MEDICAL SERVICES IN AUSTRALIA AND NEW ZEALAND*

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It is indeed a very great privilege and a very high honour to visit the South-west England faculty and to deliver the Gale Memorial lecture.

To undertake this task adequately is for me rather difficult because I have been engaged in general practice for nearly forty years and in that sphere the art of medicine perhaps takes precedence over what is often the impersonality of the ultra scientific approach, so I do not talk to you from any high scientific pinnacle.

I never had the privilege of knowing Dr Arthur Gale personally, but all of us in the College were well aware of the invaluable work he did for this faculty and of the enthusiasm with which he responded to the demands made upon his time and his wisdom. He had in full measure the gifts of serenity and equanimity, and he was quick to perceive that in our College was an organization which brought to general practice a new vitality, new hope and fresh courage to a section of the profession who were often frustrated and disappointed with the role which had been allotted to them in the Welfare State. He helped to direct our research projects and his influence in establishing cordial relations between the faculty and the university was of inestimable value. He was a great epidemiologist, and what a lot he must have had in common with our first president William Pickles. So, in what way can we better commemorate his work for our College than by establishing this lecture and recalling that Arthur Gale whose name and fame you are remembering tonight was a teacher and administrator gifted with vast knowledge and immense driving force; but, in addition, he was essentially an individualist who, although he worked under authority, never let the dead hand of bureaucracy limit his many activities. It may be therefore, not unfitting in this talk to tell you something of the way of practice in Australasia, where the doctors—general practitioners

*Delivered to the South-west Faculty of the College in the Guildhall, Plymouth, on Saturday 10th October, 1959. The Gale Memorial Lecture is made possible by courtesy of Messrs Pfizers Ltd.

and consultants alike—are engaged in a service which is absolutely free from government control and government dictation.

The majority of us practising medicine in Britain today belong to a generation affected by a sense of insecurity engendered by two major wars and two periods of uneasy peace. We find ourselves participants in a conflict between the State and the Individual. On the one hand, it is contested that the citizen, and in particular the doctor, should subordinate himself to the will of the State, and contentedly regard himself as a cog in an organizational machine, whilst, on the other hand, the doctor feels he should be free to exercise his art with complete professional freedom and a minimum of interference from any third party. The general practitioner is the adviser to whom the sick person first comes. It is to him that the great bulk of everyday disease flows. He is still the keystone in any medical service, and both society and the state should grant to him the respect and prestige that is in accordance with the dignity of his art. In both Australia and New Zealand these desirable conditions would appear to have been attained.

Medical Practice in Australia

The story of the Australian Health Service is a medical epic and shows what can be accomplished by members of the medical profession when they find themselves confronted with politicians who desire, for their own ends, to impose upon the doctors a type of service which the profession feels is not in the best interests of themselves or of the people. Prior to 1938, practice was carried out on a purely private basis or by contract with lodges for the lower income group. This type of lodge practice was distasteful to the profession and most doctors undertook the work merely as a means of gaining experience and obtaining a foothold in a town. Few of them continued to do lodge work when economically they were able to earn a living from private practice. The fees payable were 16/- per year for a single person and £3 10s. 0d. per year for a married man and his family, but they did not include the provision of medicine. In 1938, the Government introduced legislation to bring all employed persons independent of income level into a medical service in which the doctor would be paid on a capitation basis. These provisions were completely unacceptable to the profession who—consultants and general practitioners staunchly united—refused to co-operate, and the Act became a dead letter.

In 1944, the Labour Government introduced a Pharmaceutical Benefit Act, a basic provision of which was that if a patient was to receive free drugs the doctor must select these drugs from a government formulary. Strong exception was taken to this Act, and the

Medical Society of Victoria challenged the legality of the action in the High Court. After a prolonged hearing, the Court finally pronounced judgment that the Act was *ultra vires* the Constitution and so was invalid. Round two again gave victory to the doctor.

