Destiny rides again

RICHARD G ROBINSON

The New Zealand Medical Association has emerged intact from its recent conflict with the Minister of Health. This outcome prompts memories of 45 years ago when the general practitioners successfully prevented what would have been the nationalisation of the general practitioner services.

The first Labour government in New Zealand swept into power at the 1935 general election with a big majority. At that time there were few welfare benefits despite New Zealand having had a means tested old age pension since 1898. In 1935 the New Zealand Branch of the BMA, as the New Zealand Medical Association was then, was considering the desirability of some sort of national health insurance with benefits related to income and for some reform of the public hospital system. The government's health proposals included a raft of benefits that included a free public hospital system and a series of free benefits for general practice. All this would have given New Zealand a national health service in all but name long before any other English speaking country and on a par with what was being developed in Scandinavia.

The free general practitioner consultation and maternity benefits, however, proved to be a battle ground between the BMA and the government. Both sides had difficulty understanding the other's point of view and personality conflicts did not help. The arguments used against the government were that there was no need for sudden change, standards of medicine were best preserved by the private practice system, the patient would be denied a free choice of doctor, a contract system would reduce medicine to a common denominator, medicine would be subordinated to the state, and there should be a payment that was related to the service provided.

Nevertheless, despite medical opposition the Social Security Act 1938, a landmark in social legislation, was passed, establishing from April 1939 many welfare benefits as a universal right. At the 1938 general election the Labour party had won another big majority and this was a mandate for the welfare state—since added to by both political parties. The BMA continued its opposition to the general practice proposal of a generous capitation fee (15/-) in full settlement for the consultation. Though the doctors refrained from striking they resolutely refused to cooperate with the introduction of the medical benefits and the general practitioners managed to hold fast. The outbreak of war in 1939 made little difference to the struggle on the home front and if anything acted as a stiffener.

The compromise over general practitioner services did not come until mid-1941, when the impasse was resolved by both sides agreeing to a fee for service that would not be in total settlement of the consultation fee. The patient would pay and a benefit (7/6, later 75¢) be reimbursed by the state, a generous offer as 10/- was the average fee for a surgery visit. Thus the general medical services benefit came in.

The government had won on the issue of universality and the BMA had triumphed in resisting a free general practitioner service either by a full capitation fee or a full fee for service. There are several accounts of the conflict[1-3] and how much was a consequence of principle, power, or pence has never been fully resolved. But at least it can be said that money was not really at stake even if there was a final sweetener. As a leading Labour minister said of the doctors, they were "tougher even to deal with than wharfies."[4]

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Ups and downs of health benefits

After 1949 at the request of the Department of Health and to facilitate administration the accepted method of general medical services payment became a schedule by which the doctor bulk billed the department. This led the medical profession into a trap: although the general medical services benefit is technically one for the patient the doctor normally claims it from the state. Thus over the years the New Zealand Medical Association has been put in the position of being the suppliant to the government on behalf of the rather distant patient. Rarely has there been public pressure on the politicians for it to be increased.

The movement of the general medical services benefit has been small and not until 1978 was the benefit increased to \$1·25 for adults, a figure that still stands. At the same time the children's benefit went to \$4·75. (One pound sterling=NZ\$2·40, November 1985.) The general practitioners did well out of the benefit for many years. By 1948 a few doctors were taking £10 000 or so annually out of the scheme. The fee for service was, however, open to abuse, particularly as general practitioners were in short supply until the mid-1970s. The Department of Health had difficulty in policing benefits from overservicing. Avaricious doctors brought opprobrium on themselves, particularly from Labour party supporters.

These memories linger behind the present dispute. The past decade, however, has seen a growing erosion of general practitioners' incomes. Recruits to general practice have increased because of the greater output of doctors from our medical schools. Furthermore, the country's economic difficulties have aggravated the deterioration in general practitioners' incomes, with high inflation and latterly a wages and prices freeze in 1982-4, which included professional services, making their mark. Today the general medical services benefit would constitute perhaps 10% or less of the average general practice consultation fee. The public has adapted to this by a gradual switch into private health insurance that is tax deductible, a switch helped by the fact that such insurance has become a fringe benefit for some employees. There is no accurate information about the extent of this insurance but it is believed that at least 25% and perhaps as much as 33% of the population carry some health insurance. So the real value of the general medical services benefit has become almost derisory.

Under the previous National government the Minister of Health was persuaded by the profession to look at terms and conditions of service for primary care practice. The committee set up to review the position reported in August 1982, when it called for an immediate increase in the adult general medical services benefit to \$5·00 and to \$9·00 for a child.[5] This proposal fell on deaf ears.

