THE NEW ZEALAND HEALTH SCHEME

A Review contributed to this Journal at the Editor's request

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Historical and Political

The biological forces of desire, conception, birth, rise, power, decline and death, from which political parties are no more immune than their leading personalities, have brought New Zealand's political wheel full circle, and completed an almost 40 years' period. On November 30, 1949, the National Party was elected to power by the substantial majority of 46 seats to 34, and thus terminated the first 14 years of Labour Party rule. The last comparable occasion was in 1912, when W. F. Massey became Prime Minister after about 20 years of Liberal ascendancy chiefly under R. J. Seddon. New Zealand has gone in for steadier and longer-term ebbs and flows in the political tide than many other countries. In general terms there have been about 20 years of radical followed by 20 years of less radical rule. By these standards the Labour Party has not lasted as long in power as it might have done, nor as long as some expected it to do.

The present moment is, therefore, not unsuitable for a review of achievement in Health Legislation against the political background referred to. It is made more suitable by the void ahead. Not only is there a new Party in power, not one member of which has held cabinet rank before, but the Health Department is also under extensive reconstruction. The new Minister of Health is Mr. J. T. Watts of Christchurch, a barrister and solicitor of distinguished academic record, aged about 40. The Minister of Education is Mr. R. M. Algie, a former Professor of Law in Auckland University College, and a new minister, with charge of Women and Children's Welfare, Mrs. Hilda Ross of Hamilton, has been appointed. In the Department of Health, the Director-General, Dr. T. R. Ritchie, is about to retire through age and Dr. John Cairney, at present Medical Superintendent-in-Chief to Wellington Hospital Board, has been appointed his successor, to begin on February 1, 1950. The Hospital Section of the Health Department has been understaffed for some years, and is at the moment almost devoid of personnel. In many ways, therefore, the slate is clean and competent and progressive measures may be hoped for.

Throughout New Zealand's brief history there have been unusual features in its health organization. The public hospitals, for example, which

provide upwards of 80 per cent. of the beds available, have from the beginning been provided for by public money, formerly by local rates and national exchequer in roughly equal proportions, but since Social Security the ratio is more like 1 to 3 or 4. There has never been any substantial reliance on charity or public appeals and there have never been private or pay beds in the public hospitals. Private practice has therefore been confined to small nursing homes with a few specially built hospitals, often under Church auspices. The mental hospitals have all along been run as a department of the central Government.

There have also been more or less original experiments such as the Infant Welfare Movement begun by Frederick Truby King, and continued by the private society he founded, and the school dental service conducted by a division of the Health Department.

The Seddon period (the nineties chiefly) was noted for 'advanced' social legislation, but little of it touched directly on health matters. Towards the end of the first world war and in the succeeding years there was considerable talk of the public organization of medical services, but nothing came of it. In 1935 the National Government went out of office with a medical scheme in its plans, but not implemented. Its successor, the first Labour Government, had featured free medical and hospital services amongst other measures for 'social security' on its programme. The sufferings of the depression were still fresh in our minds, and there was no doubt the Labour Party had brought out a winning horse on whose back (largely) it rode to victory. The detailed enactments will be described shortly, and remain amongst the chief achievements of the Labour Party—so much so that latterly they came to point wistfully towards them as continuing reasons for their remaining in office. The National Party now assuming office have never proposed retrenchment or abolition of these health services, though they have criticized their working severely on grounds of inefficiency and waste. Particularly have they promised to reform the hospital system on a regional basis, purge the abuses of the general medical and pharmaceutical schemes, and lay emphasis on preventive medicine.

This brief review of political events should make it clear that the public organization of medical

and health services has been an inevitable trend in the public life of New Zealand for at least 30 years. It has been pressed for or supported by both political sides at all stages. To the Labour Party has fallen the chief opportunity for enactment over the years, and also (so far) most of the political rewards coming from the subject, but the thing was going to happen in any event. How well the job has been done, and how much is left to the National Party (or their successors) to do before the country has an effective and economical system of health services, remain for our consideration.

The Health Benefits Detailed

The various 'benefits' under the Social Security Act of 1938, and its subsequent amendments are as follows:—

1. April 1939.—*Mental Hospital Treatment* was made free to everyone in the Government mental hospitals.

2. April and November 1939.—*Maternity Benefits*. The patient has her medical and most of her hospital fees paid by the fund. The doctor is paid per case conducted, an inclusive fee of £6 6s. od. being paid to cover all ordinary antenatal, confinement and post-natal care. Extras are allowed for mileage, for consultation, for blood transfusions, etc. A roll of specialists who may charge higher fees is maintained by the Health Department.

