"Reflections on Changes in Medical Practice, 1963 to 2002".

Address to the Auckland Medico-Legal Society,
4 June 2002.

Madam President, thank you for the honour you have done me in inviting me to address the Society tonight and ladies and gentleman thank you for the compliment you have paid me in turning out to listen to me. I trust you have wined and dined well, since I suspect that by the time you have returned to the safety and security of your homes, that may have been your only pleasure for the evening.

To say that I have enjoyed my meal this evening is perhaps going too far; suffice to say, that since I succumbed to Ms Brandon's flattery one year ago when she, as President-elect, asked me to consider and I agreed, to contribute to the Society's programme, I have been quite severely afflicted by recurring episodes of acute anxiety. These episodes have occurred whenever I have contemplated what I might say to you. I should say that I am not sure I have solved this particular dilemma and, as result, we may be in for rather lean pickings from here on in.

My topic is "Reflections on Changes in Medical Practice, 1963 to 2002". This title presents me with at least two difficulties. The first, is that half of you have your own views of what are the significant changes in a greater or lesser part of that period and the second, is that the other half of you are experts in the analysis and criticism of prolix testimony. It is of small comfort to me that those of you in the latter group only perform such activities for a fee and those of you in the former group are driven by compassion.

It goes without saying, the changes that have occurred in the practice of medicine in the latter half of the last century have been as momentous as those in any segment of our society and have affected both the environment in which we conduct ourselves and the boundaries of science and technology within which we ply our craft.

In the interests of brevity, I will restrict my reflections to a sharing with you of my perspective of the medico-political and structural changes to the New Zealand health system that I have had the opportunity to participate in.

That should not be taken to indicate that the wonderful encounters with people; at times, sad, funny, pitiful, inspiring and usually very satisfying that have made up the fabric of general practice are not worthy of recount. Episodes like the strip tease dancer with a sore back that she attributed to her "high kicks" and who when asked to get ready to be examined said that she "knew what doctors were like" and was ready. She took off her overcoat and was wearing not a stitch of clothing. Or the boat builder who lived at the top of a steep section in Esplanade Rd in Mt Eden and who suffered intractable heart failure and bowel cancer and who I had promised I would care for and ensure to the best of my ability he would not suffer, in the final course of his illness. After about a year of visiting him at home and never seeing him outside of his bedroom or sitting room, one day he said, "Come with me, doc". He led me down steep stone steps to his garage cum workshop at the bottom of the steep section and revealed a newly completed clinker built dinghy. His explanation: "I am not going to

get any use out of this. You had better have it, doc". He had built it. Or, the wife of the octogenarian who purchased a new double bed, so her husband of more than 50 years would not need to move to a hospital bed in the final two weeks of his life, as cancer took its inexorable course. General practice has always been a marvellous job made up of people, people, and people.

In regard to the medico-political changes that I am going to touch on, I would like to look backwards a little and I am indebted to Dr John Lovell-Smith, father of Judge Jane Lovell-Smith, in doing this. John has chronicled the events that lead to the launch of social security in New Zealand, in a book entitled, "The New Zealand Doctor & the Welfare State."

In that context, I am able to relate an example of one of the many changes in the way GPs conduct their practices now, as opposed to when I started in practice. I did a locum for John Lovell-Smith, when I was a house surgeon. My wife, Lorraine and I, with our two small children moved into the Lovell-Smiths' home in Claude Road, Epsom and Lorraine looked after Jane and her younger siblings, while I went each day to the surgery in Manukau Rd and John and his wife Nan went on holiday. Such an arrangement would be unheard of today, even if one succeeded in obtaining a locum.

