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REPORT

of

The National Health Insurance Investigation Committee

A Special Committee appointed in July, 1936,
by the Minister of Health
(The Hon. P. FRASER),
to investigate the matter of providing medical
and other treatment services.

4th September, 1937.

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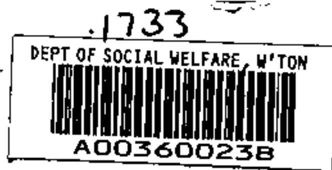
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NATIONAL HEALTH INSURANCE.

Report of Committee of Investigation appointed by the Honourable the Minister of Health.

CONSTITUTION OF THE COMMITTEE.

Dr. D.G. McMillan, M.P. (Chairman)
Mr. W.T. Anderton, M.P.
Mr. A.S. Richards, M.P.
Mr. C.H. Chapman, M.P.
Mr. D.W. Coleman, M.P.

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NATIONAL HEALTH INSURANCE INVESTIGATION COMMITTEE.

WELLINGTON.

September 4th, 1937.

The Honourable the Minister of Health,
WELLINGTON.

Sir:

The Committee appointed by you to investigate and report on the question of instituting a scheme of National Health Insurance in New Zealand have the honour to submit herewith their report:

NATIONAL HEALTH INSURANCE QUESTIONNAIRE:

The initial step in the Committee's investigations was the preparation and despatch of the under-quoted questionnaire to the representative bodies listed below:

(1) The British Medical Association (New Zealand Branch).
(2) The Hospital Boards' Association of New Zealand.
(3) The Controlling Bodies of the various Friendly Societies.
(4) The Chemists' Service Guild of New Zealand.
(5) The New Zealand Dental Association.
(6) The New Zealand Trained Masseurs' Association.
(7) The New Zealand Registered Nurses' Association.
(8) The New Zealand Institute of Opticians.
(9) The Order of St. John, New Zealand.
(10) The Faculty of Insurance, as representing the Life Insurance Offices of New Zealand.

QUESTIONNAIRE.

1. NATURE OF SCHEME:

(a) Should the scheme be contributory or non-contributory?

(b) Should any class or classes of persons be exempted from contributions?

(c) If so, should minimum and maximum income limits be applied in determining such exemptions.

2. BENEFICIARIES:

(a) Should the benefits extend to dependents of the insured? If so, who are to be regarded as coming within this category?

(b) Should any class of person be entitled to benefits without having contributed therefor, e.g. old age pensioners and unemployed?

(c) Should an insured person have his rights to benefits modified in respect of any period during which he is in receipt of payments under the Workers' Compensation Act.

3. BENEFITS:

(a) Should any of the following benefits be excluded?

(i) General medical practitioner services?
(ii) Specialist and consultant services?
(iii) Laboratory aids?
(iv) Medicines and appliances?
(v) Dental treatment?
(vi) Ophthalmic treatment and optical appliances?
(vii) Orthopaedic appliances?
(viii) Nursing and massage services (non-institutional)?
(ix) Maternity services (if not provided under other headings)?
(x) Hospital and sanatoria treatment?
(xi) Transport of patients?
(xii) Sickness benefit and disablement benefit?

4. CONTRACTS AND THIRD PARTIES.

Assuming that the relative benefits are included in the scheme:

(a) What should be the basis of payment for medical services, that is:

(i) General practitioner?
(ii) Specialist?
(iii) Consultant?

(b) What should be the general basis of arrangement for the supply of:

(i) Medicines?
(ii) Appliances?

(c) What should be the basis of payment for dental treatment?

(d) What should be the basis of payment for:

(i) Ophthalmic treatment?
(ii) Optical appliances?

(e) What should be the basis of payment for non-institutional nursing and massage services?

(f) What should be the basis of payment for non-institutional maternity services?

(g) What is to be the basis of payment from the fund in respect of treatment in:

(i) Public hospitals and sanatoria?
(ii) Private Hospitals?

(h) What is to be the basis of payment for ambulance and other transport services?

5. ADMINISTRATION:

(a) Should the administration of cash benefits, such as sickness benefit, and disablement benefit, be separated from the administration of benefits in kind, such as medical and hospital benefits?

(b) What should be the form of central administration of the scheme?

(i) Should there be a specially constituted central body with executive powers, and if so, what should be its general constitution?

(ii) Alternatively, should the National Health Insurance administration be made the function of an existing Department or Departments, enlarged for the purpose?

(c) Should local administration be undertaken by specially constituted local insurance authorities? If so, what should be their constitution and functions?

(d) To what extent should Friendly Societies and other bodies who are already administering voluntary insurance schemes be entrusted with responsibility under the general scheme?

(e) What provision should be made for consultation between the administrative bodies (central and local) and committees representative of doctors, pharmacists, dentists, and others similarly affected as contractors for supply of services?

(f) What should be the principal method or methods of payment and collection of income?

(g) Should income from all sources be allocated to separate funds for certain benefits or groups of benefits and each such fund or the National Health Insurance Fund as a whole be kept actuarially sound.

Following the receipt of replies to the questionnaire the Committee heard evidence in Wellington and a number of witnesses were examined as shown in the table appended (a) hereto.

The following is a summary of the evidence received:

(1) NATURE OF THE SCHEME:

(a) All were of the opinion that the scheme should be contributory but confusion of thought was apparent as to what was implied by this term.

In their written replies most of the witnesses suggested or implied a specific contribution definitely related in amount to the benefits received.

In their oral evidence, however, they agreed with the maxim, that contributions should be proportioned to means and the service received in accord with needs, i.e. they subscribed to the principle of financing the scheme by levying a flat wage and income tax of so much in the pound as is done today with the Employment Tax.

It is evident that the strictly contributory scheme, i.e.

one under which benefits would be available only to those who had maintained a prescribed series of contributions would have little support especially if the scheme covered a large proportion of the population.

(b) It was agreed by most witnesses that those who had no income could obviously pay no contributions.

It was also held that those, if any, who were not entitled to receive any benefits should be exempt from contributions.

(c) Of the 14 replies received to this question three state that no maximum nor minimum income limits should be applied; five state that both maximum and minimum income limits should be applied; five state that maximum income limit should be applied; while one states that minimum income limits should be applied.

The representatives of a number of those organisations which had suggested the imposition of a maximum income limit stated in their oral evidence that they had no objection to a universal service and had only specified maximum income limits because they believed that the medical profession would oppose a universal service.

Indeed, one delegate stated that their organisation had been addressed by a representative of the medical profession and that he had suggested the inclusion of the income limit in their reply to the questionnaire. The official opinion of the organised medical profession is opposed to a universal scheme. This view is set out in the official statement issued by the British Medical Association copy of which statement is appended (see appendix "B").

Apart from the official view of the medical profession however, not only is there an overwhelming body of public opinion in favour of the universal scheme but even within the ranks of the medical profession itself there is a measure of support.

Indeed, the Chairman who had discussions on health insurance with medical men in all parts of the Dominion, assures us that he is convinced that, though they would prefer a partial service, there is no doubt that the general practitioners will work a universal service conscientiously and satisfactorily, provided

that the conditions of work are reasonable and the remuneration adequate.

(2) BENEFICIARIES.

(a) Those sixteen who specifically replied to the question expressed the opinion that benefits should extend to legal dependants up to the age of 16-18 years.

(b) All were agreed that certain classes of persons, e.g. old age pensioners and unemployed should be entitled to benefits without having contributed therefor.

(c) Of the fourteen replies summarised, twelve suggest certain modifications of benefits during any period of incapacity which is otherwise compensated, e.g. Workers' Compensation Act.

(3) BENEFITS:

(a) Witnesses were agreed that all the benefits (I-XII) should be provided as far as is consistent with financial and administrative difficulties. Asked to place the benefits in order of preference all placed General Practitioner Service and the supply of medicines first, closely followed by Hospital, Sanatorium and Ambulance facilities.

The need for some form of dental benefit aiming primarily at the removal of oral sepsis was also stressed.

(i) All are agreed that a general practitioner service must form the basis of any scheme of national health insurance.

(ii) All are agreed that no service is complete without specialist and consultant services.

Some thought that they should be included from the beginning and others agreed that they might be delayed until administrative experience was obtained.

(iii) The value of laboratory aids was appreciated by all.

(iv) It was agreed by all that the provision of medicines and appliances should be one of the initial benefits.

(v) Dental Benefit.

The Dental Association suggested:

(1) That additional nurses be appointed to the

school dental service to enable all children up to the fourth standard to receive treatment.

(2) That qualified dental surgeons be appointed to that staff to treat children up to the sixth standard and/or that the fillings of those children's teeth which are performed by private dentists should carry a subsidy from the State of 5/- per filling, the balance of the cost to be borne by the patient.

(3) That the State should take over the existing dental departments of the various hospitals where indigents and needy pensioners could be treated free.

(4) And that if it is considered that a section of the adult population and their dependants are unable to afford dental treatment under the present system, that they should be referred to dentists in private practice, the Government to pay a proportion of the fee by means of a subsidy graduated according to income and number of dependants of the patient, the balance of the fee to be paid by the patient and to be purely a matter of arrangement between patient and dentist.

The Health Department's views may be summarised as follows:

1. Dental benefits to include all necessary forms of dental treatment within certain specified limits, and to include regular re-examination and treatment, at stated intervals, yearly or half-yearly.
2. Dental benefits to be provided mainly through private dental practitioners, but travelling dental surgeons, who would be full-time Government officers, would be necessary for sparsely populated areas where there are no resident dentists, and for more advanced treatment of school children.
3. The remuneration of private dental practitioners to be on the basis of a specified subsidy for each operation, the total fee payable to be a matter of arrangement between patient and dentist, the patient to have free choice of dentist.

4. Limitation of service according to the funds available at the commencement to be in the direction of providing a complete service for fewer persons, with re-examination at regular periods, rather than merely sporadic treatment for a larger number, which would be very costly, and would confer no lasting benefit. An age-limit of twenty is suggested tentatively, to commence with. Thus, with school dental clinics serving all primary schools, every person would have the opportunity of being kept dentally fit by means of regular re-examination and treatment at stated intervals, from pre-school age to the age of twenty. This age-limit of twenty is merely a suggestion, and is made without any knowledge of the probable cost. If on investigation the latter is found to be excessive, a lower age could be fixed and the contributory system outlined in paragraph 3 of this summary introduced at any stage that might be decided upon.

5. The dentist to submit to a Regional Dental Officer for approval a detailed report on the teeth of every patient who presents for treatment under the scheme, together with details of the proposed treatment, and the amount of subsidy claimed. No subsidy to be payable for any treatment that is undertaken without approval, except that some provision should be made to meet cases where emergency treatment is required. Regional Dental Officers to have the right to inspect dentists' official records, and to examine patients who have undergone treatment in order to ensure that a satisfactory standard is maintained.

6. The provision of artificial dentures to be omitted from a National scheme in the meantime except for persons over sixty years of age, and then only on production of a medical certificate to the effect that dentures are necessary in the interests of the patient's general health.

7. Indigent patients to be dealt with by Public Hospital Dental Departments who would also attend to the dental needs of hospital in-patients.

8. (a) A campaign of dental health education to be an integral part of a National Scheme, and the consumption by school-children of foodstuffs deleterious to the teeth to be controlled.

(b) Enquiry by a competent investigator into the causes of dental disease, with special reference to its prevalence in New Zealand.

(vi) Optical Examinations and Appliances.

The New Zealand Institute of Opticians appeared before the Committee requesting that they should be recognised as competent to render service under the Act and that a standard appliance should be provided free of cost to the patient. The Insurance Fund to pay an agreed-upon price. Representatives of the ophthalmic surgeons also appeared before the Committee and offered to provide service on a fee for service basis, at a figure which appeared to the Committee very reasonable.

(vii) Orthopaedic appliances.

It was agreed that this benefit should be provided when practicable.

(viii) It was agreed that nursing and massage services (non-institutional) should be provided on a fee for service or salaried service when practicable.

(ix) The importance of maternity services was stressed.

(x) Hospital and Sanatorium Treatment.

It was emphasised that this should form one of the initial benefits and those who pay hospital rates were anxious that the hospital rate should be abolished and all the cost placed upon the central fund.

They did not seem to realise that this would entail the virtual abolition of Hospital Boards.

(xi) Transport of Patients.

The St.John Ambulance Association and the Wellington Free Ambulance Association appeared before the Committee and pointed out the advantages of their organisations and both offered to co-operate together and with the Government to develop a Dominion-wide

free service on a subsidy basis.

(xii) It was recognised by all that sickness and disablement benefits were essential but it was stressed that their administration should be kept separate from that of the medical benefit.

(4) <u>CONTRACTS WITH THIRD PARTIES</u>:

It was agreed that provided the total sum payable is limited these are matters of mutual arrangement.

(a.l.) General Practitioners: There is now general agreement on the part of the medical profession that the total sum payable should be computed upon a per capita basis.

(a.ll.) Specialists and Consultants desire to be remunerated upon a fee for service basis.

(b.l. & ll.) Medicines and Appliances. It was assumed by all that this would be upon a wholesale price as computed and published in a drug tariff plus an agreed-upon dispensing fee.

The Friendly Societies instanced the advantages that had accrued to them through their combined buying and said, "If a national scheme were brought into vogue, perhaps it would nationalise buying, drugs could be supplied to our dispensaries, then at the very bedrock prices and that would enable us to dispense on the best possible basis."

(c) The dentists desire payment upon an agreed-on fee for service basis.

(d) Ophthalmic Treatment and Optical Appliances: On an agreed fee for service basis and a standard price for standard equipment.

(e) Non-institutional nursing and massage services: Fee for service on salaried basis.

(f) Non-institutional maternity services: Fee for service basis.

(g) Public Hospital, Sanatoria and Private Hospital services; an allowance in respect of each patient of so much per day of treatment.

(h) Ambulance and other transport services; Existing services to be utilised as much as possible and to be financed upon a subsidy basis.

(5) ADMINISTRATION.

Nothing but broad outlines was indicated by any but the organised medical profession.

It was generally agreed that the central body should be a department of State with local administrative units including representatives of beneficiaries and those rendering services.

(a) The replies were to the effect that the administration of cash benefits should be separated from the administration of benefits in kind.

(b) The organised medical profession was invited to submit a detailed scheme and with regard to medical benefit they recommended that the Board of Health should be re-constituted on a mainly scientific and technical basis, and that the scheme would necessarily be under the Director-General of Health and that a Commissioner with overseas experience should be appointed for a period of five years, at the end of which period the administration would be taken over by a Direetor of Medical Services under the Director-General.

(c) Local Administration.

In their detailed reply the British Medical Association suggested that in each health area there should be a local Health Committee and that however constituted it should include one medical practitioner for each 50 or part of 50 doctors practising in that area and nominated by these practitioners,

That there should also be in each area a local Medical Committee with functions similar to such Committees in England.

(d) The Dominion Council of Friendly Societies gave evidence before the Committee and agreed to forego participation in the administration of the medical benefit. They urged, however, that the Friendly Societies should be utilized in the payment of claims in respect of sickness and disablement benefit and maternity benefits.

(e) It is generally agreed that doctors and others furnishing service under the scheme should be extended facilities for regular consultation regarding terms of general arrangements for

their services. These facilities should be provided by means of special district Committees as well as Central Committees.

(f) The bulk of opinion appeared to favour a method of finance somewhat similar to the Employment Tax.

(g) Opinion was generally to the effect that separate funds for the several types of benefit should be established each fund being kept so far as practicable actuarially sound.

Evidence was tendered urging the recognition of methods of treatment administered by other than duly qualified registered persons. The Committee is of the opinion that the diagnostic and treatment service of the National Scheme should be in the hands of persons whose qualifications are recognised by Statute. It would appear that before consideration could be given to the inclusion of other curative methods it would be necessary for such methods to obtain statutory recognition.

RECOMMENDATIONS.

The Committee has carefully weighed and fully discussed the evidence placed before it. Members of the Committee have made a study of the literature upon the subject and learned as much as possible from the experience of other countries. We recognise that conditions in New Zealand, and the outlook of our people are so different from those in overseas countries that no existing scheme could be adopted in toto in New Zealand. Moreover, it is possible to over-emphasise the necessity to follow in the footsteps of others, indeed, the functioning of schemes abroad has brought to light many defects which are difficult to remedy in these countries because of the vested interests created at the inauguration of the schemes. We must evolve a scheme natural to our own particular difficulties and incorporating the best features of others. Realising that he who builds hastily builds twice we recommend an evolutionary development commencing with those foundations which are absolutely essential and building on them as administrative and practical experience is obtained. This is unavoidable as much of the data necessary for designing the complete scheme can only be obtained after the service comes into operation.

In presenting its report the Committee has formulated a scheme which, while resembling overseas schemes in some respects, yet is a pioneer attempt to incorporate the twin principles of equality and freedom in a Health Insurance Service.

It represents a distinctly "New Zealand" approach to the problem of Health Maintenance and disease prevention and provides the only type of service which will maintain and raise the standard of medical pract-

ice in this country, the only type which will be acceptable to demo-cratic independent New Zealanders. We recommend that a National Health Service be introduced and that it should include the following benefits. (Special provision is necessary for Maoris in certain districts and this is referred to in a later part of the report).

I. MEDICAL BENEFIT AND AUXILIARY SERVICES.

(a) A General Practitioner Service fully available to all.

(b) Maternity Service.

(c) Anaesthetic Service.

(d) Laboratory and Radiology Services.

(e) Specialist and Consultant Medical Services.

(f) Home Nursing and Home-Help Services.

(g) Massage and Physiotherapy Services.

Services (a), (b), (c) and (d) to be provided at the inception of the scheme.

Services (e), (f) and (g) to be provided when financially and administratively opportune. (The Bill to confer authority to make regulations for and establish these benefits at a suitable time).

II. PHARMACEUTICAL BENEFIT.

The provision of all the drugs, sera and appliances necessary to ensure the adequate treatment of patients and the prevention of disease.

III. HOSPITAL AND SANATORIA BENEFIT.

Full relief from personal liability for cost of care in public hospitals and partial relief in respect of care in private hospitals.

As the ordinary outpatient departments will cease to exist after the introduction of medical benefit we recommend that the out-patient departments of public hospitals be reorganised as specialist and con-sultant centres and that the Laboratory, Radiology, Physiotherapeutic and Massage servides be grouped as outpatient functions of our public hospitals.

IV. TRANSPORT BENEFIT.

Ambulance transport to and from hospital to be free of cost to the individual. (This benefit to be established when practic-able).

V. DENTAL BENEFIT.

We recommend: (1) The provision of a dental benefit limited at the outset to extractions and the provision of dentures. As soon as possible a full dental benefit should be provided but until administrative experience has been obtained this benefit should be limited to the services first mentioned. (2). The early extension of the School Dental Service to meet the needs of all young people up to the age of sixteen years.

VI. OPTICAL BENEFIT.

As and when the Minister is of the opinion that the institution of this benefit is practicable.

VII. MEDICAL RESEARCH.

The development of organised research into causes of disease.

VIII. HEALTH EDUCATION.

The extension of measures to educate the public in the promotion of health and the prevention of disease.

I. (a) MEDICAL BENEFIT.

Universal General Practitioner Service.

THE UNIVERSAL PRINCIPLE.

We do not hesitate to state that we consider the universal principle the most important single factor in our Health Insurance Scheme and one from which we dare not depart if we are to obtain a service natural to our New Zealand national outlook and democratic ideals.

This is the foundation stone which will determine the status of the service. If the foundation is incorrectly laid the harm may be irreparable.

Unlike overseas people self respecting freedom loving New Zealanders will never respect or tolerate a Service which gives one type of service to the poor and another type to the well-to-do.

Any scheme which savours of a poor man service, of charity, which divides the people into two groups, those able to pay private fees and those unable to do so; which differentiates

in the mind of the doctor either consciously or unconsciously, between patients would be foreign to the ideals and aspirations of the Government in particular and the people of New Zealand in general.

We visualise people being treated as patients, not as members of a class.

We visualise our National Health Service operating upon the same principles as our educational service, all contributing to its upkeep, all able to participate freely in its benefits if they so desire.

With the science of Medicine freed from the economics of medicine, and with economically secure medical men able to give single minded devotion to the science of medicine, we will obtain a fuller and more efficient medical service than is in existence today.

WHY STRESS THE GENERAL PRACTITIONER ASPECT OF THE SERVICE?

The B.M.A. (Canadian Branch) says:

"It may be argued that any scheme for medical care should be so complete as to meet all the needs of the patient, and that it is preferable to do this for a limited number rather than give partial care to a greater number. The converse is that some care is better than none, and our guiding principle should be the greatest good for the greatest number ... The family physician is the most important unit in medical care. It is stated that he can give adequate care to over 80% of those who become ill ... It follows that the plan for medical benefit is based upon making available the services of a general practitioner to all."

THE B.M.A. (Parent Body):

"A Medical Association is naturally the last body to underrate the value of the specialist, but the public must recognise as the medical profession does that the family doctor is the foundation of any complete and efficient medical service....... The family doctor is the 'home doctor' the repository of the confidence of those members of the family who employ him, and the possessor of just that knowledge which enables him to treat the patient and not merely the disease. He should be the director of the family in health matters, advising on preventive measures and wherever necessary recommending the use of those specialists and auxiliaries who may be essential to the particular circumstances of the case.

"No proper supply of efficient family doctors - no efficient medical service for the community".

The Annual Report of the Chief Medical Officer of the Ministry of Health for the year 1933:

"The general practitioner forms our first line of attack in the fight against disease and premature death. It is he who is first consulted by those in sickness. To him come

the great host of patients with what are called "trivial ailments". Many of these are undoubtedly nothing more than unimportant deviations from normal health, but some are the first signs of grave disorders of body or mind. His skill must be the sieve that distinguishes the important from the unimportant. He must appreciate what is of moment in the beginnings of disease. Ranging as he does over a wide field of medicine it is impossible that he should reach the highest standard of efficiency in all branches of practice. Such high efficiency is only attained by devoting long and unremitting special study to particular organs or systems of the body. But if the general practitioner is worthily to play his part it is essential that he should be familiar with the beginnings of disease, for it is in its beginnings that disease can be most successfully controlled.

The modern study of infectious disease has taught us the importance of "missed" cases, i.e. cases which are either not recognised at all, or not until infection has had time to spread. A single "missed" case of smallpox may give rise to a serious epidemic. Early recognition is equally important from the point of view of the patient. It may mean the difference between life and death. Diphtheria recognised in time for antitoxin to be successfully administered is a very different matter from diphtheria unrecognised until it has reached a stage when the best therapeutic agents are of no avail. In the treatment of tuberculosis, cancer, kidney disease, to name only three examples, the recognition of the first signs of the disease is of vital importance."

The Universal General Practitioner Service should be characterised by:

(a) The right of every duly qualified and registered medical practitioner to participate in the scheme (with the exception of any whose name has been deleted by the Minister).

(b) The affording of facilities to the medical practitioners serving in the scheme to participate in the local administration thereof.

(c) Freedom of choice as between doctor and patient subject of course to the usual safeguards.

Administration of Medical benefit is dealt with at length in a later part of the report.

I. (b) MATERNITY SERVICE.

The object is to provide free of charge to the patients:

(a) Ante-natal supervision, attendance at confinement and post-natal care by a medical practitioner.

(b) Nursing care and maintenance in a maternity hospital up to a period of 14 days.

(c) Where a patient is confined in her home the cost of the

attendance of a midwife or maternity nurse up to a period of fourteen days.

In view of the great benefits of nursing and medical attention and as lower fees are acceptable where payment is guaranteed we recommend that the amounts allocated to meet the cost of services should be paid direct to those who render the service.

The cost of maternity services weighs heavily upon the family budget and our recommendations aim at lightening this burden, at improving the standard of materbity service and thereby encouraging larger families. The Government will, of course, have the benefit of the report of the Committee which is at present inquiring into the maternity facilities throughout New Zealand.

We are aware of the need for ensuring that women in sufficient numbers continue to be confined in the recognised training schools. It is needless to state that it is a matter of national importance that adequate facilities be afforded for the training of medical men and midwives. If it is feared that the introduction of a universal maternity benefit will have the effect of dissuading women from entering training schools for confinement we suggest either that it be made a condition of receipt of the benefit that the patient be available for training purposes if required or that a cash payment be made to women confined in training schools.

We recommend that amounts of this benefit be fixed by the Minister after taking into account a recommendation made to him by the same Committee which makes a recommendation on the basic capitation fee.

N.B. The fee paid by the Insurance authority to a doctor rendering maternity service should be a standard one and no practitioner should be at liberty to charge the patient any additional fee provided that a specialist in obstetrics, officially recognised as such, shall be entitled to charge his patient an additional fee to be prescribed.

I. (c) ANAESTHETIC SERVICE.

The administration of an anaesthetic in respect of a service within the scope of the benefits prescribed should entitle the anaesthetist to some special payment:

(a) Because of the cost of the anaesthetic used;

(b) Because in the majority of instances he will be administering an anaesthetic to other than his insurance patients.

The amount of the payment to be fixed by the Minister after taking into account any recommendation from the Capitation Fee Committee. Provided that a specialist in anaesthetics, officially recognised as such, shall be entitled to charge his patient an additional fee to be prescribed.