Another aspect of general practice relevant to remuneration was the introduction in April 1974 of the accident compensation scheme under which an injured person has his full medical expenses covered. The general medical services benefit is also paid, and in August 1985 the acceptable fee for an adult visit to a general practitioner was \$14·25 inclusive of the general medical services benefit, or \$13·00 from the Accident Compensation Corporation with a possibility of extra on justification. Accident compensation work may constitute up to 20% of a general practitioner's workload.

Labour returns

The profession uneasily awaited the outcome of the 1984 election. In the event the Labour party under the 41 year old Mr David Lange had a massive majority in the snap election of July 1984. The problems facing the government were mainly economic: the thaw from the draconian wages and prices freeze, inflation, and the general slide in the country's standard of living over the past decade or so. No one expected handouts. The first critical step was the floating of the New Zealand dollar and the freeing of the movement of capital that had been controlled since 1938. This was a dramatic turnabout, as traumatic as it has been elsewhere, and in retrospect the harbinger of a totally new orientation of Labour policy.

The new Minister of Health was Dr Michael Bassett, a history graduate, who had been opposition spokesman on health and was not thought to have any great empathy with established medicine. He had acknowledged that resources were finite and earlier had said: "If the evidence should prove that cost is a factor for a significantly wider number of people not seeking medical care and if, as seems likely, successive governments should continue to make periodic increases to the general medical services benefit then some sort of

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state imposed upper limit will have to come. Either that or the New Zealand Medical Association will have to presume to specify scale fees for its members."[6]

All along he has continued to suggest that doctors might not be trusted and would put any benefit increase into their pockets. Labour's election promises had not been specific on health but the party had promised improvement to primary health care, especially for children and the Maori.

On taking office Dr Bassett met officers of the New Zealand Medical Association about their worries. The main ones were the perennial question of the general medical services benefit, a long overdue review of maternity fees, and conditions of work in hospital for junior and senior doctors. The subsequent row about the children's general medical services benefit has to be seen against a background of several conflicts on health matters, particularly that of the maternity benefit review. Many problems were inherited and all would need statesmanship to resolve.

Dr Bassett first told of what he had in mind in August 1984 in an address to the small South Canterbury division of the New Zealand Medical Association at Timaru. The children's benefit would be doubled to $9·50 but this would be tied to a standard maximum fee for a child's consultation, a principle that might be extended to adults. The total fee would be reviewed regularly but no doctor could change his options for two years once a decision had been made to join or stay out.

These restrictive conditions were received badly by the New Zealand Medical Association and the battle was on, directed from the medical side by Dr Dean Williams and Dr John Broadfoot, chairman and deputy chairman of the council respectively, and supported by Mr Roger Caudwell, general secretary. A working party was set up. Of some concern was the likely solidarity of the general practitioners and every effort was made to ensure wide consultation within the New Zealand Medical Association so that any opportunity for fragmentation would be minimised. A questionnaire was sent out to test reactions about the benefit, the concept of a maximum fee, and guidelines for fees.

At the regular quarterly meeting of the council of the New Zealand Medical Association in September feelings ran high against the minister. The executive committee was given full power to pursue discussions and to find out the profession's views about guidelines. The New Zealand Medical Association had previously published information about practice costs but it had not made specific recommendations or suggested a possible inflation factor. Around this time the association knew that it had strong support from its members.

The Minister of Finance presented his first budget in November and announced an increase in the children's general medical services benefit to $9·50 so long as the doctor agreed to limit the total fee. This was costed at some $14 million and was to be financed by a flat $1·00 surcharge on all drug tariff prescriptions, with exemptions for children, beneficiaries, and the chronic sick. Even more important from the national point of view he attacked the sacred cow of universal superannuation that comes in at 60. There was to be a progressive income tax surcharge on the pension so that it would be completely extinguished for an individual with an additional income of just under $22 000—a new method of means testing for New Zealand. The government also announced a switch from direct to indirect taxation so that a comprehensive goods and services tax—that would include medical services—would be introduced on 1 April 1986. All this was a new direction for the Labour party.

Remaining stumbling block

Negotiations were begun with Dr Bassett and his department and some progress was made on details, but the main stumbling block of the controlled total fee and the contract remained. His concept of the gap between the benefit and the total fee was about $2·00; doctors would have to display information about their fees and type of practice in their surgeries. Details were agreed about the central review committee. He still hoped to extend the total fee concept to other medical benefits. The proposals were sent out to members by the New Zealand Medical Association on 16 November. The conditions were to be effective from 1 February 1985.

By the time of the regular meeting of the council on 5 December the delegates were in a belligerent mood about the restrictive clauses and the government's lack of trust in the profession. The health minister spoke at the meeting but made no converts. There followed a series of resolutions that, while welcoming the benefit, emphasised that it was a benefit for patients not for doctors. The restrictive contract was unacceptable and would deny the patient freedom to choose his or her doctor. The meeting affirmed that the benefit would be passed on to the patient.

