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The ACCIDENT COMPENSATION ACT and PRIVATE HOSPITALS.

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I. INTRODUCTION

It has never been seriously suggested by any Government in New Zealand that the private hospital sector should be abolished or even discouraged. During the last two decades, State policy has become increasingly more favourable towards private hospitals through the provision of patient benefits, capital grants and loans and taxation concessions for private hospital insurance.

At 1st April 1974, New Zealand had 351 hospitals of which 197 were public hospitals containing 17, 839 hospital beds (approximately 81 percent of the total hospital beds).(1) The public hospitals are administered by formally autonomous Hospital Boards which are legally responsible for the detailed administration of the hospitals in their areas. The finances of these hospitals are provided almost entirely by the Department of Health. In the public hospitals, the medical and surgical services are provided largely by part time staff, who also have private practices, and a number of full time salaried staff.

There were also 154 private hospitals containing 4,264 hospital beds. These can be divided into three main groups - namely, maternity, medical only and medical and surgical - all of which are subject to inspection for license by the Department of Health to ensure that a high standard is maintained.(2)

The large public hospitals provide a number of services which are not provided by private hospitals, however private hospitals carry out all routine medical and surgical treatment

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(1) New Zealand Official Year Book 1975, Govt. Printer Wellington 1975 pp.144-47.

(2) Part V. Hospitals Act 1957.

including major surgery, except that requiring teamwork or extended hospitalisation. It appears that approximately 30 percent of all operations performed in New Zealand are carried out in private hospitals.(3)

It was hardly surprising therefore that the Woodhouse Report on Compensation for Personal Injury in New Zealand(4) should state:

> ... the use of private hospitals should be encouraged if this could avoid delays in treatment and promote the general purpose of rehabilitation ... we are left in no doubt that the importance of getting people well and back to productive work far outweighs (both financially and in human terms) the ostensible economic advantage of using the public hospital bed.

Following this recommendation, the legislature, in providing for the payment of the costs of medical treatment under the Accident Compensation Act 1972 (hereafter called the Act), made the Accident Compensation Commission liable (other factors considered) for the payment of private hospital fees under section 111 (1).

The Relationship Between the Provisions in Section 111 (1)

Section 111 (1) of the Act provides that:

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(3) Board of Health Committee, Private Hospitals in New Zealand, Govt. Printer, Wellington 1974 p.13.

(4) Royal Commission of Inquiry into Compensation for Personal Injury in New Zealand, Report, Govt. Printer, Wellington 1967 p.159.

See also, A Commentary on the Report of the Royal Commission of Inquiry into Compensation for Personal Injury in New Zealand. Govt. Printer, Wellington 1969 p.107; Select Committee on Compensation for Personal Injury in New Zealand, Report. Govt. Printer, Wellington 1972 p.28.

> Subject to any regulations made under this Act, where a person suffers personal injury by accident, in respect of which he has cover under the Act, if as a result of the personal injury he requires to obtain a medical certificate for the purposes of this Act, or requires any treatment to which this subsection applies, the Commission shall pay the cost thereof so far as -
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> (a) That person is not entitled to any benefit under Part II of the Social Security Act 1964 in respect thereof; and
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> (b) The Commission considers that the amount to be paid by it is reasonable by New Zealand standards ...

Subsection (2)(a) of section 111 (by reference to the definition of "hospital" in section 88 of the Social Security Act 1964) provides that subsection (1) of section 111 shall apply to the treatment of the injured person in both public and private hospitals.

Under section 111 (1)(a) the Commission has a direction to pay the costs of medical treatment so far as "That person is not entitled to any benefit under Part II of the Social Security Act 1964 in respect thereof". The basic qualification for entitlement to receive hospital and medical benefits under those provisions is laid down in section 91 of the Social Security Act and is as follows:

(a) Age over 16 years; and

(b) Ordinarily resident in New Zealand. (This second qualification extends to New Zealand citizens who are for the time being in New Zealand, although ordinarily resident overseas, and who have at some previous time been ordinarily resident in New Zealand).

A person who can show entitlement is able to claim hospital and medical benefits for himself and every member of his family under 16 years of age.

All medical and surgical treatment and nursing care and attendance afforded in any hospital to a person being maintained in the hospital for the purpose of receiving medical or surgical treatment therein qualifies for the payment of a hospital benefit.

Benefits as such are no longer paid to public hospitals for treatment of patients as this expenditure is included in the general expenditure of public hospitals. Section 101 of the Social Security Act provides that:

> ... no Hospital Board shall demand or accept or be entitled to recover from the patient or any other person any payment for hospital treatment afforded to a hospital patient who is entitled to receive hospital benefits ...

In other words, when a patient is entitled to hospital benefits under the Social Security Act, treatment is provided free by public hospitals.

A hospital benefit is paid on a daily basis for each category of patient accomodated in a private hospital. The licensee is required to apply this payment in reduction of the total charges for hospital treatment.(5)

The benefit rates from 1st October 1975 are as follows:(6)

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(5) Section 102 (2) Social Security Act 1964.

(6) New Zealand Official Year Book 1976. Govt. Printer Wellington 1976. p.139.

(a) For surgical treatment $12 a day, with a minimum of $24.

(b) For medical (including psychiatric) treatment $9 a day (from 1st January 1976).

(c) For geriatric treatment $11 a day (from 1st January 1976).

(d) Hospital treatment for maternity patients $12 a day.

These benefits are paid in respect of the hospital treatment only. A surgeon who attends on a patient in a private hospital will render his own bill of costs separately and there will be an entitlement to the specialist medical services benefit under section 97 of the Social Security Act. The attendance of an anaesthetist carries an entitlement to a general medical benefit under section 93 and section 93A of the Social Security Act.