3. July 1939.—*Hospital Benefits*. The services of the public hospitals were made free to all. The fund paid the hospital boards £3 3s. od. per week per patient, and so much for out-patient attendances, X-ray and laboratory services, etc. This meant an increase in the burden borne by the Government as against that collected by local rates, but so far there has been no change in the system of hospital control by locally elected boards, whose activities are closely watched, nevertheless, by the Hospital Section of the Health Department. Patients in private hospitals also received the £3 3s. od. per week off their bills, but the latter have risen so steeply of recent years that this relief is relatively slight.

Another accompaniment of hospital benefits was the abolition of the honorary system of staffing, and its replacement by a part-time visiting system whereby the former honorary now receives on an average £500 per annum (senior) and £300 per annum (junior). There has been a slight growth only of full-time staff throughout the country. In 1949 a series of grades, for full-time specialists, each with its salary range, was introduced ranging from principal specialists through senior and junior to registrar grades. These salary scales represent a much needed improve-

ment on what formerly obtained, but still leave full-time posts in New Zealand at a disadvantage with corresponding ones in Australia and the United Kingdom. As with university appointments, New Zealand must fish in Commonwealth waters for medical appointees.

4. May 1941.—*Pharmaceutical Benefits*. There is no direct charge—the patients merely hand their prescription to the chemist and receive their bottle. Any chemist may contract to give the service; he finds the paper work greatly increased, but seems well satisfied financially. Almost all the more modern drugs and hormones are on the free list, and many proprietary preparations are included. It is not surprising that the cost has risen steadily and now almost equals per head of population that of general medical service. Some check on over-prescribing, and in the excessive use of costly preparations may now be possible through the disciplinary committees, but within the present framework the cost will always be high. The importunity of the patient if not the compliance and carelessness of the doctor is unguarded.

5. August 1941.—*Radiological Services*, both diagnostic and therapeutic, were made free in public hospitals, whereas in private practice about half an agreed schedule of fees was to be paid by the fund and the other half by the patient. The radiologists appear well satisfied.

6. 1942.—*Physiotherapy* was made available on a similar basis in public hospitals and private practice. The physiotherapists also seem well pleased.

7. 1944.—*District Nursing Services*, or home nursing service, free to all, were begun and have proved a boon to patient and hospital alike.

8. 1946.—*Laboratory Services* were made free in both public hospitals and private laboratories. There are difficulties still to be overcome by physicians and others who do themselves, or employ technicians to do laboratory work for them, in that they are unable to claim any benefit from the fund.

9. 1947.—*Dental Benefits* applying chiefly to children from 10 to 16 years, thus extending the work of the school dental service, were begun on a fee-for-service basis from dental hospitals or willing private practitioners. The scheme has the support of the New Zealand Dental Association. Later a number of Government dental clinics are forecasted to be staffed by salaried dentists.

10. *Specialist Services* remain to be set up, power to do so by regulation having been taken in October 1949. The projected plan is a fee-for-service one on a fee schedule to be agreed on. At present there is only a financial rebate of 7s. 6d. per occasion of contact between patient and specialist on paying the usual bill.

11. November 1941.—*General Medical Benefits* or general practitioner service, the most contentious measure of the service, was introduced after a stormy six months, and the alteration of the scheme from a capitation to a fee-for-service one, the raising of the basic rate from 5s. to 7s. 6d. per service, and the considerable adjustment of the conditions of collection of the money to suit the B.M.A. There is no need now to detail the former five confusing methods of working the scheme as simplification is in progress and the basic idea—fee-for-service—remains. A feature, objectionable to the B.M.A., inability to sue for fees, was removed in 1949.

Comments on these Health Benefits

The people as a whole undoubtedly approve of the general lifting of the fear of expense from serious illness. It is a boon that all experience and all enjoy. They seem remarkably unconscious that they pay 1s. 6d. in the £ on their wages (7½ per cent.) to achieve this, but perhaps in harder times this would not be so. They also do not realize that this special social security tax finds only 75 per cent. of the money required, but against that must be put the fact that well over 50 per cent. of outgoings are spent on civil and military pensions and family benefits, the remainder only accounting for medical, pharmaceutical and hospital services.

This freedom from fear of expense is particularly beneficial in the case of maternity benefits and hospital benefits. From the community welfare point of view, the benefit is less in the case of general medical and pharmaceutical benefits where, particularly in the latter case, a token charge on each item supplied might discourage overfree use as well as actual abuse.