In 1946, the Government—licking its wounds—asked, by means of a referendum, permission to enact laws " with regard to maternity allowances, sickness and hospital benefits, medical and dental services but not so as to authorize any form of civil conscription ". This last proviso was inserted on the advice of a brilliant medical parliamentarian—Sir Earle Page—and was to prove of vital importance to the profession in its fight for freedom. The referendum was approved by the public and conferences to attempt to achieve a satisfactory agreement were held between the Federal Council of B.M.A. and the Government. These, however, were unproductive, and in 1948 a new Pharmaceutical Benefits Act was passed which still contained penal and restrictive clauses, e.g., the use of a set formulary which was quite unacceptable to the profession. When the time came to operate the Act, 98 per cent of the doctors refused service. In a last desperate effort to coerce the profession the Government introduced into the Act an amendment prohibiting doctors from prescribing any drugs contained in the formulary, except upon a special prescription form supplied by the Government. Immediately, it was realized by the profession that it must either co-operate in the scheme, or lose the right to prescribe lawfully a number of drugs used in their daily practice, e.g., sulphonamides, insulin, antibiotics, and all the ordinary B.P. drugs.

The Federal Council, backed by almost the whole profession (there were 70 dissentients out of 10,000) challenged this new legislation in the High Court which, in 1949, upheld the contention of the profession that the new Act was tantamount to civil conscription, and was accordingly again *ultra vires* the Constitution.

During all these years of turmoil and discord, no one claims that the profession in this dispute had a great wave of public support, but sufficient thoughtful people gradually realized that it was unwise to attempt to enslave and nationalize a great and free profession and at the election in 1950, the Labour Party was defeated, and the new Government appointed as Minister of Health, Sir Earle Page, a one-time country general practitioner. Under his sympathetic and skilful guidance, and fully appreciative of the principles and view of the profession, Sir Earle Page proceeded to introduce in stages and by agreement, a new Health Service which, in its general concept, has met with the approval both of the profession and of the public. He appreciated that medical men can be led but cannot be driven, that they are reasonable people who have the welfare

of the populace more near to their hearts than any selfish advancement, and that mutual confidence and co-operation will finally evolve a far better service than any attempt at autocratic compulsion.

The service in Australia is now firmly established, and since 1950, from time to time, amendments have been passed which increase the benefits available.

I have dealt with this battle for freedom, waged by our Australian colleagues at some length, because I think we should realize that political power can be exerted by a united profession—even though we are few in number—when that power is used to ensure that our great profession does not become a pawn in political manoeuvres.

The Health Service in Australia, with a population of ten million, involved in 1958 an expenditure of £50,000,000. Benefits are payable through approved societies very similar to the type of society we had in Britain prior to the inception of the N.H.S., and which we wisely, or unwisely, discarded. Enrolment in the Australian service is entirely voluntary, and at the end of the first year, only 16 per cent of the population had become contributors. In 1959, nine years later, over 70 per cent were enrolled, and an additional 10 per cent, represented by the pensioners, widows, and repatriates, were also covered; and new contributors were coming into the Medical Benefits Society alone at the rate of over 1,000 per week. It is thus obvious that, apart from those who are too careless to provide for the future, and the very wealthy who do not require to ensure against illness, the general public wholeheartedly approve of, and voluntarily contribute to their Health Service.

During the long and bitter struggle with the State, from 1938 to 1950, it became clear to many of the doctors that some scheme of insurance against sickness was desirable, and in 1947, 1,000 doctors in New South Wales each contributed £10 to form the initial capital of the Medical Benefits Fund of Australia—an organization which is still administered by a committee of doctors, is non-profit making and is far and away the biggest approved society in the country. There are, in all, 81 registered societies in Australia, all of which provide family insurance, the contributor's premium entitling his wife and any number of children under 16, to receive full benefit. All societies must pay the minimum standard of benefit which equals the State contribution, but many pay additional amounts. For example, the Medical Benefits Society pays 33⅓ per cent more than the statutory legal benefit.