Whether the payments are to be made from a special fund or whether they are to be a prior charge on the Capitation Fund must be determined before the Capitation Fee is fixed and this might well be reported on by the Capitation Fee Committee.

I. (d) LABORATORY AND RADIOLOGY SERVICES.

The Radiology service can be provided from the inception through the Outpatient Department of the Public Hospital.

Laboratory service can also be provided from the inception as a Public Hospital Outpatient service.

I. (e) SPECIALIST AND CONSULTANT SERVICES.

We realise that "In the interests of economy, efficiency and effectiveness of service, as well as in the interest of meeting the true need of the people, the scope of insurance medical benefit should be sufficiently spread to cover all necessary medical care and should be intimately correlated with other health services". Falk.=.

"If the General Practitioner is to secure the best care for the patient no economic barrier must be imposed to prevent his patient from having specialist and other service, when, in the opinion of the general practitioner, care of this type is indicated. It follows that there must be some system whereby specialists and consultants are to be designated." B.M.A.

=. I.S.Falk, member of Committee of Costs of Medical Care, U.S.A. and member of technical staff of President Roosevelt's Committee on Economic Security.

(Canadian Branch).

The B.M.A. (Eng.) deprecates the tendency on the part of young graduates who have spent a few years on post graduate study to blossom forth as specialists, "without that long training in general or hospital practice and teaching which are the means of making the only real specialist or consultant."

We recommend that a Central Advisory Body be set up and that for Health Insurance purposes only such as are approved by that body be recognised as specialists or consultants.

A medical practitioner would not be regarded as a specialist or consultant unless he could show:

(a) That he has held hospital or other appointments affording special opportunities for acquiring skill and experience of the kind required for the performance of the service rendered, and has had actual recent practice in performing the service rendered or services of a similar character, or

(b) That he has had special academic or post-graduate study of a subject that comprises the service rendered, and has had actual recent practice as aforesaid, or

(c) That he is generally recognised by other practitioners in the area as having special proficiency and experience in a subject which comprises the service rendered."

In recommending that specialist and consultant services should be provided when the Minister thinks fit we realise that it may be desirable to delay their inauguration until the general practitioner service is functioning smoothly.

As has been said the general practitioner can give adequate care to 80% of those who become ill and it would be foolish to endanger the scheme by attempting too much in the initial stages.

Moreover these services are being supplied in varying if at times inadequate ways today so that it is possible to delay them without inflicting undue hardship on anyone.

I. (f) HOME NURSING AND HOME HELP SERVICES.

"The aim should be to provide for every patient needing it, on the request of the doctor a trained nurse, and, for the nurse, such equipment as is necessary to enable her to do her work in the home efficiently". When such a service is instituted it should be possible to reduce considerably the admissions to Hospital and to shorten the period of stay therein of those who are admitted. We realise, however, that it would be courting trouble to institute such a benefit in the early years of a National Health Insurance scheme before the foundation services were consolidated and administrative experience obtained.

I. (g) MASSAGE AND PHYSIOTHERAPY SERVICES.

The provision of massage and other physiotherapeutic services (non-institutional) is embraced under this heading. What has been said of the Specialist and Consultant Benefit applies equally to this one, that is to say, it is a service the introduction of which could reasonably be postponed until after the general practitioner service is functioning smoothly.

II. PHARMACEUTICAL BENEFIT.

Drugs are an indispensable complement of medical treatment and the supply of medicaments is an essential feature of a National Health Service. The pharmaceutical medical and surgical appliances to be provided as part of the medical benefit would require to be prescribed by regulation.

We recommend the early appointment of a Central Pharmaceutical Committee (consisting of Pharmacists, Medical Practitioners and such others as the Minister thinks fit) to formulate:

1. A National Pharmacopoeia.
2. A Drug Tariff.
3. A list of appliances and articles to be provided.

The Drug Tariff would include:

(a) The prices on the basis of which the payment for drugs and appliances ordinarily supplied is to be calculated.

(b) The method for calculating the payment for drugs not

mentioned in the drug tariff.

(c) Dispensing and other fees payable in respect of the supply of drugs and appliances.

(d) Standards of quality for drugs and appliances ordinarily supplied.

As a great deal of preliminary work has to be undertaken by this Committee before contracts for supplies can be arranged, it is important that the appointments of personnel be proceeded with without delay.

Any registered pharmacist, other than one whose name has been removed by the Minister from the list of insurance pharmacists, shall be entitled to have his name placed upon the list of Insurance pharmacists.

Medicines and appliances shall be paid for upon a similar basis as is adopted in Great Britain, i.e. wholesale price as determined from the drug tariff plus a dispensing fee which is calculated to provide reimbursement of establishment costs and also professional remuneration for the pharmacists services. It is necessary for machinery to be established, similar to that for the supervision of the medical benefit, e.g. provision for the Minister to remove the name of a pharmacist who is guilty of a misdemeanour from the list of accredited pharmacists, to inflict fines for more minor offences and for the establishment of a Local Pharmaceutical Committee and a Joint Services Committee.

III. HOSPITAL AND SANATORIUM BENEFIT.

NATURE OF HOSPITAL BENEFIT.

(1) The expense of hospital or sanatorium care is a contingency that few would not welcome the opportunity of insuring against. Provision for adequate Hospital and Sanatorium Benefit could not logically be omitted from a National Health Scheme that in any substantial way aims to alleviate the hardships to the individual involved in sickness or injury.

(2) It is therefore contemplated that under the general scheme Hospital and Sanatorium Benefit will be available to any person requiring nursing and medical or surgical care or oversight of a character that cannot be efficiently and economically or in the public interests be provided in the person's own home or the doctor's surgery.

Those eligible for the benefit will include persons admitted to a hospital or similar institution for treatment, isolation, examination, observation or medical restraint.

(3) The condition of the patient is not in all cases the sole factor in determining whether institutional care is necessary or whether domiciliary care is sufficient but the patient's home conditions and location have in frequent cases to be taken into account. The availability of suitable accommodation is another important factor and is one that is subject to considerable variation from time to time and indifferent localities.

For the reasons just indicated the right to hospital and sanatorium care cannot be defined in reasonably concise terms nor can it be left to the final determination of the patient's own medical attendant, particularly if under the Health Scheme medical practitioners are under an obligation to render attention in the home or at the surgery.

In most cases a recommendation from the patient's medical attendant will secure admission but the discretionary power to refuse admission must remain vested in the institution's medical officers (subject as regards public hospitals to the overriding authority of the Department in particular cases.

The institution's medical officers must similarly be entrusted with the responsibility of discharging patients.

(4) Hospital and Sanatorium benefit should therefore be of the nature, not at present of an absolute right to free care in hospital, but of the right to be relieved of part or all of the normal personal liability in respect of such care as is received.

(5) By the normal personal liability is meant the liability imposed on (a) the patient, (b) the husband if the patient

is a married woman, (c) the parents if the patient is a child under twenty-one, or (d) any other relative who may be under obligation to contribute for maintenance of the patient.

It is not proposed that hospital benefit shall be availed of to relieve liability for hospital expenses in any case where a third party is liable for reimbursement of costs of treatment (e.g. certain accident cases).

FORM OF BENEFIT:

(6) In determining the actual form of hospital and sanatorium benefit the general structure and capacity of our hospital system has necessarily to come under review.

(7) According to the latest available statistics hospitals and sanatoria under the control of Hospital Boards and Government Departments provide accommodation as follows:

	Hospital Boards.	Govt. Instns.	Total.
For general Medical & Surgical Cases	5,839	213	6,052
For Maternity Cases	503	100	603
For Tuberculosis and Infectious Diseases Cases	2,187		2,187
For Mental Cases		6,676	6,676 x
TOTAL:	8,529	6,989	15,518

Private Hospitals accommodation is as follows:

Medical and Surgical Cases	1,567
Maternity Cases	955
Mental Cases	40
	2,562

(8) A steady growth in the demands for hospital accommodation has been the experience of all countries where the treatment of the sick has been advanced on scientific and humanitarian lines. There seems reason to believe that demands will

x 935 below the actual number of patients at 1.6.36.

continue to grow and to outpace accommodation for some years to come.

(9) The inauguration of domiciliary medical and nursing services such as is contemplated in the Health Scheme will no doubt be a factor in avoiding the "hospitalisation" of some patients. It will, however, also be a factor in bringing under hospital care patients who for various reasons are, under present conditions, cared for in the home.

(10) The inception of hospital and sanatorium benefit will tend to increase the number seeking hospital care and also to raise the average stay in hospital.

(11) Public Hospitals are not capable of meeting all present requirements and a national scheme of hospital benefit embracing the greater part of the population therefore necessitates arrangements affecting patients of both public and private hospitals.

(12) The general form of the provision proposed is that in respect of necessary care afforded to patients of recognised hospitals and sanatoria, the Government will (out of the Health Scheme Fund) pay fees according to a prescribed scale.

HOSPITAL BENEFIT IN RESPECT OF TREATMENT IN PUBLIC INSTITUTIONS.

With regard to hospitals and sanatoria under the control of hospital boards, the fees paid will be intended to relieve the individual of his normal personal liability and payment will accordingly be made directly to Boards.

Where a public hospital provides private ward accommodation to which patients are admitted at their own request and upon an undertaking to pay special rates the payment from the fund will relieve them from liability for the ordinary charges only. The extra cost of special accommodation or services provided on other than purely medical grounds will remain a charge against the individual.

It does not follow that the Health Fund will pay the full cost of care nor indeed at a scale approximating the or-

dinary charges, but at a scale that will represent in respect of those institutions as a whole a substantial increase in the amounts ordinarily collected in fees.

The reasons for not paying the full cost or approximately the full cost are that this would involve a too sudden alteration in the incidence of local taxation for hospital purposes as well as fairly radical changes in the system of administration. The aim of the present proposals is to superimpose hospital benefit provision on the present hospital system, to avoid complications and difficulties that would arise if concurrently an endeavour is made radically to alter that system and to avoid as much as possible the need for imposing special conditions and reservations affecting payment from the Fund to Hospital Boards and affecting eligibility for benefit.

In any case considerable regulation is necessary in connection with hospital benefit if anomalies are to be guarded against.

The "patients" in our public hospitals range from the type of case requiring highly specialised medical services and constant nursing care to the type of case that can be suitably cared for in an old peoples home. On the other hand we have in old peoples homes inmates requiring and receiving care that could reasonably be classed as hospital care.

There are also to be found varying practices with regard to institutional care of convalescents and chronic cases. These may be cared for in a Board's general hospital, or in a special institution under the Board's control or by arrangement with a semi-private institution.

In this connection it should also be borne in mind that a Hospital Board, as regards any relief it can lawfully afford, may contract with the Crown, any other Hospital Board, organisation or person for the granting of that relief. This provision is mainly availed of in connection with treatment in tuberculosis sanatoria, in the neurological hospital, Hanmer Springs, in the Rotorua Sanatorium and in the hospitals possessing specialist personnel and special equipment.

Apart from special treatments that are the subject of particular contracts, there are the provisions of Section 92 of Hospitals and Charitable Institutions Act which are designed to protect a Board which affords hospital care or other necessary relief to residents or recent residents of other districts.

These features of the present hospital system require to be taken into account not only in defining eligibility for hospital benefit so far as the individual is concerned, but in determining the basis of payments from the Fund to Hospital Boards.

The actual rates at which payments are to be made to Hospital Boards should be determined by special enquiry shortly before the inauguration of the scheme and such rates would of course, be subject to revision at regular intervals.

For simplicity of working it is desirable to avoid the adoption of an elaborate scale, particularly at the inception of the scheme.

For inpatient care in public hospitals a flat daily rate can be applied almost generally provided the rate is substantially less than the average daily cost in the larger hospitals.

As the rate is increased to approach cost so the need may arise for the elaboration of scales of payments covering special treatments (ray therapy, etc.) and perhaps distinguishing the several general types of cases (acute convalescent and chronic). In those same circumstances it may be necessary to limit the period of inpatient care for which the Fund accepts responsibility.

For 1935-36 the average daily number of occupied beds in hospitals of all classes under the control of Hospital Boards was 5,832.

The total inpatient maintenance expenditure was	£1,027,000.
" " " Fees Receivable (i.e. gross charges)	£1,104,000.
" " " Fees received	£348,441.

"Fees Received" include payments from one Board to another and payments by the Government (Pensions Department, etc.), the aggregate under both headings being £90,000.

The total sum recovered from individuals or through local hospital benefit schemes is not readily ascertainable but would be about £260,000, being an average amount per occupied bed of £44.10.0 per annum or 2/4 per day. (The present tendency is for fees collections per occupied bed to increase).

Only rough extimates of cost are possible with the present inadequate data but payments made from the Fund for inpatient care at average rate of 6/- per diem or £109.10.0 per annum in respect of 6,000 occupied beds would aggregate about £660,000.

Payments on such a scale would affect the several Boards to a greatly varying extent but generally would render the greatest assistance to those districts whose fees collections for various reasons are relatively low in relation to costs and whose rating burden for hospital purposes is relatively high.

Levies on local authorities in toto and ordinary Government subsidies thereon would both be reduced substantially by the increased sums paid from the Fund in respect of hospital care.

The aggregate of 5,832 occupied beds as already stated includes all classes of patients of public hospitals and sanatoria and a small proportion of inmates (e.g. old people) who would not be regarded as in need of hospital care. On the other hand, there are similarly a proportion of inmates of public charitable institutions who are in need of and generally are receiving care of the nature of hospital care, i.e. institutional nursing care and medical or surgical treatment for a specific disability. The aggregate mentioned includes maternity cases in respect of whom a special basis of payment from the Fund is proposed. This must be allowed for in arriving at estimates of cost of hospital benefit and in this connection allowance must be made for hospital care given on the financial responsibility of Hospital Boards in semi-private institutions to a smaller extent in private

hospitals and in certain Government institutions (Hanmer and Rotorua.)

In this connection it is necessary to stress that payments from the Fund in respect of hospital and sanatorium benefit are intended to relieve normal personal liability only and are not intended to affect the right of a Board to recover from another Board the cost of maintenance and treatment afforded to patients belonging to the district of the last named Board whether that right to recover arises by the operation of Section 92 of the Hospitals and Charitable Institutions Act or under special contracts (as in the case of patients sent to sanatoria or to the larger hospitals for special treatment). It is important to preserve the right and in fact to strengthen it so far as special treatment is concerned if rates of payment from the Fund are to be substantially less than the cost of treatment.

In the above cases Hospital benefit would, it is intended, be paid to the Board responsible for reimbursing the cost of treatment afforded by the other Boards.

EXISTING HOSPITAL BENEFIT SCHEMES.

Agreements entered into by Hospital Boards with Friendly Societies and other organisations pursuant to Section 90 of the Hospitals and Charitable Institutions Act have been approved for periods of one year only as a rule or if for a longer period contain a provision that they shall be terminable upon the inauguration of a national scheme of hospital benefit. No special difficulty is anticipated in this regard if ample notice is given of the scope and nature and date of commencement of hospital benefit under the national scheme, but legislative authority to terminate current agreements at the date of the commencement of the national scheme should be conferred on the societies, etc., who are parties to such agreements.

IN-PATIENTS IN RECEIPT OF PENSIONS, OR SICKNESS ALLOWANCES FROM THE FUND.

It appears desirable to amend the Pensions Act to enable regulations being made prescribing the portion of pension instalments that shall cease to be payable where hospital care

is afforded to a pensioner or to any dependant in respect of whom an allowance is paid from the Fund.

The existing right of a Hospital Board to draw the pension of a person receiving hospital care at the Board's hands should, it is proposed, be abolished but the Board would receive payment at the usual scale out of the Fund in respect of such care.

Corresponding provision would be required in respect of sickness allowances covering periods of hospital care.

THE AVAILABILITY OF HOSPITAL CARE IN PUBLIC INSTITUTIONS.

Although the obligation of the Fund so far as care in public hospitals is concerned is merely to pay for such care as is received and is not an obligation to provide care, there will arise the necessity for ensuring that no restrictions are placed on any particular classes of patients in making use of public hospitals.

The principle that needs to be strictly observed is that every Board large or small shall be under an obligation to provide the same standards of hospital care for residents of their district whether such care can be afforded in one of the Board's own institutions or has necessarily to be arranged for in the institution of another Board.

As the law stands at present Hospital Boards possess a discretionary power in the matter of providing hospital care and there are still a number of public hospitals where directly or indirectly restrictions operate against the admission of patients able to afford private treatment.

The extension of Hospital benefit to all members of the community necessitates among other things therefore an amendment to the law extending the duty of Hospital Boards in relation to hospital care and forbidding the application of arbitrary restrictions. Until public hospitals can meet all reasonable demands there will still remain the occasional necessity for deciding priority of admission on economic grounds in conjunction with medical grounds, and not purely on medical grounds.

MAINTENANCE AND TREATMENT IN GOVERNMENT HOSPITALS.

St. Helens Maternity Hospitals. Institutional benefit in respect of care in these institutions will be covered by maternity

benefit.

Queen Mary Neurological Hospital, Hanmer Springs. Hospital Boards should be made responsible for fees (approximating cost) in respect of necessary care in this institution but will be entitled to payment from the Fund at the scale prescribed for hospital care generally. Special accommodation or services provided other than on purely medical grounds will presumably remain as a charge against the individual.

Queen Mary Hospital, Hanmer, for 1935-36 averaged 84.3 patients daily and Rotorua Sanatorium 23.8, a total of 108. These patients are taken into account in estimating, above, at 6000 the daily number of Hospital Board patients in respect of whom Hospital benefit would be paid.

Mental Hospitals. It is assumed (a) that hospital benefit will apply in respect of maintenance and care in a mental hospital and that steps will be taken to absolve the patient or certain relatives of the patient from liability to pay the cost of maintenance and care, and (b) that payments will be made from the Fund to the Mental Hospitals Department, such payments either to be at a daily rate per patient or lump sum periodically.

Payment by patients, etc., in 1935-36 for mental hospital care totalled £137,661 and this affords a rough indication of the extra cost to the Consolidated Fund or the Insurance Fund if hospital benefit is applied to care in mental hospitals.

OUTPATIENT CARE TO BE THE SUBJECT OF HOSPITAL BENEFIT.

Outpatient consultations and treatment of the character that will fall under the description of medical benefit will, it is assumed, cease to be provided at public hospitals but the following outpatient services would be continued or developed thereat and would accordingly require to be made the subject of special payments from the Fund.

(a) Casualty and emergency attention.

(b) X-ray examinations and treatment, Radium treatment and other special examinations and treatments.

(c) Laboratory Services.

(d) Consultations with specialists at Tuberculosis, Cancer, Ophthalmic, Diabetic, etc., Clinics.

Maintenance expenditure of Outpatient departments attached to public hospitals for 1935-36 totalled £61,000 for other than Dental and £13,000 for Dental Departments, but figures are not available to indicate the probable payments from the Fund in respect of outpatient care in the above-mentioned categories.

It could be reasonably assumed, however, that the total annual payments would in the earlier years be between £30,000 and £45,000.

ADDITIONAL COST OF MEDICAL STAFFING OF PUBLIC HOSPITALS.

Reference has been made to the decided change in hospital policy that will be associated with the inauguration of hospital benefit, namely the removal of all direct or indirect restrictions on the admission to public hospitals of patients able to afford private treatment. Doubtless an important consequence of this change of policy will be that the medical profession will no longer be prepared to give their services to the hospitals in an honorary capacity.

The total salaries paid at the larger of the hospitals staffed by stipendary staffs furnishes an index to the expenditure involved in the cessation of honorary services.

An additional annual expenditure of £20,000 is estimated to be involved.

HOSPITAL BENEFIT IN RESPECT OF PRIVATE HOSPITAL CARE:

In view of the fact that licensed private hospitals provide some 1500 beds for general medical and surgical cases (apart from maternity cases) and that it is manifestly impossible for public hospitals to meet all demands for hospital care it is concluded that Hospital benefit will, with limitations, extend to patients of private hospitals.

In the category of private hospitals are included the following types:

(i) Purely proprietary hospitals.

(ii) Hospitals leased by Hospital Boards to private licensees and in receipt of annual grants from Boards.

(iii) Hospitals that are mainly self supporting but relying partly on voluntary contributions (Mater Misericordiae, Lewisham, St. Georges).

(iv). Hospitals supported entirely from voluntary contributions (Home of Compassion).

(v) Karitane Hospitals (Plunket Society).

With regard to patients of the three first mentioned types of hospital it is recommended that hospital benefit at rates approximating but not exceeding those paid by the Fund to Hospital Boards should be paid in respect of approved hospital care afforded.

Payment should be made to the individual or to the Hospital on his order subject in each case to appropriate verification and check.

With regard to the Home of Compassion and the Karitane Hospitals payment from the Fund should be on a special basis preferably in the form of a lump grant.

There are not available at present any statistics of bed occupancy of private hospitals but assuming that of a total of 1600 to 1700 beds for general cases there are on an average 1200 always in occupation by bona fide hospital cases, payments from the Fund at 6/- per diem or £109.10.0 per annum would amount to £131,000.

TOTAL PAYMENTS ON ACCOUNT OF HOSPITAL AND SANATORIUM BENEFIT.

An estimate of the direct payments on account of the benefit is as follows:

Public Hospitals:	Inpatient	£660,000	
	Outpatient	35,000	£695,000
Mental Hospitals			150,000
Private Hospitals			130,000
			£975,000

Administration expenses would be comparatively low in regard to public hospitals and mental hospitals.

Additional expenditure would be involved in connection with medical staffing but as previously explained, payments at the suggested scale of 6/- per diem from the Fund for care in public hospitals will relieve local levies and Government subsidy thereon each to the extent of about £200,000 annually.

If, by reason of the aggregate cost of the Health Services Scheme, it is considered necessary to modify hospital and sanatorium benefit, it is recommended that that should be done either (a) by restricting the benefit to hospital care involving relatively substantial expense, for example by providing that only hospital care in excess of six days in any one year shall be the subject of benefit, or (b) excluding ordinary maintenance (as distinct from medical and nursing attention) from the scope of benefit.

N.B. Economy and efficiency would be enhanced if Hospital Board areas were consolidated and made to correspond on a unit basis with the proposed local Health area.

Consideration should be given both to the advisability of reorganising the Hospital Board areas on this basis and to the advisability of giving the Central authority more control so that the Hospital system can be co-ordinated and organised upon a national basis.

IV. TRANSPORT BENEFIT.

This Service can be established at a cost of less than £70,000 per annum and we recommend that it be inaugurated as soon as the Minister considers it practicable utilising existing and voluntary organizations wherever possible.

V. DENTAL BENEFIT.

"Dental Disease is one of the chief, if not the chief cause of the ill health of the people." Chief Medical Officer of the British Ministry of Health.

"Dental disease is not a mere chance unfortunate disability of the day, it is a more serious national scourge than cancer or consumption." Sir Truby King.

From the point of view of prevention of dental disease stress is laid upon the care of the teeth of young people.

From the medical point of view emphasis is laid upon the urgent necessity of coping with the large amount of oral sepsis and dentureless mouths which levy such a heavy toll on the good health of our community. In the opinion of

some members of the Committee it would be attempting too much to provide a full dental benefit at the inception of the scheme. We stress the importance of conservative dentistry but it cannot be denied that there are in New Zealand today many people whose condition can only be dealt with by radical measures. We recommend therefore that a benefit be supplied providing for free extractions and free dentures and that this benefit be expanded as soon as practicable.

Owing to arrears of work, there is not sufficient trained personnel to do more in the early stages but the benefit could be expanded as these arrears were overtaken and administrative experience obtained. In the meantime a measure of relief can be obtained through an expansion of Hospital Board activities in the provision of dental departments in the larger hospitals or the arrangements of contracts with practising dentists.

A reasonably complete dental service should embrace:

(1) The scaling, filling (including root treatment) and extracting of teeth.

(2) Treatment of the gums.

(3) The provision of dentures (including their repair and remodelling) and crowning.

(4) Orthodontics.

(5) The administration of the necessary anaesthetics.

(6) The necessary examination and advice.

The following administrative control is recommended.

Before undertaking any dental service coming within the scope of the National Scheme, the dental practitioners would be required to submit to a Regional Dental Officer (specially appointed for the purpose) a chart showing the patients dental condition and the treatment proposed.

The Regional Dental Officer would then be in a position to approve or modify the intended treatment. In addition the Regional Dental Officer would at irregular intervals and as occasion demanded, make personal inspections to guard against unnecessary or excessive treatment. Every registered dentist, except any whose name was removed from the list by the Minister,

should have the right to be listed to undertake treatment under the scheme and similar complaints and disciplinary machinery to that suggested under the Medical Benefit should be developed in relation to the dental benefit. That the basis of payment be upon a fee for service basis to be fixed by the Minister after considering a report on the subject made by an Investigation and Costing Committee appointed by him.

VI. OPTICAL BENEFIT

To be provided when the Minister thinks fit. (Ophthalmic treatment will be included under specialist service). It is recommended that upon receipt of written advice from his general practitioner the insured shall be able to have his eyes examined either by an eye specialist or an optician and be entitled to a standard type of optical appliance. If he desires anything more elaborate he would be required to pay the difference himself.