An offset to these boons is the fact that in some cases the service is either not available at all or only so under poor conditions, or after inconvenient or intolerable delay. Wartime shortage of doctors is now made up, but general prosperity (plus high taxes) make them harder to get at night and during holidays and week-ends. Hospital services are still inclined to get into arrears through staff shortages, building delays and the greater need to use hospitals through lack of help in the home.

The fee-for-service system is obviously open to abuse and in some respects is fundamentally wrong. It is at its best perhaps in maternity service and X-ray and laboratory services. In general medical service it places the emphasis on quantity rather than quality and leads the doctor to do personally many minor tasks more suitable for nurse or other assistant. Under it, of course, the doctor has become very prosperous very quickly, though the rapid increase in the numbers practising since

the war is reaching saturation point now. It has helped the poorer sections of the people to get service, but the rural dweller less so. It has not prevented the pushing of a lot of general medical work, already paid for, on to the hospitals. It has left the doctor almost as free as before to practice where and how he wishes, and his relations with his patients are also very little disturbed. The doctor has much more paper work of all kinds.

One effect of the easy rewards has been an early recourse to general practice by the younger men to make money for use in two or three years time for postgraduate study leading to the abandonment of general practice. This state of affairs is lowering to the status of the general practitioner.

A general criticism of all the schemes is that former modes and standards were accepted as all that could be desired—that their freer availability was the only thing needful. What could not have been achieved had some enlightened authority set aside a small percentage of the outgoings in each section for the maintenance and raising of standards and for research? We could have had postgraduate training institutes for obstetrics and general practice, and been in a position to oblige all participants in the schemes to use them. We could have had a pharmacological institute for the standardization of all products in use, and research into native and other products. Funds for research in all branches could have been made available.

Not only has this great opportunity been lost, perhaps never or only with difficulty to be recovered, but concomitant duties in hospital reform and development of new modes in practice (such as health centres for group practice) have been hitherto completely ignored. Whether this has been due to the continued variance between the Government and the B.M.A., or to the omission of the setting up of any planning or steering authority, particularly in relation to general practice, is hard to say. The obvious lines of development in the future are outlined in the last section.

Comments on the Experiment as a Whole

What are we to say of the whole story now, more than 11 years after the first major enactment? Undoubtedly a social change of the first magnitude has taken place, even if it be yet not so comprehensive as the later but more overwhelming one in Great Britain. The principle of state organized health and medical services of all kinds, financed by special taxes, has been introduced and accepted by the whole community. Neither of the main political parties criticize the thing in principle, nor are there substantial murmurs from any section of

the community, professional or otherwise, to be heard. This unanimity is most surprising, as many of the projects involved were undertaken without serious study, and yet remain to be proved as the best, or even as good methods of carrying out the functions concerned; and the cost to the individual is quite substantial, though not intolerable, at least in good times such as we continue to enjoy. It seems as if a world-wide movement, at least temporarily irresistible, had spread over English-speaking countries and had to be given a trial.

We need not deny genuinely humanitarian motives in those who took the lead in introducing the scheme into New Zealand. The pains of war and depression were fresh in the minds of the people, and all seemed well lost for social and medical security. At the same time there was enormous party political advantage in it, and this was undoubtedly the main motive at the outset and almost ever since. The only difference was that latterly defects in the scheme were becoming more obvious, and the party advantage swung over a little—though not nearly as much as it might have done—to the critics.

What part did the medical profession play in this piece of social history? In 1935 there were plenty of gaps and inefficiencies in the health services, known to thoughtful medical men, but not actively discussed or pressed either by the profession as such or by the Health Department. How culpable this was is a moot point. Certain criticisms of the doctors were made from time to time by the politicians and by the laity on the ground of social irresponsibility and lack of leadership. But under the current modes of the period there was no arrangement for securing such leadership in a social sense, except perhaps the Government Health Department. This department in New Zealand has never been very strong in personnel or influence, and it is doubtful how far the profession as a whole would have followed its lead had it raised a flag of reform. It had no special machinery for doing so and did not take the lead. The profession, as organized, was little more than a trade union. It certainly carried out some educational and scientific functions, but not even to this day has it built up the machinery for, nor assumed the duty of, planning health services for the community. It is very doubtful whether it should do so even if it could, for there is a large element of public responsibility in such a duty which an interested group should not be asked to carry.

When the storm broke, however, in New Zealand, the initiative lay entirely with the politicians, and so up to a point, must the responsibility for the result. Their motives were

those of Party advantage and humanitarianism in varying proportions at different stages.