At negotiations progress was made about possible ways of revising the total fee. The minister showed no sign of giving way or being prepared to compromise about the total fee or the contract. The Department of Health sent out contracts during January and opposition to these mounted so a special meeting of the council was called for 30 January. The delegates went back to the principle of universality, with all children having a right to the benefit, which should not depend on whether the doctor was in or out of the scheme. The association would not provide nominees for the proposed central review committee. The council was adamant that the main conditions linked to the benefit were unacceptable. A special letter to association members on 20 February set out its continuing opposition to the scheme.

United front

At this stage the association's main problem was to keep a united front because some general practitioners had already joined the scheme. The association hoped, however, that time would not be on the minister's side. The working party looked at a wide range of options in relation to the current economic climate, and everyone acknowledged that there would have to be some restraint. Dr Bassett's approach was to keep a low profile and hope that attrition would break the doctors' ranks. By early March about 400 doctors had joined the scheme but after that the ranks held pretty steady, though ill feelings developed between doctors in and out of the scheme.

Antagonism to Dr Bassett's proposals was particularly strong in Auckland, the country's largest population centre. Informal discussions about whether the validity of the scheme should be tested in the High Court led to three Auckland doctors—with a nod from the New Zealand Medical Association and some help from the medical defence societies—filing an injunction at the end of February. This greatly helped to preserve professional unity and fewer than 25% of the 2000 or so general practitioners accepted the terms of the new benefit.

New association officials

Meanwhile, at the meeting of council in mid-May, Dr John Broadfoot became chairman of council and Dr M A H Baird deputy chairman. Elections to the executive committee were keenly contested and several new faces emerged reflecting firm opposition to the minister.

The High Court hearing at Auckland was held from 27 to 31 May and at the hearing and in the judgment on 28 June there was little doubt that Dr Bassett was determined to control doctors' fees by regulation. The new benefit had been promulgated under an obscure clause of the Social Security Act about provisions in special circumstances. The main use that had been made of the section was to provide medical services for isolated country areas. The department had advised early on that legislative change would be needed for the benefit. Furthermore, the Act did give a right of the benefit to all in New Zealand without restriction.[7] Dr Bassett's scheme was held invalid. Thus the Minister of Health was dealt a resounding blow, and he commented that he had not expected to fight lawyers as well as doctors.

While the government threatened to appeal it realised that something would have to be done to resolve the impasse. A worry for the New Zealand Medical Association had been that if the court action went against the minister retrospective legislation might be passed. As a matter of general policy, however, the government did not favour that tactic. All the indications were that Dr Bassett was under political pressure to get the general medical services benefit fixed up as the government saw little political milage in the issue.

After a series of exchanges between the government and the association some new proposals were put to a special meeting of the council on 14 August. The Cabinet wanted the general medical services benefit available to all children with a total charge being held for, say, one year. There was no talk of a contract. A guideline fee was desirable with an orderly adjustment and with agreed disciplinary procedures. There was obviously room for negotiation. The council recognised that the association should issue advice about the adjustment of fees and it was acknowledged that there were regional variations in children's fees whose total might vary from $11 to $18. The association's constitution was to be altered to deal with fees and complaints on a divisional basis.

Dr Bassett accepted that there would be a range of fees that would be revised in the light of circumstances. The Cabinet agreed and the Minister of Health was able to promulgate definitive arrangements to start on 17 September. The general medical services benefit was now $10·25 and was to be passed on to the patient but without statutory sanction. General practitioners would notify their usual fee to a divisional fees complaints officer who would publish these in the local press and give the range in the district. A divisional fees complaints committee of two doctors and a layman appointed by the minister, with the local medical officer of health as observer, would handle complaints. Thus the control of fees and the management of discipline remained firmly in the hands of the profession and the New Zealand Medical Association. There was nothing in the final scheme that could not have been agreed at the start of the year except for Dr

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Council election 1986

Ballot papers have been issued for the election of the BMA council, which will take office in June, giving details of the craft nominees. Details of the election were published on 11 January (p 154). Twenty members have been nominated for the six members engaged wholly or mainly in general practice; 12 members have been nominated for the four senior hospital doctor places; eight junior doctors have been nominated for the five places; five members engaged wholly or mainly in community medicine or community health have been nominated for the two places; and three whole time university or medical research doctors have been nominated for the two places. There will be no election for the two members to represent doctors in the armed forces or occupational medicine. The closing date for the return of ballot papers is *Friday 21 February*.

This is the first stage in the election of the council. The regional representatives will be elected in March and April and the four "other" representatives in May and June.

Candidates

The candidates in the election for craft representatives are listed below.