I entered general practice in September 1966, joining Drs Victor McGeorge, Butt Adams and Noel Wilson at 457 Mt Eden Rd. Victor McGeorge had purchased the practice from Dr Edward Roche who had established it in 1931. Roche, who became the doyen of Auckland cardiology, had purchased the premises in 1931 finding the house, which is recognisable in a photograph taken from the summit of Mt Eden in the 1880s, a "gracious family home, well suited to a medical practice". "There was no social security and it was the middle of the depression". He told me in a letter when I started, at which time he was still in private consulting practice as a cardiologist, that in his first year "we made more money playing cards than we took in fees".

The world's first social insurance scheme was introduced in 1883. Chancellor Bismark in Germany was its author. From that beginning has evolved all the arrangements throughout the world where governments contribute to a greater or lesser extent to the provision of payment for health services. Bismark's pioneering achievement, however, was preceded by the introduction of a bill, in the New Zealand Parliament in 1882, attempting to establish a social insurance scheme that would have provided sick pay for workers. The bill was not passed, but interest in such social policy was clearly present, in New Zealand from a very early time.

Eventually hospital boards were established, and in the 1920s, those organisations showed renewed interest in insurance arrangements that would involve employer and individual levies to pay for medical services. The New Zealand Division of the BMA (as the NZMA was, until 1967) also showed interest in, but anxiety with these developments and various committees were formed. Unsurprisingly perhaps, little progress was made.

Then, the first Labour government was elected in 1935 with a campaign promise to institute a free health service. Thus was heralded a monumental struggle between the doctors and the government.

The BMA elected Dr J S Jamieson, of Nelson, to lead them. He was a general practitioner who was an immigrant from Scotland. He had two brothers who were also doctors. They were both eminent anatomists and one of them was the author of Jamieson's Anatomical Atlases that were indispensable anatomy dissection room companions of generations of Otago medical students.

Jamieson articulated the principle that could be paraphrased as, ***the contract between patient and doctor has no room for a third party.*** Tense and, at times, acrimonious negotiations were conducted between the government and BMA representatives that went on for seven years before the Social Security Act was finally passed in 1942. The process involved widespread consultation between BMA members, virtually the entire medical workforce and their BMA officials. That process aroused widespread public interest which, amongst other things, involved public meetings to full houses in Town Halls of the major cities and eventually and tellingly, produced widespread public support for the doctors' position. Minhinnick and other cartoonists produced a marvellous pictorial record of the events as they unfolded.

The BMA's process for consultation with its members was complicated by the outbreak of war in 1939. Eventually, almost 20% of the medical workforce was overseas, serving with the Allied forces. Communication with those doctors was complicated by security arrangements that largely prevented knowledge of where they were.

As an aside, the three doctors who I joined in practice in 1966 had all been flatmates in Dunedin, as students, qualifying in 1938. They and a fourth flatmate, Dick Feltham, had all joined up at the commencement of hostilities and had done military medical examinations on one another, as Accredited Examiners. They decided it was not important for the authorities to know that Captain McGeorge was asthmatic and Captain Feltham had rheumatic heart disease. In the event, McGeorge went into status asthmaticus (the obsolete term for severe acute asthma) and was invalided out of the Army following his TAB inoculation (given after Final Leave and prior to embarkation). When he had recovered, he joined Dr Roche as an assistant and then purchased the practice. Adams and Wilson joined him at various stages after the war and then I joined the three of them in 1966. Feltham went overseas with his rheumatic heart valves, was taken POW, escaped from prison camp in Germany, made his way across Europe to neutral Portugal and returned to finish the war with the New Zealand Division in Italy. He returned to practice in Hunterville where he became a leading community figure as mayor as well as a much loved GP.

The passage of the Social Security Act required a back down by the government that permitted doctors to charge their usual fees, with patients able to seek a refund of the subsidy that the government would offer as a contribution towards their costs. The BMA's position was that the refund system should be the norm. The government encouraged, however, doctors to claim the subsidy directly, on the patient's behalf. Both arrangements were permitted – schedule claiming, or refund.

