members of the Association and one or more departmental medical officers which Committee would be recognized by the Minister as the principal consultative and advisory body in all matters involving consultation with representatives of the medical profession or any branch of the profession relating to medical services. This Committee could be appointed under section 83 of the Social Security Act, 1938. The Committees already set up under this section—*e.g.*, the Radiological Committee—would continue to function, and further committees might from time to time need to be set up under this section. The suggested General Advisory Committee would co-ordinate the activities of all committees now or hereafter set up under section 83 to deal with any particular benefits relating to medical services.

DISCIPLINARY COMMITTEE

53. Some of the existing regulations dealing with the administration of particular benefits contain provisions to enable the Minister to control and penalize practitioners who do not conform to the regulations. The Minister's powers are exercisable after reference to a committee appointed under section 83 of the Social Security Act, 1938. For example, there are provisions in the Social Security (General Medical Services) Regulations 1941 (Serial No. 1941/187) empowering the Minister, after consultation with the appropriate committee, to disallow a claim on the fund where the practitioner concerned has refused to furnish information requested of him with respect to the claim. Again, in the Social Security (Pharmaceutical Supplies) Regulations, Amendment No. 2

(Serial No. 1942 3), there is a provision which empowers the Minister to refer to the appropriate committee for investigation a complaint as to excessive prescribing, &c. If the committee so recommends, the Minister may impose certain penalties on the practitioner concerned.

The Committee considers that it will be necessary to amplify the provisions of the regulations dealing with general medical services so as to enable more effective control to be exercised in cases of over-visiting, excessive number of patients seen, and the like; and it recommends that there be set up a Disciplinary Committee of members of the Association to which the Minister will refer for investigation and report all complaints against medical practitioners arising out of any of the regulations relating to medical benefits, and that provision be made for imposing penalties where the Disciplinary Committee so recommends.

54. The Committee suggests, however, that the Disciplinary Committee's functions should not be confined to advising the Minister in cases of alleged breaches of the various Social Security regulations, but that it should have jurisdiction to deal with all complaints relating to the professional conduct of medical practitioners not at present falling within the jurisdiction of the Medical Council. At the present time the only provision in force enabling disciplinary powers to be exercised against practitioners are those contained in section 22 of the Medical Practitioners Act, 1914, and section 6 of the Medical Practitioners Amendment Act, 1924. These powers are, however, exercisable only in cases of "grave impropriety or infamous conduct in a professional respect." They do not apply to minor irregularities or misconduct in practice. It appeared to the Committee that there was a general opinion amongst members of the profession in favour of the constitution of a domestic body to exercise disciplinary powers in cases that were not serious or grave enough to invoke the powers conferred upon the Medical Council. If the profession is to give the assistance, which this report contemplates it will, in the control of its own members in all matters relating to medical benefits then the case for such a domestic disciplinary body becomes much stronger. The Committee accordingly recommends that, in addition to the advisory functions referred to in paragraph 53, the suggested Disciplinary Committee should have jurisdiction to hear and determine all complaints of professional misconduct against practitioners not serious enough to give rise to the preferment of a charge of grave impropriety or infamous conduct before the Medical Council.

55. The setting-up of a Disciplinary Committee having the powers and functions recommended in this report would involve appropriate amendments to the Medical Practitioners Act, 1914. The suggestion that a committee of the Association should exercise disciplinary powers over all practitioners also gives rise to the question whether all registered practitioners should not have an automatic right to membership of the Association.

LOCAL INVESTIGATING COMMITTEES

56. It was considered that a Central Disciplinary Committee would be unable to exercise satisfactorily the powers suggested in the preceding paragraphs of this report unless it were assisted by Local Investigating Committees in each health district. The functions of a Local Investigating Committee (consisting of members of the Association together with a medical officer of the Department) would be to make preliminary investigations into complaints against the practitioners in the district, whether such complaints were made by the Department of Health or by patients, and to obtain explanations from the practitioner concerned. It would then decide whether the complaint merited further inquiry by the Disciplinary Committee, and in particular whether a charge should be preferred against the practitioner concerned.