The Commonwealth Government adopted a schedule of benefits which covered almost every service a doctor could render, and stipulated that any society seeking approved registration must match,

from its own funds, the contribution payable by the Government. Receipted doctors' accounts are presented by the patient to the approved society, which pays out to the patient over the counter without any delay, the combined Government and society benefit, always provided that such payment does not exceed 90 per cent of the doctor's fees. For the minimum premium, the average return is about 80 per cent of general practitioner's fees and 60 per cent of hospital and specialist fees, but a greater proportion is refundable if higher premiums are paid, though in no case will more than 90 per cent be refunded. Both political parties and the doctors are in complete agreement that the patient must make some direct payment himself towards the practitioner who provides his medical care; that which is apparently free is held in Australia as of little value, and tends to be abused. Arrangements can be made in cases of hardship whereby the unreceipted bill can be taken to the society and authority given for the society to pay the doctor direct with the exception of that part of the bill which must be paid by the patient himself. In such cases, it is very seldom that the patient fails to pay his small remaining share. The society is reimbursed by the government for that part which is the State's contribution; thus no third party intervenes between doctor and patient, and the approved society receives no government assistance for their administrative costs. There is an initial waiting period of two months before a contributor is entitled to draw benefit, but there is no medical examination and any citizen can insure whatever his state of health. There is complete freedom of choice of doctor by patient, and of patient by doctor; there is no state regulation as to what the doctor may charge or where he practises. One of the major criticisms of the scheme was that it did not provide adequate cover for major operation fees and at the time of my visit, consultations were taking place between the societies and the B.M.A. as to how best this can be arranged.

For general-practitioner services, the minimum weekly contribution is 1/- for a single person, and from 2/- to 3/- for a married man and family, depending on the number of children. For this contribution he will receive at least 12/- for a visit or consultation (the Medical Benefits Society gives him 13/6) and the usual medical fee is 15/- for a consultation and £1 1s. 0d. for a house call. For these minimal premiums, the total amount payable as benefit in any one year is limited to £30 from the Society Fund, but there is no limit to the amount (6/- per service) which is paid by the Government towards visits and consultations. Assuming the patient to be a member of the Medical Benefits Society (the doctors' organization) he will receive as minimum benefits 13/6 for each consultation and 15/- for each house call. For a specialist consultation when referred by a general practitioner, he will receive for the first visit £2 13s. 0d., and for subsequent visits £1 6s. 0d. The normal specialist's fee is £3 3s. 0d. for the first visit, and £2 2s. 0d. for subsequent visits. The cost of medical benefits paid by the State in 1958 was £8½ million, or about 17/- per head.

There are, at present, in Australia 850 private hospitals and

750 public hospitals. Many of the private institutions are maintained by religious bodies, masonic temples, and the Order of St John. They also invariably receive some government grants. Many of the smaller private hospitals are finding difficulty in providing all that is best in modern equipment, and it is probable that most new hospitals in future will be State-owned. It is however significant that when a large, new, private hospital is built, the government makes a substantial contribution to the building cost. Very sensibly, the State recognizes that a well-built and well-equipped private hospital serves a real public need, and reduces the demand for accommodation in the public hospitals, the building and maintenance of which is entirely a charge on government funds.

The hospital benefits of the Health Service are financed by contributory schemes, but in every case whether insured or not, the government pays to the hospital 8/- for each day a patient occupies a bed in a public or in an approved private hospital. If the patient is a contributor to an approved society, the government pays £1 per day and the society 16/- per day, making the joint contribution £12 12s. 0d. per week, which completely covers the charge for maintenance in a public ward. Invalid pensioners, old age pensioners and widows are exempted from all hospital charges. For these benefits contributors pay a minimum of 1/- per week for a single person and from 2/- to 4/- a week for family cover. The actual cost of maintaining a bed is about £30 per week and the deficit is met in part by the state, and in part by donations from the State lotteries. In each State a lottery is drawn often. Tickets are on sale at 2/6d. and the first prize, known as the Golden Casket, is usually £10,000. The residual money goes to hospital maintenance and building, and amounts of £40/50,000 a month are allocated by each State to the hospital funds.