VII. MEDICAL RESEARCH

Recognizing the great benefits that may accrue from organized medical research that we have medical conditions peculiar to New Zealand and that we have some obligation to research workers in other lands we recommend that a Medical Research Council should be appointed to organize and supervise medical research in New Zealand.

The functions of such a Council would be to co-ordinate and direct medical research in New Zealand, to allocate funds to approved enquiries and generally to advise the Government on the subject. The Research Council should act in close association with the Department of Health and its personnel might consist of:

The Director-General of Health, Chairman ex officio.

The Secretary of the Department of Scientific and Industrial Research.

A representative of the Medical Faculty, Otago University.

A representative of the New Zealand Branch of the British Medical Association.

One or more medical practitioners nominated by the Honourable the Minister of Health.

Separate and ad hoc committees to be set up as occasion required. The personnel of such Committee would be selected from those most competent to give advice in regard to the particular disease under investigation. It would consist not only of medical men but of veterinarians, scientific workers and any other persons who could contribute anything of value.

We recommend that an annual grant equal to one penny per insured person be paid over to the Medical Research Council to cover the cost of medical research.

VIII. HEALTH EDUCATION

The Department of Health already carries out much useful work in this direction.

School Medical Officers, dental officers, school nurses and district nurses in the normal course of their duties undertake a considerable amount of individual health education whilst an endeavour is made to reach the mass of the population by the distribution of pamphlets dealing with common conditions of ill-health.

In addition, Departmental officers deliver radio addresses on specially selected health questions at regular intervals in the main centres whilst suitable articles appear in the public press from time to time.

The Department also meets the cost of printing "The Expectant Mother and Baby's First Month" which is distributed through the Plunket Society and the Registrars of Births.

Furthermore such organisations as the Plunket Society, Red Cross Society and St. John Ambulance Association reach an extensive section of the community.

It is realized that although a considerable section of the community is reached by the foregoing means there is yet definite scope for more intensive activities being undertaken in this important branch of preventive medicine and we recommend accordingly.

We recognise that the Broadcasting Service offers a

splendid medium for educating the people in matters of personal health and hygiene and we recommend the greater use of the radio by means of more frequent and varied health talks and perhaps as is now done in America the broadcasting pf Health plays. More use of the public press for health propaganda purposes is indicated and the employment of moving pictures on health subjects is another avenue that should be utilized.

The foregoing recommendations would involve the appointment of additional staff and the granting of additional finance and we accordingly recommend the engagement of an officer with some literary ability and experience in publicity to co-ordinate and direct such activities.

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METHOD OF OBTAINING MEDICAL ATTENDANCE

At an opportune time before the inauguration of the scheme all doctors who are prepared to take service on the terms and conditions offered by the Minister will be invited to declare their willingness. Lists of the names of those practitioners will be prepared and displayed in the Post Offices and persons over the age of 16 years will be invited to nominate the doctor of their choice for themselves and their families.

All insured persons will obtain from the District Health Office or from any Post Office a Medical Card which will include directions as to how to obtain the services of a practitioner. The insured person will complete the Medical Card and present it either personally or by an agent to the doctor of his choice who will signify his acceptance of the applicant in writing in the place provided on the Medical Card, or decline to accept as the case may be. If the practitioner accepts responsibility for the medical care of the applicant, the former will send the Medical Card to the District Health Office where the insured person's name will be added to the practitioner's list. The Medical Card will be returned to the insured person and the practitioner will be furnished with a Record Card which will

serve the double purpose of forming part of the practitioners card index of insured persons for whose treatment he is responsible and a record on which he enters particulars of his attendances on his patients and of the illnesses for which he has treated them. If or when the patient is transferred to another practitioner's list, the practitioner is required to forward the Record Card to the patient's new doctor under penalty of a fine if he defaults. These cards are to be open to inspection by the Regional Medical Officer.

If the practitioner declines to accept the applicant he must give the applicant the name and address of another practitioner to whom application might be made and he must give the applicant such treatment as he may require until a practitioner has accepted him or he has been assigned by the Allocation Sub-Committee. The practitioner must also notify the Medical Officer of Health that he has refused to accept the applicant.

If a person fails to secure voluntary acceptance by a practitioner he may apply to the Medical Officer of Health who will arrange for his assignment by the Allocation sub-Committee to a practitioner selected by them.

TEMPORARY RESIDENCE:

A person temporarily absent from home may obtain medical attendance from any Insurance Practitioner in his area of temporary residence.

Provision for remuneration should be made both in the allocation of the Central Fund to the different Health Districts and in the allocation to individual doctors. Provision should be made for the discharge of the duties of practitioners by deputies when they are unable to attend their patients themselves. If neither the practitioner nor his deputy is able to attend the person and give him any treatment immediately required owing to an accident or other sudden emergency, it is the duty of an insurance practitioner who may be summoned and can attend to give such treatment as may be necessary. The Insurance practitioners of a district are expected to accept

collective responsibility for the treatment of all insured persons in the area.

FIRST AID TO INJURED WORKERS:

Whether or not workers compensation is made a State monopoly we recommend that the first aid fee should be retained.

NIGHT CALLS:

Because of the frailty of human nature consideration should be given to the desirability or otherwise of making a small fee payable for requests for medical attention at night time between 8 p.m. and 7 a.m. and on Sundays and holidays.

PROVISION FOR HOLIDAYS:

Consideration should also be given to the possibility of permitting practitioners to combine into groups and one of their members doing night work, Sunday and holiday work.

ORGANISATION AND ADMINISTRATION.

The administration of the National Health Service may be considered under two heads, Central and Local.

1. CENTRAL ADMINISTRATION:

We recommend that the National Health Service be administered separately under the Minister of Health and as a division of the Department of Health.

Associated with the Department there should be:

(a) A Central Health Committee appointed by the Minister and comprising persons specially interested in the administration of the scheme and including some representatives of national bodies particularly concerned in the working of the scheme and its development.

The principal function of the Committee will be to advise the Minister on various questions that arise in the establishment of the scheme and particularly as to scope and nature and the suitable date of inauguration of benefits contemplated but not provided.

The necessity will almost inevitably occur for modifying, elaborating and improving various details of the scheme in the

light of experience and for the earlier years following the initiation of the scheme it appears of special importance to provide a consultative and advisory body to meet this need and to assist the administration.

Having regard to this object it is particularly desirable that the personnel of the Central Health Committee should consist of persons sympathetic to the effective and smooth working and development of the comprehensive service aimed at.

(b) A Central Medical Committee appointed by the Minister and consisting of representatives of the medical profession to provide a means of consultation by the Central Health Committee and the Minister on matters peculiarly affecting medical service under the scheme.

(c) A Central Pharmaceutical Committee comprising an equal number of medical practitioners and pharmacists to be appointed by the Minister. The principal function of this Committee will be to review the Drug Tariff.

(d) A Capitation Fee Committee consisting of a medical practitioner, an accountant of Dominion repute and such other person or persons as the Minister thinks fit. This Committee's function would be to investigate and report to the Minister from time to time regarding amounts of remuneration to practitioners and mileage anaesthetic and maternity fees.

This Committee will be appointed and called upon only as occasion requires and there may be intervals of several years between investigations into basic rates of remuneration.

(e) A Distribution Committee appointed by the Minister consisting of representatives of the medical profession and expert officers (including the Government Actuary and the Government Statistician). The function of such a committee would be to determine at the beginning of each quarter the allocation from the Fund for the remuneration of general practitioners to the several districts.

2. <u>LOCAL ADMINISTRATION:</u>

We recommend that New Zealand should be divided up

into the following areas for local administration: North Auckland, Central Auckland, South Auckland, Thames-Tauranga, East Cape, Wairarapa-Hawkes Bay, Taranaki, Wanganui-Horowhenua, Central Wellington, Nelson-Marlborough, West Coast, Canterbury, Otago, Southland, and that these areas should be taken as the territorial areas for Health Districts and for the administration of the various Social Insurance Cash Benefits. The local medical benefit administration office should be a branch of the Central administration, consisting of a local Medical Officer of Health and staff to which is to be attached a Regional Medical Officer.

Associated with the local administration there should be the Local Health Committee whose duty it will be:

1. To assist in the local administration of the Medical, Pharmaceutical and Hospital Benefits.
2. Receive reports of inquiries into complaints arising from the provision of these benefits.
3. To assist in taking such steps as are necessary to acquaint the insured persons of the procedure necessary to obtain benefits.
4. To assist in general Health Propaganda.

The Chairman of this Committee should be the Medical Officer of Health of the district. That the Committee should consist of:

1. The Medical Officer of Health or his deputy.
2. One Representative of the Hospital Boards included in the local Health area nominated by the Hospital Boards and appointed by the Minister.
3. One Representative of the Pharmacists working under the Act nominated by them and appointed by the Minister.
4. One Representative for every 50 or part of 50 medical practitioners working under the Act but not more than three nominated by the medical practitioners working under the Act and appointed by the Minister.

5. One representative for every 30,000 insured in the area, but not less than 4 or more than 9, one of whom must be the representative of the Friendly Societies and one a woman.
   These with the exception of the Friendly Societies representative to be nominated by the City, Borough and County Councils and independent Town Boards of the District and appointed by the Minister. Alternatively they may be elected by popular franchise.

The following advisory bodies should operate under the supervision of the Local Administration.

1. Local Medical Committee.
2. Local Pharmaceutical Committee.
3. Local Hospital Committee.
4. Medical Service Sub-Committee.
5. Pharmaceutical Service Sub-Committee.
6. Hospital Service Sub-Committee.
7. Joint Services Committee.
8. Allocation Sub-Committee.

(1) LOCAL MEDICAL COMMITTEE:

A committee representative of the Insurance practitioners of that area and elected by them. This Committee to be consulted by the Medical Officer of Health on all general questions affecting the administration of the medical service.

(2) LOCAL PHARMACEUTICAL COMMITTEE:

Representative of the pharmacists of the district with functions in relation to the supply of medicines and appliances similar to that of the Local Medical Committee in relation to general practitioner service.

(3) LOCAL HOSPITAL COMMITTEE:

This Committee shall include representatives elected by the Hospitals Boards of the Local Health Area and a representative elected by the owners of the privately owned hospitals in the area.

(4) MEDICAL SERVICE SUB-COMMITTEE:

To consist of equal numbers (3) of (a) Medical Practition-

ers appointed by the Local Medical Committee and (b) members appointed by and from the members of the Local Health Committee who represent insured persons and (c) an independent chairman. The function of this sub-committee is to investigate complaints by insured persons about practitioners and vice versa to establish the facts thereof as far as possible and to report through the Medical Officer of Health to the Local Health Committee.

(5) PHARMACEUTICAL SERVICE SUB-COMMITTEE.

To be appointed in a similar manner, to have a similar composition and similar functions in relation to pharmacists as the Medical Service Sub-Committee has in relation to Medical Practitioners.

(6) HOSPITAL SERVICE SUB-COMMITTEE.

To be appointed in a similar manner, to have a similar composition and similar functions in relation to Institutions as the Medical Service Sub-Committee has in relation to medical practitioners.

(7) JOINT SERVICES COMMITTEE:

Consisting of equal numbers of nominees of the Local Medical, Local Pharmaceutical, Local Hospital Service and insured persons appointed by the Local Health Committee.

It shall be the function of this Committee to investigate complaints in which it is not clear whether the practitioner, the pharmacist or the institution is at fault and complaints of doctors re pharmacists; doctors re institutions; pharmacists re institutions and vice versa.

(8) ALLOCATION SUB COMMITTEE.

To consist of three members of the Local Medical Committee in addition to the Medical Officer of Health or his deputy. The function of this Sub-Committee is to assign to a doctor selected by it any person who is unable to find a practitioner willing to accept him as a patient.

PROCEDURE REGARDING COMPLAINTS IN RELATION TO MEDICAL SERVICE:

The Local Health Committee may, if satisfied that a practitioner is unable to give adequate treatment to all the persons on his list, impose (after consultation with the Local Medical Committee) a special limit on the number of persons for whom he may assume responsibility. They shall also have the power to direct the recovery from a practitioner of expenses reasonably and necessarily incurred, or by or on behalf of any insured person on account of the practitioners default. Further, it is open to the Local Health Committee, if they think fit to request the Medical Officer of Health to bring a case specially to the notice of the Minister, in order that he may consider whether remuneration should be withheld from the practitioner.

Lastly, the Committee may be of opinion that the case before them, alone or when considered in conjunction with other cases affecting the same practitioner, shows that his continuance on the medical list would be prejudicial to the efficiency of the service and in that event it is open to them to make through the Medical Officer of Health representation to the Minister to that effect. Any party to the case can appeal to the Minister whose decision is final.

REMOVAL FROM THE MEDICAL LIST:

The list of practitioners available for Insurance Practice should include all those doctors who are duly qualified and registered and who have signified their willingness to serve provided that the Minister may on special grounds remove any name from the list.

The Local Health Committee may take steps to secure the removal from the list of any practitioner whose continuance on the list they deem to be prejudicial to the efficiency of the Medical Service.

The procedure is for the Committee to make a representation through the Medical Officer of Health to the Minister to that effect, and a similar representation may be made by the

Local Medical Committee or by any other body or person. On receiving such a representation the Minister, unless he considers that the complaint is trivial, constitutes an Inquiry Committee consisting of a barrister or solicitor in actual practice and two practising doctors, and refers the case to them for investigation. The Inquiry Committee, after hearing the relevant evidence, report to the Minister their findings of fact and their inferences from the facts, and on the report the Minister decides the question whether the continuance of the practitioner would be prejudicial to the medical service.

If the practitioner's name is removed from the list he cannot enter the Insurance Medical Service in any area without the sanction of the Minister. In Great Britain in dealing with cases in which it is alleged that a practitioner has been negligent in his treatment of a patient the Minister has the assistance of a Medical Advisory Committee constituted by him and consisting of the Chief Medical Officer and two Medical Officers of the Ministry and of three practitioners selected by the Minister from a panel of Insurance Practitioners nominated by a Central Committee of doctors which is regarded by the Minister as representative of the general body of Insurance Practitioners and called the Insurance Acts Committee of the B.M.A. We recommend some similar Committee in New Zealand.

DEDUCTIONS FROM REMUNERATION OF MEDICAL PRACTITIONERS:

The Medical Officer of Health must send to the Minister copies of all reports of the Medical Service Sub-Committee, and if in any case the Minister thinks that the conduct of the practitioner calls for the imposition of a monetary penalty (whether the Committee have so recommended or not) he may deduct a certain sum from the amount payable to the practitioner. Before any deduction is made the practitioner should be afforded the opportunity of making representations in writing or orally, oral representation being heard by officers of the Ministry, who attend for the purposes a place reasonably convenient to the practitioner, and have sitting with them in each case in which negligence is alleged a practitioner selected by the

Minister from an approved panel of doctors. The Local Health Committee and Local Medical Committee are given due notice of such hearings, and are entitled to send representatives to be present.

The Minister may withhold remuneration in cases coming to his notice otherwise than on a report from a Medical Service Sub-Committee.

THE CONTROL OF UNNECESSARILY EXPENSIVE PRESCRIBING.

We recommend the establishment of machinery similar to that in Great Britain, namely:

1. The establishment at each District Health Office of a pricing branch who will ascertain the sums payable to the insurance pharmacists for the supply of medicines and appliances and keep a record of the cost entailed by the prescribing of each insurance practitioner.
2. Particulars of the cost of each practitioner's prescribing are furnished to the Minister of Health, and if it appears that any practitioner may have been extravagant in his prescribing he is interviewed by a Regional Medical Officer who obtains the practitioner's explanation of the apparently high cost and discusses with him the various means by which economy can be secured without loss of efficiency in treatment.
3. If the practitioner's explanation is unsatisfactory he is warned and if he is gravely or repeatedly at fault the Minister may refer the matter to the Local Medical Committee for their consideration and report.
4. If, after considering the case, the Local Medical Committee decide that the practitioner's prescribing has imposed a cost on the funds in excess of what was reasonably necessary for adequate treatment they must assess the amount of the excess cost and inform the practitioner, the Medical Officer of Health and the Minister accordingly.
5. The practitioner or the Minister is entitled to appeal against the decision of the Local Medical Committee and if an appeal is made the Minister must appoint one or more

persons (other than officers of the Department) to hear the appeal.

One at least of the persons so appointed must be a medical practitioner.

6. The Medical Officer of Health after considering the decision of the Local Medical Committee, or if an appeal has been made, of the person determining the appeal, must make a recommendation to the Minister in regard to withholding remuneration from the doctor and the Minister may withhold such sum, if any, as he thinks fit.

FRIENDLY SOCIETIES AND LOCAL ADMINISTRATION.

When the Friendly Societies Council appeared before the Committee they agreed to forego participation in the administration of the Medical Benefit provided they were supplied with the medical certificates necessary for the payment of sickness and disablement benefits. We are of the opinion, however, that one member of each Local Health Committee might well be a nominee of the Friendly Societies in that Local Health District.

In view of our small population and the desirability of administering the benefits upon a unified co-ordinated basis in simple topographical areas we are not in favour of treating the Friendly Societies as different actuarial entities but recommend that cash benefits payable to Friendly Society Members should be payable to the member through the Friendly Society and that there should be an additional amount payable to the Society sufficient to compensate for the administrative work involved. Admittedly this would increase the administrative work to a minor degree but it is due to the Friendly Societies that the work they have done in the past should be recognised and it is desirable that their continued existence should be made possible.

This system will avoid the necessity for complicated computations to allocate individual contributions, and to assess reserve values, and will avoid undesirable differentiation of benefits and give the whole scheme greater actuarial stability,

for surveys of the incidence of sickness indicate that an actuarial basis is uncertain until at least 30,000 or 40,000 persons are included.

PARTICIPATION BY DOCTORS IN THE INSURANCE MEDICAL SERVICE.

Any registered medical practitioner (other than a practitioner whose name has been removed from a medical list by the Minister) shall have the right to have his name placed upon the list of Insurance Practitioners who undertake to give medical attendance and treatment to insured persons on the terms of service for insurance practitioners offered by the Minister.

There should as far as is practicable be free choice as between doctor and patient subject to the same exceptions as apply in Great Britain, e.g., a practitioner is not obliged to accept a person who applies for inclusion in his list, but if he refuses he must give the applicant such treatment as he may require until another has accepted or been allotted him.

He must notify the Medical Officer of Health that he has refused to accept the applicant.

He must also render service to all patients who have been allotted to him by the appropriate authority.

A doctor may also obtain the removal from his list of an insured person for whose treatment he no longer wishes to be responsible, subject to the consent of the Local Health Committee.

REGIONAL MEDICAL STAFF.

These will be full time salaried doctors on the staff of the Health Department appointed to discharge certain important duties in connection with the Insurance Medical Service.

There will be one or more of them as required in each Local Health District. Their duties would include those of (a) acting as referee in regard to certificates of incapacity; (b) acting as consultant when required; (c) inspecting the standard of service and benefits in the area; (d) discharging any other functions assigned them by the Medical Officer of Health.

There is no doubt that the sickness benefit payment is going to be the most difficult benefit to administer and is going to require eagle eyed vigilance to prevent the fund being exploited and the scheme thereby being brought into disrepute.

We cannot emphasise too strongly the necessity of making the supervising and inspectorial machinery as efficient and watertight as possible. The colossal drain which loose certification places upon the Insurance Fund will be realised when it is pointed out that in Great Britain in 1934 there were 468,576 references to the Regional Medical Staff for advice as to incapacity for work. (1) Of these 246,088 were examined; 134,678 were reported to have received a final certificate before the date furnished for examination; and 86,628 failed to attend for other reasons. (2) Of those examined, incapacity was confirmed in 179010 cases.

(1). The most important duty of the Regional Medical Officer will be to examine patients referred to him by the Department responsible for the payment of sickness allowance or by the insured's medical attendant for an opinion as to his incapacity for work. The patient and the practitioner are informed of the time and place of the examination, the practitioner having the right to be in attendance if he so desires.

The practitioner is also required to send to the Regional Medical Officer on a form specially provided for the purpose a short statement of the history and condition of the patient and the treatment given. Disciplinary action would be taken against practitioners who failed to send this report within reasonable time. After examining the patient the Regional Medical Officer communicates his findings both to the practitioner and to the Department concerned with the payment of cash payments and his opinion on incapacity is final.

(2) When requested by a practitioner the Regional Medical Officer will also act in a consultative capacity.

(3) He will inspect the Records kept by Insurance Practitioners, investigate complaints of over-prescribing and generally super-

vise the standard of benefits in his area.

(4) He will perform any other duties required of him by the Medical Officer of Health.

In certain localities and at certain periods of the year it may be necessary to employ Part Time Regional Officers. Practitioners should not be used for this function in areas in which they are in active practice.

For purposes of unity and co-ordination it is desirable that the Regional Medical Officer should also act as Medical Officer of the Pensions and Employment Department.

REMUNERATION OF INSURANCE PRACTITIONERS.

The total sum payable as remuneration will be calculated primarily on the number of persons entitled to medical benefit. This sum is obtained by multiplying the number of persons by the basic capitation fee.

We recommend that the basic capitation fee be fixed by the Minister after considering the findings of the Capitation Fee Committee set up to investigate and report on the matter and that provision be made for the revision of the Capitation fee at intervals.

From the Central Capitation Fund as arrived at shall be deducted the amount estimated to be required for the payment of mileage allowance.

MILEAGE: We recommend that a sum payable for mileage, say 4/- per mile one way for all distances in excess of, say, 2 miles be paid to doctors who are obliged to visit patients in their own homes.

We further recommend that half the mileage charge, say 2/- per mile, should be recovered from the patient in all cases where he is able to pay and such recoveries paid into the Capitation Fund. Where he is not indigent but neglects to pay power should be taken to deduct the amount due from any cash benefits payable to him.

The mileage rate and the mileage limit shall also be referred to the Capitation Fee Committee referred to above

and fixed by the Minister after the consideration of their report.

It is essential that the patient should be required to pay a portion of the mileage fee in order to minimise -

(1) Frivolous calls by patients.

(2) Overvisiting by doctors.

A large proportion of the incomes of country practitioners is made up by mileage fees and it is necessary to retain these sums if practitioners are to be kept in the country districts. The mileage fee is only payable to the nearest doctor - hence there would be no mileage fees payable in the metropolitan centres for in them but few patients live more than 2 miles from a doctor.

It might be argued that this provision would limit free choice of doctor. There would be no more restriction than there is today, for it is customary for mileage charges to be made by doctors under existing conditions.

Some few country districts would still be unable to obtain the services of a doctor and it is recommended that in those cases where the Minister sees fit he should make a special grant from Government funds to assist in securing medical services.

After these deductions from the Central Fund had been made one quarter of the balance would be allocated to the different Local Health Districts every quarter taking into account the number of people resident in those districts permanently and temporarily. This allocation would be made by the Minister on the advice of a Distribution Committee appointed by him and on which Insurance Practitioners are represented.

PAYMENT FOR GENERAL PRACTITIONER SERVICES: The sum allocated to each Local Health District shall after deducting the estimated sum to cover maternity and anaesthetic benefits be divided among the Insurance Practitioners in accordance with a scheme prepared by the Local Medical Committee and approved by the Minister. We agree, "That both the Insurance authorities and the medical profession have much to gain and little to lose in

following the British practice of leaving to the profession broad choice in the method of remuneration. Among per capita, per illness and per attendance procedures each has its advantages in particular circumstances, though the per capita procedure seems on the whole the most satisfactory to physicians and the simplest for the administrative authorities. Whatever the method of remuneration, the total sum of money available from the pool of insurance funds for remuneration of doctors must be fixed, but this total sum should be subject to periodic adjustment by a competent body upon which doctors are adequately and effectively represented."

<u>PAYMENT FOR MATERNITY SERVICES</u>. The Basic Maternity Fee shall be fixed by the Minister having taken into consideration the opinions of the Capitation Fee Committee.

At the beginning of each quarter the Minister shall after considering the opinions of the Distribution Committee determine for each Local Health District what sum of money shall form the Maternity Fund of that District. The sum would be determined by regard to the average quarterly number of births registered in the respective districts during the preceding year.

The Maternity Fund shall be kept in a separate account and at a specified time after the termination of the quarter this fund shall be used to remunerate the Medical Practitioners who have attended maternity cases in that area in proportion to the number of patients confined.

Within a specified time after attendance at a confinement it shall be encumbent upon every practitioner who desires payment for his services to complete a prescribed form and forward it to the District Health Office.

The Regulations will need to include a definition of a confinement and what services it is necessary for a practitioner to render in order to ensure that he receives payment in full.

<u>PAYMENT FOR ANAESTHETIC SERVICE</u>: This benefit is difficult to cost in advance as there are no reliable figures available which would permit the number of anaesthetics given to be determined but the Medical Profession have been asked to keep records to enable

a reliable estimate to be made.

The basic anaesthetic fee shall be fixed by the Minister having taken into consideration the opinions of the Capitation Fee Committee.

At the beginning of the quarter the Minister shall after considering the opinions of the Distribution Committee determine for each Local Health District what sum of money shall form the Anaesthetic Fund of that District. The sum would be determined by regard to the number of anaesthetics which it is estimated will be administered during the quarter.

The Anaesthetic Fund shall be kept as a separate account and at a specified time after the termination of the quarter this fund shall be used to remunerate the medical practitioners who have administered anaesthetics in that area during the quarter.