DISTRIBUTION OF PRACTITIONERS

57. A major problem that arises in connection with medical services is that of ensuring an equitable distribution of medical practitioners throughout the Dominion. The trend has been towards larger centres, although lately there has been a tendency for practitioners to seek practices in the country. It is in the more remote areas that difficulty is still met in providing general practitioner services. Similarly, the shortage of specialist services is, in general, and with some exceptions more evident in the secondary centres than in the metropolitan areas.

58. The inauguration of general medical services benefits has already assisted considerably in bringing about a better distribution of general practitioners. Nevertheless, it is agreed that in some areas the only effective means of securing a doctor is by an appointment of a man on a salaried or subsidized basis, giving him an assured income at the outset. It is in these circumstances usually that special arrangements have been and are being made under section 82 of the Act. As is mentioned in paragraph 15, the Committee agreed that this procedure must still be followed, but that the policy should be to encourage general practice under uniform conditions throughout the Dominion and that the employment of medical practitioners to provide domiciliary care on a salaried basis should not be undertaken or continued except where it is the only means of providing medical services for a particular area.

59. The Committee recommends that the Department, through its Medical Officers of Health, with the assistance of the local divisions of the Association, maintain a continuous survey of the requirements of every area and that efforts be made to encourage general practitioners to establish themselves in practice in areas inadequately served. This procedure, with the necessary modifications, is recommended in order to ensure a better distribution of specialist services.

60. Closely related to this matter is the question of arrangements whereby practitioners may be available for night and week-end calls. The Committee was satisfied that the Association is actively pursuing several avenues to mitigate legitimate criticism, and has already, with the assistance of the Post Office, the Free Ambulances, and other agencies made a good deal of progress. If the Committee's recommendations as to the setting-up of Local Investigating Committees are put into operation, there will be a ready means of dealing with any well-grounded complaints which should result in the disappearance of genuine grievances.

SALARIED MEDICAL POSTS

61. Departmental representatives pointed out that grounds for dissatisfaction occasionally arise in connection with the selection of appointees to medical posts under Hospital Boards. Certain of the larger Boards have established Consultative Medical Committees to advise the Boards as to the professional qualifications, experience, and suitability of applicants. Smaller Boards have no ready means of obtaining competent advice of this nature. The Department has the duty of making recommendations to Boards, but is often at a disadvantage by reason of its limited knowledge of the applicants and inability, owing to staff shortage, to pursue adequate inquiry. With the amalgamation of hospital districts and thus with larger administrative areas the appointment of consultative committees should be made easier. In the meantime the Committee suggests that consideration should be given to the establishment of Regional Consultative Committees to assist those Hospital Boards who have no local consultative committee in the making of medical appointments.

62. In view of the growing importance of preventive medicine, the small number of New Zealand graduates attracted to the New Zealand Public Health Service of recent years or at present undergoing post-graduate training in specialist preventive medicine

exercised the minds of the Committee. To what extent this is due to unsatisfactory financial conditions of employment it is difficult to say, but this aspect of the problem should be investigated. There was information before the Committee that the divergence between the monetary rewards of private practice and the salaries paid to full-time medical public servants had already occasioned difficulty in filling positions, and it may be expected that this difficulty will continue in the future. The view of the Committee is that the position should be carefully watched and that consideration be given for the betterment of conditions of service, and emoluments derived therefrom, for salaried officers in general.

MEDICAL EDUCATION

63. The Committee gave some time to a consideration of the length of the immediate post-graduate hospital experience of the newly-qualified practitioner. The Committee was concerned that the desirable custom of graduates taking a full-time post in one of the larger hospitals for at least one year was liable to be affected by the attractions of early entrance into practice, and felt that the matter was of such importance that the question of making such post-graduate experience compulsory deserved full investigation by the appropriate authorities.