The differences between the public and private sectors in this area has obvious implications for the operation of section 111 (1)(b) of the Act. Under this provision the Commission is liable for the excess costs beyond the hospital and medical benefits so far as "The Commission considers that the amount to be paid by it is reasonable by New Zealand standards". Where the patient has been treated in a public hospital there is no liability on the Commission at all because the whole cost is met by the Health Department. However the hospital benefit for private hospitals leaves the Commission with an area of liability which it is bound to meet unless it considers that the amount to be paid by it is unreasonable by New Zealand standards. Also, where treatment is obtained in private hospitals the Commission is liable under subsection (2)(a) of section 111 for that part of the specialist's and anaesthetist's bill not covered by the

respective benefits.

Defining the Issue

It is the discretion which the Commission has under section 111 (1)(b) to meet the costs of private hospital treatment which is the subject of this paper. Four main areas will be considered, each of which concerns in one way or another the policy which the Commission follows in exercising that discretion.

The way in which the Commission has formulated and applied its policy will be the general theme throughout the paper. The basic policy which the Commission follows is set out in the Accident Compensation Medical Handbook(7) but, as the Commission itself stresses and as practice shows, this is intended to be a guideline only. The paper will indicate how the Commission has supplemented this basic policy with memoranda and technical information circulars where a particular situation has warranted special consideration.

After examining the policy as it is set out in the Medical Handbook, the paper will consider the administrative law aspects of the discretion and the validity of the Commission's policy formulation in the light of these considerations. Basically two related questions will be considered here: the fettering of discretion by self-created rules of policy; and, the abuse of discretion by taking into account irrelevant considerations.

There will be an examination of how the Commission's policy has been applied in practice. This will involve a review of relevant decisions both by the Hearing Officers at the Review Hearings

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(7) Accident Compensation Commission, Accident Compensation Medical Handbook 1974 pp.14-16.

and by the Appeal Authority on appeal.

Finally the paper will consider particular problem areas which the commission has had to deal with in the application of its policy. Three basic issues will be looked at: the question of the amount to be paid under section 111 (1)(b) and how this relates to private medical insurance; the medical profession and its relationship and interaction with the Commission; the Auckland geriatric patient problem.

II. THE POLICY GUIDELINES

It was clear from the way in which the Commission's liability for hospital treatment under section 111 had been enacted with reference to Part II of the Social Security Act, that Government policy was that Government funds (through the Department of Health) should pay for the public hospital treatment of accident victims. It was considered that the extra cost to the hospital system (compared with the recoveries they previously made from insurance companies) would be largely balanced by the saving to Government funds as a result of the Commission paying for what previously the Social Security Department paid out in sickness and invalidity benefits to accidentally injured people.

It was, therefore, decided that the funds which citizens contributed to the Commission were to be calculated on the basis that the public hospital system would be the point of first referral for an accident victim requiring hospital attention. It was felt that, since the populace of New Zealand had already provided, through taxation, for the full maintenance of the public hospital system and for some subsidy for private hospital treatment, it would not be appropriate that in normal cases the citizen should pay (through Accident Compensation levies) an additional amount to provide the full cost of private hospital treatment where adequate personnel and facilities were available at a public hospital.

Nevertheless, the Commission accepted, with the make up of New Zealand's health system being as it was, that the private sector had a necessary part to play in those services, and that, in appropriate cases, some portion of its funds should be available for the payment of the costs for private hospital treatment.

Accordingly, the Commission formulated a set of policy guidelines to be used as a point of reference, in each case where the payment of costs for private hospital treatment was in issue, as an aid to determining whether or not the particular case was an appropriate one for such fees to be paid. These guidelines are set out in the Accident Compensation Medical Handbook, which was issued by the Commission in 1974 for the information of medical practitioners and other interested parties on particular areas of the Act which were open to interpretation.

The Commission emphasises in the Handbook that its policy is intended to be "flexible and co-operative, the welfare of the patient being regarded as paramount".(8) However, because it has a responsibility for "the best economic and social use of public funds", the Commission points out that it cannot undertake to meet the cost of private hospital treatment, with accompanying specialist medical fees, in every case where the patient or his doctor might wish it.

The Commission recognises that it should not interfere with the traditional doctor-patient relationship and that the responsibility for the clinical management of an accident patient's medical treatment, including any decision to enter a public or private hospital, must be the concern of the doctor and the patient themselves. However the Commission and their agents (the State Insurance Office Managers) alone have the authority to accept the financial responsibility for private hospital treatment where the injured person has chosen to enter a private hospital. Medical practitioners are not authorised to commit the Commission

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(8) ibid 16.

to acceptance of such costs. In view of this, the Commission recommends that:(9)

> The Commission's acceptance of financial responsibility should be obtained in advance of any proposed private hospital treatment. Such advance acceptance does not have to be obtained but if it is not, the patient faces the risk that the Commission may not later agree. The financial responsibility would then be that of the patient. An informal advance approach to the Commission's local claims-handling Agent would therefore be desirable and in the patient's own interests. However, an exception could be made in the case where urgent treatment, which could only be obtained in a private hospital, does not allow sufficient time to obtain Commission approval.

Bearing in mind that it has no liability at all to meet the costs of public hospital treatment, the Commission has listed a number of factors by which it could be influenced in making its decision on the amount (if any) it considers reasonable to pay in cases where the injured person has received treatment in a private hospital. These are:(10)

(a) The Act's emphasis on rehabilitation of the injured.
(b) The overall economics of the compensation scheme, which might become distorted if disproportionate expenditure were incurred for private hospital treatment.
(c) The economics of the particular case. The Commission will consider:
    (i) The actual cost of the private hospital treatment.
    (ii) The comparison between that cost on the one hand and, on the other, the overall cost to the Commission if compensation payments would have

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(9) idem.

(10) ibid 15-16.

to run for a longer time because admission to public hospital could not soon be arranged. Even if this comparison still shows that private hospital treatment will involve greater cost, that cost could still be regarded as reasonable by the Commission if the private hospital treatment would result in rehabilitation of the patient being materially and substantially advanced, so that the greater cost is outweighed by the benefits to the patient.

(d) Any factors of public interest such as the desirability of retaining and attracting adequate medical services.

(e) The extent and quality of professional services and general facilities available at hospitals in the area.

(f) The convenience of the patient and his family.

(g) The emergency nature of any treatment required and the location of available facilities.