Within a specified time after the administration of the anaesthetic it shall be encumbent upon every practitioner who desires payment for an anaesthetic to complete a prescribed form and forward it to the Local Health Office.

He will, at an appropriate time, be paid for this service on a pro rata basis from a fund allocated for the purpose.

At the beginning of the quarter the Minister shall having taken into consideration the recommendations of the Medical Distribution Committee, allot to each Local Health area from the Central Capitation Fund a sum to be known as the mileage fund and computed by multiplying the total estimated mileage by the basic mileage fee.

This sum shall comprise the local mileage fund which shall be paid pro rata to those practitioners entitled to payment for mileage at the end of the quarter.

Admittedly the mileage claims will be difficult to estimate for the first quarter but thereafter should be capable of fairly close estimate.

NOTE: Administrative simplicity would be obtained if the Fund paid the doctor half the basic mileage fee and left him to collect the balance from the patient himself. Taking all factors into consideration, however, the method already outlined seems the most equitable.

In no case shall a practitioner be permitted to render one of his own listed patients an account for services which come under the category of General Practitioner Services, Maternity or Anaesthetic Services, or mileage without the consent of the Local Health Committee.

LIMITATION OF PATIENTS.

There will obviously require to be some limit placed upon the number of patients who will be allowed to place their names upon a doctor's list.

One of the chief reasons for granting patients free choice of doctor is to keep the spirit of competition active amongst the medical profession.

It ensures that the doctor who satisfies his patients is chosen by many and is remunerated accordingly.

In fixing the number of persons who may be listed by a doctor care must be taken not to destroy this incentive to good work by making the limit too low. The average number of people (exclusive of Maoris) per general practitioner in New Zealand at present varies from 1,771 in one Health District to 2,374 in another and inclusive of Maoris from 1,778 to 2,914.

In Great Britain the limit is fixed at 2,500 per medical practitioner but in that country all practitioners have many private patients as well so that their contract patients often comprise less than half of their clientele.

Under a universal scheme in New Zealand the limit would indicate the total number of patients whose medical needs were being met by the practitioner and the limit must, of necessity be high.

Accordingly we recommend that the limit be fixed at not less than 3,000 exclusive of Maoris and probably higher.

It is not desirable that this limit should be fixed before the service is in actual operation.

MEDICAL RECORDS.

An Insurance practitioner will be required to keep a record card of each patient. This fills a double purpose, (a)

providing a list of patients for whom he is responsible and (b) containing a concise account of the illnesses and treatment of each patient.

When a patient transfers to a new doctor the records go to the new doctor, care being taken that the confidential character of the entries is strictly observed.

Though these records would be available for statistical purposes perhaps their chief value lies in the fact that they provide the practitioner for the time being responsible for the treatment of a patient with particulars of the patient's previous medical history.

In this way, as the Annual Report of the Chief Medical Officer of the Ministry of Health for 1924, says, "The Insurance Practitioner has an advantage in the case of an insured patient which is lacking in that of a private patient; for in order to obtain a trustworthy medical history of a private patient while under the care of other practitioners it would be necessary to make a special communication to each of those practitioners, and this takes time and in many cases would be impracticable. But with a properly kept insurance record the information is to hand".

CERTIFICATES OF INCAPACITY FOR WORK.

One of the duties of Insurance Practitioners is to give certificates on prescribed forms to those of his patients who are unfit for work, to report at regular intervals upon their condition and to certify when they are fit to resume work.

PROVISION OF MEDICINE AND APPLIANCES.

Except in those places where there is no chemist the Insurance Practitioner will supply the necessary prescription to the patient who is free to take it to be dispensed by any Insurance pharmacist - the patient having free choice of pharmacist as well as free choice of doctor. In those districts where patients would have difficulty in obtaining their requirements from pharmacists the dispensing will be undertaken by doctors - as it is to-day.

MAORIS.

Except in those districts where the Maoris are few

and Europeanised it is not possible to place them upon the same basis as Europeans.

It is recommended however that a sum of money equal to the amount that would be available to provide medical benefit for a similar number of Europeans should be set aside to provide the Maoris with as good a service as is being provided the Europeans.

There are three ways of meeting this need:

1. A full time doctor service on a salaried basis.

   The main weaknesses in this proposal are:

   (a) Areas may be too large.

   (b) There would be financial injury to existing practitioners, a portion of whose incomes at present comes from the Maoris.

11. To place them on the same basis as Europeans. Neither doctors nor Maoris are ready for this type of service.

111. The extension of the present Maori nurse cum doctor service.

We recommend that this policy should be adhered to.

At present the State is not providing very ample medical supervision but no doubt the additional money that will become available will overcome this weakness.

Sick Maoris to be visited in their homes will offer no difficulty.

They should all be visited by the nurse who should have discretionary power to summon a doctor if or when she thought fit.

When summoned by a nurse the doctor to be paid upon an agreed-upon fee for service.

Those Maoris who visit the doctor in his own consulting room offer a more difficult problem and consideration will necessarily have to be given to the question of whether or not a modified consultation or capitation fee should not be paid in such cases.

CAPITATION FEE COMMITTEE.

It is proposed that the total sum to be appropriated for the purpose of remunerating medical practitioners shall rep-

resent a definite amount per capita of the population.

Obviously there will be difficulty in determining what basic capitation fee should be fixed to cover Maternity, Anaesthetic and general practitioner services and mileage. Unfortunately the official reply of the organised medical profession was to the effect that they were unable at this stage to suggest or accept any amount. In order to be fair both to the funds and to the medical profession we recommend that the Basic Capitation Fee be fixed by the Minister after considering the report of the Capitation Fee Committee set up to investigate and hear evidence on the matter.

To this Committee shall also be referred all other questions of medical remuneration, e.g. mileage, anaesthetic and maternity fees.

THE DISTRIBUTION COMMITTEE.

The Minister shall set up a Committee on which Insurance Practitioners are adequately represented to be known as the Distribution Committee whose function it shall be to recommend to the Minister what sums shall be allocated to the several Local Health areas from the Central Capitation Fund for -

(a) Payment of mileage fees:

(b) Payment for general practitioner maternity and anaesthetic services.

POST-GRADUATE STUDY.

In order that all practitioners should be kept in touch with the advances of medical science, we recommend that provision should be made for practitioners to receive periodic post-graduate courses of instruction.

Practitioners resident in the cities could attend such courses in their centres without much financial loss, but it is recommended that financial assistance be provided those who are obliged to reside away from home when taking such courses.

N.B. In England, practitioners receiving similar post-graduate instruction are provided with a locum by the Insurance Authority and receive a monetary grant to cover the cost of residence away from home.

At present the young graduate's diploma of qualification confers upon him the right to practise as long as he lives, provided he commits no misdemeanours, without placing upon him any obligation to undergo any further period of training or study. Such is not in the best interests of the people of New Zealand.

"The Insurance Medical Service rightly, therefore, takes its place as one of the most effective branches of the public health service............ In this connection it is significant that the interest shown by practitioners in post graduate study courses is steadily growing and every year more practitioners feel impelled to devote part of their hard earned leisure to attending the refresher courses of study increasingly provided by many of the medical schools throughout the country." This is an extract from the 1935 annual report of the Chief Medical Officer of the Ministry of Health, Great Britain, and quoted with approbation by the British Medical Association in the supplement to the British Medical Journal, May 29th, 1937.

Doubtless the introduction of a Health Insurance service in New Zealand will give the same stimulus to post graduate study in New Zealand as it did in Great Britain.

More rapid advance will be achieved if the Health Insurance authority directs and encourages this tendency as has been suggested above.

SCOPE OF GENERAL PRACTITIONER SERVICE.

That the scope of the general practitioner service be defined by the Minister taking into consideration the recommendations of a special sub-committee set up by him for that purpose. As a minimum the Committee recommends that the scope of the general practitioner service should be as defined in the English scheme, viz. "all proper and necessary medical services other than those involving the application of special skill and experience of a degree or kind which general practitioners as a class cannot reasonably be expected to possess".

An appeal authority consisting of three referees, two of whom should be medical practitioners, and one a barrister or

solicitor should be set up by the Minister to determine disputes as to whether or not a particular service came within the scope of the contract. A practitioner who wished to make a special charge would supply the Local Health Committee with particulars of the service he had performed or was about to perform. The opinion of the Local Medical Committee would be obtained and if the Committees disagreed the case would be referred to the Minister who would refer it to the Referees whose decision would be final. Even if the Committees agree the Minister should have the power to refer the case to the Referees.

THE POSITION OF THE MEDICAL OFFICER OF HEALTH.

Under a National Health Service the Medical Officer of Health will occupy an increasingly important position.

"The Medical Officer of Health of the administrative area concerned will be the administrative head of those parts of the scheme which need central administration. He will be the liason officer between the local profession engaged on the work of family medical attention and the authority which is responsible for the financing and general direction of those parts of the scheme which are administered on an insurance basis or provided by the community ..., He will be the director of the local health propaganda and of education in all health matters. His position will be an increasingly important one in the community in the campaign against all forms of disease. His talents as an organiser and a tactful leader will be more needed than ever when a scheme is put into operation which for the first time combines all the medical forces in the area, preventive, curative, domiciliary and institutional.

In short the position of the Chief Medical Officer in every area will call for a high level of professional ability and equipment and with large and increasing responsibilities, will offer an opportunity for public service even greater than at present".

SICKNESS AND DISABLEMENT BENEFIT.

The National Health Insurance Investigation Committee being primarily concerned with benefits in kind has only an indirect interest in Sickness Allowances. This three-fold indirect interest may be expressed thus:

(1) Nothing is more important than an adequate and balanced diet for the maintenance of good health. When the breadwinner is incapacitated by sickness, this is difficult to obtain.

(2) It is illogical and uneconomic to provide free medical attention and free medicine without providing the most important medicine of all - food.

(3) The certificates upon which sickness benefits are paid must obviously be issued by the patient's medical attendant and this provision comes under the direct control and supervision of the Health Insurance Authorities.

For the reasons which follow, however, we recommend the postponement of the introduction of this benefit except in respect of periods of incapacity in excess of four weeks. The period of postponement suggested is until such time as the General Practitioner Service has been properly organised and brought under efficient supervision.

It is known that there are very considerable administrative difficulties which are peculiar to Sickness Benefit payments and there is of course the ever present possibility of abuse which arises out of the payment of cash benefits even under the most efficient supervision.

A point of particular importance is that if the doctor is lax in the matter of certification he burdens the Insurance Fund with unnecessary expense. If on the other hand he is strict, he may lose his patients.

As has already been pointed out in this report there were in Great Britain in 1934, 468,576 references to the Regional Medical Staff for advice as to incapacity for work; (1) of that number 246,088 were examined, 134,678 were reported to have received a final certificate before the date furnished for examination, and 86,628 failed to attend for other reasons; (2) of those examined, incapacity was confirmed in 179,010 cases.

The only safeguard against over-certification is strict supervision by medical officers in the Government's employ. Incidentally this makes the benefit unpopular with many members of the medical profession who consequently overstate its administrative difficulties and understate its benefits. In view of the heavy demands that will be made on the time of the Department's medical staff during the earlier months following the inauguration of the general practitioner and other services, it does not appear possible for them to afford the close supervision that the situation will require.

There is a very considerable body of workers comprising farmers, storekeepers and other independent workers who are not necessarily involved in direct or complete financial loss on account of temporary absences from work due to sickness and doubtless in the great majority of instances are able to make suitable and economic arrangements for the carrying on of their business during such periods.

A substantial number of employees, for example Public servants, Bank Officers, local body employees and in fact a large proportion of clerical and indoor workers employed by large commercial houses are already provided for in the matter of payment during sick leave of absence. Friendly Societies, too, meet part of the needs of many people.

It is the breadwinner who suffers prolonged incapacity owing to illness whose position is most tragic. By providing a sickness and disablement benefit after incapacity of four weeks, the needs of this group would be met, and time would be given for the establishment of a Health Service on a firm foundation and morbidity statistics obtained which would permit accurate budgeting of the costs.

The 1926 Census return estimates the number of working days lost owing to sickness at from 8 to 20 million so that sickness and disablement benefit would doubtless prove to be one of the largest, if not the largest, single item of expense in a comprehensive scheme of National Health Insurance.

The incomes of the unemployed are such that there is no prospect of their making any provision even for a short period of incapacity, and it is anticipated that the present practice of continuing their allowance during the first three weeks of sickness will be continued. The need of those who are unable to make any provision for short periods of incapacity might be met in the meantime by ensuring that hospital boards adopt a more liberal policy in the matter of out-door relief.

The underlying principles of benefits in cash differ greatly from those of benefits in kind. Whereas the former may be determined by a means test without deterioration, the latter, depending as they do on personal factors, tend to depreciate if they have any semblance of poor relief.

For the foregoing reasons as already indicated the Committee recommends the postponement of the payment of sickness benefits except in respect of periods of incapacity in excess of four weeks until such time as the General Practitioner service has been properly organised and brought under efficient supervision.

SUMMARY OF RECOMMENDATIONS.

We recommend:

(1) General: That a National Health Service be introduced (p.12) and that the development of the service should be evolutionary, commencing with those foundations which are absolutely essential, and building on them as administrative and practical experience is obtained (p.11).

(2) Services to be provided at inception of scheme: (p.12). That the following services be provided at the inauguration of the Scheme:

(1) Medical Benefit:

(a) A general practitioner service fully available to all. (p.13).

(b) A maternity service - to provide free of charge to the patient ante-natal supervision, attendance at confinement, and post-natal care by a medical practitioner, nursing care

and maintenance in a maternity hospital up to a period of 14 days, or where patient is confined in her own home, the cost of attendance by a midwife or maternity nurse up to a period of 14 days (p.15).

(c) Anaesthetic service. (p.17).

(d) Laboratory and Radiology service - to be provided through Out-patient Departments of Public Hospitals.

(II) Pharmaceutical Benefit: The provision of all drugs, sera and appliances necessary to ensure the adequate treatment of patients and the prevention of disease (p.19).

(III) Hospital and Sanatoria Benefit: Comprising full relief from personal liability in the cases of care in or at public hospitals, and partial relief in respect of care in private hospitals. (p.20). The ordinary services of the outpatients departments of public hospitals to cease to exist after the introduction of medical benefit (p.12) but these departments to be reorganised as specialist and consultant centres and the Laboratory, Radiology, Physiotherapeutic and Massage services to be grouped as outpatient functions of our public hospitals.

(IV) Dental Benefit: Limited at the outset to extractions and the provision of dentures (p.13).

(V) Medical Research: The development of organised research into causes of disease. We recommend the setting up of a Medical Research Council, and an annual grant to the Council's funds of 1d. per insured person. (p.34).

(VI) Health Education: Being an extension of measures to educate the public in the protection of Health and the prevention of disease. (p.35).

(3) Extension of Services: (p.12). That the following services be provided when financially and administratively opportune -

(I) Medical Benefit:

(a) Specialist and consultant service. (p.17).

(b) Home nursing and home help service. (p.19).

(c) Massage and physio-therapy service. (non-institutional). (p.19).

(II) Transport Benefit. (p.32).

(III) Full Dental Benefit: We also recommend the early extension of the School Dental Service to meet the needs of all young people up to the age of 16 years (p.13).

(IV) Optical Benefit: (p.34).

(4) Central Administration: (P.38). That the National Health Service be centrally administered under the Minister of Health, and as a division of the Department of Health, and that the following Committees be set up to be associated with the Department in consultative and advisory capacities -

(I) A central Health Committee. (p.38).

(II) A central Medical Committee. (p.39).

(III) A central Pharmaceutical Committee. (p.39).

We recommend (p.19) the early appointment of this Committee to formulate -

(a) A National Pharmacopoeia.

(b) A drug tariff.

(c) A list of appliances and articles to be provided.

(IV) A Capitation Fee Committee. (p.39).

(V) A Distribution Committee. (p.39).

(VI) A Central Advisory Body to approve for Health Insurance purposes of those practitioners who are to be recognised as specialists and consultants. (p.18).

(5) Local Administration. (p.39). That the National Health Service be locally administered as a branch of the Central Administration by a Medical Officer of Health, and a staff including a Regional Medical Officer. Associated with the Local Administration, to advise and report on specific matters, there should be -

(I) A Local Health Committee. (p.40).

(II) A Local Medical Committee. (p.41).

(III) A Local Pharmaceutical Committee. (p.41).

(IV) A Local Hospital Committee. (p.41).

(V) A Medical Services Sub-Committee. (p.41).

(VI) A Pharmaceutical Services Sub-Committee. (p.42).

(VII) A Hospital Services Sub-committee. (p.42).

(VIII) A Joint Services Sub-Committee (p.42)

(IX) An Allocation Sub-Committee. (p.42)

In regard to Dental Benefit we recommend the appointment of Regional Dental Officers to supervise dental treatment.(p.33)

As regards the position of Friendly Societies in relation to Local administration of cash benefits we recommend, for the reasons outlined in this report (p.46), that cash benefits payable to Friendly Societies members should be payable to the member through the Friendly Society and that there should be an additional amount payable to the Society sufficient to compensate for the administrative work involved.

(6) Control of Unnecessarily Expensive Prescribing: That machinery similar to that in Great Britain be established for this purpose (p.45.)

(7) Remuneration: That all questions as to rates of medical remuneration i.e. general practitioner, mileage, anaesthetic and maternity fees, and of payments to private and public hospitals and midwives or maternity nurses in respect of maternity services be referred to the Capitation Fee Committee.

(I) General Practitioner: (p.49). That the total sum payable as remuneration to Insurance Practitioners (The Central Capitation Fund) be calculated by multiplying the number of insured persons by the basic capitation fee fixed by the Minister after considering the report of the Capitation Fee Committee.

(II) Mileage payable to Practitioners: That the amount estimated to be required for the payment of mileage allowance be deducted from the central capitation fund, and that, say, 4/- per mile one way be paid to practitioners attending patients in their own homes in respect of all distances in excess of, say, 2 miles from the practitioners' respective surgeries. (p.49).

We recommend that half the mileage charge, say, 2/- per mile be recovered from the patient in all cases where he is able to pay (p.49).

(III) Payment for Maternity and Anaesthetic Services. (p.51) That the basic Maternity Fee and the basic Anaesthetic

Fee payable to practitioners be fixed by the Minister. after considering the report of the Capitation Fee Committee.

(IV) First Aid Fees: (p.38) The retention of the payment of the first aid fee in respect of injured workers.

(V) Sparsely Populated Districts; (p.50) That in cases of country districts where, for financial reasons, it would not be possible to maintain a doctor, the Minister, if he sees fit, should make a special grant from Government Funds to assist in securing medical services.

(8) Limitation of Patients: That the limit of the number of patients on any practitioner's list be fixed at not less than 3000 exclusive of Maoris. (p.53)

(9) Maoris: (p.54) That a sum of money equal to the amount that would be available to provide medical benefit for a similar number of Europeans, be set aside to provide the Maoris with as good a service as is being provided to the Europeans. To meet the needs of the Maoris in the matter of health services, we recommend, for reasons outlined in this report, an extension of the present Maori nurse cum doctor service.

(10) Post Graduate Study: (p.56) That provision should be made for practitioners to receive periodic post graduate courses of instruction, and that these practitioners who are obliged to reside away from home whilst taking such courses should receive financial assistance.

(11) Scope of General Practitioner Service: (p.57) That the scope of general practitioner services be defined by the Minister after considering the report of a special sub-committee set up for the purpose, and that as a minimum the scope should comprise the services covered by the definition under the English Scheme.

(12) Sickness and Disablement Benefit: (p. 59) For the reasons set out in the report, we recommend the postponement of the introduction of this benefit except in respect of periods of incapacity in excess of 4 weeks.

The inauguration of the National Health Service such as is recommended in this Report will necessitate a great deal of preliminary work not only in defining the terms of contacts with the various agencies that will render service under the scheme but also in the organisation and instruction of staff. An early decision as to the scope of the scheme and its principal features is therefore necessary if it is aimed to commence the scheme next year.

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Dr. M.H. Watt, Director-General of Health, and Mr. A.V. Keisenberg, Secretary to the Department of Health, have been associated with the Committee throughout the course of its investigations and have rendered considerable assistance in connection therewith.

The Committee desires to place on record its appreciation of the industrious and highly efficient manner in which Mr. C.E. Wynne has carried out his duties as Secretary.

(SGD) D.G. McMILLAN.
Chairman.
A.S. RICHARDS.
W.T. ANDERTON.
C.H. CHAPMAN.
D.W. COLEMAN.

(Sgd.) C.E. WYNNE.
Secretary.

APPENDIX A.

List of Witnesses.

Date.	Witnesses examined.
Thursday, 4th February, 1937.	The Hospital Boards' Association of N.Z. (represented by E. Cannons, Esq., Secretary to the Association).
	Mr. A. F. Hickey, Dominion Life Office, Wellington.
	The Life Insurance Officers' Association of New Zealand (represented by F. F. Innes, Esq.).
	The New Zealand Registered Nurses' Association, (represented by Miss J. Bicknell, President),
	The Chemists' Service Guild of New Zealand (represented by Messrs. E. C. Cachemaille, Secretary, and C. H. Farquharson, Editor, "The Pharmaceutical Journal of New Zealand").
	D. S. Henderson, Esq., General Manager, "Boots" The Chemists, Ltd., Wellington.
	The Institute of Opticians of New Zealand (represented by Messrs. E. A. Sargent and R. Brooke-Taylor, President and Vice-President respectively).
Friday, 5th February, 1937.	The New Zealand Dental Association (represented by H. S. Wilkinson, Esq., Hon. Secretary).
	The British Medical Association (N.Z. Branch) represented by Drs. J.P.S. Jamieson, T.D.M. Stout, L.G. Drury and E.S. Stubbs).
	The New Zealand Trained Masseurs Association (represented by Miss M. McLean).
	Order of St. John (N.Z.) Ambulance Association (represented by Messrs. C. S. Falconer, Hon. Secretary, and S. E. Langstone, Secretary-Manager Auckland Centre.
Wednesday, 24th February, 1937.	Drs. G. W. Harty and W. J. Hope-Robertson (representing the ophthalmic surgeons of New Zealand).
	Dr. Frank Birkinshaw, Christchurch.
	Dr. W. F. Shirer, Wellington.
	Wellington Free Ambulance Association (represented by C. J. B. Norwood, Esq., President, and F. Roffe, Esq., Superintendent).

Date.	Witnesses examined.
Thursday, 25th February, 1937.	Order of St. John (N.Z.) Nursing Division (represented by Dr. A. R. Falconer and C. S. Falconer, Esq., Hon. Secretary). The Dominion Council of Friendly Societies - represented by: C. H. Rudkin, Esq., Chairman. W. J. Gregory, Esq., Vice-President. A. G. Shrimpton, Esq., Secretary. I. J. Mackersey, Esq., Secretary, Friendly Societies Dispensary, Wellington. J. A. Clarke, Esq., Secretary, Friendly Societies Dispensary, Christchurch. J. S. Chapman, Esq., Manager, Friendly Societies Dispensary, Wellington. W. J. Gillies, Esq., Manager, Friendly Societies Dispensary, Wanganui. F. E. Talbot, Esq., Grand Secretary, U.A.O.D. Canterbury. A. W. O. Travis, Esq., Secretary, A.O.F., Wellington. Professor C. E. Hercus, Dean of the Medical Faculty, University of Otago, Dunedin.
Friday, 26th February, 1937.	Dr. W. P. P. Gordon, Stratford. Dr. W. T. Simmons, Patea.
Thursday, 11th March, 1937.	Dr. T. L. Paget, Inspector of Private Hospitals, Wellington. Dr. T. F. Corkill, Obstetrician and Anaesthetist, Wellington. Dr. G. F. V. Anson, Anaesthetist, Wellington.
Thursday, 15th April, 1937.	Dr. G. M. Smith and W. H. White, Esq. (representing the Hokianga Hospital Board). Dr. R. R. D. Milligan, Christchurch. Mr. C. Croall, Hamilton. Sisters Angela, de Lourdes and Adelma (representing the Home of Compassion, Island Bay, Wellington). J. L. Saunders, Esq., Director, Division of Dental Hygiene, Department of Health, Wellington.
Thursday, 3rd June, 1937.	Dr. Sydney C. Allen, New Plymouth.
Tuesday, 27th July, 1937.	Dr. Ulric Williams, Wanganui.
Saturday, 21st August, 1937.	Municipal Association of New Zealand (Inc.) (represented by T. Jordan, Esq., President and A. E. Hurley, Esq., Secretary).
Friday, 3rd September, 1937.	Christian Scientists of New Zealand (represented by A. E. F. Court, Esq., Auckland, and Edgar G. Harris, Christchurch).

APPENDIX A (1).

ESTIMATE OF COST OF SERVICES WHICH THE COMMITTEE HAS RECOMMENDED SHOULD BE PROVIDED AT THE INCEPTION OF THE NATIONAL SCHEME.

