International Perspectives

The New Zealand Family Physician and the Hospital

John G. Richards, MD
Auckland, New Zealand

A fundamental feature of the New Zealand health care system is that most hospitals are state owned and thus designated "public." The management is decentralized, and there are 13 elected hospital boards throughout the country responsible for hospital policy in their area. Some of these boards administer several major hospitals, whereas others control perhaps only one small hospital. A global sum is determined annually by the National Treasury and made available through the Health Department for allocation to the boards according to the size of the population served. Sometimes this is a very considerable sum; the budget of the Auckland Hospital Board is said to exceed the national budget for the whole of the Fiji Islands.

Staffing

Each hospital board has a superintendent-in-chief who is medically qualified and who acts as an advisor to the board. Each hospital in turn has a superintendent who is also medically qualified and who is responsible for the day-to-day running of that hospital. The superintendent is assisted by the chief nurse, who holds responsibility for the nursing staff, and numerous other senior executive officers, as in any other large bureaucratic organization.

Public hospital medical staffing is provided by a combination of full-time and part-time specialists. In addition, there is a full complement of house officers who, as elsewhere, are full-time and consist primarily of (1) interns, who are completing the statutory requirement of one year's rotating internship prior to acceptance by the Medical Council for full registration as a medical practitioner; (2) second year house officers, who are doing a second year of three-month rotating posts in order to further their experience; and (3) registrars, who are in their third year subsequent to qualification and who, having decided upon their future vocation in medicine, are embarking upon their first year of formal specialty training.

The full-time specialists are usually employed in areas where very special skills are required or where continuity is necessary. A few so-called full-time specialists have a rotational half-day each week in which they are permitted to do private work outside the hospital in order to supplement their salary. The truly part-time specialists are usually employed for three to four half-days each week. During this time they attend the patients in the wards for which they are responsible. In smaller centers, it is not uncommon for family physicians who have had some specialized training, such as in anesthesiology or geriatric medicine, to hold a position of this type in a public hospital.

Depending on the day of the week, patients in the public hospitals are allotted to the team which has been given responsibility for all new admissions on that day. The specialist who heads that team has overall responsibility for the patient throughout his or her hospital stay, unless the nature of the problem falls within the province of another specialty, when a change of team may be arranged. Whenever possible, patients who require readmission for further treatment are returned to the care of the original team.

Continued on page 188

0094-3509/82/010185-03$00.75

Continued from page 185

A major incentive to use the public hospital is that all services and accommodations are free to the New Zealand citizen. Thus no patient need ever fear that highly specialized medical care will be a financial embarrassment.

From the patient's point of view the disadvantages of the "public" hospital are that there is no choice of physician and, furthermore, that the family physician is unable to influence management in hospital except indirectly through discussion with the physician in whose ward the patient has been placed.

Private Care

For those who can afford it and those who have private medical insurance (this now represents in excess of 500,000 people out of a population of 3.1 million), there is still a private hospital system operating in parallel with the public system. One disadvantage of most of these hospitals is that they are usually geared to relatively unsophisticated medical and surgical procedures; only one in the whole of New Zealand has a resident medical staff. This particular hospital has facilities for open heart surgery and can cope with most intensive care procedures.

A few of the private hospitals are owned by a consortium of physicians; several are owned by the largest medical insurance company, while most of the others are owned by nonprofit making charitable organizations such as the various religious denominations.

Even these hospitals would find it difficult to continue to serve the public without a small bed subsidy from the Department of Health, and are thus paid for out of taxation. This is due to recognition by the government of the important role that these hospitals play in relieving pressure on the public hospitals. The size of the subsidy, however, is such that the private patient still has to find a substantial part of the hospital fee himself, and without private insurance many individuals find this prohibitive.

The private hospitals flourish because the patient has a choice of physician and elective surgery can usually be done promptly, whereas in many

urban public hospitals there is a long waiting list for such procedures. The private hospitals can also offer minor luxuries, such as a telephone at the bedside and, for an extra fee, single-bedded rooms, at the option of the patient.

Family physicians may admit their patients to private hospitals and care for them there, but usually such patients are looked after by the specialist to whom they have been referred by the family physician. Although referral is not obligatory, most such admissions have complexities that are considered to warrant specialist assistance. Furthermore, it is uncommon for New Zealand family physicians to perform major surgery, so virtually all surgical cases requiring hospitalization are likely to be referred for specialist management. Physicians using the private hospitals work on a fee-for-service basis and have the right to charge whatever they consider a fair fee for the service rendered.

Domiciliary Care

A further feature of the New Zealand health services is the excellent domiciliary facilities available. In most of the larger urban areas, there is a full domiciliary pathology service available. The laboratories employ young women to collect samples and take blood. They are provided with a car, which is in radio contact with the base laboratory. This leads to a very prompt service, and laboratory results in urgent cases can be phoned to the family physician and are often available more rapidly than when similar tests are sought in hospital for hospitalized patients. This efficient service, which is subsidized in full by the Health Department, is therefore available without charge either to the physician or his patient. As a result of this service many patients who would otherwise require inpatient care (eg, for stabilization of anticoagulant therapy) may be cared for at home. In some areas there is also a domiciliary x-ray service that provides radiographs of sufficient quality to exclude such problems as fractures, pneumonia, and pleural effusion. This service is subsidized but is not completely free to the patient.

The concept of the extramural "hospital" has been described in a previous article.[1] Such organizations, which now exist in several urban areas, are under the control of the local hospital boards but are designed to support the general practitioner in the care of patients in their own homes. The extramural services were originally conceived at a time when there was a serious shortage of hospital beds. The service can provide home nursing, physical therapy, occupational therapy, dietary advice, domestic services, meals on wheels, and social worker support. In addition, there is a linen service and an oxygen service, and wheelchairs, crutches, and other aids to daily living are available on loan. Almost all these services are available without charge to the patient at the request of the family physician. Although this facility is not inexpensive to provide, it is believed that it reduces considerably the usage of expensive hospital beds.

Comment

Many New Zealand family physicians take the view that most hospital care requires procedures involving high technology beyond the capacity of anybody not constantly working with such technology. Thus, the monitoring of a patient with an acute myocardial infarction over the first one to two days has become such a highly specialized skill that many feel that delegating to a physician who does little else is in the best interests of their patients. On the other hand, were it not for logistic reasons relating principally to distance from the hospital, many family physicians would welcome the opportunity to provide general surveillance for patients in hospital in partnership with the specialists, thus providing a continuity of care which is at present lacking. They also feel that a closer attachment to the hospital would be beneficial in their efforts to keep thir medical knowledge updated. Meantime, well-developed facilities designed to assist in the diagnosis and management of patients in their own homes go some distance toward compensating the New Zealand family physician for the common absence of hospital privileges.

Reference

1. Richards JG: The allied health professional in New Zealand general practice. J Fam Pract 11:145, 1980