(h) The opinion of the patient's medical advisers on the above or any other relevant factors.

The Commission makes it clear that it could not normally be expected to meet the costs of private hospital treatment if the patient's stay in the private hospital is likely to exceed ten days or if proper treatment in a public hospital were available immediately or within a reasonable time.

The existence of these policy guidelines not only serves as an indication to the medical practitioner and his patient of what the Commission's attitude is to the question of its liability to meet the costs of private hospital treatment, but also facilitates a certain degree of uniformity and consistency in the exercise of the discretion under section 111 at three main levels:[11] first, where prior approval of the Commission is

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(11) The Managers of the State Insurance Office and the Hearing Officers can exercise such of the functions and powers of the Commission as are delegated to them in accordance with section 29 of the Act.

being sought to incur the costs of private hospital treatment; secondly, where prior approval has not been obtained but where a claim for the costs is being made through the State Insurance Office; thirdly, where such a claim has been refused at the initial stage and the question is being considered by a Hearing Officer at the Review Hearing.

The formulation of such a policy is in accordance with the ability of all government departments to make rules which are not inconsistent with the relevant Act and Regulations (assuming at this stage that the Commission's policy guidelines are not inconsistent with the Act or any Regulations made under the Act). In the Social Welfare Department, for example, uniform policies and procedures throughout the district offices are ensured by reference to the departmental manuals which incorporate instructions of the Social Security Commission and rules of guidance.

However there is a significant difference between the Commission's Medical Handbook and the manuals of other government departments such as Social Welfare. Access to departmental manuals is invariably limited to authorised officers of the department. Given that extensive recourse is had to these manuals particularly in the whole context of the exercise of discretion, the effect is that decisions affecting benefit applicants and beneficiaries, for example, are made according to "secret law" and there is no opportunity for challenge on such grounds as excess or abuse of discretion. On the other hand, the Medical Handbook and the policy guidelines therein are freely accessible to any interested persons and this makes the possibility of making a successful challenge much greater. It is this question which the paper now considers.

III. FETTERING OF DISCRETION BY SELF-CREATED RULES OF POLICY

De Smith states the general proposition that: "A Tribunal entrusted with a discretion must not, by the adoption of a fixed rule of policy, disable itself from exercising its discretion in individual cases."(12)

The relevant principles were stated in R v Port of London Authority, Ex parte Kynoch Ltd.(13) In that case the owners of land adjoining the river Thames wished to construct a deep-water wharf. The Port of London Authority refused permission on the ground that Parliament had charged the Authority itself with the duty of providing such facilities. It appeared that, before reaching its decision, the Authority had fully considered the case on its merits and in relation to the public interest and the decision was therefore upheld. Bankes L.J. said:(14)

> There are on the one hand cases where a tribunal in the honest exercise of its discretion had adopted a policy, and, without refusing to hear an applicant, intimates to him what its policy is, and that after hearing him it will in accordance with its policy decide against him, unless there is something exceptional in his case ... if the policy has been adopted for reasons which the tribunal may legitimately entertain, no objection could be taken to such a course. On the other hand there are cases where a tribunal has passed a rule, or come to a determination, not to hear any application of a particular character by whomsoever made. There is a wide distinction to be drawn between these two classes.

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(12) S.A. de Smith, Judicial Review of Administrative Action (3rd ed. 1973) p.274.

(13) [1919] 1 K.B. 176.

(14) ibid 184.

An earlier New Zealand case, Isitt v Quill,[15] had intimated at a similar conclusion. That case involved the Sydenham Licensing Committee's refusal to renew the licenses of all eight licensed houses in the district. The Committee was dominated by prohibitionists who had pledged, on their election, to close all the hotels and public houses under their jurisdiction. The Court found that the majority of the Committee were incapable, through bias, of exercising a judicial discretion in determining whether the licenses were required in the neighbourhood.

Williams J. however considered that the question before the Court was one of fact:[16]

> Have the appellants laid down an arbitrary rule by which their action was to be governed, and have they followed that rule? Have they ... expressed and acted upon a general intention with regard to all licenses, whereas it was their duty to consider each individual case on its own special merits. If they have, then, although there was a necessity of a separate hearing in each case, the appellants have not really exercised their discretion, and this Court should interfere.

In Franklin v Minister of Town and Country Planning[17] the House of Lords held that it was enough that the Minister had genuinely considered the report and objections to a new town designation and in exercising his discretion the Minister could have in mind such factors as the policy of the party to which he belonged.

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(15) (1893) 11 N.Z.L.R. 224.

(16) ibid 256.

(17) [1948] A.C. 87, 104-5.

In the recent case of British Oxygen v Minister of Technology[18] the House of Lords again considered the principles of law involved in the fettering of a discretion. Lord Reid said in that case:[19]

> The general rule is that anyone who has to exercise a statutory discretion must not "shut (his) ears to the application (to quote from Bankes L.J. [in Kynoch's case]). I do not think that there is any great difference between a policy and a rule. There may be cases where an officer or authority ought to listen to a substantial argument reasonably presented arguing a change of policy. What the authority must not do is to refuse to listen at all. But a Ministry or large authority may have had to deal already with a multitude of similar applications and then they will almost certainly have evolved a policy so precise that it could well be called a rule. There can be no objection to that provided the authority is always willing to listen to anyone with something new to say ... .

The principle enunciated in the British Oxygen case was accepted in Sagnata Investments Ltd. v Norwich Corporation.[20] In that case the local authority had adopted a general policy not to permit amusement arcades in their City. The applicant, who had had his request for a permit turned down by the authority, appealed to quarter sessions where the recorder found that it was open to the local authority to adopt the general policy of refusing such applications provided that no inflexible, unvarying attitude was adopted and that the local authority was prepared to depart from it where the justice of the particular case so required. However on the evidence before him the recorder concluded:[21]

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(18) [1971] A.C. 610; [1970] 3 All E.R. 165.
(19) ibid 624; ibid 170.
(20) [1971] 2 Q.B. 614 (C.A.).
(21) Reported in [1971] 2 Q.B. 614, at 632-33.