The BMA also backed down and accepted a maternity arrangement that paid a full fee for GP obstetrics. There were safeguards built into this arrangement, to ensure that the fees paid kept up with rising costs. I will come to the fate of these safeguards in a little while, but they included the establishment of a tribunal with binding powers,

chaired by a Supreme Court judge, to resolve disagreements between the doctors and the government.

So the scene is set. The subsidy payable to patients, as partial reimbursement of GPs' fees, was known as the General Medical Services Benefit (GMS) and on 1 November 1941, following the enactment of the Social Security Amendment Act 1941 and under the Social Security (General Medical Services Benefit) Regulations 1941, became applicable. The GMS attached to daytime consultations was 7/6, with 12/6 for consultations after 8.00pm and on Sundays. This subsidy was 75% of the common fee charged by GPs at the time, i.e. half a guinea. Those subsidy rates were still the same 24 years later when I started practice in 1966. At that time our total fee was about one pound (already 2 shillings behind inflation). The distrust of governments that had driven Dr Jamieson and his colleagues to retain the right to charge a fee commensurate with the service provided, seemed more than justified.

There was no change to the GMS rates until 1972, during the time of the Kirk Labour government. The standard GMS of 7/6, now 75 cents, increased to $1.25c. Had the increase in the CPI been applied to the 1942 GMS rate, the new figure would have been $2.60c. Differential rates were introduced, in respect of attendances on beneficiaries and pensioners and their dependants, in 1969 and children under the age of 10 years in 1972. In 1977, the GMS payable for children (now any child for whom a Family Benefit was payable) was increased to $4.75c.

While not wishing to labour the point, application of the CPI index increases to the 1942 total fee for a usual consultation would indicate an appropriate fee for a GP consultation, in $2002, would be $69.00.

GPs, by and large, had the impression that governments did not trust them and were generally out to get them. Regretfully, nothing much has changed over the years to correct that impression.

I was exposed to various events that influenced me in those early years. Some of those events were more memorable than others, but a significant one involved fees payable for the provision of Cremation Certificates. A Cremation Certificate is a moderately involved document that certifies that certain elements of hanky panky did not occur prior to death and is required before the Medical Referee will allow a cremation to take place. At the time I started that fee was two guineas and was generally slipped to the GP, in cash, by the undertaker. Amongst the tasks that were required to be done was often a visit to the undertaker's premises to view the body, usually at an inconvenient time and sometimes quite a distance. One evening after Butt Adams had been to some social event, to which I had driven him, we were having a nightcap in his kitchen when our thoughts moved to the subject of cremation fees and the parsimonious nature of them. We agreed that it was time for action and so the next time one of was required to perform this duty, which I hasten to add occurs infrequently in well run general practices, we gave the undertaker what we thought was an account for an appropriate fee for the service rendered. All hell then broke out, because in the interval Robert Muldoon had imposed one of his much loved "price freezes". We heard about the excitement we had caused and the consternation afoot in the undertakers' world by our action, on the radio and were somewhat surprised at the excitement we had caused. In spite of threats from Muldoon and

Ossie Malcolm, we held our ground, the dust settled, fixed cremation fees were a thing of the past and I had learnt a lesson in the value medico-political activism.

Butt Adams, father of the current Chairman of the NZMA was the epitome of the good family doctor, and known to some of you. He had a warm and at times mischievous nature that concealed an underlying aggression. He had a Blue for boxing from Otago. One day in the early 1970s we received what could be described as a "shirty" letter from our bank manager. Butt took great umbrage when he and I read the letter and immediately he got on the telephone and rang the hapless Mr Brown. To say that Mr Brown received a dressing down is to understate the case. I was embarrassed and said so. Butt said, "Do you think I over did it?" "You certainly did", I replied, "he could bounce our cheques and all sort of things". "Well, what shall we do?" said Butt. I told him I thought we should go down the road immediately and apologise to Mr Brown and generally put things right. So without delay we hopped into my Holden and drove to the end of Grange Road, where the bank premises were. We went in, identified ourselves to the receptionist and said we would like to see Mr Brown, if that were possible. The very nice young lady apologised and told us that was not possible because Mr Brown had just gone home with a migraine! Another important lesson; never be scared of a bank manager.