All public hospitals are controlled by a special hospital board publicly elected (but on which medical representation is adequate) which is responsible to the Ministry of Health. The hospitals are staffed by visiting consultants on an honorary basis, except in Queensland, where the senior consultants receive £2,250 annually, and the juniors progressively less. In Tasmania, small sessional fees were paid to the visiting staff, amounting, at most, to £700 a year, but this has now ceased.

In North Queensland and the N.W. Territories of Western Australia, there are many small isolated communities, who are served by the Flying Doctor Service. This is financed partly by the Government and partly by local contributions, and the doctors are paid by salary—£4,000 to £5,000 per annum. The flying doctor is provided with a pilot, and is always in radio contact with his community bases. He has a radio consulting hour—usually 8—9 a.m.—when he is contacted by patients and may give advice, or may decide to pay a flying visit to the case. Emergency cases are flown back to hospital, but it is the intention of the government to provide a flying surgical team who will be able to deal with even major surgery on the spot.

Formerly, pensioners of all categories were almost wholly dependent

on the charity and generosity of the medical profession for their treatment, but in 1957 the Government introduced the Pensioners' Medical Service, by which general practitioners provide all services normally given by the family doctor for a concessional fee, based on a fee for service payment of 11/- for a consultation and 13/- for a house call, plus a mileage fee of 1/3d. each mile. The service, being entirely free to the patient, has led to some abuse by the doctor. The average number of services given to the ordinary patient is 4.5 per annum; to the pensioner it is 8.0, but as the pensioners are an aged and infirm group, the difference is considered as reasonable. Ministry officials assured me that 80 per cent of the doctors in no way over-visit, 15 per cent to a small extent may over-visit, and 5 per cent try to exploit the scheme. An example of exploitation may be quoted: a doctor who paid 50 visits in seven days to a patient with pneumonia, a doctor who claimed for 105 visits in 25 days to a hemiplegic, including 13 visits on the day on which the patient died. All cases which appear to exploit the service, and which in the opinion of the Minister require investigation are referred to a Medical Committee of Inquiry—five in number, solely medical in composition and appointed by the Minister from a panel of names submitted by the B.M.A. This committee may recommend (1) no action, (2) a reprimand, (3) a surcharge, or (4) termination of service for any period up to 12 months; against the last penalty the practitioner may appeal to the Supreme Court. Since the inception of the Pensioners' Service, 260 cases have been reported to the committee, and of these 113 have been summoned to appear in person. In 68 cases, surcharges amounting *in toto* to over £10,000 were ordered; 14 doctors were reprimanded, two were suspended and 29 were exonerated. It is generally agreed that this committee performs its very difficult and ividious task with scrupulous fairness. Most practitioners agree that any action on the part of one of their colleagues which is worthy of censure by the Minister of Health is likely to lower the standards of the profession, and unless investigated by their own committee might well lead to a demand for government control. It is well to remind ourselves occasionally of the direct relationship between liberty and discipline, and that we must never forget our need to maintain a high and ethical standard of practice.

All life-saving drugs—241 in number—are listed, and until a month ago were available to every citizen in Australia on the prescription of a legally qualified medical practitioner. In the recent Budget, a charge of 5/- per prescription has now been enforced for these drugs. A special committee, on which the profession is adequately represented constantly reviews the schedule of life-

saving drugs and recommends to the Minister any additions or deletions considered desirable. For all non-schedule drugs, the patient pays in full.

There is no doubt that the health service in Australia is giving satisfaction, both to the medical profession and to the people. The design and concept of the scheme has been to establish a partnership between the State, the doctors, the insurance societies and the people, giving to all the partners that sense of security needed to develop a satisfactory cover against sickness for the whole of the community. The medical profession having been brought into active and voluntary partnership enables the whole scheme to work smoothly, efficiently and completely free from bureaucratic control. The moderate degree of professional control does much to prevent abuse of the service.