Training grade members (five to be elected)

E L Rose — Bridgend, Mid Glamorgan
J Wight — Sheffield
P G R Godwin — Leeds
R Gilbert — Bristol
C Marriott — Belfast
P C Hawker — Moseley, Birmingham
D J Brodie — Glasgow
S O Fradd — Burton-on-Trent

Senior hospital members (four to be elected)

G H Hall — Exeter
J M Cundy — Bromley, Kent
J Chawner — Bangor, Gwynedd
A P Ross — Winchester, Hants
M M Burrows — Birkenhead, Mersey
A H Grabham — Kettering, Northants
W J Appleyard — Canterbury, Kent
E B Lewis — Hythe, Kent
A K Clarke — Bath, Avon
J W Stephenson — Bromley, Kent
R Greenwood — Rothley, Leicester
G M C Paterson — Oxford

General practitioner members (six to be elected)

C J P Saunders — Bearsted, Kent
G R H Fairbairn — Cheltenham, Glos
D J D Farrow — Hawkhurst, Kent
P J Enoch — Ilkeston, Derbyshire
D K Bose — Wolverhampton
J B Lynch — Clwyd
S C Drew — West Cornforth, Durham
M A Wilson — Huntington, Yorks
L Kopelowitz — Newcastle upon Tyne
G W Taylor — Reading, Berks
P F Kielty — Harpenden, Herts
J A Riddell — Glasgow
C D Evans — Lancaster
W J C Scott — Alexandria, Dunbartonshire
M H Husain — Rotherham
F D Roberts — Northampton
S J Richards — Exeter
E M Rosser — London, SE21
M J Dawson — Telford
D C L'e Burges — Edgbaston, Birmingham

Community medicine/health members (two to be elected)

D P B Miles — Truro, Cornwall
A J Jenkins — Abingdon, Oxon
G Scally — Belfast
L F Fisher — Prestbury, Cheshire
P Anderson — Edgbaston, Birmingham

Academic members (two to be elected)

D R Bowsher — Liverpool
C L Smith — Southampton
J P Payne — London, SW19

*Armed forces members**

C A Gauci — London, SE18
D S Wright — Gosport, Hants

*Occupational health members**

W M Dixon — Chalfont St Giles, Bucks
J L Kearns — London, W5

* Elected unopposed.

Elections to COMAR

Medical academic staff are being invited to elect representatives to the conference of medical academic representatives, which will be held on Monday 2 June at BMA House. The constitution provides for the election of one clinical and one preclinical representative from each medical school, the representatives to be nominated and elected by the clinical academic and medically qualified preclinical staff respectively. Existing representatives have been sent nomination forms, which should be returned to the industrial relations officer in the region concerned by Friday 14 February. If an election is necessary the industrial relations officer will help to organise it.

The industrial relations officers plan to contact representatives at schools in their regions to offer help in strengthening local organisation, to hold meetings to discuss topics of interest to medical academic staff, and to advise BMA members on individual problems relating to terms and conditions of service.

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Bassett's fixed ideas about the control of fees. The minister's own press release expected that the differential would be $4 to $5 but that statement was not in the document of intent to the association.[8]

Peace or truce?

Since the settlement both parties have tended to keep their heads down. There has been some press confusion because the actual agreement and the ministerial press release did not say quite the same thing. Furthermore, the Consumers' Institute, a quango, has not hesitated to criticise doctors' fees in the same way that it did at the height of the row, although there is little to suggest that the institute has any intimate knowledge of the structure of general practice.

It is not clear why the Minister of Health should have taken on the New Zealand Medical Association in the way that he did. Admittedly, he had an antipathy to the profession about fees, and the previous history of relations with doctors rankled with some sections of his party. The profession also has its critics, with the standard official excuse being that a lot of public money is spent on health benefits. But the total general medical services payments for all categories amounts to only 1·75% of the $2000 million or so of the parliamentary vote on health.

Another argument was that doctors like lawyers should have a recognised scale of fees. Unfortunately, this prop was knocked away when it became known that the New Zealand Law Society, prompted by the government, had abandoned its fixed scales. The Labour Party has a strong interventionist wing and New Zealand society contains a strong streak of egalitarianism. Dr Bassett would seem to belong to this sector. Since the election a shift of power in the party has meant that the old guard has lost out to the new group around the Prime Minister and the Minister of Finance. They have initiated new policies and recognised that universal benefits are not feasible, given the country's economic plight.

In this dispute principles and money were mixed, but in the end it was principles that counted. In 1935 the BMA had complained about the profession being picked on for nationalisation, and certainly in 1985 the New Zealand Medical Association could see no reason for being specially regulated. The general practitioner, like any other businessman or professional person, wants to be able to run his own affairs as the others do, though, of course, to appropriate professional standards. Twice the profession has laid its principles on the line and prevailed. I hope that the lesson will have been learnt this time.

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