Through out the period of the Kirk and Muldoon governments there existed an uneasy truce between the government and the NZMA. Doctors got used to, but did not enjoy, being attacked throughout that period of high inflation, as "greedy doctors". There were only small changes in the value of GMS benefits, in spite of the well recognised erosion of those benefits and the recommendations of various committees, but not, as a matter of interest, the NZMA, which held to the view that doctors should not be negotiating patients' benefits. The NZMA position arose from the conviction that such negotiation would provide further ammunition to the politicians' penchant for the "greedy doctor" label (is there a parallel here with the current media treatment of Legal Aid payments?) and that, in any case, subsidies were a matter for the government and patients to determine and no concern of doctors.

We saw the introduction of the ACC and no fault compensation in 1974. This legislation probably affected lawyers more than doctors, initially. The ability to sue doctors for negligence in a professional sense was lost and that has remained a controversial matter and I am neither willing nor prepared to enter into a general debate on this matter, but will express my opinion that it has been a beneficial consequence for New Zealanders. The escalating cost of professional indemnity insurance in other jurisdictions has had generally detrimental effects on the costs of healthcare provision in those countries. In Australia, in the past two months, we have seen the collapse of United Medical Protection Society (UMP) and the near paralysis of medical services, as a result. Temporary respite has been provided there by a government guarantee that indemnifies doctors against malpractice suit until 30 June 2004. Uncertainty remains thereafter. In the USA, earlier in the year, St Paul's, the fifth largest indemnity insurer in that country, folded. In Australia, insurance premiums for some groups of doctors had reached levels as high as $160,000s per annum and still UMP's reserves were inadequate for regulatory requirements.

On the national front nothing much else of consequence changed. There was a minor hiccough in the provision of obstetrical services in Central Auckland. With the

closure of the Mater Maternity wards, there was an attempt to severely restrict access to National Women's Hospital, by general practitioner and specialist obstetricians, in private practice. That was an inconsequential event when viewed from 2002 and the decimation of general practice obstetrics that has been wrought by the Nurses Amendment Act (1988). At the time, however, it seemed that action would have had the same decimatory effect as the later unanticipated law change. Obstetricians (GPs and specialists) applied concerted pressure was and the restrictions were lifted.

Momentous events were on the horizon. Orwellian aware doctors were unsurprised when 1984 arrived and threats to professional independence became apparent. The Opposition's spokesperson on health, Michael Bassett was making speeches, as part of the run up to the General Election which made it clear that the if Labour was elected, it intended to introduce a scheme that restricted the right, secured in 1941, to charge a fee commensurate with the service given. Well they won the election, of course and in Roger Douglas' first budget, a proposed arrangement to introduce such a scheme to apply to paediatric consultations was announced.

Intense opposition to the scheme from doctors and the NZMA rapidly developed and negotiations between the officers of the NZMA and the government ensued. The NZMA developed Red Letters. These communications kept the membership apprised of the unsatisfactory course of the negotiations and served to strengthen the resolve of the doctors who, by and large, remained implacably opposed to the scheme, which became known as SAPS ("Special Arrangement for Paediatric Services") for fairly obvious reasons which will become even more readily apparent shortly. The Red Letters were thought to warn, "Stop". An impasse and probable failure of the scheme seemed more and more likely. Then over the Christmas and New Year holiday period, 1984/85, Dr Bassett and his senior advisor, with the chairman and the deputy chairman of the NZMA went off to the minister's holiday cottage. There, they reached some sort of agreement and the next NZMA communication was a, (surprise, surprise), a Green Letter. Although vigorously denied by the chairman, the Green Letter was widely interpreted as a "Go" signal, and the fruits of their holiday labours. Unfortunately, the membership was deeply disturbed by this turn of events, while the minister was emboldened by them.