Compulsory insurance, as in Britain, tends to centralize in the Ministry of Health both the control and the policy of all medical care, and necessitates the establishment of a gigantic bureaucracy to enforce that control, whereas under the Australian scheme, the whole administration remains in the hands of the profession, and of the approved societies, both of whom are actually providing the benefits. The government has established a partnership between the State and the individual through the union of governmental aid with voluntary effort. This partnership is a recognition that both the State and the citizen have obligations in a national health scheme, and it endeavours to make use of all these factors and organizations that have been built up over the years to assist in maintaining health. It keeps alive the elements of initiative and competition which I think provide incentive and make for progress and advancement, and from the treasury viewpoint, the government has full control over its own commitments.

The practice and traditions of medicine have evolved slowly over thousands of years from the days when the tribe was dominated by the " Medicine Man ", with secret powers jealously guarded, giving him knowledge of witchcraft, taboos, and mystic relations with the spirits, endowing him with absolute authority and establishing his right to unconditional obedience to stand unchallenged. Progress has been the result of many generations of individual study and research, not of government effort or control, and now when the costs of diagnosis and treatment are becoming ever greater, a challenge has been thrown out to the medical profession as to how the health of the nation can be improved, and the standard and quality of medical practice raised. In Australia that challenge has been met by the co-partnership of voluntary insurance and government aid. All the best elements of private practice have

been retained and rewards are available for special skills and experience. There is no third party interference with the doctor-patient relationship, and government control has been reduced to the minimum. There is no direct relationship between the government and the profession; there is no fixation of fees by the government; that is left to the discretion and judgment of the individual doctor, according to the service given and the skill displayed.

The government grant-in-aid serves a dual purpose; it makes voluntary assurance more attractive, and it doubles the amount which is normally available from the insurance society. By utilizing the services of the friendly societies and medical benefit funds, the Australian Government has obviated the need to create a large and unwieldy body of civil servants to administer the scheme, and has saved the taxpayer a large salary bill because all ordinary administrative costs are paid by the societies. Above all, at no stage does the government come between doctor and patient.

In all matters of policy, the government deals directly with the Federal Council of the British Medical Association who represent both the general practitioners and the Royal Australian College. The consultants have wisely delegated to B.M.A. all discussions on political and financial matters, so that only one medical voice is heard on all these subjects. In Australia they have long since realized that unity is strength, and that the policy of " Divide and Rule " can be disastrous to the medical profession.

I do not claim that medical practice in Australia is perfect, but I can assure you that all the doctors I met in all sections of the profession are happy and contented in their job. They work very hard for five days in the week, and in common with all Australians, they relax during the week-ends when deputizing arrangements are made. They earn large incomes; £5,000 to £7,000 per year as general practitioners and much more as successful consultants. The public, well satisfied with their own five-day week, accept without irritation or rancour the fact that the doctor too should have some leisure.

In the cities, the general practitioner is excluded from the public hospitals unless he is on the staff, and unfortunately even though he may have taken a higher qualification the tendency is, as at home, to penalize the man who is doing general practice, even as a specialist in a group. In the rural and semi-rural areas this disability does not exist, and the young well-trained surgeon can quickly build up a lucrative and pleasant practice as nearly all country hospitals are well staffed with nurses, and well equipped.

To the man who contemplates emigration, I would say if you are

under 40, have some surgical experience, and have a wife who can happily live a somewhat self-contained life, Australia offers great opportunities. The profession there will never accept the nationalization or the socialization of medicine. You will find an independent type of people who are sometimes a little intolerant. The keynote of the Australian character appears to be an easy optimism. Depressions may and do occur, but why worry about them? They will pass, and meantime the sea is blue and the sun is shining. The Australians are prepared to welcome the stranger on his merits, and to give him every opportunity to play his full part in civic life. You will find the standards of practice are good, and your prestige in the community will be high. I would not suggest that Australia is the doctor's Utopia, but it is a land where he is completely free from State control, where incentive and opportunity still exist, where he frequently has access to hospital facilities, and where the general practitioner is recognized as the family doctor in the widest and truest sense.