> ... in this case, where the application met with all the ordinary requirements as to suitability of site, premises and management, the general policy must have applied. In other words, no application to the local authority, however suitable, would succeed ... . In my view (and [counsel for the local authority] virtually conceded this), the licensing committee have decided that they will not grant a permit for any amusement place with prizes in the City of Norwich, and the reasons they give for this refusal would apply to any application.

Having reached this conclusion, the recorder approached the matter de novo and "with a complete and unfettered discretion" and decided in favour of the applicants. From that decision the local authority applied by case stated to the Divisional Court who upheld the decision of the recorder.

In the Court of Appeal,(22) Edmund Davies and Phillimore L.JJ agreed with the conclusion of the recorder on the question of the local authority's application of its general policy. Phillimore L.J. said:(23)

> In other words the council had not exercised any form of discretion. They had simply dismissed this application after going through the necessary motions without regard to its individual merits or demerits. I take this to be a finding of fact with which this Court is in no position to interfere ... . This is a case where the recorder was satisfied that the council's committee had failed to keep an open mind and had applied their policy without regard to the facts of the individual case.

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(22) [1971] 2 Q.B. 614.

(23) ibid 639; see also ibid 632-33 per Edmund Davies L.J.

Lord Denning M.R. in his dissenting judgment, while agreeing with the general principle in the British Oxygen case, reached a different conclusion on the facts. He said:(24)

> ... it is apparent that, although the city council laid down a general policy, the licensing committee did not regard that policy as inflexible or as binding on them: that they listened to everything that the applicants had to say: and yet decided against them ...
> ... [The recorder] acknowledges that the policy was fairly and honestly formed and was a reasonable policy. If so, the local authority were entitled to have the policy and to apply it in this individual case, provided that they listened to all the applicant had to say - which they clearly did.

It becomes apparent from these cases that where the Courts have been concerned to determine whether a tribunal type body has unlawfully fettered its discretion, it has been concerned with the actual state of mind rather than appearances.(25)

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(24) ibid 627.

(25) In this respect the question of fettering of discretion is different from the question of bias. In the latter case, the question generally is as to whether the members of the tribunal have so conducted themselves as to lead other persons to believe that there is a real possibility of the tribunal having predetermined matters in issue before it. The requirement of justice not only being done but appearing to be done is important in the context of bias: see e.g. R v Sussex Justices, Ex parte McCarthy [1924] 1 K.B. 256. S.A. de Smith, supra n.12 p.218
It appears therefore that the fettering of discretion question is a harder one to make out than the bias question.

In a recent New Zealand case, Hamilton City v Electricity Distribution Commission,[26] Richmond J. in the Supreme Court was faced with determining whether the Commission had fettered its discretion by adopting preconceived principles. The Commission proposed to constitute an electricity authority to administer the supply and distribution of electricity in the Waikato Area Electric Supply District. The proposal entailed the merger of the plaintiff, which was an existing supply authority, with five other power boards in the area to form the new authority. This meant the revocation of the existing electric line licenses of the merging supply authorities.

The plaintiffs challenged the validity of the proposal on the ground that the Commission had fettered its discretion before initiating the proposal. Richmond J. said:[27]

> When it comes to questions of fettering a discretion, however, I believe that the Court is concerned to ascertain the reality of the position rather than the inference which people could reasonably draw from the conduct of members of the tribunal ... . This approach to the matter is, I believe correct in principle because the basic question must always be whether in the exercise of a particular discretion the person or body entrusted with the discretion exercised it in a real and genuine sense. In the context of the present case the question is - had the Commission in fact retained the capacity to apply itself genuinely to the particular problems which arose in the Waikato. This problem is one of an actual state of mind rather than of appearances.

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(26) [1972] N.Z.L.R. 605.

(27) ibid 638-39 (emphasis added).

The learned Judge was of the view that the Commission was entitled to carry out widespread investigations throughout New Zealand and to form views as to the desirability of reorganisation of electrical supply distribution in individual localities. After considering the House of Lords decision in the British Oxygen case, Richmond J. concluded:(28)

> I see nothing legally wrong with the Commission having given serious consideration to the best way of solving these problems, in a general sense, and in arriving at firm opinions as to what ought, as a matter of general principle, to be done ...
> I can see no objection to the Commission bringing to the task of initiating a particular proposal the benefit of its own previous thinking as to the best policy to be followed in meeting a particular problem of widespread recurrence throughout the country. In my opinion it need do no more than give genuine consideration to the question whether the particular problem in the locality is in fact of a kind which falls fairly within the category of case to which the Commission's earlier thinking was directed.

It appears therefore that the Accident Compensation Commission has not unlawfully fettered its discretion merely by formulating a preconceived policy to determine its liability to meet the costs of private hospital treatment. In one sense the type of situation which exists here is in contrast with the type of situation which the Courts were concerned with in cases like Hamilton City, Sagnata Investments and Isitt for example, where the respective tribunals had a deliberate fixed policy such as "municipal authorities should not distribute electricity", or

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(28) ibid 634-35.

"no amusement arcades will be permitted", or "no liquor licenses will be granted or renewed". As far as the Commission is concerned however, there is no general policy that private hospital fees will not be paid at all. On the contrary, the guidelines in the Medical Handbook have been formulated on the basis that there are appropriate cases where the cost of private hospital treatment should be met out of the Commission's funds.

As Blair J. (the Appeal Authority) has said, "obviously the Commission must deal with each case on its merits",(29) and the analysis, undertaken later in this paper, of the Commission's interpretation and application of its policy indicates that it is far from being rigid and inflexible in its approach - it does not "shut its ears" to any claim.

(29) Re Turner (1976) 1 N.Z.A.R. 7, 11. Accident Compensation Appeal Authority Decision No 6.

