International Perspectives

Paying for Medical Care—The New Zealand System

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The New Zealand system of paying the doctor is one which deserves considerable study as it provides an interesting compromise between those situations in which the patient personally pays the whole fee and those where the government takes total responsibility for the cost of medical care. This system preserves the patient's right to see the physician of his choice and to change his doctor if he so desires, and it reduces for the individual the burden of paying excessive medical costs while maintaining a fair measure of private enterprise.

The New Zealand physician in private practice is paid for each item of service; but payment comes from two sources—one component from the government and another from the patient. It is thus a government subsidized service. The subsidy which the government pays is fixed but the physician has the right to vary the amount charged to the patient and, of course, may waive the fee altogether if he feels the service is minor or that the patient will be financially embarrassed.

On average, New Zealand physicians are the best paid professional group in the country but incomes probably appear low by North American standards. The subsidy for general practitioner services was fixed in 1941 at 75 cents for all services and it was over 30 years before the government saw fit to increase it in an endeavour to keep pace with inflation. Even so, the principal increase was in the subsidy for children, age beneficiaries, and anyone on a sickness benefit. For such people the subsidy was raised to $3 for an office consultation or a domiciliary visit. Out-of-hours services are remunerated at the rate of $6 in the office and $7 for a domiciliary visit. For those people who are of working age and not on a benefit, the subsidy is only $1.25 for an office consultation or a home visit. This increases to $3 for an office consultation and $4 for a home consultation if the service is provided outside of normal hours. In addition to this, the physician will usually charge the patient a further sum which will give a total payment for an office visit of $5 to $6 and for a home visit $10 to $12. Domiciliary visits have diminished in recent years but can still occasionally represent as much as one third of total consultations.

Fees will vary slightly from one part of the country to another and there are still a few physicians who regularly accept the subsidy only, and charge the patient nothing. On the whole, however, fees tend to be very similar from place to place and although the Medical Association regularly emphasizes the desirability of charging a "fee commensurate with the service," in fact most general practitioners vary their fee very little unless some prolonged or difficult service is provided. There is no upper limit, other than the law of the marketplace, to the sum which the physician may charge his patient over and above the subsidy.

It is only quite recently that there has been anything like a realistic subsidy for private specialist services. As from January 1, 1978, there has been a $20 subsidy for consultation with physicians, pediatricians, psychiatrists, neurologists, and neurosurgeons, and a $5 subsidy for consultation with all other specialists, increasing to $10 for children. These subsidies are dependent on referral from a general practitioner, and there is a much smaller subsidy if a specialist is seen without referral, a practice which is actively discouraged. On the whole, specialist incomes tend to be rather higher than general practitioner incomes.

Physicians have a choice as to how they receive the subsidy. It is possible to operate a "refund" system whereby the patient is charged the full fee and given a form completed by the physician

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which the patient takes by way of a receipt, and which when presented to the Post Office enables the patient to obtain the subsidy immediately. Most doctors prefer to utilize the "schedule" system whereby the name of each patient attended is listed, together with a note of the amount of subsidy to which they are entitled. The Health Department is then bulk billed for the total sum.

There are political disadvantages to this latter system in that the patient is usually unaware of the subsidy and its amount, being interested only in the sum which he or she is personally obliged to pay. Patients, therefore, do little to encourage the government to increase the subsidy, as they do not feel this would necessarily be to their personal advantage, but would merely further line the doctors' pockets.

As a result, when an increase in the subsidy to keep pace with rising costs has been thought desirable, the initiative has usually come largely from the physicians, who do not represent a very significant proportion of the voting population at election time. It is probably for this reason that the subsidy remained unchanged for so long.

All medical services provided in the public hospitals are completely free to the patient and for urgent problems a bed can always be found. This means that there is little or no anxiety concerning the high cost of specialized procedures, such as intensive care.

The disadvantages of this system lie in the fact that: (1) family practitioners do not have hospital beds; (2) the patient in hospital is unable to select his own physician; he is placed in the care of the team which is on acute call at the time of his admission; furthermore, there is no opportunity for privately organized consultations in the public hospital; and (3) because of a shortage of hospital beds, there is a long waiting list for many non-urgent conditions.

In parallel with the public hospitals, there is a subsidized system of small hospitals, mostly established privately by individuals or charitable organizations. A patient who elects to enter such a hospital—some of which are very well equipped but few of which have resident medical staff—will be able to have a choice of physicians and will probably be able to have non-urgent procedures dealt with promptly. The family practitioner may continue to care for his own patient in the private hospital whereas in the public hospital he is denied that right. Many see the exclusion of family physicians from the public hospitals as a distinct disadvantage and, in general, it leads to a deterioration in most physicians' ability to provide continuing care particularly in acute conditions. To some extent, however, this disadvantage is offset by the excellent laboratory services which are available and which are completely subsidized and hence free to the patient regardless of whether they are provided through the public hospital or a private laboratory. In fact, in most large population centers the private pathological services compete for the patronage of the medical profession and even provide a domiciliary collecting service using nurses with cars in direct two-way radio contact with the laboratory. As a consequence many cases which elsewhere would require hospitalization for management, can be cared for in the home by the family practitioner. Thus a patient can be fully anticoagulated and controlled in his own environment. Furthermore, in some places simple roentgenograms may be performed in the home using portable equipment privately available.

District nursing services are also fully paid for by the government and the family practitioner can call on them in order to assist in keeping the patient out of hospital.

Public hospital outpatient facilities are extensive and like all public hospital services are free to the New Zealand citizen. As with inpatient services the patient is denied a choice of physician. Because of this there is still an active private practice in the specialties, with many physicians spending part of their week working for a salary within the public hospital, and part of their time working on a fee-for-service basis in the community, utilizing the specialist subsidy already described and, in addition, charging the patient the difference between the total fee and the subsidy. Some physicians elect to work by salary solely in the public hospital while others survive on private work alone.

Because of the shortfall between subsidy and private fee for general practitioners and specialists, and also between subsidy and cost of private hospital beds, many people have taken out private medical insurance against such expenses. One medical insurance company claims to have over 500,000 subscribing members out of a total population for the country of somewhat in excess of three million.

Almost all medication is provided free to the patient on a doctor's prescription. In some cases where there are two or more preparations available, apparently equally effective but differently priced, when the physician prescribes the more expensive form, the patient may be required to pay the difference in cost between the cheaper form and the prescribed preparation.

The cost of health care is paid for by the government out of the consolidated fund. That is to say there is no special tax imposed for this purpose and a certain sum is set aside from the total budget each year.

The picture has recently been complicated by the establishment in 1974 of the Accident Compensation Commission set up to ensure that no person should be seriously disadvantaged financially as a result of an accident of any sort. Where it is demonstrated that a disorder is a result of an accident, the Accident Compensation Commission takes the responsibility for meeting all medical expenses over and above the General Medical Services subsidy described above. There is a flexibility in the sum which the commission is prepared to pay, so that the physician retains the right to charge "a fee commensurate with the service," provided that the fee is reasonable by New Zealand standards and provided that the average fee claimed by each physician does not exceed a stated maximum indicated by the commission. The commission is also responsible for reimbursing salary loss and will pay up to 80 percent of an accident victim's normal salary (with a maximum of $240 weekly) while he or she is unable to work. It is a no-fault system and the injured person is unable to sue for damages. The implications of this for medical practice have not been tested but it seems likely that most litigation for medical negligence—which has never been a major problem in this country—will cease.

The money for the Accident Compensation provisions comes principally from a levy on employers and self-employed persons. It remains to be seen whether the country can afford to continue supporting such a comprehensive and innovative social welfare measure.