New Zealand

May we now cross the Tasman Sea and take a quick look at New Zealand? " We have few stupid jealousies among the doctors here, and although not a Utopia, it is really well worth seeing ". So ran an invitation to visit a prosperous country town some 80 miles across the mountains from Wellington. In Masterton, the local general hospital is staffed wholly by general practitioners who have either a higher qualification or a diploma in their specialty. The doctors work a rota system which ensures they have adequate week-end leisure. Such a doctor retains the fees he earns during his duty period, and consequently there is no difficulty about payments as between doctors. The duty doctor reports to his colleagues on any case he has seen on their behalf, and it is a point of honour that no doctor will continue to attend another doctor's patient for the illness which necessitated the emergency call. The penalty for any doctor who does not conform to this arrangement is simple; he is precluded from the rota list in future, and can count on no help from his colleagues.

In New Zealand the present health service was introduced in 1937. Its inception was stormy. The Labour Government of that time introduced a service on a capitation fee basis, which would have placed the profession almost completely under the control of the State. At that time there were just over 700 doctors in New Zealand, but only three were willing to enter the service, the necessary act for which had been approved by Parliament. The doctors, by their unity and loyalty to their leaders completely defeated the politicians who, after a few weeks, invited the profession to discuss

with them the type of service they were willing to provide. From these discussions emerged the present Health Service in New Zealand which has functioned with little alteration during the past 20 years, and has been broadly accepted as satisfactory by the people, the general practitioners, and the State.

At its inception there were few specialists or consultants, but with the growth of specialism and the appearance of many true consultants, it is now necessary to obtain for that section of the profession better terms and conditions, as at present the refund the patient obtains for his specialist care is no greater than what he obtains for his general practitioner treatment. There are three methods of payment in New Zealand: (1) a few salaried posts in outlying districts where on a fee for service, a doctor could not earn a living. These posts are usually filled by young graduates whose medical education has been entirely subsidized by the State, and who, in return, agree to serve the State for three years as and where required; (2) the Refund System used by about 40 per cent of the doctors. An itemized bill is submitted to the patient, who then pays the doctor in full. The doctor can charge whatever fee he desires. The patient then presents his receipted bill to the Social Security Department, and is refunded 7/6 for each ordinary visit and 12/6 for a night visit or Sunday visit. (3) The Schedule System; the doctor enters the name and address of the patient in duplicate on a form with a note of the fee claimed from the State. The patient pays—usually at the time—whatever supplementary fee the doctor charges, or he may elect to receive a bill for the surcharge. The doctor submits these claim forms weekly to the Social Security Department and receives payment within 10/14 days.

The usual fee charged is 10/- to 12/6 for a consultation, and 15/- to 17/6 for a house call. In addition, for attendance at a distance of more than two miles, a mileage fee of 2/- a mile is chargeable of which the State pays half and the patient pays half.

The scale of refunds by the State has not varied since 1937, but to increase the benefit would entail a higher social security tax. The present levy is 1/6 in the £1 on all earnings and investment income, and under present day conditions, it finances 80 per cent of the social services, the remaining 20 per cent coming from general taxation. Both the people and the State appear unwilling to increase the tax, and the B.M.A. feel, quite rightly I think, that it is not their duty to approach the government about larger refunds to the patient. Obviously that is a matter between the people and the government. The Act lays down that the doctor may accept the State contribution in whole or in part payment, and as long as he can charge a reasonable fee for his services, the doctor has no quarrel about the amount

of the refund. Old age pensioners, widows and the indigent are all treated without any surcharge. The proportion of house calls to consultations is low—about 1 in 10—and a successful doctor gives on an average about 200 services per week. Appointments are fixed at 15 minute intervals, and in established practices only emergencies are seen without appointment.