IV. THE EXERCISE OF A DISCRETIONARY POWER ON IRRELEVANT GROUNDS

Although the Commission may not have unlawfully fettered its discretion by formulating a preconceived policy, that policy must not be based on considerations extraneous to those contemplated by the enabling Act, otherwise it has exercised its discretion by taking irrelevant considerations into account.(30) The established principle of law upon which a statutory discretion must be exercised was set out by Lord Greene M.R. in Associated Provincial Picture Houses Ltd v Wednesbury Corporation.(31) His Lordship said:(32)

> ... a person entrusted with a discretion must, so to speak, direct himself properly in law. He must call his own attention to the matters which he is bound to consider. He must exclude from his consideration matters which are irrelevant to what he has to consider.

In Flanagan v D.C.C.,(33) the Council had passed a resolution that taxi licenses would not be granted to deserters. The Court held that the Council was entitled to lay down general rules for guidance in dealing with applications, but that such rules must be related to the merits of the application. As the rule in this case was not so related it was held to be invalid.

Predetermined rules of policy were examined in Attorney General v Car Haulaways (N.Z.) Ltd.(34) The Court of Appeal held that the Transport Licensing Appeal Authority, in basing its decision on a predetermined policy that a newcomer must make out a strong case before it could be licensed to compete with an established

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(30) S.A. de Smith, supra n.12 p.297.

(31) [1948] 1 K.B. 223; se also Rowling v Takaro Properties Ltd [1975] 2 N.Z.L.R. 62, 67-68.

(32) ibid 229.

(33) (1920) N.Z.L.R. 713.

(34) [1974] 2 N.Z.L.R. 331 (C.A.)

operator over the same route, was acting within its jurisdiction.(35) If the policy had been ultra vires the empowering Act then the Authority would have abused its discretionary power to grant transport licenses by failing to exercise it in accordance with its empowering instrument.

The general proposition is well stated by Richmond J. in Hamilton City v Electricity Distribution Commission:(36)

> It is, however, quite clear in the light of the British Oxygen case that there is in general no legal objection to an administrative body formulating a general rule of policy, provided, of course, that the particular discretion in question is not qualified in some way which would prevent the formulation of such a rule.

The argument made in respect to the Commission's policy as set out in the Medical Handbook is that, while the Commission has a discretion under section 111 (1)(b) to consider whether any amount to be paid is reasonable in regard to the services rendered nevertheless, the incidence of cost can bear no relevance to whether it is reasonable - that is, the amount to be paid can be no more or less reasonable because it is paid from one public fund rather than another. In other words, the argument is that the Commission should only be concerned with the actual monetary amount which is claimed and the only question which the Commission should ask itself is: Is the amount claimed a reasonable amount by New Zealand standards for the treatment given? If the answer is "Yes", then the Commission is liable to meet those costs under section 111 (1)(b).

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(35) ibid 337-38.

(36) [1972] N.Z.L.R. 605, 634 (emphasis added).

Any consideration of other factors such as those set out in the Medical Handbook, it is argued, are ultra vires the Act and the Commission is therefore guilty of abusing its statutory discretion if it takes them into account.

This argument was made by counsel for the applicant in Re Manthel[37] when the case came before the Appeal Authority. Blair J., after considering the Commission's policy, said:[38]

> It is unnecessary to state that regulations made under the statute must be intra vires the statute and of course the same rule applies to any informal exposition or explanation of the policy which the Commission proposes to follow in administering the section such as contained in the Medical Handbook. Such a policy statement can go so far but no further than it is authorised to go by the governing statute.

The learned Judge went on to say that if counsel's submission was right then the Commission's stated policy to limit its financial responsibility to those patients who seek private hospital treatment is wrong. He thought however that this would be so only if section 111 were to be read literally and in isolation and Blair J., applying the ordinary rules of statutory interpretation,[39] considered that the statutory language had to be read in context.

Since section 111 is made "subject to any regulations under the Act", Blair J. thought it relevant to turn to section 181 (1) para.(1). Section 181 (1) empowers the making of regulations

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(37) Re Manthel (1976) 1 N.Z.A.R. 69. Accident Compensation Appeal Authority Decision No 15.
See also Review Hearings: No 74/R00334; No 75/R0336.

(38) ibid 70.

(39) Maxwell on the Interpretation of Statutes (12th ed. 1969) p.47 and 58.

for various purposes and para.(1) of that subsection states that regulations can be made:

> Prescribing the circumstances in which, the extent to which and the method by which the Commission shall, in accordance with section 111 of this Act, pay the cost of treatments ... in respect of which payments are to be made under that section ...

Accordingly, Blair J. considered that:(40)

> ... the words in the paragraph contemplate that in deciding upon the reasonableness of the charges the Commission can have regard to the circumstances in which they were incurred and this would include deciding, in each case, whether it was reasonable for the patient to prefer the private hospital system to that of the public. Such a decision would be made in the light of the Commission's knowledge of the structure of hospital services in this country and it can be assumed that Parliament, in enacting the Accident Compensation Act would be aware also of this structure and the necessity for the Commission or some like authority to have some control over the respective weight which the public and private hospital systems would bear in caring for accident victims. The point I am making is that the "circumstances" for the Commission to have regard to would include the background hospital situation in New Zealand and the need to control the flow of accident cases into different arms of the hospital service. I think that s. 181 authorises the making of regulations to do this. Though no regulations have been made the Commission has in fact formulated a policy which seems to me to conform with para. (1)

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(40) (1976) 1 N.Z.A.R. 69, 71.

> in that it sets out the circumstances in which it will pay hospital charges. If I am right in utilising s. 181 as an aid to the interpretation of s. 111 the Commission is entitled to apply that section in the way it did in this case.

With respect, it is not clear what the learned Judge is saying here. It appears that there are two possible interpretations of his reasoning. The first is that Blair J. is reading the words in section 111 in the context of the unexercised regulation-making power relating to them in section 181. As one commentator(41) has suggested, this approach would have "serious implications". It amounts to a proposition that a policy which could have been promulgated in regulations can be held to be valid, even though no such regulations have been made, on the ground that these regulations could have been made. This somewhat circular argument is clearly untenable. The effect of this proposition is that the policy set out in the Medical Handbook is held to be valid because regulations embracing the same policy could have been made under section 181. However the power to make regulations under section 181 is conferred on the Governor-General in Council not on the Commission itself. To take the above argument would be to say that in effect the Commission has exercised the regulation-making power in section 181 - a power which it clearly does not have.