General Practitioner Service: (including mileage payments and anaesthetic fees) @ £1. per head		£1,600,000.
Maternity Services:		
Medical Practitioners fees @ £5. per confinements	£100,000	
Payments to private maternity hospitals @ £10 per confinement:	120,000	
St. Helens Hospitals @ £10 per confinement	20,000	
Payments for confinements, @ £10, in unlicensed homes and private homes	45,000	285,000
(Payments in respect of confinements in Public Hospitals included in estimate of cost of Hospital and Sanatoria benefit - the amount estimated under this heading £68,000 for 6,800 confinements)		
Laboratory and Radiology Services in outpatient Departments of Public Hospitals		20,000
Pharmaceutical Benefit (drugs, sera and appliances) - approx. 7/- per head		550,000
Hospital and Sanatoria Benefit:		
Public Hospitals:	£660,000	
Private "	130,000	
Mental v "	150,000	940,000
Dental Benefit (extractions and dentures):		250,000
Medical Research:		6,000
Health Education:		3,000
		3,654,000
Administration, say 5%		182,000
		£3,836,000

The estimated payment in respect of Public Hospital treatment is computed on the basis of 6/- per diem per patient. This payment, it is anticipated, will relieve local levies and Government subsidy thereon each to the extent of about £200,000 annually.

APPENDIX "B".

BRITISH MEDICAL ASSOCIATION : NEW ZEALAND BRANCH.

Wellington,
July 6th., 1937.

The Secretary,
Government Investigation Committee
on National Health Insurance.

Dear Sir:

By your letter dated 24th. February last, and by verbal request from the Chairman of your Committee, this Association has been asked to furnish certain additional items of information for your Committee. In the interval discussions have taken place between the Chairman of your Committee and members of this Association throughout the country, as a result of which we believe that the objects of the requests of your Committee will be better served by a statement of the views of this Association than by specific answers to the individual questions submitted.

The Chairman of your Committee has kindly acquainted this Association with the form in which the ideas of your Committee are tending to crystallise; and this Association feels it should reciprocate by explaining in skeleton form, as an alternative to the universal General Practitioner system favoured by your Committee, a Plan which it believes may be developed with less disadvantage to the community.

This Association has already urged, and still maintains, that improvements in the health service of the community should be of evolutionary character, based on actual experience, rather than that untried methods of unpredictable effect should be hastily introduced. In particular, the earliest improvement attempted should be in the direction of giving necessary service as fully as possible to those who are unable to provide for themselves. In the light of experience further improvements and extension may be made as needs appear and means become available.

It is not to be taken that in submitting the attached Plan to give effect to this policy the Association is urging the immediate introduction of its full scope. The profession does not look upon National Health Insurance as the only or necessarily the most desirable means of securing more complete and efficient health service for the people, but as a possible means of meeting difficulties at special points. Consequently it regards the system only as a part of the whole health service to be applied in a limited manner only where it can be seen to have value. In view of the defects which experience of the system has shown in other countries, and of the wide provisions already existing in our own system, we think the utmost caution is to be exercised in adapting the principle to our own particular case. We say without hesitation that the more we have enquired into the matter the more we are forced to this conclusion.

In presenting this material to your Committee this Association begs to point out that a great amount of statistical actuarial, financial and fiscal information is required before any scheme can be presented competently to the legislature. Some of this is not available until the material of the last Census has been analysed, and what is available has not yet been fully studied. Your Committee must have been impressed by this in the course of its own investigation. Elsewhere, prolonged enquiry into every aspect is undertaken by bodies specially qualified for the investigation required, prior to discussion by the legislature. In this country, so far as we are aware, the question has been enquired into for a relatively short period by only your Committee composed of members of Parliament of one Party and this Association's Committee, both of which have insufficient and partly obselete data. Without disrespect, this Association submits that neither body is entirely competent to deal with all the questions involved, and if they were, cannot do so until more information, especially information from the last Census, is available.

We concur entirely with the view expressed by the Chairman of your Committee that the scientific question of how best to care for the health of the people should not be carried into the political arena. It is evident that it is a matter on which all representatives of the people should be equally informed and the people themselves allowed time in which to reach considered opinion. For this reason we propose to make public the contents of this report.

We do not overlook the fact that the introduction of even a limited system involves increase of administrative cost to the State and addition to the taxation of the people, and we think all should have the opportunity to weigh the cost against the assumed advantages.

Your Chairman has informed us that your Committee favours a Universal Practitioner Service, and other associated services, at an estimated addition to taxation of three and a half millions, equivalent to sevenpence to eightpence in the pound on all wages, salary or income. This is a large burden. It would have to be assumed immediately if that project is to be put into operation on the 1st. April next, as we have been assured is the intention. But there is nothing in the health condition of the country to indicate the necessity for such speedy adoption of new remedial measures at so great fiscal cost.

This Association, therefore, earnestly urges that legislation should be delayed until full data are available, complete investigation has been made, and the people and their representatives have reached informed conclusions.

We have complied with your Committee's request for information regarding a National Health Insurance scheme, and have pointed out the methods by which we think it might be applied. But we have also indicated in a previous communication that we consider other lines of advance of greater ultimate benefit under our conditions and with our already extensive system of health service; and we still reserve freedom of action in further dealings with the matter.

THE PLAN.

The following plan is based on what are judged to be the needs apparent at the present time which may be met by a modified adoption of the insurance principle for incorporation in our system on a limited scale. In the formation of the Plan it has been necessary to deal with the needs of the community sectionally. We wish to emphasise that in doing this there is no thought in the mind of the profession of any social or class distinction other than the differences with which we have actually to deal in medical work whereby the endowment of health, the circumstances affecting health and accessibility to health services vary amongst individuals from innumerable causes. In the suggestions offered the Association wishes further to emphasise that it does not seek the institution of a "poor man's service" or a system of "poor relief", but desires to meet special difficulties where they arise so that complete health service may be equally attainable, though not necessarily "free", to the whole community.

We have grouped the population into four sections, following the above principle, thus:-

SECTION I.

Old age pensioners, unemployed and unemployable, part-time and casual workers, others of small earnings or income who are not dependants of other persons, and the dependants of all those where their earnings or total income (in the case of married people, their combined income) does not exceed old age pension, unemployed or sustenance rates.

For these we suggest that complete service might be provided, as hereinafter outlined, in order that they may be as advantageously placed as the rest of the community in respect of necessary health service.

This section of the population receives at present hospital services and other services attached to hospitals, though not always on an understood free basis. Not being able to afford domiciliary medical attention

they tend to occupy hospital accommodation for conditions for which hospital treatment is not required. They require more adequate service, especially in the direction of ordinary domiciliary medical and nursing service, the provision of which should give some relief in the matter of hospital accommodation.

Past experience has shown that the local effects of periods of stringency, and the shift of population which occurs at such periods, at times throw undue burden on local finance to the detriment of medical care of this section. We consider, therefore, that in order to equalise the incidence of costs and maintain efficient care, the cost of services for this section should be arranged in a more national basis than at present, and that the State should provide domiciliary medical and nursing care.

This, in our opinion, is the only section of the community which requires complete service solely at the expense of the public funds. The rest of the community can and should, either in whole or in part, provide for their own health services.

In regard to probable costs, we are unable on account of insufficient data to give any accurate indication, but as amongst those affected there is a relatively high incidence of sickness and special disability, a higher rate of remuneration would be required than obtains in existing contract practice which embraces a selected body of people.

SECTION II.

Wages and salary-earners whose total income does not exceed:

(a). 60/- per week, gross, single.

(b). 80/- per week, gross, married, without children (combined income); 10/- per week higher income for each child under 16 years being allowed to entitle inclusion.

For this section we propose that they should be contributors for themselves and their dependants to a scheme whereby they would be provided with complete health service as in Section I.

In the light of past experience, we think their contribution could be made on such a scale as would defray the cost of general practitioner service, and some of the cost of hospital service; but to furnish complete service, public funds would be required to bear part of the Costs.

Superficially, it may seem anomalous not to include in this section those who are working on their own account, but of sometimes no greater income than the above. But such people do not as a rule suffer entire loss of income when laid aside by sickness. Arrangements are generally made whereby their trade or business is carried on, so that their need is not usually as great as in the case of those whose temporary inability to work means cessation of income. Further, in all assessments of income from wages and salary it will be necessary to include allowances in kind of every description; and, as had been found in every country, the corresponding assessment of equities in the case of independent workers presents a very complicated problem. But in the next section we hope to show that something can be done to guard the main risk of this deserving body.

SECTION III.

All having income not exceeding £500. p.a. and not included in Section II.

The sickness risk which presses on such people is not ordinary domiciliary and consulting room medical attendance. It is the more serious illness involving hospitalisation, specialists' services and costly diagnostic procedures. We suggest, therefore, that this section should make their own arrangements for themselves and their dependants for ordinary medical attendance, but should contribute to an insurance fund for

hospital, specialist and consultant services, this fund to provide a cash benefit for those purposes. This should be on a compulsory and self-supporting basis. It has been demonstrated that, spread over such a group, a scheme can be run on a sound basis, e.g., "Oxford and District Provident Association" in England.

We believe that this would give considerable relief to the problem of hospital accommodation and finance.

SECTION IV.

Those with income exceeding £500. p.a.

This section is capable of providing all services for themselves. There are opportunities for insurance against sickness risks open to them if they like to avail themselves of them, and they could be admitted, if they chose, to the scheme suggested for Section III.

The underlying idea of these suggestions is that the insurance principle should be brought in to assist people to meet their needs where these press most heavily, and that they should rely more and more on that principle as their circumstances permit them to use it. Where the circumstances are such that contributions cannot be made, or can be made to only small extent, public finance assists. Thus, in the first section it is only insurance in the sense that the individual's contributions are paid from public funds. In the second section the individual covers part of his own risk by insurance contributions, the rest being borne by public funds. In the third section the individual's main risks are covered in conformity with the insurance principle without other assistance.

As will be seen presently when the items which comprise a complete service are detailed, to provide these services wholly from public funds for Section 1 and partly for Section II would be a heavy burden. Modern figures are not available, but it is probable that Section I alone includes a quarter of a million individuals. Even so, the taxation cost would be less than under the Universal Scheme contemplated by your Committee

THE ELEMENTS OF COMPLETE HEALTH SERVICE.

The term "Complete Health Service" has been used in the foregoing, and it is necessary to explain what is understood in that term. The Health System as a whole embraces a wide variety of activities which fall, broadly, under two headings: Preventive medicine and Curative medicine. The former is chiefly a departmental function, and we do not propose to consider it in detail, but only to take this further opportunity of emphasising our opinion, previously given, that the Government and the people are more likely to get a dividend by generous support of every aspect of preventive medicine than by putting their money on an extensive system of contract practice of curative medicine.

What we wish to show here is how an insurance scheme can be dove-tailed into the existing system of Curative Medicine.

The elements of a complete service have the family doctor as the essential pivotal point, and are here set out in the order in which they are commonly related to his work. Normally, these various elements should be employed through reference by the general practitioner who is the family doctor.

(a). General Practitioner Service.
(b). Nursing Service (Home).
(c). Anaesthetics.
(d). Pharmaceutical Service.
(e). Consultant and Specialist Services.
(f). Laboratory and Radiology Services.
(g). Hospital Services and Ambulance.
(h). Maternity Services.
(i). Physio-therapy and Massage Services.
(j). Dental Services.

We are not including here certain items which appear to come more conveniently under direct departmental control, such as Mental Hospitals, Spas and provision for certain special diseases.

We next propose to discuss a little more fully the various items of a complete service:

GENERAL PRACTITIONER SERVICE:

Where employed under an insurance system the general character of ordinary private practice should be preserved as it exists at present; but surgery, excepting certain minor surgery, maternity work and the administration of anaesthetics, local and general, must be excluded. General Practitioner Service should be linked with other services in order that full and consecutive knowledge of the health condition of patients can be maintained. The Association has formulated certain principles which are in conformity with those adopted elsewhere in the relationship of this branch of service to Health Insurance systems. These principles provide -

That the confidential basis between family doctor and his patients be maintained and that satisfactory relationships between him and all other agencies concerned in serving the health interests of the people should be fostered.

That there be statutory right of every registered medical practitioner to undertake National Health Insurance Service.

That to ensure the best quality of service, remuneration be adequate.

That there be free choice as between doctor and patient.

That income limit be fixed for those eligible.

NURSING SERVICE:

Home nursing service to undertake the proper nursing of the sick in their own homes in suitable cases under medical supervision would be a great assistance, and would tend to relieve the costs of hospitalisation.

Quite apart from nursing, a valuable ancillary might be added by the provision of home help when the mother of a family is unfit on account of sickness or pregnancy.

PHARMACEUTICAL SERVICE:

Supply of drugs, dressings and medical and surgical appliances should be made only under medical prescription. Under insurance conditions there is a tendency to rising costs due to increased consumption of drugs, not actually necessary but difficult to avoid. To control this undesirable development we think it advisable that the patient should bear some part of the cost of medicines, or at least of repeat prescriptions.

ANAESTHETICS:

In modern medicine the variety and choice of anaesthetics suitable in different conditions have become very wide. They are more costly than is commonly supposed. In former days a whiff of chloroform on a handkerchief was cheap and easy, though dangerous. At the present time the selection of suitable types of anaesthesia is an important part of every surgical procedure. The administration in particular cases is a matter of special skill and costly apparatus and material. Consequently, anaesthetics must be considered as a separate service, and allowance made for special types of anaesthesia where required.

CONSULTANT AND SPECIALIST SERVICES:

In the best interests of the people these should be available as called for by the family doctor. The general practitioner should feel free to refer questions of difficulty to consultants and specialists.

LABORATORY AND RADIOLOGY SERVICES:

In modern medicine diagnosis has come to depend more and more upon investigations of this kind, and effective treatment in many conditions depends upon the laboratory and radiology department. These types of service entail exceptionally costly equipment, and specialised, technical and professional personnel, but are quite essential to complete service.

HOSPITAL SERVICE:

This is, naturally, a most important factor in complete service, and in order to be most effective must be closely related to treatment by the family medical attendant, and available in both public and private hospitals. The linking up of hospital service with domiciliary and convalescent treatment would be facilitated by the employment of hospital almoners. Experience has shown that better service to the patient and economy to hospitals are obtainable by convalescent arrangements made by these officers, and the employment of trained persons for this work should be encouraged.

Out-patient departments should be retained purely for casualty and emergency work.

In the Plan submitted we contemplate Section I being given hospital benefit in public hospitals, when recommended by the practitioner, at no cost to themselves. In the case of Section II some fraction of hospital cost would be defrayed by their insurance contributions. As regards Section III (and Section IV, if electing to join) the benefit is a cash one and normally sufficient for hospital, consultant and specialists' costs, thus relieving rates and taxes.

In the case of all sections, persons preferring to be treated in private hospitals should have maintenance costs paid on the same scale as allowed in public hospital, and an allowance toward specialist treatment for Section I and II. It can be demonstrated that stay in private hospital tends to be shorter than in public hospital for several reasons, so that there is no need for differentiation.

In order to provide more efficient service for special types of disease better linking up of hospitals is required. This can only be achieved by a redistribution of hospital districts so as to provide larger districts, permitting proper classification of hospitals according to their ability to deal with special varieties of work. Patients would thus be easily transferred from one hospital to another according to their medical and surgical requirements rather than according to their geographical domicile.

To facilitate the treatment of special classes of cases requiring facilities which can be provided only in public hospitals, it will be necessary to institute a system of community hospitals, involving re-organisation of the system of hospital administration.

We visualise these changes coming about, not by immediate radical overthrow, but by gradual development, until Health districts, Hospital districts, and Health Insurance districts are the same, with all health activities in a district relationship.

MATERNITY SERVICES:

Provision for this elemental human need by complete maternity servives, both domiciliary and hospital, including ante- and post-natal attendance by a medical practitioner, should be made for those unable to meet their own requirements, even if no other part of this plan be adopted. In view of the enquiry now proceeding we do not propose to comment further on this excepting to point out that of recent years ante-natal supervision has assumed great importance and entails much additional attention by practitioners, and further, that allowance has to be made for the more common reliance on specialists in difficult cases.

PHYSIO-THERAPY AND MASSAGE SERVICE:

This is a necessary modern adjunct to treatment required through reference by practitioners.

DENTAL SERVICE:

This is a matter for discussion with the Dental Association and we merely mention it as we frequently, as a part of medical treatment, have to refer patients to this allied profession.

MEDICAL SERVICE FOR THE MAORIS:

This Association has come to the conclusion after discussion with members who have had experience and with the Department, that this is at present a separate problem which cannot be dealt with in an insurance question. We think the matter has been taken up on correct lines by the Health Department. Much has to be done on public health lines, and as regards curative medicine, development of the system instituted by which nurses working amongst native population call in medical assistance as required is the best method.

MILEAGE:

The question of mileage has proved in all overseas Dominions one of the knotty problems in the discussion of National Health Insurance, and we have heard of no full solution. To meet special difficulties we suggest that it may be possible, in addition to transport allowances for ordinary circumstances, to make allocation for places specially difficult of access.

MEDICAL RESEARCH:

The profession appreciates the interest your Committee has shown in this matter. There are many questions specifically affecting the health of the New Zealand people, not only on the field of diseases but also as regards nutrition which require investigation, as well as points related to medical research elsewhere. We urge the strongest possible support for this need.

It is felt that the first step should be the institution of a Council of Medical Research to instigate and supervise Medical Research and control expenditure. We suggest that a suitable body for this purpose might be found in the medical members of the Board of Health, for which Body we are later proposing reconstitution.

THE COST.

This Association regrets having to disappoint your Committee in regard to a submission of terms and costs. The plain fact is that there is not sufficient information available to make this possible. We are not in a position to make or accept an offer. For the same reason we venture to suggest that your Committee is similarly placed.

We were asked to submit a scheme sectionally arranged so that one part or another could be adopted. This we have done and we trust that it will demonstrate the magnitude of a complete scheme. If, and when, the people, knowing the implications, decide that such a plan or part of it should be adopted, and when full data are available, then costs and definitions can be discussed.

It is too often overlooked that in National Health Insurance the real insurance carriers are the medical profession. The State funds for the purpose, but its liability is defined by the amount of its funds; the liability of the profession is indeterminate. In other words, the community seeks to pass on its unknown sickness risk to the profession for a known sum. Hence caution is excusable.

In Life Insurance the risk taken by the insurance carrier can be actuarily determined. In insurance against hospitalisation limits may be set and a fair computation made. But general sickness risk is an incalculable thing in unselected bodies.

The basis of any figure we could suggest would be a knowledge of the work we should have to do. This knowledge is lacking. Under British conditions, early experience of the Panel System gave for general practitioner service an average of 3.5 attendances per patient per annum. According to more recent figures this has risen to 5.11 attendances, and the British

system does not include dependants who, on the average, require a little over twice as many attendances as the insured worker. Other English records relating to work comparable to general practitioner service for Section I. in the Plan above, give a figure for one year's experience of 9.3 attendances per patient per annum. Further experience may give higher figures.

Add to this the fact of which we, as a profession, are well aware, that the public of New Zealand as a whole is accustomed to and expects a more detailed and time-consuming type of service than contents the British working man, and good reasons are apparent why we cannot comply with your Committee's request.

We have not here touched on the subject of cash benefits during sickness, a provision so valuable in voluntarily controlled benefit societies. But the public should be apprised that, historically, the introduction of these benefits in nationally controlled schemes, on account of being so readily turned to political account, leads always to steadily rising cost.

ADMINISTRATION.

GENERAL.

The administration of an Insurance Scheme should, naturally, fit into the administrative system of the Health Department as a whole, and for that reason some adjustment for co-relation would be required. It may be necessary later to enter more fully into discussions on these points of relationship between the Insurance Plan and other branches of curative and preventive medicine, but at present the only part of the general administration to which we wish to refer is the Board of Health.

We recommend that this Board should be constituted on a mainly scientific and technical basis, and should be capable of advising on all the various activities of the Health Department. As already suggested, its medical members might form a Council of Medical Research.

FOR INSURANCE PLAN:

Before outlining the system of administration for the Insurance Plan we wish to refer to certain conditions which are considered by the profession to be essential to such administration. These are:-

1. THAT medical practitioners should have the right to be consulted by the Government or its nominees before any regulations are promulgated that can in any way affect them.

2. THAT medical practitioners should have the right to be adequately represented on any controlling body and that they should have the right to approach the responsible Minister directly through their representatives.

3. THE statutory right of every registered medical practitioner to undertake National Health Insurance Service.

4. FREE choice as between doctor and patient subject to the right of the doctor to refuse to accept a particular patient. Any regulations affecting this must be most carefully drawn. The present British regulations seem quite fair to all parties and work well.

5. ADMINISTRATION of medical benefit to be separated from the administration of the cash benefits, and to be through a body having effective representation of the practising profession.

6. PROFESSIONAL discipline to be maintained by tribunals mainly professional in constitution as in the British system.

7. THE relations between specialists and general practitioners to be adjusted by a Central Medical Authority set up by the profession.

In accordance with these principles we submit the following system of

administration:

1. CENTRAL ADMINISTRATION.

As part of the general health administration, the administration of the insurance Plan would necessarily be under the Director-General of Health as chief executive officer of the Minister of Health. Under the Director-General, and specifically controlling the National Health Insurance Plan, we recommend a Commissioner, who should be an overseas authority specially appointed for a period of five years to inaugurate and administer the Plan. At the end of that period the administration would be taken over by a Director of Medical Services under the Director-General.

The following advisory bodies should form part of the central administration:

(a). A Central Committee, or Committees, representing various interests, to be consulted by the Authorities on all matters appertaining to their respective interests.

(b). A Central Medical Committee, representative of the medical practitioners of the Dominion, appointed by the Council of the New Zealand Branch of the British Medical Association, with special representation of the Faculty of Medicine of the University of Otago, of the Royal Australasian College of Surgeons and of the Australasian College of Physicians.

This Committee should have the right to be consulted by the Minister responsible for Health Services before any regulations affecting the Medical Practitioners of the Dominion are promulgated.

It should also be the body to which a Local Medical Committee may refer any question that imports a matter involving a general principle.

It should have the right to approach the Minister directly through its Chairman or deputy appointed in his place, on any matter affecting the medical practitioners of the Dominion.

Where any matter is referred to it by the Minister or by any branch of the Government, adequate time should be allowed it to consider, discuss and report its opinion on the matter.

2. LOCAL ADMINISTRATION:

We recommend that districts for local administration should be large, and should divide the whole population into parts as even as may be consonant with geographical features and natural lines of communication. They should correspond generally to Health Districts or such re-arrangement of these as may be determined upon in the general system of Health administration.

The local administration should be a branch of the Central Administration, consisting of a local Health Officer and staff, to which is to be attached a Regional Medical Officer.

The following advisory bodies should form part of the local administration:

(a). Local Health Committee:

The Local Health Committee in each area to have advisory and such other functions as may be delegated by higher authorities. However constituted it should include one Medical member nominated by Medical Practitioners actually practising, in the district for each 50 or part of 50 doctors practising. It should advise on all health matters in the district particularly in regard to the interests of the insured persons in that area.

(b). Local Medical Committee:

There should be a local Medical Committee for each district consisting of one representative for every ten, or part of ten, medical practitioners actually practising in that district, and nominated by them. It would be

well to provide that there be no less than three members on any such Committee. The Local Medical Committee should be responsible for the quality of the medical service provided in its district. It should be responsible for allocating patients who do not make a choice of doctor. It should be required to report on any matter referred by the local Health Authority. On any matter that involves a general principle the Local Medical Committee should be empowered to refer the matter through the Central Medical Committee direct to the Central Authority.

(c). Enquiries and Complaints:

As far as possible the practice as it obtains in England should be followed. Any complaints as between one doctor and another; or regarding the quality of medical services rendered by any medical practitioner in the area should be referred to the Local Medical Committee This Committee should be empowered to require evidence and if necessary to make recommendations to the Minister. Trivial complaints as between patients and doctor should be settled by the Local Health Officer or the Regional Medical Officer. More serious complaints should be referred to a Committee made up of an equal number of representatives of the Local Health Committee and the Local Medical Committee with an independent Chairman. This Committee should not have penal power over medical practitioners but should make recommendations to the Minister. Both individual practitioner and the patient should have the same right of appeal as in England.

The representations we trust will meet the requirements of your Committee.

Yours faithfully,

(Sgd). P. P. LYNCH.

APPENDIX C.

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APPENDIX "C".

GENERAL ARRANGEMENT OF MEDICAL BENEFITS.

N.B. The following notes are submitted as an outline of matters that will require to be covered by Regulation and as an indication of the form of the Regulations.

In preparing these notes considerable use has been made of the Medical Benefit Consolidated Regulations, 1928, under the British scheme of National Health Insurance. They are to be regarded purely as an approximate guide. At the present stage it was not thought necessary to devote any considerable time in adapting them particularly to the recommendations contained in the foregoing report.

TERMS OF SERVICE FOR MEDICAL PRACTITIONERS: The Minister shall, after consultation with the Medical Profession and the special Sub-Committee appointed for the purpose issue regulations setting out the scope of the Medical Benefit and the terms under which it is proposed to invite practitioners to undertake service.

He shall also invite those practitioners who are willing to accept service under the terms and conditions offered by the Minister to notify the Medical Officer of Health of the district or districts in which they practice, to that effect.

MEDICAL LIST: (1) The Medical Officer of Health shall cause to be prepared a list to be called "The Medical List" of the practitioners (hereinafter referred to as Insurance Practitioners) who have notified him that they are willing to accept service upon the terms of service set out by the Minister.