If the doctor consistently renders more than 40 services per day, his claim comes under careful scrutiny. If he averages more than 50, it is probable that the claim will be referred to the Disciplinary Committee, a purely medical body appointed by the B.M.A., charged with the duty of preventing abuse of the service by over-visiting. The committee has power to recommend surcharges and in extreme cases to recommend temporary removal from the Social Security List. Under the schedule system, no signature from the patient is necessary, but to prevent falsification by the very rare dishonest doctor, a small percentage of the claims are referred to the patient for verification. In a few cases, a doctor has been found guilty of false entries, but it has been found that the existence of the check, curbs the activities of the few black sheep.

In the poorer industrial areas often no supplementary cash payments are requested by the young incomer trying to establish a practice, and from the Maori it is almost impossible to obtain any direct payment. In both these types of practice, the number of services given per patient is higher than the average for the country, which is now almost the same as Australia—4.4. Thus, despite the fee for service method of payment, the number of services is less than in Britain where we give 5.5. The numbers involved in these poorer and Maori areas is not very large and the apparent over-visiting has not yet become a major issue. The vast majority of doctors charge supplementary fees, and this is sufficient to prevent exploitation of the service.

Treatment in the public hospitals is free to everyone independent of any means test, but there are long waiting lists for the non-urgent cases, as in Britain. At the inception of the service, the majority of middle-class patients were treated on a fee paying basis in private hospitals, which were then of good standards. During the past decade many new public hospitals have been erected and the standard of comfort and excellency of equipment is now generally superior to that in the old private hospital, which is unable to draw on the resources of the tax payer. More and more of the well-to-do are entering public hospitals, and with the increasing number of specialists competing for the decreasing volume of private work, it has become very obvious that the remuneration of the part-time public hospital staff is quite inadequate, and has indeed remained

unchanged since 1937. The B.M.A. is actively engaged in obtaining reasonable remuneration for the specialists, and the outcome of these negotiations is eagerly awaited. The B.M.A. does not advocate increased refunds to those patients who go direct to a consultant, and in this they are supported by the consultants, who agree that reference by a general practitioner is much more desirable than a direct approach by the patient. Despite the excellence of the public hospitals, many patients still prefer the private hospital, and the religious orders have built some very well-equipped new hospitals, and in the large cities, groups of doctors have combined to build small, but very well-equipped nursing homes. The government has, under favourable consideration, the possibility of granting £1 per £1 towards the building costs of new private hospitals. Since the inception of the service, they have always made a grant-in-aid to those patients who enter a private hospital, and this grant is at present £9 per week. The maintenance cost of a bed in a private hospital ranges from £21 to £25 weekly as compared with £30 per week for the public hospital.

A service which I think is unique to New Zealand is the government-sponsored private pathological service. There are today, throughout the Dominion, 20 private pathologists and more are required. The family doctor can have any pathological or laboratory service performed free of charge to his patient. The pathologist, whose qualifications and laboratory equipment must be approved by the Minister of Health, is paid on an agreed scale of fees by the State, who considers that it is more economical and more desirable to pay the pathologist a private fee rather than to build expensive additions to the existing hospital laboratories. I am told that these private pathologists undertake about 80 per cent of the pathological examinations required by general practitioners. Everyone is agreed that the scheme is not abused. For x-ray examinations by a private radiologist, the patient pays half and the government pays half. In both these instances, the Government considers that this co-operation with private enterprise is both satisfactory and economical. In New Zealand the willingness of the State to work harmoniously and in close co-operation and even partnership with the medical profession is outstandingly evident.

Foreigners in New Zealand who require hospital care are charged £4 per day, and pay no additional medical fees. The payment is made to the hospital board and is considerably less than what is paid by a guest in a first-class hotel.

The drug bill in New Zealand is high, and is rising each year. In 1958, the cost was £2 per person per annum. All B.P. drugs are free. Proprietary preparations not yet in the Pharmacopoeia must

first be evaluated by a special committee which receives reports from the hospitals as to their efficacy, and then decides whether they go on the free list. For proprietary drugs for which there is a B.P. equivalent the patient pays the difference in price.