In making their plans and executing them, the politicians, in this country, relied on their own resources to an extraordinary extent. To this day the medical men of the Health Department have contributed almost nothing to the schemes except the routine labour of putting them into effect. Similarly there is no known influence attributable to the one national medical school nor to the few lone medical and other voluntary writers on these events. The B.M.A., being the only organized body in the profession, was approached by the politicians at the outset, and with the exception of certain periods 'at loggerheads,' negotiations have continued to this day, being more amicable and fruitful in the very recent past than at any other stage. These negotiations were never happy, frank or fruitful. The politicians claim sympathy and cooperation on the part of the B.M.A. The B.M.A. claim secrecy, self-sufficiency and unwillingness to listen to legitimate professional requests on the part of the Government. The resulting enactments were in important cases (e.g. maternity and general medical benefits), very different from the original Government proposals, and represented substantial financial and other gains on the part of the B.M.A., which came to accept the end-result with considerable satisfaction.

The process, however, was anything but a constructive and cooperative one between a noble profession and the elected representatives of the people towards the common good. The general idea of prepaid universal health services, we have seen, was in the air and appears to have been inescapable. The profession made no move to implement it. The politicians can claim that without their intervention (ill-informed and blundering as it may have been through lack of professional cooperation or other causes) no progress would have yet been made.

The contemporary position is that the country has on its hands an increasingly costly system of medical care which tends to confirm outmoded methods, and which has so far included no single step towards more promising methods either in organization, nor towards professional standards. Quality, economy, efficacy and efficiency are the tasks of the next period.

Why quality could not be applied in the first place—why a major reform must be initiated in an incompetent fashion when it would seem just as easy or easier to do it well—must remain one of the mysteries of human affairs. The doctors may have been right not 'to play' under the circumstances confronting them in New Zealand. The people might have had to wait indefinitely for

reform had not the politicians been ready to 'blunder' in as they did. But it is not a story of which an enlightened society can be particularly proud.

Matters for Early Attention

The Public Hospitals

The work of the Hospital Section of the Health Department in Wellington is several years in arrears, owing to the frustration of the efforts of the local Hospital Boards to keep their plans and buildings up-to-date. The Section is also at present virtually devoid of professional staff.

Apart from this the whole structure of hospital administration is outmoded, having been almost unchanged since 1910.

Several studies are either under way (e.g. by the Hospital Boards' Association), or have been published (e.g. 'Hospital Reform in New Zealand, 1948,' by Selwyn Morris and Douglas Robb), and the published policy of the National Party (already referred to).

In general it may be said that there is a recognition throughout the country that large-scale reform is needed, and that there is much support for doing it on a regional basis. For example, the country might be divided into six regions centred in Auckland, Hamilton, Palmerston North, Wellington, Christchurch and Dunedin, each with an average of some 300,000 people, and as nearly as possible autonomous Regional Boards might be put in charge of all hospital work within the territory. Opinions differ as to the detail of the nature and extent of the central control necessary, and as to how detached it can or should be from the control of other health services and from the political side.

Clearly, however, here is an obviously long-neglected task for investigation and early action. If wholesale regionalization cannot be applied at once, let a trial region, say in Auckland, be set up.

Other matters such as the constitution of the regional and other hospital authorities need attention. Should professional and, at times, university representatives be given places? The status financially and in other respects of medical staff members, particularly in the full-time categories, needs consideration in relation to part-time members who are also in private practice, and in relation to overseas standards. The correlation of the more specialized services (neurosurgery, thoracic surgery, etc.) throughout the regions needs planning, also the extended provision of out-patient departments and geriatric services and the avoidance of overlap between hospital and general practitioner services.

The Health Department

All along the status and influence of the medical members of the Health Department have been less than they should have been. Recruitment has been inadequate, and there are some grounds for complaints of over-centralization, leading to frustration of the efforts of district officers. Many extra duties arising out of social security measures have been flung upon a department unprepared and unfortified for them.

The status and prospects of members of the department need revision in relation to those of other medical men in New Zealand, and to overseas standards.

The organization of the work of the department should be reconsidered with a view to possible regionalization on a basis similar to that suggested for hospitals, and integration with hospital and medical work in practice.

The Institute of Public Health, for research and teaching purposes, which has been planned for Wellington, should be pushed forward.

General Medical Practice

There is a general recognition that the present fee-for-service scheme, in all its variations, is a costly if not a positively wasteful one. The same is felt in varying degrees of maternity benefits, pharmaceutical benefits, laboratory services and the proposed specialist services, all of which employ the fee-for-service basis. Recent proposals in the Cleary Report have been implemented (October 1949) for the control of various abuses by disciplinary committees made up wholly of professional members. This is a good measure long overdue, but it will not satisfy those who feel that the 'fee-for-service' is a faulty principle. However, the B.M.A. have set their face again recently against both salary and capitation as possible alternatives.