(2) The Medical List shall contain, in addition to the names of the Insurance Practitioners:

(a) The private address and the address of any surgery, dispensary or other place, at which the practitioner undertakes to attend for the purpose of treating insured persons.

(b) Particulars of the days and hours at which he undertakes to be in attendance at each place.

(c) Where two or more practitioners intend to practise in partnership, the name of the firm or partnership, and

(d) The name and address of any assistant whose name the Local Health Committee may require to be placed upon the Medical List with a reference to the name and address of the principal;

and may, if the Committee thinks fit, be so arranged as to show the part of the district in which each practitioner undertakes treatment.

(3) Copies of the Medical List shall be available for inspection at the District Health Office, at the Post Office and at such other

places as appear to the Medical Officer of Health to be convenient for informing all persons interested and shall be kept revised up-to-date.

(4) The Medical Officer of Health shall send a copy of the Medical List to the Minister and shall, as soon as may be, inform him of any alteration which may from time to time be made therein.

The Medical Officer of Health shall also send a copy of the List to the Medical and Pharmaceutical Committees and to each person, firm or body corporate undertaking the supply of drugs and appliances to insured persons or, if the List is arranged by reference to districts, shall send that portion of the list which relates to the district in which the place of business of such person, firm or body corporate is situated.

At intervals of not more than three months the Medical Officer of Health shall notify each such person, firm or body corporate of any alterations made in the Medical List or in the relevant portion of the List.

PRESCRIBED APPLIANCES AND REAGENTS: (1) The medical and surgical appliances to be provided as part of medical benefit shall be the appliances specified in the Schedule to these Regulations.

(2) The chemical reagents to be provided as part of the medical benefit shall be those specified in the Schedule to these Regulations.

PRICES AND STANDARDS OF DRUGS AND APPLIANCES: (1) For the purpose of enabling arrangements to be made for the supply of drugs and appliances of proper quality, the Minister shall cause to be prepared a statement referred to as the Drug Tariff which shall include:

(a) The prices on the basis of which the payment for drugs and appliances ordinarily supplied is to be calculated,

(b) The method of calculating the payment for drugs not mentioned in the Drug Tariff.

(c) Dispensing or other fees payable in respect of the supply of drugs and appliances.

(d) Standards of quality for drugs and appliances ordinarily supplied.

The prices referred to in paragraph (a) may be fixed prices or may be subject to monthly or other periodical variations to be determined by reference to fluctuations in the cost price of drugs

and appliances;

<u>TERMS OF SERVICE FOR PHARMACISTS</u>: The Minister, after consultation with the Central Pharmaceutical Committee and representatives of the Pharmacists shall issue regulations setting forth the terms and conditions upon which it is proposed to invite persons, firms or bodies corporate to undertake the supply of drugs and appliances. The terms of service shall include the Drug Tariff as from time to time determined by the Minister.

The Minister shall also invite those persons, firms or bodies corporate who are willing to undertake service on the terms and conditions offered by the Minister to notify the Medical Officer of Health in the district in which they operate to that effect.

<u>LIST OF PERSONS SUPPLYING DRUGS AND APPLIANCES</u>: (1) The Medical Officer of Health shall, after consultation with the Pharmaceutical Committee, prepare a list of the names and places of business of the persons, firms and bodies corporate ("persons supplying drugs and appliances") who have notified him that they will undertake the supply of drugs or appliances on the terms offered by the Minister and the list shall indicate whether they have undertaken to supply drugs or appliances or both and shall distinguish those who are entitled to dispense medicines and shall also indicate the days and hours on which the several places of business are open.

(2) Copies of the List shall be available for inspection of insured persons at the District Health Office, the Post Offices and at such other places as appear to the Medical Officer of Health to be convenient for informing all persons interested and shall be revised and kept up to date.

(3) The Medical Officer of Health shall send a copy of the list to the Minister and shall, as soon as may be, inform him of any alteration which may from time to time be made therein. The Medical Officer of Health shall also send a copy of the List to the Medical and Pharmaceutical Committees and to each insurance practitioner or if the list is arranged in districts, shall send that portion of the List which relates to the district in which such practitioner carries on medical practice.

At intervals of not more than one year, the Medical Officer of Health shall notify each such practitioner of any alterations made in the list or in the relevant portion of the list.

SCHEMES FOR SECURING PROPER PHARMACEUTICAL SERVICE: (1) The Local Health Committee and the Pharmaceutical Committee shall jointly prepare schemes for testing the quality and amount of the drugs and appliances supplied to insured persons by persons supplying drugs or appliances and for securing that one or more places of business of persons supplying drugs or appliances in each district shall, at all reasonable times, be open to insured persons and the latter scheme shall specify the days and hours on and at which such places shall be open and, subject to the approval of the Minister, the schemes shall form part of the terms of service of persons supplying drugs or appliances.

(2) In the event of the Committees failing to agree on the schemes the matter shall be referred to the Minister, whose determination shall be final.

(3) Subject to the approval of the Minister, the schemes may from time to time be amended jointly by the Local Health Committee and Pharmaceutical Committee, or, in default of agreement between the two Committees, by the Minister and the provisions of the schemes for the time being in force shall form part of the terms of service for persons supplying drugs or appliances.

(4) The number of tests to be taken annually in pursuance of a scheme for testing the quality and amount of drugs and appliances supplied shall be such as the Minister, after consultation with the Local Health Committee and the Pharmaceutical Committee, may from time to time determine.

ARRANGEMENTS FOR SUPPLY BY PRACTITIONERS OF DRUGS AND APPLIANCES:

(1) Where the Medical Officer of Health is satisfied that an insured person, by reason of distance or inadequacy of means of communication will have serious difficulty in obtaining any necessary drugs or appliances from a chemist on the list of persons supplying drugs or appliances, the Medical Officer of Health shall require the practitioner in whose list the insured person is included to supply to that person until further notice, such drugs and appliances as would otherwise

have been supplied by a person supplying drugs or appliances.

(2) In the case of an insured person who is resident in a rural area at a distance of more than five miles from the nearest chemist on the list of persons supplying drugs or appliances, the Medical Officer of Health shall decide whether he shall be entitled to obtain drugs and appliances from the practitioner in whose list he is included or from a chemist on the list of persons supplying drugs or appliances and shall give notice to such insured person accordingly and the notice shall state that he may elect to adopt the alternative method of obtaining drugs and appliances by giving notice to the Medical Officer of Health within seven days of the receipt of the Medical Officer of Health's notice.

(3) The decision of the Medical Officer of Health shall hold good unless the insured person gives notice within the said period of his desire to adopt the alternative method and if the method decided upon by the Medical Officer of Health or adopted by the insured person is that of a supply of drugs and appliances by the practitioner, the Medical Officer of Health shall require the practitioner to supply to that person, until further notice, such drugs and appliances.

(4) A practitioner shall not be required to undertake the supply of drugs and appliances if he satisfies the Medical Officer of Health or, on appeal, the Minister that he is not in the habit of dispensing drugs for patients or that the patient can with at least equal facility obtain a supply of drugs and appliances from a chemist on the list of persons supplying drugs and appliances.

A practitioner shall be entitled to receive reasonable notice from the Medical Officer of Health that he is required to undertake the supply of drugs and appliances or that such supply is to be discontinued.

PUBLICATION OF PARTICULARS: The Medical Officer of Health shall cause to be published in such manner as appears to him best calculated to inform all persons interested, particulars of the arrangements made, including a statement of the places where copies of the terms of service for insurance practitioners and persons supplying drugs and appliances and copies of the Medical List, and the List of persons supplying drugs or appliances and of a List of approved institutions, may be seen and

where any forms of application necessary to be obtained by beneficiaries are available any any other particulars which it is considered proper.

METHODS OF OBTAINING MEDICAL BENEFIT: A general outline of how individuals shall apply for and be placed upon the list of a medical practitioner has already been given on page 36 of the Report.

ALLOCATION SCHEME: The Local Health Committee and the Medical Committee shall jointly prepare a scheme (the allocation scheme) which shall provide for the following matters:

(a) The constitution of a sub-committee, consisting of three members of the Local Medical Committee with the Medical Officer of Health as Chairman and the assignment to such sub-committee of such powers and duties relating to the administration of the scheme as may be specified therein.

(b) The steps to be taken by an insurance practitioner to enable a person, who has applied for and been refused acceptance by him, to be accepted by or assigned to an insurance practitioner.

(c) The provision of any treatment required by the person pending such acceptance or assignment.

(d) The period within which notice of acceptance of a person is to be given to the Medical Officer of Health by any insurance practitioner.

(e) The assignment to an insurance practitioner of any person entitled to select a practitioner who applies for assignment.

(f) The assignment, as far as practicable, to an insurance practitioner of any person who is entitled, but after receiving from the Medical Officer of Health notice as may be specified in the scheme has failed or neglected to select a practitioner and whom the Medical Officer of Health considers should make such choice.

(g) The provision of treatment by an insurance practitioner where neither the insurance practitioner responsible for providing treatment nor his deputy is available for giving treatment immediately necessary owing to an accident or other sudden emergency.

(h) The restrictions, if any, to be imposed on the right of an insurance practitioner to require the removal of any person from his list in such cases as the scheme may specify as being likely to involve hardship on the person owing to his condition of health at the date when the removal would take effect.

(i) Such incidental or consequential provisions as may be deemed necessary.

(2) The allocation scheme shall also provide for a limit to be placed on the number of persons who may be placed on the list of an insurance practitioner and, except in cases in which, owing to special circumstances the Minister, after considering the recommendations of the Local Health Committee may otherwise authorise.

(3) The allocation scheme shall also provide for enabling a practitioner, the number of persons on whose list exceeds the limit, to make arrangements within a specified period for bringing the number within the limit, either by securing the services of a practitioner as partner or by engaging a permanent assistant or by reducing the number of persons on his list and may include, if the circumstances so require, provision for fixing different limits in different parts of the area and for determining the limit in the case of a practitioner whose practice extends over districts in which different limits operate and for securing the necessary consultation and co-ordination in this respect between adjoining Health areas.

(4) If in any area a system of payment of insurance practitioners by reference to attendances given and services rendered is adopted, the foregoing provisions with regard to the limitation of practitioners' lists shall not apply but the allocation schemes shall contain such corresponding provisions for limiting the number of persons for whose treatment a practitioner may undertake responsibility as the Minister may approve.

(5) In the event of the Local Health Committee and the Medical Committee failing to agree on any provision of the allocation scheme the matter shall be referred to the Minister, whose determination shall be final.

(6) The provisions of the allocation scheme shall be subject

to the approval of the Minister and, if so approved, shall be incorporated in and form part of the terms of service of insurance practitioners.

(7) Subject to the approval of the Minister, the allocation scheme may from time to time be amended jointly by the Local Health Committee and Medical Committee, or, in default of agreement between the two committees, by the Minister and the provisions of the scheme for the time being in force shall form part of the terms of service of insurance practitioners.

(8) If the Local Health Committee and the Medical Committee fail to submit an allocation scheme to the Minister within a reasonable time, the Minister may determine a scheme and such scheme shall have effect within the Local Health District as though it had been agreed by the two committees and approved by the Minister.

<u>CHANGE OF PRACTITIONER</u>. (1) A person over the age of sixteen years other than a member of certain specified institutions may at any time make application for acceptance by an insurance practitioner notwithstanding that he is at the date of application included in the list of another practitioner and if accepted shall forthwith be entitled to obtain treatment from the practitioner to whom application has been made. Provided that the insured person has not removed either permanently or temporarily outside the district within which the practitioner has undertaken to provide treatment, the application of such person shall only be accepted if, either -

(a) Both the practitioner in whose list the person is included and the practitioner to whom he applies for acceptance consent to the transfer, or

(b) The person has not later than one month before the termination of the quarter, given notice to the Medical Officer of Health in writing of his desire to transfer, whereupon he will be entitled to transfer as from the end of the quarter.

(2) If a person's name is removed by the Medical Officer of Health from the list of a practitioner owing to the death or removal or withdrawal from the Medical List of the practitioner, the insured person shall thereupon become entitled to apply to another practitioner for acceptance. Provided that, if in the case of death or withdrawal from the Medical List of a practitioner, public notice shall be given

that another practitioner is willing to accept the person for treatment, the person's name shall be deemed to be included in the list of the practitioner named in such notice as from the date of death or withdrawal, unless within one month of the receipt by him of the notice of the proposed transfer he has given notice to the Medical Officer of Health of his objection to inclusion in such practitioner's list, or has secured acceptance by another practitioner.

(3) The person and the insurance practitioner in whose list he is included may at any time, by consent, arrange for his transfer to a specific institution and notice of the transfer shall be given to the Medical Officer of Health by the institution on a form provided for the purpose and to be signed by the person, the practitioner and an officer of the institution.

Such notice shall be sent to the Medical Officer of Health within seven days of the date on which it is accepted by the institution, which shall become responsible for the treatment of the person from the date of acceptance.

The foregoing provision shall apply mutatis mutandis to a transfer by consent of a member of an institution to the list of an insurance practitioner.

CASES OF REMOVAL FROM DISTRICT: If a person removes permanently or temporarily from his place of residence he shall on removal be entitled to select a practitioner in that area unless his new place of residence is within the area within which his original nominee is bound to provide service without charging any mileage fee.

If his change of residence is permanent and he is entitled to change his practitioner, his name shall be removed from his original list as from the date on which the Medical Officer of Health is notified that he has been accepted by or assigned to another practitioner or institution.

If the removal is temporary he may be accepted for treatment as a temporary resident and his name shall not be removed from the list of the practitioner or institution in which it may be included as aforesaid.

The removal of a person shall be deemed to be temporary if

at the date when he removes he intends to remain for a period of less than three months in the area within which the practitioner or institution accepting him for treatment has undertaken to provide treatment.

Provided that if his stay within such area extends to three months his removal shall then be deemed to be of a permanent character.

PRACTITIONERS' AND INSTITUTIONS' LISTS: The Medical Officer of Health shall prepare and keep revised up to date a list of persons for whose treatment each insurance practitioner or institution is for the time being responsible and shall from time to time furnish the practitioner or institution with information in such form as the Minister may determine with regard to persons included in or removed from such list.

PERSONS FREQUENTLY REMOVING: (1) Any person who by reason of his employment or occupation is frequently changing or intends frequently to change his place of residence may make application to the Medical Officer of Health in whose register his name is included, on a form to be provided for the purpose, to be allowed to obtain his medical benefit as though he were a temporary resident in each place in which he resides and if the application is granted the Minister shall be informed accordingly.

(2) The applicant shall thereupon be furnished with a voucher and his name shall be removed from the register and lists of the Medical Officer of Health and he shall be entitled, for a period of six months or such longer period or periods as the Minister may from time to time determine, to obtain medical benefit as though he were a temporary resident.

FINANCIAL PROVISIONS.

GENERAL PRACTITIONERS' FUND: Out of the sum available the Minister shall, after consultation with the Capitation Fee Committee, determine the amount to be appropriated for defraying the cost of treatment to be provided during the year by Insurance Practitioners.

Provided that the Minister may, if it appears to him that the circumstances so require, make a provisional determination for any year either before or as soon as possible after the commencement of the

year and may, at the end of the year, credit the said funds with any supplemental amounts, and in that event a corresponding procedure may be adopted for distributing the said funds amongst the Local Health Districts and for distributing the district funds to practitioners.

THE DISTRIBUTION COMMITTEE: (1) The Minister shall appoint a Committee on which Insurance Practitioners are adequately represented to be known as "The Distribution Committee", whose duty it shall be to consider, having regard to the distribution of the population, and other relevant factors, the basis on which and the proportions in which the Central Capitation Fund, after the deduction of such sums as are necessary to meet payments to practitioners in the form of mileage allowances and maternity and anaesthetic fees, and to make special provision where necessary for adequate medical service in particular areas or for Maoris in rural areas, should be distributed among the Local Health Districts. In considering such distribution the Distribution Committee shall have regard to any representations made to them by any committee on the matter.

The Distribution Committee shall have power to incur reasonable expenses in obtaining information from any insurance practitioners in the area and from other sources to enable such representations to be made to the Distribution Committee.

(2) The Minister shall appoint the chairman of the Distribution Committee.

(3) The members of the Distribution Committee shall hold office during the pleasure of the Minister, and the Minister shall have power to fill casual or other vacancies as they occur.

(4) The Distribution Committee shall, before the commencement of each year, report to the Minister as to the basis on which and proportions in which the Central Capitation Fund should be distributed amongst the several Local Health Districts for the year, except that on the commencement of the scheme the Distribution Committee shall make their report to the Minister before the end of the first quarter.

(5) After considering such reports, the Minister shall deter-

mine the distribution of the Central Capitation Fund and the amount allotted to each Local Health District shall be credited to a fund in the books of the District Health Office called the Capitation Fund.

Provided that if in any area (for example an area in which there is a large preponderance of Maoris or an area in which the population is widely scattered) the Minister is satisfied that an adequate medical service cannot be provided by general practitioners employed under the usual terms of service he may reduce the amount to be credited to the District out of the Capitation Fund by such sums as he considers necessary in the circumstances and apply them in the provision of alternative services.

DISTRIBUTION SCHEME: The Local Health Committee and the Medical Committee shall jointly prepare, or in default of agreement the Minister shall prepare, a scheme to be approved by the Minister for the division of the Practitioners' Fund amongst the various practitioners entitled thereto.

MILEAGE, MATERNITY AND ANAESTHETIC FEES: Mileage allowance and maternity and anaesthetic fees shall be at respective rates determined by the Minister after consultation with the Capitation Fee Committee. The total amount to be appropriated each year for the payment of such allowance and fees shall be determined by the Minister after considering the reports of the Distribution Committee and shall be a prior charge on the Central Capitation Fund.

PHARMACISTS' CENTRAL FUND: (1) Out of the sums available the Minister shall determine the amount (The Pharmacists' Central Fund) to be appropriated for defraying the cost of drugs and appliances supplied during the year by persons supplying drugs or appliances.

(2) Each Medical Officer of Health shall furnish to the Minister, in such form and at such times in the course of each year as he may require, returns of accounts rendered to him by persons supplying drugs or appliances in respect of drugs and appliances supplied during the year.

PHARMACEUTICAL DISTRIBUTION COMMITTEE: (1) The Minister shall appoint a Committee consisting of registered pharmacists and other persons,

"the Pharmaceutical Distribution Committee", whose duty it shall be to consider, having regard to the amount of the accounts furnished by each Medical Officer of Health, and to any other circumstances which they consider material, the proportions in which the Pharmacists' Central Fund should be distributed amongst the several Local Health Districts.

(2) The Minister shall appoint the chairman of the Pharmaceutical Distribution Committee and the procedure of the Committee shall be such as they may from time to time determine.

(3) The members of the Pharmaceutical Distribution Committee shall hold office during the pleasure of the Minister and the Minister shall have power to fill casual and other vacancies as they occur.

PAYMENTS TO PERSONS SUPPLYING DRUGS OR APPLIANCES: The sum payable out of the Chemists' Fund to persons supplying drugs or appliances shall be calculated in the manner following:

Firstly, each such person shall be credited with the cost of drugs and appliances (excluding dispensing fees) supplied by him during the year and shown in the accounts for drugs and appliances submitted by him and passed by the Committee.

The Fund shall, as soon as may be after the expiration of the year, be distributed accordingly.

Provided that from time to time throughout the year payment shall be made by way of advances to persons supplying drugs or appliances at such rates as the Minister may determine and in determining any such rates the Minister shall have regard to any recommendation made to him by the Pharmaceutical Distribution Committee.

Practitioners dispensing drugs and appliances shall be regarded for that purpose as listed pharmacists.

N.B. At the inauguration of the scheme it may be necessary to guarantee to pharmacists full payment in accordance with the prices and scales of fees prescribed in the drug tariff. Such payment would include not only the cost of drugs (including drugs not specified in the Drug Tariff) and appliances but also the prescribed fees for dispensing. In the absence of reliable statistical data in the initial stages of the scheme there would be difficulties in the adoption of the

per capita method of payment for dispensing services as now followed in England.

The establishment of pricing bureaux whose functions would include the collection of statistical data under the following headings:

(1) Total cost of prescriptions for the district.

(2) Total number of prescriptions for the district.

(3) Total cost of prescriptions for each doctor.

(4) Total number of prescriptions for each doctor.

(5) Average cost per insured person on doctors' lists for the whole district.

(6) Average number of prescriptions per insured person on lists for whole district.

(7) Average of cost per insured person on each doctor's list.

(8) Average number of prescriptions per insured person on each doctor's list.

(9) Average cost per prescription for whole district.

(10) Average cost per prescription of each doctor prescribing,

should, in a few years, result in valuable statistics being available if it were deemed necessary in some subsequent years for stricter financial control or any other reason to adopt the per capita method.

PAYMENTS TO INSTITUTIONS FOR MEDICAL TREATMENT. (1) Every recognised institution shall, at the commencement of each quarter, furnish to the Medical Officer of Health a certificate, on a form to be provided, of the number of insured members on the list of the institution.

(2) The Medical Officer of Health shall furnish to the Minister at such times as he may direct, such particulars with regard to insured members of each such institution as he may require and the Minister shall determine on the basis of such particulars the number of insured members of each such institution resident in the local Health District.

(3) As soon as may be after the expiration of each quarter, the Medical Officer of Health shall pay each institution submitting the certificate, by way of an advance on the amount due to it, such sum as

the Minister may determine.

Provided that the Medical Officer of Health, at the end of each month in the quarter, upon the application of any such institution make payment on account not exceeding one-third of the amount to which the institution would be entitled after the expiration of the quarter.

(4) If an institution ceases in the course of a quarter to provide treatment for its insured members or to be approved, an appropriate reduction shall be made in the amount which would otherwise be available for payment to the institution and such adjustments, if any, shall be made between the various funds.

(5) Where, owing to the failure on the part of any institution to comply with any of the conditions prescribed by or in pursuance of any regulation for the administration of medical benefit for the time being in force, a reduction shall be made in the amount paid in that year to the institution which is in default.

INVESTIGATIONS, DISPUTES, APPEALS:

Constitution of Medical Service Sub-Committee:

(1) Every Local Health Committee shall constitute a special sub-committee called the Medical Service Sub-committee consisting of an equal number of representatives of insured persons and of practitioners, together with the Medical Officer of Health or his deputy as chairman, and if the committee so decide, a vice-chairman.

(2) The members of the Sub-committee shall be appointed in the following manner:

Not more than five nor less than three members of the sub-committee shall be appointed by and from the members of the Local Health Committee who represent insured persons and an equal number of persons shall be appointed by the Local Medical Committee.

Provided that if none of the members representing practitioners is a woman, at least one of those appointed to represent insured persons shall be a woman but the woman so appointed may be a person who is not a member of the Local Health Committee or who, being a member of the Committee, does not represent insured persons thereon.

If the Local Medical Committee fail to appoint a member or

members of the Medical Service Sub-committee within one month after being requested to do so by the Local Health Committee, the Local Health Committee shall appoint the necessary number of practitioners to fill the vacancy or vacancies.

(3) There shall be appointed in the same manner as the members of the Medical Service Sub-Committee, a corresponding number of persons having the same qualifications, if any, to act as deputies for the members representing practitioners and insured persons respectively and in the absence of members of the Sub-committees such persons shall be entitled to act accordingly.

(4) If at any time after the expiration of three months from the date of the first meeting of the Sub-committee the Minister, upon representations being made to him by the Local Health Committee, is satisfied that the duties of the Sub-committee are not being properly carried out, may approve for such period and with such modifications, if any, as he thinks fit, any scheme which the Committee may submit to him for reconstituting the Sub-committee or for securing that their duties shall be carried out by other means and any scheme so approved shall have effect as if it were incorporated in and formed part of these regulations.

(5) If, in the opinion of the Chairman, any member of the Medical Service Sub-committee is interested in, or in the case of a practitioner, is partner or principal or assistant to a practitioner interested in, a question referred to them, that member shall take no part in the hearing thereof but a deputy having the same qualifications, if any, as the member who has withdrawn shall act in his place.

(6) The Committee may, with the consent of the Minister, appoint two or more Medical Service Sub-committees.

INVESTIGATIONS BY MEDICAL SERVICE SUB-COMMITTEE: (1) Any question arising between an insurance practitioner and a person who is or has been or claim to be or to have been, entitled to obtain treatment from that practitioner or between the representatives of any such person, if deceased, and the practitioner in respect of the treatment rendered by the practitioner or any alleged failure to render treatment or other breach by the practitioner of his duties under the terms of service or in respect of the person while receiving treatment as to the action

of a practitioner with regard to any medical certificate which he is required to furnish, shall be investigated by the Medical Service Sub-committee.

The person desiring to raise any such question shall, within six weeks after the event which gave rise to the question, give written notice to the Medical Officer of Health stating the substance of the matter which it is desired to have investigated:

Providing that notwithstanding failure to give notice within the said period the sub-committee may investigate the matter if they are satisfied that such failure was occasioned by illness or other reasonable cause and:

(a) The complaint is made within two months after the said event;

(b) The practitioner consents to the investigation taking place notwithstanding the failure to give notice within the prescribed period; or

(c) The Minister's consent to the investigation has been obtained.