The dental service in New Zealand is rather interesting. Dental decay is very common and there is a great shortage of dentists. Children under 16 are treated free at school by dental nurses who do fillings, scalings, and extractions. These nurses receive only 18 months training, and work without any supervision. If a nurse considers additional skill is necessary she can recommend that the child visits a dentist who will undertake the work, but for this the parents must pay in full. All persons over 16 pay dental fees in full.

The average amount paid to doctors from the Social Security Fund is £2,114 which is equivalent to a capitation fee of 30/- per year. As that amount is much augmented by mileage and supplementary payments from patients, it can give us much food for thought when we contrast it with the meagre amount that we can extract from our own government for a service which is much more comprehensive, and which renders the doctor liable to severe penalties for breach of regulations, such as our New Zealand colleagues would never accept.

What then of the future? New Zealand has now a population of over two million, and is served by over 2,000 doctors. From her own medical school, where the teaching is of a high order, about 90 students graduate each year, and about 60 emigrant doctors enter from the United Kingdom. Medicine is still the profession most favoured by the student, and the doctors are definitely in the upper income group, the successful practitioner earning from £3,000 to £5,000 a year gross of which about one-third goes in expenses.

The people are kindly, courteous and generous to strangers. They are of all our Commonwealth peoples perhaps the most akin and most loyal to Britain. To the young graduate who is prepared to work at first in the country areas and particularly to the young surgical registrar, there are still opportunities to practise his art untrammelled by any State control, but for his wife life may be difficult. She must undertake nearly all her own household chores, and she must be willing to lead a fairly self-contained existence with her home, her family, her husband and his practice as her main interests. Almost all the doctors I met who had emigrated from Britain were happy and content. The few who were disappointed attributed the fact to the inability of their wives to merge into the ways and customs and manner of life in New Zealand—still, in many places, a pioneer's country. There is no easy road to success, but New Zealand, although adequately doctored, still offers a

challenge and an opportunity to those who are willing to give of their best to the country of their adoption.

Conclusion

I have tried to present to you a picture of medical practice in Australasia. The Health Services in Australia and New Zealand, though different in many ways, have one common factor—the doctor is completely independent and is in no way subservient to, or controlled by, the State. He is completely free to place his own value on his own skill. So we have the two idealogies—that of Australasia where there is a partnership between the State, the people and the medical profession, which ensures that no one is deprived of the best medical care through lack of means, and that of Britain where the State is paramount, and by law and regulations controls both the people and the medical profession, and has power to inflict penalties on those who infringe these regulations. During the past decade we have lived through a social revolution, and have created the Welfare State. Whether this paternalism is the best way of life for our people, only time can show, but we in the College of General Practitioners have done, and are doing our very best to maintain and enhance the high standards of medical practice, which we have inherited from our fathers. We do not claim as College members that we are better doctors than are those who are outwith our ranks, but we do claim that we are doing much to make good doctors better doctors, and that, despite the disappointments, frustrations, and difficulties with which we have to contend, we are all—College members and non-members alike—striving to give to the people of this great country the very best medical service it is in our power to give. Towards that end, we are inspired by the memory of Gale, and each year at the time of this commemoration lecture, let us re-dedicate ourselves to maintaining the high ideals to which he so unselfishly devoted his own life.

Trial of a Liquid Antipyretic in Paediatric Practice. D. C. SAUNDERS, M.B., B.CH., B.SC., D.C.H., *The Practitioner* (September 1959), **183,** 335.

N-acetyl-para-aminophenol is a liquid preparation with antipyretic properties, and it was used in a palatable form in 53 instances. The patients ranged in age from 1 to 15 years; there were 22 boys and 31 girls. The effects compared well with soluble aspirin. In two cases vomiting followed administration of the drug and appeared to be due to it.