The preferred interpretation of the learned Judge's reasoning is that, in looking at section 111 in terms of the policy of the Act, Blair J. considers that the legislature obviously intended

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(41) G. W. Palmer, "Accident Compensation and Private Hospitals" (1977) N.Z.L.J. 50, 52.

that the Commission should formulate a policy along the lines of that in the Medical Handbook, and that this conclusion is supported by the regulation-making power in section 181. From this point of view, Blair J. is not saying that the Commission's policy is valid because the same policy could have been implemented by the promulgation of regulations, but rather that section 111 read in the context of the Act as a whole envisages that the Commission would lay down such a policy, and para. (1) of section 181 supports the conclusion that the policy set out in the Medical Handbook is not ultra vires the Act.

This interpretation is supported by the reasoning of Blair J. in the earlier Appeal Authority decision of Re Turner.(42) There the learned Judge said:(43)

> I turn now to s. 111 which must of course be construed in its context as part of the Act. The general purpose of this section is to impose liability on the Commission for the costs of medical hospital and related services payable as a result of expenses covered by the legislation ... There are a number of references to the Social Security Act in the Accident Compensation Act and it is obvious enough that in enacting the latter Act Parliament would do so with full knowledge of the rights and privileges available to New Zealanders under the Social Security Act. Paragraph (b) uses the words "the amount to be paid is reasonable by New Zealand standards". In my opinion the Commission in applying these words is perfectly entitled to look at the general structure of medical services in this country and ask itself in each particular case whether it is reasonable by New Zealand standards that it should pay private hospital charges with their associated specialist fees taking into account

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(42) (1976) 1 N.Z.A.R. 7.

(43) ibid 9.

> that a "free" hospital and medical service is available under the Social Security Act.

After considering the policy guidelines in the Medical Handbook, Blair J. went on to say:(44)

> The above policy statements are not of course part of the Act and are not necessarily binding on the Commission or anyone else. The booklet as a whole is designed to provide a helpful accessory to the Act and I accept it as such. The policy statements are really an alternative to regulations which could have been made pursuant to para.(1) of s. 181 ... It is apparent that s. 181 contemplates that some flesh should be put on the bare bones of s. 111. I think it is clear that there is a measure of discretion vested in the Commission in s. 111 as to the payment of medical costs and the Commission's decision to produce a policy statement on its proposed application of the section is desirable.

The import of this judgment is that Blair J. considers that it was the intention of the legislature that the Commission should follow some form of policy guideline in the application of section 111 which complimented its context as part of the Act as a whole. The learned Judge considers that the provisions of section 181 support this argument - that is, since the legislature provided in that section for regulations to be made which would have the same ultimate effect as the policy in the Medical Handbook had, it indicates that the legislature intended that such considerations would be relevant in the application of section 111.

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(44) ibid 10.

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It is suggested however that much of the argument concerning the Commission's ability to take into account the factors set out in the Medical Handbook has centred around a misconstruction of para. (b). It will be recalled that in Re Manthel[45] Blair J. said that "if this section is read literally and in isolation", then he thought that counsel's submission, to the effect that the Commission's discretion relates to and is restricted to quantum only, was correct. This conclusion however is based on the ground that, "read literally and in isolation", section 111 (1)(b) confers an obligation on the Commission to pay private hospital and related charges so long as such charges are fair and reasonable and the type and extent of treatment is normal by New Zealand standards. With respect, it is submitted that the Commission's discretion under section 111 (1)(b) relates to whether "the amount to be paid by it [the Commission]" is reasonable by New Zealand standards not, as the above argument suggests, to whether the hospital charges themselves are reasonable by New Zealand standards. This is a fine distinction but it is crucial in determining the validity of the policy guidelines used by the Commission.

If the "reasonableness" question refers to hospital charges themselves, it would be difficult for the Commission to deny liability for the costs under section 111. The Woodhouse Report in 1967 said:[46]

> We are informed by the Health Department that, with increasing annual costs of public hospitals, there may

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(45) (1976) 1 N.Z.A.R. 69, 71; Ante p.23.
(46) Supra n.4 p.159.

> be little difference between the cost of public and private hospitals today. Indeed there is evidence which shows that in some respects the public hospital bed can be more expensive.

This is supported by a study carried out in 1974 which shows that if anything the cost per patient day in a private hospital is actually less than the corresponding cost in the public hospital.(47)

If however the emphasis of the provision is not on the actual hospital bill itself but on the charge to the Commission, then the question whether or not the amount is reasonable by New Zealand standards has to be determined in relation to other charges placed on the Commission. If this is the case, then it appears that the Commission is justified in only paying for the costs of private hospital treatment in appropriate cases. As already indicated, if the patient is treated in a public hospital then no amount is payable by the Commission and therefore it could hardly be "reasonable" by New Zealand standards for the Commission to meet the costs of private hospital treatment unless there were exceptional circumstances.

Certainly this interpretation of section 111 (1)(b) would give a more reasonable and practicable result than that argued by counsel in Re Manthel. Blair J., in that case, recognised the difficulties which might occur if the latter interpretation was accepted. He pointed out that if, in a particular weekend, all the Wellington accident victims elected private hospital

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(47) J. T. Ward, "Towards a Policy for Private Hospitals" New Zealand Journal of Public Administration (1975) vol.37 p.34.

treatment chaos would occur, and he stressed the need to regulate the hospital treatment of accident patients according to the abilities of the public and private systems to accomodate such patients.

It is submitted that such considerations are relevant in determining how section 111 (1)(b) should be interpreted. As Maxwell on the Interpretation of Statutes points out, if the language is capable of more than one interpretation the more natural meaning should be discarded if it leads to an unreasonable result, and the interpretation which leads to a reasonable and practicable result should be adopted.(48) In Shannon Realities Ltd. v Ville de Michel(49) Lord Shaw said:(50)

> Where alternative constructions are equally open that alternative is to be chosen which will be consistent with the smooth working of the system which the Statute purports to be regulating; and that alternative is to be rejected which will introduce uncertainty, friction or confusion into the working of the system.