In applying for such consent the Sub-committee shall furnish the Minister and the practitioner with a copy of the said notice, a statement of reasons for the failure to give notice within the prescribed period and with any further information which the Minister may require, and the practitioner shall be entitled within seven days after the receipt by him of such statement or further information to forward to the Minister a statement of the grounds on which he contends that the investigation should not take place.

(2) The Committee and any Sub-committee of the Committee duly authorised in that behalf by the Committee may and if the Medical Committee so desire shall, refer for investigation by the Medical Service Sub-committee any matter relating to the administration of medical benefit or to the discharge by any practitioner of his duties under the terms of service whether such matter has been raised by or on behalf of an insured person or not, and the Medical Service Sub-committee shall investigate it accordingly.

Provided that no question which involves an allegation against a practitioner of a breach of the terms of service shall without the Minister's consent be referred for investigation under

this paragraph except within a period of six weeks after the occurrence of the event on which such allegation is based and the provisions of the preceding paragraph with reference to the procedure to be adopted on application for the Minister's consent shall mutatis mutandis apply to any application for his consent under this paragraph.

(3) Where the action of a practitioner in issuing a medical certificate under these regulations has been referred for the consideration of a Medical Committee or other committee, such action shall not form the subject of an investigation by the Medical Service Sub-committee under the regulation.

PROCEDURE OF SUB-COMMITTEE: (1) The Medical Service Sub-committee may, if they think fit, permit any person concerned in an investigation to be assisted in the presentation of his case by some other person; provided that no personshall be entitled to appear in the capacity of counsel, solicitor or other paid advocate.

(2) The proceedings at the hearing before the Medical Service Sub-committee shall be private and no person shall be admitted to those proceedings except -

(a) The persons concerned in the investigation and the persons if any, permitted to appear for the purpose of assisting them;

(b) The secretary or other officer of the Medical Committee;

(c) Persons whose attendance is required for the purpose of giving evidence and who shall unless, the Sub-committee otherwise direct, be excluded from the hearing except when they are actually giving evidence;

and

(d) Such officers and servants of the Committee as they may appoint for the purpose.

(3) The Local Health Committee shall, after consultation with the Local Medical Committee prepare and submit to the Minister for his approval rules which shall provide for the quorum and term of office of the Medical Service Sub-Committee and, subject to the provisions of this regulation, for notice of the hearing to be

given to the persons concerned in the investigation, including the secretary of the medical committee and for the procedure before and at the hearing with regard to the nature of the evidence to be admitted and otherwise, and such rules may empower the sub-committee to dispense with a hearing if they are satisfied that the complaint is frivolous or vexatious or that the written statement or statements of the complainant do not disclose any prima facie ground of complaint and may delegate to the chairman of the Sub-committee such powers in this respect as the Committee think fit.

(4) The Medical Service Sub-committee shall draw up a report stating such relevant facts as appear to them to be established by the evidence placed before them and the inferences of fact which in their opinion may properly be drawn from the facts, together with a recommendation as to the action, if any, which should be taken and shall present the report to the Local Health Committee and the Committee shall accept as conclusive any finding of fact contained in the report.

In presenting such report to the Committee the Medical Service Sub-committee may, if they think fit, draw the attention of the Committee to any previous reports made by the Medical Service Sub-committee or by the Joint Services Sub-committee in connection with the practitioner and to any action taken by the Minister on such reports and may recommend that account should be taken thereof in determining what action if any, should be taken.

(5) The Local Health Committee shall in every case furnish the Minister with a copy of the report of the Medical Service Sub-Committee and a statement of the Committee's decision thereon.

ACTION BY COMMITTEE:

(1) After an investigation by the Medical Service Sub-committee into any question relating to the conduct of an insured person, the Local Health Committee may deal with him under the

rules of the Committee relating to fines and suspension from medical benefit.

(2) After an investigation by the Medical Service Sub-committee into any question relating to the conduct of a practitioner the Committee may take action in any one or more of the following ways:

(a) If the Local Health Committee are satisfied that owing to the number of persons included in his list the practitioner is unable to give adequate treatment to all those persons they may, after consultation with the Medical Committee, impose a special limit on the number of insured persons for whom the practitioner may undertake to provide treatment and in that event any number in excess of that limit shall be dealt with as though the list of the practitioner was by that number in excess of the general limit fixed for the list of practitioners in the area.

(b) The Committee may recover from the practitioner, by deduction from his remuneration or otherwise, any expenses (other than expenses incurred in connection with an investigation by the Medical Services Sub-committee) which have been reasonably and necessarily incurred by them or by any insured person or any person acting on his behalf or on behalf of the family of a deceased insured person owing to the practitioner's failure or neglect to comply with the terms of service and any sum so recovered shall, in the case of expenses incurred by or on behalf of an insured person or on behalf of the family of a deceased insured person, be repaid to the insured person or other person by whom the expenses have been incurred.

(c) The Committee may make representations to the Minister that owing to the failure or neglect of the practitioner to comply with the terms of service the conditions of which the money for defraying the cost of medical benefit is payable to the Committee have not been fulfilled.

(d) If the Committee are of opinion that the continuance on the Medical List of the practitioner will be prejudicial to the efficiency of the medical service of the insured, they may make repres-

entations to the Minister to that effect.

CONSTITUTION OF PHARMACEUTICAL SERVICE SUB-COMMITTEE:

(1) Every Local Health Committee shall constitute a special sub-committee referred to as "The Pharmaceutical Service Sub-committee" consisting of an equal number of representatives of insured persons and of registered pharmacists, together with the Medical Officer of Health or his deputy as chairman.

(2) The members of the Sub-committee shall be appointed in the following manner:

(1) Three members of the Sub-committee shall be appointed by and from the members of the Committee who represent insured persons and three members shall be registered pharmacists appointed by the Pharmaceutical Committee: Provided that if none of the members representing pharmacists is a woman, at least one of those appointed to represent insured persons shall be a woman but the woman so appointed may be a person who is not a member of the Committee or who, being a member of the Committee, does not represent insured persons thereon.

(2) If the Pharmaceutical Committee fail to appoint a member or members of the Pharmaceutical Service Sub-committee within one month after being requested to do so by the Committee, the Committee shall appoint the necessary number of registered pharmacists to fill the vacancy or vacancies.

(3) There shall be appointed in the same manner as the members of the Pharmaceutical Service Sub-committee a corresponding number of persons having the same qualifications, if any, to act as deputies for the members representing pharmacists and insured persons respectively and in the absence of members of the Sub-committee such persons shall be entitled to act accordingly.

(4) If in the opinion of the chairman any member of the Pharmaceutical Service Sub-committee is interested or, in the case of a person supplying drugs or appliances, is a partner or manager or assistant to a person interested in a question referred to them, that member shall take no part in the hearing thereof by a deputy having the same qualifications, if any, as the member who has withdrawn shall act in his place.

(5) The Committee may, with the consent of the Minister, appoint two or more Pharmaceutical Service Sub-committees.

<u>INVESTIGATIONS BY PHARMACEUTICAL SERVICE SUB-COMMITTEE</u>:

(1) Any complaint made by an insured person or the representative of such person, if deceased, against a person (other than a practitioner) supplying drugs or appliances in respect of the quality or quantity of any drugs or appliances supplied under the arrangements made by the Department or in respect of any failure to supply drugs or appliances under those arrangements within a reasonable space of time or in connection with any other matter relating to the duties of the person supplying drugs or appliances under the terms of service, shall be investigated by the Pharmaceutical Service Sub-Committee.

The person desiring to make any complaint under this regulation shall within six weeks after the event which gave rise to the complaint give written notice to the Medical Officer of Health stating the substance of the matter which he desires to be investigated:

Provided that notwithstanding failure to give notice within the said period, the Sub-committee may investigate the matter if they are satisfied that such failure was occasioned by illness or other reasonable cause and (a) the complaint is made within two months after the said event or (b) the person supplying drugs or appliances consents to the investigation taking place notwithstanding the failure to give notice within the prescribed period, or (c) the Minister's consent to the investigation has been obtained.

In applying for such consent the Sub-committee shall furnish the Minister and the person supplying drugs or appliances with a copy of the said notice, a statement of the reasons for the failure to give notice within the prescribed period and any further information which the Minister may require and such person shall be entitled, within seven days after the receipt by him of such statement or further information to forward to the Minister a statement of the grounds on which he contends that the investigation should not take place.

The representative of the deceased insured person shall include a member of the insured person's family and any other person who satisfies the Pharmaceutical Service Sub-committee that he is acting in the interests of the insured person's family.

(2) The Sub-committee shall also investigate any matter relating to the administration of medical benefit or to the discharge by any person supplying drugs or appliances of his duties under the terms of service which may be referred to them by the Committee or by any other Sub-committee of the Committee, whether such matter has been raised by or on behalf of an insured person or not and shall also perform such other duties in connection with the testing of drugs and appliances supplied to insured persons as may be imposed on them by the scheme.

(3) The provisions of these regulations relating to persons entitled to be admitted to the proceedings of the Medical Service Sub-committee, the powers and the duties of that Sub-committee, with respect to hearing and reporting on a question and the powers and duties of the Committee upon the receipt of a report from the Sub-committee, shall apply to the Pharmaceutical Service Sub-committee with the substitution of the words "Pharmaceutical Service Sub-committee" for "Medical Services Sub-

committee" and "Pharmaceutical Committee" for "Medical Committee" and with such other modifications as the circumstances may require; and subject thereto the quorum of the Pharmaceutical Service Sub-committee, their term of office and the procedure with regard to the hearing of a complaint, the nature of the evidence admitted and otherwise shall, subject to the approval of the Minister, be determined by the Committee.

CONSTITUTION OF HOSPITAL SERVICES SUB-COMMITTEE:

(1) Every Local Health Committee shall constitute a special sub-committee referred to as "The Hospital Services Sub-committee" consisting of an equal number of appointees of the Local Hospital Committee and of the appointees of the Local Health Committee together with the Medical Officer of Health or his deputy as Chairman.

(2) The members of the Sub-committee shall be appointed in the following manner:

(a) Three members of the Sub-committee shall be appointed by and from the members of the local Health Committee; provided that if none of the members appointed by the Local Hospital Committee is a woman at least one of those appointed to represent the Local Health Committee shall be a woman but the woman so appointed may be a person who is not a member of the Committee.

(b) Three representatives shall be appointed by and from the Local Hospital Committee of the area and if they fail to appoint a member or members of the Hospital Service Sub-committee within one month after being requested to do so by the Committee, the Committee shall appoint the necessary number from the Local Hospital Committee members of the Local Health area.

(3) There shall be appointed in the same manner as the members of the Hospital Service Sub-committee a corresponding number of persons having the same qualifications, if any, to act as

deputies for the members and in the absence of members of the Sub-committee such persons shall be entitled to act accordingly.

(4) The Local Health Committee may, with the consent of the Minister appoint two or more Hospital Service Sub-committees.

INVESTIGATIONS BY HOSPITAL SERVICE SUB-COMMITTEE:

(1) Any complaint made by an insured person or the representative of such person, if deceased, against any person, firm or body corporate in respect of the quality of service he received in any recognised institution under the arrangements made by the Department shall be investigated by the Hospital Service Sub-committee.

The person desiring to make any complaint shall within six weeks after the event which gave rise to the complaint give written notice to the Medical Officer of Health stating the substance of the matter which he desires to be investigated. Provided that notwithstanding failure to give notice within the said period, the Sub-committee may investigate the matter if they are satisfied that such failure was occasioned by illness or other reasonable cause and (a) the complaint is made within two months after the said event or, (b) the persons providing the services consent to the investigation taking place notwithstanding the failure to give notice within the prescribed period, or, (c) the Minister's consent to the investigation has been obtained.

In applying for such consent the Sub-committee shall furnish the Minister and the person providing services with a copy of the said notice, a statement of the reasons for the failure to give notice within the prescribed period and any further information which the Minister may require and such person shall be entitled, within seven days after the receipt by him of such statement or further information to forward to the Minister a statement of the grounds on which he contends that the investigation should not take place.

The representative of a deceased insured person shall

include a member of the insured person's family and any other person who satisfies the Hospital Service Sub-committee that he is acting in the interests of the insured person's family.

(2) The Sub-committee shall also investigate any matter relating to the administration of hospital and sanatorium benefit or to the discharge by any person providing institutional service of his duties under the terms of service which may be referred to them by the Local Health Committee or by any other Sub-committee of the Committee whether such matter has been raised by or on behalf of an insured person or not and shall also perform such other duties in connection with the provision of institutional treatment as may be imposed upon them by the Local Health Committee.

(3) The provision of these Regulations relating to the persons entitled to be admitted to the proceedings of the Medical Service Sub-committee, the powers and duties of that Sub-committee with respect to hearing and reporting on a question, and the powers and duties of the Local Health Committee upon the receipt of a report from the Sub-committee, shall apply to the Hospital Service Sub-committee with the substitution of the words "Hospital Service Sub-committee" for "Medical Service Sub-committee" and "Hospital Committee" for "Medical Committee" and with such other modifications as the circumstances may require; and subject thereto the quorum of the Hospital Service Sub-committee, their term of office and the procedure with regard to the hearing of a complaint, the nature of the evidence admitted and otherwise shall, subject to the approval of the Minister be determined by the Local Health Committee.

JOINT SERVICES SUB-COMMITTEE: (1) Every Local Health Committee shall constitute a special sub-committee (referred to in these Regulations as "the Joint Services Sub-committee") in the following manner:

(i) The Medical Service Sub-committee shall appoint from amongst its members two practitioners.

(ii) The Pharmaceutical Service Sub-committee shall appoint from amongst its members two registered pharmacists.

(iii) The Hospital Service Sub-committee shall appoint from amongst its members two persons representative of the Hospital Committee.

(iv). Two persons shall be appointed by and from the members of the Local Health Committee who represent insured persons

Provided that, unless any of the persons appointed by the Medical Service Sub-committee or the Pharmaceutical Service Sub-committee or the Hospital Service Sub-committee, is a woman, at least one of the persons appointed by the members of the Committee who represent insured persons shall be a woman, but the woman so appointed may be a person who is not a member of the Committee or who, being a member of the Committee, does not represent insured persons thereon.

(v). The chairman shall be the Medical Officer of Health or his deputy.

(2). There shall be appointed in the same manner as the members of the Joint Services Sub-committee a corresponding number of persons to act as deputies for the members representing practitioners, pharmacists, the Local Hospital Committee, and insured persons respectively, and in the absence of members of the Sub-committee such persons shall be entitled to act accordingly. The persons appointed to act as deputies for practitioners or for registered pharmacists shall be practitioners or registered pharmacists and shall be members or deputy members of the Medical Service Sub-committee or of the Pharmaceutical Service Sub-committee as the case may be.

(3). If, in the opinion of the chairman, any member of the Joint Services Sub-committee is interested or, in the case of a practitioner or person supplying drugs or appliances, is partner or principal, manager or assistant to a person interested in a question referred to them, that member shall take no part in the hearing thereof but a deputy having the same qualifications, if any, as the member who has withdrawn shall act in his place.

(4). If, in the opinion of the Medical Service Sub-committee any matter referred to that Sub-committee involves a question relating to a person (other than a practitioner) supplying drugs and appliances or to a person or body corporate providing institutional treatment, or if in the opinion of the Pharmaceutical Service Sub-committee involves a question relating to an insurance practitioner or an institution or, if in the opinion of the Hospital Service Sub-committee any matter referred

to that Sub-committee involves a question relating to an insurance practitioner or to a person supplying drugs or appliances, the Sub-committee shall, in lieu of dealing with the matter themselves, refer it to the Joint Services Sub-committee.

(5). Any matter which would otherwise have been referred by the Committee or by any sub-committee to the Medical Service or Pharmaceutical Service or Hospital Service Sub-Committee for investigation may, if the Committee or Sub-committee are satisfied that it is appropriate to the Joint Services Sub-committee, be referred by them to that Sub-committee.

(6). The persons entitled to be admitted to their proceedings and the duties of that Sub-committee with respect to hearing and reporting on a question, shall apply to the Joint Services Sub-committee with the substitution of the words "Joint Services Sub-committee for "Medical Services Sub-committee", save that the secretaries or other officers of the Medical Committee and of the Pharmaceutical Committee and of the Hospital Service Sub-committee shall be entitled to be admitted and subject thereto the quorum of the Joint Services Sub-committee, their term of office and theprocedure with regard to the hearing of a question, the nature of the evidence admitted and otherwise shall, subject to the approval of the Minister, be determined by the Committee.

(7). The Local Health Committee shall be entitled to take action on a report made by the Jpint Services Sub-committee in respect of an insurance practitioner, a person supplying drugs or appliances or an insured person in the same manner as on a report made by the Medical Service Sub-committee, Pharmaceutical Service Sub-committee or Hospital Service Sub-committee.

APPEAL TO MINISTER: (1). The person concerned in any investigation by the Medical, Pharmaceutical, or Hospital Service or Joint Services Sub-committee shall be informed of the decision of the Local Health Committee in the matter and shall be furnished with a copy of the rdport of the Sub-committee, in so far as it deals with the case with which they are concerned

and at the same time such persons shall be informed of their right to appeal to the Minister under this regilation and of the Minister's power on such an appeal to award costs. Any such person aggrieved by the decision of the Committee shall be entitled to appeal to the Minister by sending to the Minister notice of appeal within one month from the date on which notification of the decision was received. Provided that no appeal shall lie against a decision of the Committee to make representations with regard to the continuance of a practitioner or of a person supplying drugs or appliances on the list and if a Committee decide both to make such representations and to take other action and an appeal is made against such action, the Minister may treat as conclusive for the purpose of the appeal any relevant findings of fact and inferences of fact contained in the report of the enquiry committee constituted to investigate the case.

(2). The notice of appeal shall contain a concise statement of the facts and contentions upon which the appellant intends to reply.

(3). The Minister may, on the application of any person desiring to appeal, extend the time for giving notice of appeal in such manner as he thinks fit and may so extend the time although the application is not made until after the expiration of one month from the date on which notice of the Committee's decision was received.

(4). Any application for the extension of the time for giving notice of appeal must be made in writing to the Minister, stating the grounds for the application.

PROCEDURE ON APPEAL: (1). If the Minister, after considering the notice of appeal and any further particulars furnished by the appellant, is of opinion that the said notice and particulars disclose no reasonable grounds of appeal or that the appeal is otherwise vexatious or frivolous, he may dismiss the appeal forthwith.

(2). If the Minister is of opinion that the case is of such a nature that it can properly be determined without an oral hearing, he may dispense with an oral hearing and may determine the appeal summarily.

(3). If the Minister is of opinion that an oral hearing is necessary he may appoint an officer or officers of the Department of Health or some other fit person or persons, not exceeding three in number, to hear the appeal and to draw up a report and the Minister, after taking such report into consideration, shall give his decision, which shall be final and conclusive. Provided that where one of the parties to an appeal is an insurance practitioner and the decision of the Committee involves finding that the practitioner has been guilty of negligence, as defined in these Regulations (on page 32) the persons appointed to hear the appeal shall include a practitioner selected by the Minister from the panel of practitioners.

(4). The Minister shall send a copy of the notice of appeal and of any further particulars furnished by the appellant to the Committee and to the person or persons, if any, who were parties to the proceedings before the Medical Services, Pharmaceutical Service, Hospital Service or Joint Services Sub-committee and who appear to him to be interested in the appeal and in the event of a hearing the Committee and such person or persons, if any, may appear and take such part in the proceedings as the person or persons before whom the hearing takes place may think proper.

(5). A party to any question investigated by the Medical or Pharmaceutical Service Sub-committee or the Joint Services Sub-committee shall not, except with the consent of the Minister or, in the case of a hearing, of the person or persons before whom the hearing takes place, be entitled to rely upon any facts or contentions which do not appear to the Minister or to the person or persons hearing the appeal to have been raised before the Sub-committee in the course of the proceedings in respect of which the appeal is brought.

(6). Where an appeal is dismissed the Minister may make such contribution towards the cost of the respondent as he thinks fit.

<u>PROCEDURE OF WITHHOLDING MONEY FROM COMMITTEE.</u> (1). If the Minister is satisfied, whether on consideration of any report made by a Medical Service,

Pharmaceutical Service, Hospital Service, or Joint Services Sub-committee or on the report of an enquiry committee that an insurance practitioner or a person supplying drugs or appliances or a person or body corporate providing institutional treatment, has failed or neglected to comply with the terms of service applicable to him or on the report of his medical officers that a practitioner has failed to comply with any obligations arising under his terms of service, he may withhold such amount as he thinks fit from the money payable for the purposes of medical benefit to the Local Health District which list the practitioner or persons supplying drugs or appliances is included and a like amount shall be recovered by the Medical Officer of Health from the practitioner or person supplying drugs or appliances by deduction from his remuneration or otherwise.

Provided that, except in cases in which the facts have already been the subject of an investigation in the course of an appeal made to the Minister, the Minister shall, before deciding to withhold any such amount, afford the practitioner or person or body corporate concerned a reasonable opportunity of making representations to him on the matter and if he decides to make representations orally the Minister may appoint persons to hear the case and report thereon to him. The Committee and the Medical Committee, Pharmaceutical Committee or Hospital Committee, as the case may be, shall be entitled to be represented at such hearing and to take part in the proceedings as the persons appointed to hear the case may think fit.

(2). An advisory committee shall be constituted for the purpose of assisting the Minister in the discharge of his duties under this Regulation and before withholding money in respect of an alleged breach of the terms of service applicable to insurance practitioners the Minister shall, where such breach consists of negligence as hereinafter defined and in any other case may refer the case to such Committee and consider any report which they may make to him thereon.

(3). The said advisory committee shall consist of the Director-General of Health or his deputy and of two other medical

officers of the Department of Health and of three practitioners selected so far as may be in rotation by the Minister from a panel of practitioners who are or have been insurance practitioners nominated by a body which is in the Minister's opinion representative of the general body of insurance practitioners. The Director-General of Health or in case of his absence, his deputy, shall act as Chairman.

(4). The persons appointed to hear the oral representations of an insurance practitioner under this regulation shall include a practitioner selected for the purpose by the Minister from the said panel.

(5). In this regulation "negligence" includes failure to exercise reasonable skill and care in the treatment of a patient, failure to visit or treat a patient when necessary, failure to order or supply any necessary medicine or appliances for the use of a patient or failure to discharge the obligations imposed on insurance practitioners by these regulations to advise a patient as to the steps which should be taken to obtain necessary treatment if the condition of the patient is such as to require treatment which is not within the scope of the practitioner's obligations under the terms of service.

INVESTIGATION OF EXCESSIVE PRESCRIBING: (1). Where it appears to the Minister after an investigation of the orders for drugs and appliances given by an insurance practitioner to insured persons on his list and of the accounts furnished by the practitioner for drugs and appliances supplied to these persons, that there is a prima facie case for considering that by reason of the character or quantity of the drugs or appliances so ordered or supplied, the charge imposed upon the funds available for the provision of medical benefit is in excess of what was reasonably necessary for the adequate treatment of those persons, the Minister may refer

the matter to the Medical Committee for their consideration: provided that if any Medical Committee make an application in that behalf and satisfy the Minister that they have made and are carrying out adequate arrangements for investigating the character and amount of the drugs and appliances so ordered or supplied by the insurance practitioner in the area, the Minister, may, subject to such conditions and for such period as he thinks fit, dispense with the foregoing procedure and arrange for the Medical Committee to continue to carry out such investigation.

(2). Where a case has been referred to the Medical Committee under the preceding paragraph or where the Medical Committee are themselves satisfied, after a preliminary investigation made under the proviso to that paragraph, that there is a prima facie case for consideration, the Medical Committee shall furnish the practitioner concerned with a statement indicating the matters on which an explanation is required and shall afford him reasonable opportunity of appearing before and being heard by them, or if he thinks fit, of submitting to them any statement in writing.

(3). After duly considering the case, the Medical Committee shall decide whether any cost has been imposed on the funds available for the provision of medical benefit in excess of what may reasonably be necessary by reason of the character or quantity of the drugs or appliances ordered or supplied by the practitioner as aforesaid and, if so, what is the amount of the excess cost imposed on those funds.

(4). Where the Medical Committee have decided that excessive cost has been so imposed by reason of the drugs or appliances ordered or supplied by the practitioner, they shall inform the Committee, the practitioner and the Minister of their decision and may add a statement of any consideration to which, in their opinion, the Committee and the Minister should have regard in making any recommendation or decision with reference to the withholding of money.

(5). The practitioner shall be entitled to appeal against

the decision of the Medical Committee by sending to the Minister notice of appeal within one month from the date on which notice of the Medical Committee's decision was received. The Minister shall appoint a person or persons (not exceeding three in number and not being an officer or officers of the Department of Health) of whom at least one shall be a medical practitioner who shall hear and determine the appeal.

(6). If the Minister is dissatisfied with the decision of the Medical Committee in any case referred by him to that Committee he may appoint a person or persons to hear and determine the matter in the manner provided in the last preceding paragraph and the provision of that paragraph shall apply accordingly.

(7). After consideration of the decision of the Medical Committee, or, if an appeal has been made, of the decision of the person or persons determining the appeal, the Local Health Committee shall, if such decision is that excessive cost has been imposed on the funds available for the provision of medical benefit, make a recommendation to the Minister with regard to the withholding such sum as he thinks fit, and the provisions of these Regulations, including the right of the practitioner to make representations to the Minister. shall apply accordingly.