The consequence was that the scheme was introduced. In Auckland, the executive committee of the Auckland (NZMA) Division was deeply disturbed. Tony Baird, as President and the GP members of the committee, the President-elect, Mike Cooper, David de Lacey and me began to run around like headless chooks. The effect of the scheme, which was introduced as a Special Arrangement, in terms of Section 117 of the Social Security Act 1964 (hence the SAPS acronym), would be to deny the benefit of reduced doctors' fees to parents whose doctors did not join the scheme. The unfairness of that effect had us clutching at straws and a naïve belief that there might be a legal remedy. Judge Anand Satyanand's father, "Old Saty" advised us, "Get a barrister with mana (and we did not pose the question 'is that an oxymoron'), get Paul Temm. Paul, as many of you will know, was an old friend of mine and so with a doctor's disregard for niceties, I called Paul and he saw us in short time. His initial advice was not promising, but then after a day or two he rang me and said he thought the minister may have put himself in peril and we should get ourselves a solicitor and come to see him, again, very quickly. At that stage our naivety would become even more apparent to an outside observer, because we had no idea of the costs we were

about to incur by mounting a High Court action. John Lovell-Smith had not long retired from the Auckland Division executive and so we immediately decided his daughter, Jane Lovell-Smith would be an excellent choice, as a solicitor, and we called her. Jane was the local representative of the Medical Protection Society and she thought that was the reason we had called her. As a result, she rang Hugh Rennie who was the senior MPS figure, in New Zealand, to enquire whether MPS would fund a prospective action. Hugh contacted London and literally, before we knew it, funding to pursue our action was in place. Some anxiety developed when we became acquainted with the situation, because of the four of us, I was the only one who was an MPS member. Baird, Cooper and de Lacey were all members of the rival Medical Defence Union. When it was determined that Baird, as an O&G specialist did not have standing to appear as a plaintiff in an action that involved general practice it left Cooper, de Lacey and Marshall, in alphabetical order, but because of my membership of the MPS, the case was documented as Marshall & others v. the Minister of Health. Such is the path to posterity.

There followed some of the most memorable time of the lives of we three plaintiffs and Tony Baird. Paul referred to us as "the Three Musketeers and d'Artagnan (Baird)".

The six of us met at least weekly to permit Paul "to immerse himself in general practice" and to prepare for the case. We obtained affidavits from officers of every NZMA Division in the country, from dozens of parents of children affected by the arrangement and from the most eminent general practitioners in the country. Then we had the immense pleasure of watching Paul and Jane in action, in the High Court. Paul's cross-examination of the sole deponent for the minister, Dr John Shirley Phillips, Deputy Director General of Health was merciless. Discovery had revealed incredible insights into the antipathy of the government towards doctors and Paul, in particular, saw a bigger picture that involved an attack on all the professions. So it was with immense relief and icing on the cake when Mr Justice Vautier found that the minister had in fact acted without authority and his scheme was invalid.

There followed a period of intense activity that eventually lead to agreement being reached on a proposal that delivered the higher rate of GMS to all children and without restriction on the fees that doctors could charge and provided an assurance to the government that the increase in the subsidy would benefit patients and not those "greedy doctors". Baird, Cooper, de Lacey and I had insisted on being involved in that process, refusing to leave it to Williams the chairman and Broadfoot the deputy chairman of the NZMA. We thought they were lucky to keep their jobs and certainly not to be trusted to finesse the advance we had made. So we successfully defended Jamieson's achievement and the profession lived again!

The whole arrangement, including whether doctors had reduced their fees by the amount of the increased subsidy or simply, as the government had anticipated, pocketed the extra was reviewed at the end of one year by Colin Pigeon QC, appointed by the minister. Mr Pigeon in an extensive and highly readable review found that the doctors had acted as the NZMA had assured the minister they would. Patients benefited by cheaper and presumably more accessible doctors' consultations.