64. The Committee has in paragraph 40 hereof set out its recommendation that the policy of the open-hospital system should as far as possible be put into operation in order to assist in the training of specialist practitioners. There are other phases of medical education that arise when consideration is given to the general quality of the service. There is, for instance, a growing realization that the general practitioner does not work as closely as he might with public health, nursing, and other agencies actively concerned with the care and treatment of patients. This defect is only partly due to omissions to develop administrative arrangements for such contact, and is perhaps mainly due to lack of appreciation of the scope and functions of these other agencies. Essentially it is a problem of medical education. The Committee considered that there is need for greater contact between general medical practitioners and the public hospitals, particularly in the following directions :—

- (a) Clinical courses of instruction for general practitioners of the district should be encouraged to as great an extent as possible :
- (b) The fullest possible information should be exchanged between the hospital and the general practitioner as regards the treatment and progress of the patient.

At the risk of trespassing beyond its order of reference the Committee feels that it should draw attention to the importance of these matters and the advantages to be gained from closer co-operation in these directions.

SUMMARY OF RECOMMENDATIONS

65. The following is a summary of the Committee's recommendations :—

ADMINISTRATION

(1) (a) That steps be taken to place upon the medical profession itself as a body a large measure of responsibility for the ethical behaviour of its members and for the general quality of all medical services afforded in relation to benefits (para. 10).

(b) That there be established a General Advisory Committee recognized by the Minister as the principal consultative and advisory body in matters affecting medical services (para 52).

(c) That there be constituted a central Disciplinary Committee to make recommendations to the Minister on complaints relating to breaches of regulations governing benefits in respect of medical services, and to deal with other complaints relating to professional conduct other than matters for the Medical Council (para. 53).

(d) That there be established in each health district a Local Investigating Committee whose function would be to make preliminary investigation into complaints against medical practitioners (para. 56).

GENERAL PRACTITIONER SERVICES

(2) (a) That no practitioner be permitted to practise under both the capitation system and the fee-for-service system at the same time (para. 14).

(b) That the system of remuneration by salary be adopted only in those remote areas where it is necessary to assure a definite income to the doctor (para. 15).

(c) That there be only one fee-for-service method of payment from the Fund—namely, a method by which the medical practitioner shall be required to claim on the Fund on behalf of the patient the appropriate amount payable from the Fund for the service, and apply that amount in full or part settlement of his charge for the service (para. 19).

(d) That the practice of obtaining patients' certificates be discontinued, but that other checks be imposed (para. 21).

(e) That the amounts payable from the Fund be limited substantially to the amounts at present paid, except that "up to 10s." be paid for a domiciliary visit instead of 7s. 6d. as at present (para. 22).

(f) That where the only service is to repeat a prescription no payment be made either from the Fund or by the patient (para. 22).

(g) That consideration be given to the question of increasing the present mileage rate of 1s. 3d. per mile on the condition that the payment from the Fund is accepted in full satisfaction of the practitioner's charge for mileage (para. 23).

(h) That section 8 of the Social Security Amendment Act, 1941, under which the right to recover fees from patients is restricted, be replaced by a provision permitting recovery of fees, but only after one month of the delivery of a detailed account, the patient to have the right in the meantime to refer the account to the Local Investigating Committee (paras. 26 and 27).

(i) That, as a transitional measure after the new fee-for-service system is adopted, the Minister be empowered to approve the continuance of the present refund system for those practitioners who have wholly practised that system since its inception in 1941 and desire to continue to do so (para. 29).

SPECIALIST MEDICAL SERVICES

(3) (a) That the benefits in respect of specialist medical services not already the subject of benefits be made available under a method by which the specialist will be required to claim on the Fund, on behalf of the patient, a prescribed amount for the particular service and apply it in full or part settlement of his charge for the service (para. 32).

(b) That legislative provision be made for the official recognition of specialists of different kinds, somewhat similar to that already provided for the recognition of obstetric specialists (para. 35).

(c) That the scale of benefits payable from the Fund be fixed by agreement between the Minister and the Association by a procedure similar to that adopted with respect to medical services in relation to maternity benefits (para. 37).

(d) That additional measures to overcome the shortage of specialists include the adoption of the "open hospital" system of medical staffing as far as possible, the employment in hospitals on visiting staffs of more young practitioners with specialist qualifications, the creation of additional specialists registrarships, and the granting of bursaries to selected men to obtain specialist qualifications (para. 40).