Policy Aspects of the Arguments

The effect of the argument put forward by counsel in Re Manthel would be to open private hospital treatment to every accident victim in New Zealand at the public expense. This cannot have been the intention of the legislature.

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(48) Maxwell on the Interpretation of Statutes (12th ed. 1969) 45, 203-5 see e.g. Gill v Donald Humbershaw & Co Ltd [1963] 3 All E.R. 180 at 183 per Lord Reid.

(49) [1924] A.C. 185.

(50) ibid 192-93.

Because contributions to the various funds under the Act were calculated on the basis that the public hospital would be the point of first referral for persons injured by accident, it is suggested that the Commission would not be acting responsibly if it agreed to pay private hospital expenses in every case where the injured person or his doctor elected that treatment be carried out in a private hospital. As Blair J. said in Re Turner:(51)

> ... the legislation imposes a duty on the Commission to have regard to the cost factor and this involves the Commission in considering in each case whether the public or private hospital system should be used. The Commission has a dual responsibility. On the one hand it is the guardian of the patients' welfare as regards costs of medical and hospital treatment, while on the other hand it is the administrator of the taxpayers' contributions to its funds and must ensure that these funds are prudently expanded.

There is support for this in Roberts v Hopwood(52) where the House of Lords was concerned with the question of a local authority's obligation to pay its employees "such wages as it may think fit". Lord Atkinson said:(53)

> A body charged with the administration for definite purposes of funds contributed in whole or in part by persons other than members of that body, owes, in my view, a duty to those latter persons to conduct that administration in a fairly businesslike manner with reasonable care, skill and caution, and with a due and alert regard to the interest of those contributors

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(51) (1976) 1 N.Z.A.R. 7, 9.
(52) [1925] A.C. 578.
(53) ibid 595-96.

> who are not members of that body ... This duty is, I think, a legal duty as well as a moral one.

Accordingly, it was held in that case that the discretion conferred upon the Council by the Statute must be exercised reasonably, and that the fixing by the Council of an arbitrary sum for wages without regard to existing labour conditions was not an exercise of that discretion.

The Accident Compensation Act is an original piece of legislation which breaks new ground in providing compensation for victims of accidents. It constitutes a code of its own and, as regards the compensation provisions, the broad scheme is to cushion the financial losses which accrue to victims of accidents but it does not purport to give full recompense to those who have suffered accidents. The Act creates a code between the State and the Subjects of the State and the Commission is charged with the administration of the various funds entrusted by the Act to its care.

In Re Ngamotu[54] Blair J., in dealing with a claim for funeral expenses under section 122, had cause to consider what were the legitimate uses of the Commission's funds. In that case the claim for the funeral expenses of a young Maori girl included not only the burial expenses but also the other expenses arising from the traditional tangihanga preceeding the burial. Section 122 provides that the Commission shall pay the funeral expenses "to the extent that it considers the amount thereof is reasonable by New Zealand standards". Blair J. in determining the question of what was "reasonable by New Zealand standards",

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(54) Re Ngamotu (1976) 1 N.Z.A.R. 89; Accident Compensation Appeal Authority Decision No 1.

looked at the scheme of the Act as a whole, and concluded:(55)

> The broad purpose of the Accident Compensation Act would not seem to be consistent with the idea that indirect expenses or expenses that are above average should be a charge on the common fund. Though the Act is a remedial and liberal one it does not purport to be fully compensatory. Its scheme is rather to be comprehensive in its cover and practical in its application.

Of course, if the only purpose of the Commission's policy as regards admissions to private hospitals was to preserve its own funds then this, by itself, would not be a proper consideration but clearly this is not the case. As Blair J. said in Re Graham:(56)

> These policy guidelines are what one would expect from a statutory body which is charged with the responsibility not only to accident victims but also to see that the common fund that is administered by the Commission is expended prudently and in accordance with the statute.

There must also be serious implications for the health system as a whole if the Commission was liable to meet the costs of private hospital charges provided only that such charges were "reasonable" by New Zealand standards. Governments in New Zealand have continually featured in their health policies the right of the individual to the freedom of choice between the public and private health systems, but in 1972 the Royal Commission of Inquiry into Social Security issued this ominous warning:(57)

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(55) ibid 95.

(56) Re Graham (1976) 1 N.Z.A.R. 102, 103; Accident Compensation Appeal Authority Decision No 5.

(57) Royal Commission of Inquiry into Social Security in New Zealand. Report Govt. Printer, Wellington 1972 p.395.

> ... the pragmatic approach which New Zealand has followed [in the health field] ... has allowed a dual system to develop - State and private side by side. Given limited community resources, there is an inherent danger that enhancement of the private sector may enable it to claim too great a share of these resources and so weaken the State sector that it cannot operate as it was intended to. The result could well be that an adequate health service would not be available to all who need it, but only to those who could afford it.

The effect of imposing the above liability on the Commission would be to fully support the private hospital services from quasi-public funds in all cases of personal injury by accident. This could, in the course of time, make private hospitals much more sought after places of treatment for accident victims. This would inevitably lead to a deterioration in the public health services and accentuate the very real problems which already exist there unless Government was prepared to take steps to remedy the situation.

It might also be asked whether a person suffering an injury by accident and having cover under the Act should have better access to the nation's health facilities than someone who is not so covered. For example, should a person who suffers a hernia as a result of a personal injury by accident[58] be able to avoid the waiting lists for public hospital treatment, while another person who also suffers a hernia but who does not have cover under the Act has no choice but to take his place in the queue. On humanitarian and welfare grounds such discrimination should not occur although it can be argued, that in so far as the scheme of the Act itself distinguishes between accident victims and sickness

(58) See section 66 of the Act for the circumstances in which a person suffering a hernia will be entitled to compensation under the Act.

victims, there would be no anomaly if persons who have cover under the Act were given freeprivate hospital treatment.