Soon afterwards, maternity issues became a further source of conflict and the NZMA determined to invoke the tribunal, permitted since 1941. It had not been used previously and Paul Temm was asked, this time to represent the NZMA. The tribunal gave a binding ruling that delivered a one hundred per cent increase in maternity fees. Success was sweet, at least for the doctors.

The government found both these results unpalatable and quickly moved to amend the Social Security Act. Provision was made:

1. to restrict the maternity tribunals, so that their findings would no longer be binding on the government of the day,
2. to permit introduction of schemes such as SAPS by regulation,
3. to semantically describe GMS subsidies as payment to doctors, not subsidies to patients,
4. to remove the symbolic right to refund (less than a handful of GPs still used that system, by then).

All that took place on the Friday prior to the National Party's Annual Conference, when large numbers of opposition members were absent from the house. Paul Temm had warned us such a law change was to be expected and so throughout the country doctors had been to see government MPs and warned them we would be making submissions to the Select Committee when the amending bill was presented. Unsurprisingly, perhaps, the amendment was introduce under urgency and all three stages of the amended bill were passed in one sitting without the need for Select Committee scrutiny.

Conflict with the government continued and in 1988 Helen Clark who by that time was Minister of Health produced another scheme similar to Bassett's and the NZMA with Lewis King (son of Norman King, a minister in the Kirk Labour government and who died last week), as chairman together with its affiliate the NZGPA of which I was chairman, in spite of the amended Social Security Act, determined to enter the lists once more. Temm advising us we had no chance of success, and in an attempt to persuade us not to waste our money, declined to act for us and of course we did lose.

However, we had bought time and the number of doctors who decided to participate in the new contract arrangements remained small and the ballot box saved us.

National regained the Treasury benches soon after Mr Justice Thomas delivered his judgement that favoured the government. The incoming government abandoned Helen Clark's scheme and immediately set about developing the health reforms that were eventually introduced in 1993.

The 1993 reforms created an environment that favoured a leading position for primary care and at the time, I was chairman of the NZGPA and deputy-chairman of the NZMA. I took a position that favoured the reforms and set about investigating structures that would enable GPs to have some strength in negotiating with the proposed funding authorities and be in a position to be influential participants in the changed health system. I had the belief that we had an opportunity to put in place a mechanism for primary care that would be so successful that no government would want to change it. I thought we had fired all our powder, by then and governments of

any hue of colour would eventually be hostile to our profession. We needed to get ahead of them. This proved to be a controversial course to take.

Alister Scott, the chairman of the NZMA, took a different view and regarded the reforms as slightly more offensive than the devil incarnate. GPs, after initial strong support for my activities, became split. A faction in the Wairarapa acquired a vocal following under the guidance of Laurie Bryant, a prominent Wellington and Martinborough public relations consultant. The NZGPA proceeded with development work on the model we chose, independent practitioner associations (IPAs).

Democracy ran its course and after a fairly acrimonious relationship with Alister Scott lasting two years, in 1993 I resigned as deputy-NZMA and at about the same time was voted out as chairman of the NZGPA. Clearly, today's rooster is tomorrow's feather duster.

Considerable numbers of GPs, however, adopted the IPA model and there are now something like two dozen of these organisations throughout the country and as many as 80% of the country's GPS may be participating in them.

I am currently the chairman of ProCare, which is one of the largest of them. It is owned by 370 GPs and has a collective register of patients numbering about 650.000. We have contracted with the Northern RHA, then the Transitional HFA, then the HFA and now the three DHBs in the Auckland region. Our GPs are located from Whangaparoa in the north, Helensville in the west, Glen Innes in the east to Drury in the south. You have a good chance of being a patient of a ProCare GP and you may be aware of us from our magazine ProCare Pulse, the first issue of which was distributed with the NZ Herald, early last month.