PHARMACEUTICAL

(4) (a) That the principle of part payment by the patient be adopted in respect of pharmaceutical requirements (para. 48).

(b) That the present Formulary issued by the Department be revised and extended with a view to its general adoption as a standard of prescribing (para. 49).

(c) That the present machinery for dealing with abuses, supplemented by the powers which it is suggested be conferred on the Local Investigating Committee, be invoked in all cases where there appears to be reasonable evidence of unnecessary or over prescribing (para. 49).

GROUP SERVICES

(5) That proposals for the provision of medical services for groups of individuals in factories, boarding schools, &c., covering preventive or curative services, or both, be submitted to the Association for their consideration (para. 50).

HEALTH CENTRES

(6) That the establishment of joint health and medical centres should be encouraged, but before their establishment full agreement should be reached through the Association with medical practitioners in the areas affected as to methods of administration, types of work and other conditions (para. 51).

DISTRIBUTION OF PRACTITIONERS

(7) That Medical Officers of Health, with the assistance of local divisions of the Association, maintain a continuous survey of the requirements of every area (para. 59).

SALARIED MEDICAL POSTS

(8) That regional consultative medical committees be set up to advise these Hospital Boards who have no local consultative committee in the making of medical appointments (para. 61).

MEDICAL EDUCATION

(9) That, to improve the contact between hospitals and practitioners—(a) clinical courses of instruction for general practitioners should be encouraged, and (b) there should be the fullest possible exchange of information between the hospital and general practitioner as regards the treatment and progress of the patient (para. 64).

We have the honour to be,

Madam,

Your obedient Servants,

T. P. CLEARY, Chairman.

W. F. BUIST.

ALAN PARK.

E. DOUGLAS PULLON.

D. S. WYLIE.

DUNCAN COOK.

L. C. McNICKLE.

A. V. KEISENBERG.

APPENDIX.—GENERAL PRACTITIONERS SERVICE: SUGGESTED FORM OF CLAIM ON FUND BY A MEDICAL PRACTITIONER (VIDE PARA. 20)

				[FOR DEPARTMENTAL USE]																										
(1)	(2)	(3)	(4)	(5)			(6)																							
Date of Attendance.	Code.	Name of Patient (and if Child under Sixteen, Name of Parent or Guardian.	Address.	Total Fee Charged.			Amount Claimed from Fund.			Ledger Reference.																				
				£	s.	d.	£	s.	d.																					
(2) CODE (to be printed on cover of pad of forms) <table border="1"> <tr> <td>M</td> <td>Morning, 7–12 noon</td> <td>T</td> <td>Telephone consultation</td> </tr> <tr> <td>A</td> <td>Afternoon, 12–9 p.m.</td> <td>E</td> <td>Extended more than 30 min.</td> </tr> <tr> <td>N</td> <td>Night, 9 p.m.–7 a.m.</td> <td>P</td> <td>Visit in private hospital</td> </tr> <tr> <td>S</td> <td>Sunday or public holidays</td> <td>R</td> <td>Reduced (short or trivial consultation)</td> </tr> <tr> <td>D</td> <td>Domiciliary</td> <td>B</td> <td>Materials</td> </tr> </table>											M	Morning, 7–12 noon	T	Telephone consultation	A	Afternoon, 12–9 p.m.	E	Extended more than 30 min.	N	Night, 9 p.m.–7 a.m.	P	Visit in private hospital	S	Sunday or public holidays	R	Reduced (short or trivial consultation)	D	Domiciliary	B	Materials
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D	Domiciliary	B	Materials																											
							£																							

To the Medical Officer of Health,

I certify that the above particulars of general medical services afforded by me are true and correct, and I claim the sum shown at the foot of column (6) on behalf of the patients listed in column (3).

Date :...../...../.....

.....
Signature of Practitioner.

Approximate Cost of Paper.—Preparation, not given; printing (4,403 copies), £64.

By Authority: E. V. PAUL, Government Printer, Wellington.—1948.

Price 9d.]