Sharpening the lines of demarcation between general practice and hospital-and-specialist practice is necessary to avoid waste, but may not be possible until general practice is more under control, particularly in well-equipped health centres.

There has been no attempt, and no step towards making it, to set up trial health centres for group practice under varying conditions. Little has come, so far, of voluntary efforts in this direction. There seems to be a need for a joint body (Government and B.M.A.) to plan developments of this sort in medical practice, and to use them for purposes of postgraduate education amongst general practitioners along with hospitals and other facilities. Such postgraduate education should be a recognized and regular duty of the health service towards all general practitioners working in it.

Should the Regional Hospital Boards, if and when set up, be extended in due course to carry out these and other functions in relation to general practice, and so ultimately become Regional Health Boards in a comprehensive way to unite and coordinate all health activities?

Specialist Practice

Hitherto the omission of provision for a Specialists' Service Benefit has constituted the sole remaining major gap in the series. However, in October 1949, power was taken to set this up by regulation, the basis to be a fee-for-service system with a schedule of fees, as recommended by the Cleary Report.

It is suggested that the whole subject be looked into afresh before action is taken, and that in addition the following aspects be considered.

1. The provision, in conjunction with the larger hospitals, of special polyclinics as a base for specialist services. Out-patient departments have been notoriously undeveloped in New Zealand hospitals.

2. The grouping of rural centres and their service by a team of specialists suitably based and suitably mobile, e.g. in Northland with base facilities at Whangarei, but with peripatetic duties in the other five centres.

3. The planning by a suitable committee (representing, say, the Government, the B.M.A., and the Royal Australasian Colleges) of the more highly specialized services on a national basis, e.g. how many centres for neuro-surgery, thoracic surgery, X-ray therapy, etc.?

4. The establishment of a special centre for the postgraduate training of physicians, surgeons and laboratory men under university auspices. This would in no sense aim at abolishing overseas travel for young graduates, but rather encourage it and make it more effective through better liaison with overseas hospitals, universities and foundations. It would also offer opportunities for such men to return to New Zealand, first to the centre and then to appointments elsewhere in New Zealand; it would improve the quality and effectiveness of the already substantial postgraduate education effort in New Zealand; it would be a national resource of great value to both this country and the Commonwealth in time of war, and for purposes of interchange in times of peace.

Nursing

In common with most English-speaking countries, there is a chronic shortage of nursing and domestic help in hospitals in New Zealand. The problem is related to the absolute supply of 'woman power' in the country and has not been fully investigated.

Nursing education needs overhauling. It may be that in a simpler, shorter, more practical basic training we may at the same time secure more and better nurses, leaving the more specialized branches in teaching and practice to the post-graduate stage.

APPENDIX

FIGURES RELATING TO COST OF SOCIAL SECURITY BENEFITS

Taken from the Annual Report (1949) of the Director-General of Health

1. GENERAL

Mean population for 1948	Europeans	1,731,583
	Maoris	109,948
	Total	1,841,531

(An increase of 38,894 over 1947)

Births	Europeans	44,193
	Maoris	4,956
	Total	49,149

Birth rate per 1,000 of mean population	European	25.52
	Maori	45.08
	Combined	26.66

2. COSTS OF MEDICAL BENEFITS

Maternity Benefits:	1948-49	1940-48
Paid to medical practitioners	£298,961	£167,301
Paid to hospitals and nurses	£617,159	£351,674
Total	£916,120	£518,975

Medical Benefits (G.P. Service) (almost wholly fees paid to medical practitioners):

In 1948-49	£2,306,881
In 1942-43	£1,016,053

Hospital Benefits (for treatment as in-patients or out-patients in public and private hospitals):

In 1948-49	£1,997,375
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The relation of this to the whole cost to the country of the public hospitals (excluding mental hospitals) is best shown in these figures for 1947-48:

Disbursements (Capital and Maintenance)	£
by all hospital boards	7,908,487
Of this, hospital benefits provided	1,949,489
Local rates provided	1,374,441
and the remainder came from Consolidated Fund.	

Pharmaceutical Benefits:	£
Costs for 1948-49	1,793,159
Costs for 1942-43	563,247

Supplementary Benefits (radiology, laboratory, massage, nursing, dental, artificial aids, etc.):

Costs for 1948-49	£861,913
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Totals (net)	£
For 1948-49	7,843,634
For 1945-46	5,536,564
For 1942-43	3,721,179