ProCare, like other IPAs generates funds, by managing government funds for pharmaceutical prescribing and since commencement of operations in 1995, has accumulated savings in this activity of some $32 million dollars. We have received 50% of this, although the first tranche of these savings was only acquired after a painful and costly arbitration. We have begun to use this fund for the provision of health services for our patients. There have been some dramatic, if relatively unheralded successes. In a randomised controlled trial, in collaboration with secondary care colleagues at Middlemore Hospital, we have demonstrated a 60% reduction in length of hospital stay for patients with COPD - chronic bronchitis or emphysema. Adequately funded primary care based case management of the intervention group of patients has achieved this. The rate of increase in the incidence of acute medical admissions has been reduced by 50% at North Shore and Middlemore Hospitals by implementation of a programme developed by Pegasus, another large IPA based in Christchurch. GPs are given immediate access to funds to avoid admission when faced with a sick patient for whom admission may be indicated. Those funds may be spent in any way required. It may be to pay for an urgent investigation, or nursing assistance, or further medical attention. It is planned that this programme will become available at Auckland Hospital on 1 July. As a further example, we are providing free consultations to the hard to reach group aged between 16 and 22 years for the provision of sexual and reproductive health services. The importance of this programme can be understood when reading the report in last Thursday's NZ Herald that New Zealand has the third highest rate of teenage

pregnancy in the "rich world". Just how we qualified to be competing in that division is something of a riddle, perhaps.

IPAs have been tackling with a good deal of success the goals set out in this government's Primary Health Care Strategy. It is thus with a moderate degree of alarm and surprise that we are confronted with a proposal to establish new structures as ordained by the Ministry of Health. Plans are in hand and in some places well advanced to establish "community based" organisations called Primary Health Organisations. Funding arrangements for these new animals have been set out in a confidential paper that has been circulated to a hand picked audience in the past few days. These proposed arrangements contain features that had been so obnoxious when found in the iterations of primary health care organisations promulgated by previous governments. The proposal intends to make funds available to reduce the cost of general practice services.

A confidential draft document, copies of which have been falling off the back of a truck, as it went up and down the Terrace, have indicated a bizarre plan to distribute additional funding for subsidies for payment of medical fees to patients, by allocating funds to practices with a threshold figure of people in the highest category of need. Practices or organisations with 50% or more of their registered patients who are either Maori of Pacific Islander, or are residing in areas that fall in the 5th quintile on the NZ Deprivation index, will receive enhanced funding, sufficient it is said to make direct fees to patients very low or not necessary. Those low fees would then be charged to all patients in the practices, regardless of individual socio-economic status. Conversely, an adjacent practice with only 30 to 40%, say, of its population in the most needy category will not qualify for enhanced subsidies and there will be a consequent inability to offer low fees to those people. The manifest unfairness of this position for those needy patients and its commercially destabilising effect on practices is met with blithe disdain. It is a situation that GP organisations cannot accept and we believe it is a situation that the general public will have difficulty accepting also. The prospect of a very wealthy person who attends a doctor with a substantial proportion of her or his practice receiving free medical consultations and free pharmaceuticals, while a poor person attending a doctor whose proportion of poor people does not reach the threshold determined will have to pay up to $50 for a GP consultation and pharmaceutical prescriptions at $15 per item seems unfair, if not irrational.

On top of that, the funding formula proposed by Health Ministry officials, in spite of repeated assurances by the Minister of Health that the government does not intend to limit the fees doctors may charge, includes specific instruction, that to qualify for the maximum enhanced funding available, practices or organisations will have to agree to a set fee for a fixed period of time. This is anathema to the vast majority of GPs and unless this apparent conflict between the minister's assurances and the ministry's dictum is resolved very quickly, the old battle lines will be drawn heading into an election.

On that grim note, I shall conclude.

Thank you.