INVESTIGATION of CERTIFICATION: (1). Where it appears to the Minister, after an investigation of the medical certificates issued by an insurance practitioner to persons on his list or to persons for whose treatment he is responsible, that there is a prima facie case for considering that the practitioner has failed to exercise reasonable care in the issue of such certificates, the Minister may refer the matter for consideration to the Medical Committee.

(2). Any reference to the Medical Committee under the preceding paragraph shall be accompanied by a statement indicating the matters on which it appears to the Minister that an explanation is required.

(3) (a) The Medical Committee shall furnish the practitioner concerned with a copy of the said statement and shall afford him reasonable opportunity of submitting to them a statement in writing and of appearing before and being heard by them.

(b) A copy of any such statement by the practitioner shall be forwarded to the Minister by the Medical Committee for his observations and a representative or representatives of the Minister shall be entitled in case of a hearing to attend and be heard by the Medical Committee.

(4) (a) After duly considering the case the Medical Committee shall draw up a report of their findings on the question whether there has been a failure on the part of the practitioner to exercise reasonable care in certification and, if so, what is the extent and gravity of the failure, together with a recommendation as to the action, if any, which should be taken by the Minister either by the withholding money or otherwise as the Medical Committee may think fit.

(b) The Medical Committee shall forward the report to the Minister and shall furnish the practitioner with a copy of the report.

(5) (a) The practitioner shall be entitled to appeal against any findings of the Medical Committee contained in the report by sending to the Minister notice of appeal within one month from the date on which a copy of the report was received by him, and the provisions of these Regulations relating to the determination of appeals shall apply accordingly.

(b) If the Minister is dissatisfied with any findings of the Medical Committee in any case referred by him to that Committee, he may appoint a person or persons to hear and determine the matter in the manner provided by regulations.

(6) After consideration of the findings and recommendation of the Medical Committee or, if an appeal has been made, of the findings of the person or persons determining the appeal, the Minister may, if he is satisfied that there has been a failure on the part of the practitioner to exercise reasonable care in certification, withhold such amount as he thinks fit from the

money payable for the purpose of medical benefit subject to the provisions of these Regulations, relating to the procedure on withholding money.

INVESTIGATION OF RECORD KEEPING: (1) Where it appears to the Minister, after an examination by the medical officer of any record cards held by a practitioner, that there is a prima facie case for considering that the practitioner has failed to carry out his obligations, so far as such obligations involve the recording of clinical data regarding his patients, the Minister may refer the matter for the consideration of the Medical Committee.

(2) Any such reference to the Medical Committee shall be accompanied by a statement of the grounds for considering that such obligations have not been fulfilled.

(3) (a) The Medical Committee shall furnish the practitioner concerned with a copy of the said statement and shall afford him reasonable opportunity of submitting to them a statement in writing and of appearing before and being heard by them.

(b) A copy of any such statement by the practitioner shall be forwarded to the Minister by the Medical Committee for his observations and a representative or representatives of the Minister shall be entitled, in case of a hearing, to attend and be heard by the Medical Committee.

(4) If so required by notice in writing, signed by the chairman of the Medical Committee, the practitioner shall -

(a) Produce at the hearing all record cards held by him or such of the record cards as may be specified in the notice;

(b) Give to any members of the Medical Committee specified in the notice access at all reasonable times to the practitioner's surgery or other place where the record cards are kept, for the purpose of inspection of such record cards and shall furnish such persons with any such record cards and with any necessary information with regard thereto as they may require.

(5) After considering the case, the Medical Committee shall report to the Minister whether there has been a failure on the part of the practitioner to carry out his said obligations and, if so, the extent and gravity of such failure and shall make

a recommendation as to the action, if any, which should be taken by the Minister either by the withholding money or otherwise. A copy of the report of the Medical Committee shall be forwarded to the practitioner.

(6) (a) The Practitioner shall be entitled to appeal against any findings of the Medical Committee contained in the report by sending to the Minister notice of appeal within one month from the date on which a copy of the report was received by him.

(b) If the Minister is dissatisfied with the findings of the Medical Committee he may appoint a person or persons to hear and determine the matter.

(7) In this regulation 'medical officer' means any medical officer appointed by the Minister for the district in which the practitioner carries on insurance practice: 'record cards' means the cards on which the practitioner is required to keep records of the diseases of his patients.

DECISION AS TO RANGE OF MEDICAL SERVICE: (1) If a question arises, either in the course of an investigation by the Medical Services Sub-committee or otherwise, as to whether an operation or other service which a practitioner has advised for or rendered to a patient was within the scope of the practitioner's obligations under the terms of service, that question shall be referred to the local Medical Committee and if the local Medical Committee and the Committee disagree, the matter shall be submitted to referees appointed under these Regulations for decision in accordance with the rules set out in the regulations, and the decision of those referees given after hearing such parties and taking such evidence, if any, as they think just, shall be final and the referees in giving any such decision shall state whether in arriving at their decision they have had regard to any custom or practice of the medical profession which is peculiar to the area in which the question arose.

(2) For the purpose of giving effect to these regulations the Minister shall, upon any such question arising, nominate as referees two practitioners (who shall be selected from any panel of practitioners set up by the Minister for the purpose or if no such panel exists, from among practitioners in actual practice) and one barrister or solicitor in actual practice.

(3) The referees may decide any question coming before them by a majority but, subject as aforesaid, their procedure shall be such as they may from time to time determine.

(4) If on any question referred to the local Medical Committee under this regulation the Committee and the local Medical Committee are agreed, the committee shall report the matter to the Minister and the Minister may, if he thinks fit, refer the question for decision to referees in the manner provided and the foregoing provisions of this regulation shall apply accordingly.

(5) In every case in which particulars are furnished to the Committee by a practitioner in accordance with the provisions of these regulations a question within the meaning of this regulation shall be deemed to have arisen.

<u>DECISION OF QUESTION WHETHER A SUBSTANCE OR ARTICLE WAS A DRUG OR A PRESCRIBED APPLIANCE:</u> (1) Any question whether a substance or article supplied by a chemist or an insurance practitioner under these regulations to an insured person was a drug or an appliance forming part of medical benefit, shall, if the practitioner concerned so desires and may in any other case in which a Committee or the Minister think fit, be referred to the Medical Committee, and the Local Health Committee or the Minister, as the case may be, shall inform the other and the Pharmaceutical Committee that the question has been so referred.

(2) The Medical Committee shall furnish the practitioner concerned with a statement indicating the nature of the question referred to them under this regulation and shall afford him reasonable opportunity of appearing before and being heard by

them, or, if he thinks fit, of submitting to them any statement in writing.

The Medical Committee shall further consider ant representations made to them on the question by the Pharmaceutical Committee, the Local Health Committee or the Minister and, if the practitioner appears before and is heard by them, shall afford an opportunity to a representative of the Pharmaceutical Committee, the Local Health Committee and the Minister of appearing before and being heard by them.

(3) The finding at which the Medical Committee have arrived on the question referred to them shall be conveyed to the practitioner, the Pharmaceutical Committee, the Local Health Committee and the Minister.

(4) If the practitioner, the Pharmaceutical Committee or the Local Health Committee are dissatisfied with the finding of the Medical Committee and inform the Minister accordingly within one month from the date on which the notice of the Medical Committee's finding was received, the question shall be referred for decision to the referees nominated by the Minister under this regulation, and if the Minister is dissatisfied with the findings of the Medical Committee he may, if he thinks fit, refer the question for decision to referees so nominated.

(5) For the purpose of obtaining a decision on any question arising under the preceding clause of this regulation the Minister shall, upon any such question arising, nominate as referees a person or persons (not exceeding three in number and not being an officer or officers of the Ministry of Health) of whom at least one shall be a medical ptactitioner. The referees may decide any question coming before them by a majority, but, subject as aforesaid, their procedure shall be such as they may from time to time determine.

RECOVERY OF COST OF SUBSTANCE OR ARTICLE HELD NOT TO BE A DRUG OR A PRESCRIBED APPLIANCE: (1) If it appears to a Local Health Committee that any substance or article supplied to an insured person on a prescription issued by a practitioner on an official form or at the expense of the Practitioners' Drugs Account was not a drug or an appliance forming part of medical benefit, the Medical Officer of Health shall recover from the practitioner, by deduction from his remuneration or otherwise an amount calculated in the manner provided.

Provided that before any such amount is recovered the Committee shall, unless it has already been decided in accordance with the preceding regulation that the substance or article supplied in that case was not such a drug or appliance, bring the question to the practitioner's notice in writing and enquire whether he desires it to be referred for decision under that regulation; and if the practitioner within one week after the receipt of such notice informs the Committee that he desires the question to be so referred, the Committee shall refer it to the Medical Committee and the provisions of the preceding regulation shall apply accordingly.

(2) For the purpose of clause (1) of this regulation the amount to be recovered in respect of the supply of any substance or article shall be a sum calculated in the manner set forth in the Drug Tariff:

Provided that if any substance which was not a drug was an ingredient in a preparation of which other ingredients were drugs, the amount to be recovered shall be the price of that substance calculated in the manner set forth in the Drug Tariff, together with half the amount of the dispensing fee payable in respect of the supply of the preparation.

(3) Any moneys recovered under this regulation shall be paid into the Chemists' Fund.

POWER OF LOCAL MEDICAL COMMITTEE TO CONSIDER COMPLAINTS: The Local Medical Committee shall have power to consider any complaint made by an insurance practitioner against any other insurance practitioner involving

any question of the efficiency of the medical service of insured persons and the local Medical Committee may make representations to the Minister that the continuance on the medical list of the practitioner against whom complaint is made would be prejudicial to the efficiency of the service.

POWER OF PHARMACEUTICAL COMMITTEE TO CONSIDER COMPLAINTS: The pharmaceutical Committee shall have power to consider any complaint made by a person supplying drugs or appliances involving any question of the efficiency of the service of drugs or appliances to insured persons and the Pharmaceutical Committee may make representations to the Minister that the continuance on the list of the person against whom complaint is made would be prejudicial to the efficiency of the service.

ENQUIRIES RELATING TO PRACTITIONERS. POWER TO HOLD ENQUIRY: If any representation is made to the Minister by any local Health Committee or Local Medical Committee, the Minister shall and if by any other person or body, the Minister may, subject as hereinafter provided, hold an inquiry in the matter prescribed by regulations dealing with enquiries relating to practitioner.

(N.B. "Representation" means a representation made to the Minister that the continuance of a practitioner upon the medical list would be prejudicial to the efficiency of the medical service of the insured).

REPRESENTATION AND PRELIMINARY STATEMENT: (1) A representation shall be in writing signed by or on behalf of the complainant.

(N.B. "Complainant" means any person or body making a representation to the Minister in relation to Insurance Practitioners).

(2) The Minister may, if he thinks fit, require the complainant to send him a preliminary statement setting out the alleged facts and grounds on which the representation is based and, where a fact is not within the personal knowledge of the complainant, the source of the information and grounds for the belief of the complainant in its truth, together with such further particulars as he may think necessary and may require

the preliminary statement to be verified by statutory declaration.

POWER TO REFUSE ENQUIRY: If it appears to the Minister, after due consideration of any representation or of any preliminary statement furnished to him by the complainant, not being a Local Health Committee or Local Medical Committee, that no good cause has been shown why an enquiry should be held, he may refuse to hold an enquiry and shall inform the complainant accordingly.

NOTICES TO BE SENT IN CASE OF ENQUIRY: (1) The Minister shall, in all cases where an enquiry is to be held, send the following notices, namely:

(a) A notice to the practitioner informing him that it is proposed to hold an enquiry as to the representation made by the complainant;

and

(b) A notice to the complainant informing him that it is proposed to hold an enquiry as to the representation made by him and requiring him, within a time specified in the notice, to send to the Minister a concise statement of the alleged facts and grounds on which the representation is based (in this part of these regulations referred to as "the statement of complaint") together with a list of all the documents which he proposes to put in evidence.

Provided that where the complainant has sent a preliminary statement to the Minister, the Minister may, if he thinks fit, dispense with a statement of complaint and in that case the preliminary statement shall, for the purposes of the enquiry, be treated as the statement of complaint.

(2) The Minister may, if he thinks fit, on the application of the complainant, or some person authorised by him, extend the time for sending to him the statement of complaint.

PRACTITIONER MAY ADMIT OR DENY ALLEGATIONS: The Minister shall send to the practitioner a copy of the statement of complaint and of the list of documents which the complainant proposes to put in evidence together with a notice informing him that he may, if he so desires, within a time specified in the notice, by a statement in writing addressed to the Minister, admit or dis-

pute the truth of all or any of the allegations appearing in the statement of complaint.

RIGHT OF PRACTITIONER TO INSPECT DOCUMENTS: (1) The practitioner may, on giving due notice to the complainant, inspect, either personally or by an agent authorised in writing, the documents included in the list sent by the complainant to the Minister and the complainant shall give reasonable facilities for the purpose.

(2) The practitioner shall be entitled, on making application to the Minister, to a copy of any document in that list and the Minister may, for the purpose of supplying to the practitioner copies of any such documents, require the complainant to deposit with one of his officers appointed for the purpose any of the documents for copies of which application has been made and shall return the documents to the complainant as soon as may be.

POWER TO TREAT REPRESENTATION AS WITHDRAWN IN CERTAIN CASES: If the complainant fails, within the time specified in the notice or within any extended period, to send a statement of complaint to the Minister or if he fails to comply with any other requirements of this part of these Regulations, the Minister may treat the representations as having been withdrawn.

CONSTITUTION OF INQUIRY COMMITTEE: (1) For the purpose of each inquiry the Minister shall constitute an Inquiry Committee composed of a barrister or solicitor in actual practice and two practitioners and if any body of practitioners has been established for the purpose by the Minister the two practitioners so appointed shall be selected from that body.

(2) The Minister shall appoint one of the members of the Inquiry Committee to be Chairman.

(3) The Minister shall appoint a fit person to act as clerk to the Inquiry Committee.

NOTICE OF INQUIRY TO BE GIVEN: (1) The Minister shall appoint a day for the holding of the inquiry and shall, not less than seven days before the appointed day, send notices to the complainant and

the practitioner informing them that the inquiry will be held on the appointed day.

(2) The Minister shall send to each Committee (other than a Committee which is the complainant) of the district in which medical list the name of the practitioner appears, notice of the proposed inquiry and of the date, time and place on and at which it is proposed to hold the inquiry and each such Committee may appear and take such part in the proceedings at the inquiry as the Inquiry Committee shall think proper.

POWER TO POSTPONE INQUIRY: The Minister may, if he thinks fit, or on the application of either party, postpone the holding of the inquiry until such date later than the appointed day as he may determine and thereupon that later day shall for the purposes of this part of these Regulations be the appointed day.

APPEARANCE BY REPRESENTATIVES: (1) Any Committee, Local Medical Committee, or other body whether corporate or unincorporate, entitled to appear at the inquiry, may appear by their representative duly appointed for the purpose, or, with the consent of the Chairman or the Inquiry Committee, by counsel or solicitor.

(2) The complainant, not being one of the bodies above-mentioned and the practitioner may, with the consent of the Chairman of the Inquiry Committee, appear at the inquiry -

(a) by any member of his family;

(b) by counsel or solicitor:

(c) by any officer or member of any society or other body of persons of which the person in question is a member or with which he is connected.

(3) If either party to an inquiry or a Committee to whom notice of the inquiry has been given, desires to appear at the inquiry by a representative and the consent of the Chairman of the Inquiry Committee is required, the party or Committee shall send an application for leave so to appear to the clerk of the Inquiry Committee not less than five days before the appointed day and the clerk shall inform the Chairman, who shall, as soon as may be, notify the applicant and such other parties

as appear to him to be interested, of his decision in the matter, without prejudice to his power at any time during the hearing to consent to any such application and to adjourn the inquiry for that purpose.

WITHDRAWAL OF REPRESENTATION: (1) The complainant may at any time before the appointed day withdraw the representation by giving notice of withdrawal in writing to the Minister.

(2) Where the representation has been withdrawn or is treated by the Minister as having been withdrawn, the Minister shall (without prejudice to his power to hold an inquiry as hereinafter provided) forthwith inform the practitioner that the representation has been withdrawn or is treated as having been withdrawn, as the case may be.

AMENDMENT OF STATEMENT OF COMPLAINT: The Minister at any time before the appointed day and the Inquiry Committee at any time on or after the appointed day before the conclusion of the inquiry, may allow the statement of complaint to be amended upon such conditions as he or they may think just and may require the complainant to furnish to him or them in writing further particulars of the alleged facts and grounds appearing in the statement of complaint.

PROCEDURE AT INQUIRY: Unless the Inquiry Committee, with the approval of the Minister, otherwise determine, the procedure at the inquiry shall be governed by the rules set out in the Schedule to these Regulations.

POWER TO HOLD INQUIRY IN ABSENCE OF REPRESENTATION: In any case where it appears to the Minister desirable to hold an inquiry for the purpose of ascertaining whether the continuance of a practitioner who has been convicted of a criminal offence on any medical list would be prejudicial to the efficiency of the medical service of the insured, the Minister may, notwithstanding either that -

(i) no representation to that effect has been made to him or that -

(ii) if such representation has been made, it has been withdrawn or has been treated as withdrawn,

proceed to hold an inquiry for that purpose, and this part of these Regulations shall, with the necessary modifications and subject as hereinafter provided, apply accordingly.

NOTICE TO BE SENT TO PRACTITIONER: The Minister shall send to the practitioner a statement of the facts and grounds which appear to him to justify the holding of an inquiry together with a notice informing him that he may, if he so desires, within a time specified in the notice, by a statement in writing addressed to the Minister, admit or dispute the truth of all or any of the allegations appearing in the case for inquiry.

CONSTITUTION OF INQUIRY COMMITTEE: If after considering the statement of the practitioner or, if no statement is received, after such lapse of time as the Minister may think reasonable, the Minister is of opinion that it is desirable to hold an inquiry, he shall constitute an Inquiry Committee in the manner hereinbefore provided and shall appoint a day for the holding of the inquiry and shall send -

(a) to the practitioner, a notice informing him that the inquiry will be held on the appointed day: and

(b) to each Committee on whose list of practitioners undertaking the treatment of insured persons the name of the practitioner appears, a notice of the proposed inquiry stating the date, time and place on and at which it is proposed to hold the inquiry,

and each such Committee may appear and may take such part in the proceedings at the inquiry as the inquiry committee shall think proper.

PROCEDURE AT INQUIRY: The Minister shall appoint some fit person to appear at the inquiry in support of the allegations in the case of inquiry, and subject thereto the procedure at the inquiry shall be governed as nearly as may be by the rules set out in the Schedule to these Regulations, but those rules may be varied or modified as the circumstances of the case may require and as the Minister or the Inquiry Committee with the approval of the Minister, may think fit.

REPORT BY INQUIRY COMMITTEE: (1) At the conclusion of the inquiry, the Inquiry Committee shall, as soon as may be, draw up a report stating such relevant facts as appear to them to be established by the evidence and the inferences of fact which, in the opinion of the inquiry committee, may properly be drawn from the facts so established and the Minister shall refer such report to an Advisory Committee constituted in accordance with the provisions of these Regulations and shall, after taking such report and any recommendations of the Advisory Committee into consideration, give his decision in due course and may cause it to be published in such manner as he shall think fit.

(2) Before he comes to his decision the Minister shall inform the practitioner that it is open to him to submit in writing such evidence as he thinks fit as to his personal character and professional standing and the Minister shall have regard to any such evidence which may be submitted and shall also take into consideration any reports which may have been previously furnished to him in accordance with the provisions of the regulations relating to the administration of medical benefit of cases investigated by Medical Service Sub-committee or Joint Services Sub-Committee relating to the practitioner and any findings of fact contained in such reports or, if an appeal has been made to the Minister, in the decision given on the appeal, shall be deemed to have been conclusively proved.

POWER TO SUSPEND PROCEEDINGS IN CERTAIN CASES: Where it appears to the Minister that the alleged facts on which any representation or case for inquiry is based are or may be the subject of investigation by any other tribunal, he may, if he thinks fit, direct that no further steps shall be taken under this Part of these Regulations pending the issue of such other investigation.

POWER TO DISPENSE WITH INQUIRY: Notwithstanding anything in this Part of these Regulations, where the grounds on which any representation or case for inquiry is based consists solely of an allegation that the practitioner has been convicted of a criminal offence and the practitioner admits the truth of such allegation, the

Inquiry Committee may, with the consent of the practitioner, dispense with an oral inquiry and report to the Minister upon such documentary evidence as may be submitted to them.

SERVICE OF NOTICES ETC: (1) Where any notice or other document is required or authorised by this Part of these Regulations to be sent by or on behalf of the Minister, it shall be sufficient compliance with the Regulations if the notice or other document is sent by post in a registered letter directed to the person for whom it is intended at his ordinary address or, if he is a practitioner, at the address set opposite his name in the Medical List, and in the case of a Committee, to the Medical Officer of Health.

(2) Where any application, statement or other document is required or authorised by this Part of these Regulations to be sent to the Minister or to an Inquiry Committee or to the Chairman of an Inquiry Committee, it shall be a sufficient compliance with the regulations if the application, statement or other document is sent by post directed to the Minister of Health or to the clerk to the Inquiry Committee at the office of the Department, as the case may require, and where leave to appear by a solicitor has been granted to any part to an inquiry it shall be a sufficient compliance with this part of these Regulations if the notice or other document is sent in the manner aforesaid to the solicitor at his professional address.

(3) Until the contrary is proved, any notice, application, statement or other document sent as aforesaid shall be deemed to be served at the time at which a letter would be delivered in the ordinary course of post.

POWER TO DISPENSE WITH REQUIREMENTS AS TO NOTICE: The Minister or the Inquiry Committee may dispense with any requirements of this Part of these Regulations respecting notices, applications, documents or otherwise in any case where it appears to the Minister or the inquiry committee just and proper to do so.

INQUIRIES RELATING TO PERSONS SUPPLYING DRUGS OR APPLIANCES:

CONSTITUTION OF INQUIRY COMMITTEE: (1) For the purpose of holding an inquiry as to whether the inclusion or continuance of a person supplying drugs or appliances in the list of persons supplying drugs or appliances to insured persons would be prejudicial to the efficiency of the service, the Minister shall constitute an Inquiry Committee composed of a barrister or solicitor in actual practice and two other persons who, if any body has been established for the purpose by the Minister, shall be selected from that body and of whom at least one shall be a registered pharmacist.

(2) The Minister shall appoint one of the members of the Inquiry Committee to be Chairman.

(3) The Minister shall apppint a fit person to act as clerk to the Inquiry Committee.

APPLICATION OF REGULATIONS DEALING WITH INQUIRIES RELATING TO PRACTITIONERS: Subject, as aforesaid, the procedure to be adopted in connection with an inquiry, the report of the Inquiry Committee and otherwise shall, with the substitution of the words "pharmaceutical committee" for "Local Medical Committee" and such other modifications as may be necessary, apply to inquiries held under this Part of these Regulations, and the forms set out in the relative schedule, with the necessary modifications or other forms substantially to the like effect, shall be used for the purposes of inquiries under this Part of these Regulations in all cases to which those forms are applicable: Provided that when a representation is made by a body which is in the opinion of the Minister representative of the general body of persons supplying drugs or appliances the Minister shall hold an inquiry under this Part of these Regulations.

INQUIRIES RELATING TO PERSONS OR FIRMS OR BODIES CORPORATE SUPPLYING INSTITUTIONAL TREATMENT:

CONSTITUTION OF INQUIRY COMMITTEE: (1) For the purpose of holding an inquiry as to whether the actions of a person, firm or body corporate providing institutional treatment is

prejudicial to the efficiency of the service, the Minister shall constitute an Inquiry Committee composed of a barrister or solicitor in actual practice and two other persons who if any body has been established for the purpose by the Minister, shall be selected from that body and of whom at least one shall be a Hospital Board member.

(2) The Minister shall appoint one of the members of the inquiry committee to be chairman.

(3) The Minister shall appoint a fit person to act as clerk to the inquiry committee.

APPLICATION OF REGULATIONS: Subject as aforesaid, the procedure to be adopted in connection with an inquiry, the report of the Inquiry Committee and otherwise shall, with the substitution of the words "local Hospital Committee" for "local Medical Committee" and such other modifications as may be necessary, apply to inquiries held under this Part of these Regulations and the forms set out in the relative schedule, with the necessary modifications or other forms substantially to the like effect, shall be used for the purposes of inquiries under this Part of these Regulations in all cases to which these forms are applicable.

Provided that when a representation is made by a body which is in the opinion of the Minister representative of the general body of persons providing institutional treatment the Minister shall hold an inquiry under this Part of these Regulations.

PREPARATION OF RULES.

MISCELLANEOUS: The Local Health Committee shall, after consultation with the Local Medical Committee prepare rules with regard to the administration of medical benefit and shall submit them for the approval of the Minister.

APPROVAL OF FORMS BY THE MINISTER: All forms and other documents to be provided under regulations shall be submitted for the approval of the Minister and the Committee shall not make use of any such form or document until the same has been approved.

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