V. THE APPLICATION OF THE POLICY

This section of the paper is concerned with the way in which the Commission's policy guidelines laid down in the Medical Handbook have been applied at the Review Hearings and on appeal to the Appeal Authority. This has involved a review of the available decisions and the primary aim of the exercise has been to observe the trends which have emerged concerning the application of the Commission's policy. It will be both necessary and desirable to consider briefly the differing functions and powers of the two levels of hearing during the course of the discussion.

Applications for Review

The relevant section in the Act covering the hearing of applications for review is section 154. The nature of the Review Hearing was examined by the Appeal Authority in Re Harvey.(59) Blair J. said:(60)

> This is not a judicial enquiry in the strict sense. Its purpose, as its name suggests, is to have afresh look at the administrative deicision made by the Commission while giving the appellant the opportunity to dispute the decision and introduce any new evidence or information which may be relevant. Evidence can be received whether or not it is admissible in a Court of Law. The only limitation on evidence is that it should be relevant and that it should be available to the claimant. Proceedings are conducted more or less informally. The Hearing Officer attempts both to give information to the claimant and to obtain information from him which will throw light on his case.

In several of the Review Hearings(61) where the Commission's original decision has been reversed it has been pointed out by

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(59) Re Harvey (1977) 1 N.Z.A.R. 166. Accident Compensation Appeal Authority Decision No 16.

(60) ibid 171.

(61) see e.g. Review Hearings - No 74/R00321; No 75/R0392

the Hearing Officer concerned that the evidence presented at the Hearing has been different in some way from that on which the original decision was based.

A survey of all Review Hearing decisions up until July 1976 revealed that applications for review concerning private hospital expenses under section 111 constituted about 13% of total Review Hearings, second only to those concerned with the question of personal injury by accident under section 2 which made up about 25% of total Review Hearings. Of the 46 Review Hearings concerning the payment of private hospital costs which had been decided at that date, 72% of the applications had been allowed in whole or in part and only 28% had been declined.

It is only those cases where prior approval to the admission to private hospital has not been obtained from the Commission which give rise to problems in this area (including the odd case where approval has been sought and refused and the applicant has nevertheless entered a private hospital and still claimed the costs incurred from the Commission(62)). The fact that the Commission's approval has not been sought prior to the operation has no bearing on the decision reached. It has been recognised that in many cases where, for example, there are circumstances existing which make it essential that the operation be performed immediately (though the urgency is not such to warrant immediate admission to a public hospital), the time factor would probably have dictated the carrying out of the operation before an answer could be given by the Commission even if approval had been sought.(63)

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(62) See e.g. Review Hearing No 75/R0711.
(63) See e.g. Review Hearings: No 74/R00298; No 75/R0768.

In practice the broad policy which has developed is that the Commission will not usually pay private hospital costs if the patient could have obtained equally satisfactory treatment in the public hospital or within a reasonable time. However this is by no means strictly applied and the Commission has been involved in the delicate exercising of balancing the various factors, one against the other, using the policy considerations set out in the Medical Handbook as a guide.

The waiting time involved in obtaining treatment at the public hospital is a primary consideration.(64) There is little criticism of the record of public hospitals in dealing with emergency cases for patients whose need is considered as urgent, but for other cases the extensive waiting lists and the fact that public hospital treatment is not universally available within a reasonable period is forcing more and more people to accept private specialist and hospital care. The Commission has set this factor off against others which might materially affect the welfare of the patient. Where the patient would have suffered undue pain and discomfort, albeit not sufficient to warrant immediate admission to a public hospital, the Commission has been reluctant to decline liability for the costs of private hospital treatment.(65) The convenience of the patient alone would probably not be sufficient to warrant the Commission accepting the liability for private hospital charges but where there are other considerations as well it is a relevant factor.(66)

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(64) At the Census of Hospitals on 23rd March 1971, there were 36,003 names on waiting lists for admission to public hospitals, a rate of 12.6 persons per 1,000 residents: Supra n.6 Govt. Printer, Wellington 1976 p.146.

(65) See e.g. Review Hearings: No 75/R0968; No 75/R0031; No 76/R1665.

(66) See e.g. Review Hearings: No 75/R0031; No 74/R00178.

Section 4 outlines the purposes and scope of the Act and para. (b) of that section provides for "the rehabilitation of persons who suffer personal injury by accident ... so as to seek to restore all such persons to the fullest physical, mental, social, vocational, and economic usefulness of which they are capable". The Commission has therefore been very conscious of the "rehabilitation" factor and in many instances the costs of private hospital treatment has been met because such treatment has materially aided the "rehabilitation" of the patient.(67)

Two Review Hearing decisions have helped in the interpretation of what is meant by "rehabilitation". The first case(68) concerned a university student who had transferred himself from a public to a private hospital because he considered that his chances of passing his final two subjects would have disappeared if he had remained in the public hospital. He argued that the Commission should pay the costs of the private hospital treatment on the grounds that it had materially and substantially advanced his rehabilitation. The Hearing Officer did not agree and said:

> Rehabilitation in this sense means restoration to the patient's pre-accident physical and economic position. The fact that any person happens, at the time of the accident, to be engaged in any particular course of study which may in the future improve their economic position is not in itself sufficient to justify that person's removal from a public to a private hospital at the expense of the Accident Compensation Commission.

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(67) See e.g. Review Hearings: No. 74/R00289; No 74/R0178; No 75/R0062; No 75/R0308.

(68) Review Hearing No 74/R00181.

In the second case[69] the Hearing Officer considered that the Commission had been too restrictive in denying the claim on the grounds that the case would not fall into the urgent category, and that the patient's employment had not been hampered by the injury. He said:

> I do not think these grounds are sufficient to decline the claim. It is, certainly, important to consider rehabilitation for employment purposes, but the concept of rehabilitation goes much wider than this. Rehabilitation extends to the restoration, as speedily as possible, to the fullest physical, mental and social fitness of which that person is capable ...
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> The applicant was, due to injury, precluded from following pursuits which formed a large and important part of his life and, due to inability to receive public hospital treatment, he would have been precluded from pursuing his leisure activities for some considerable time in the future. The mere fact alone that the applicant could continue to work is not sufficient reason for denying him surgical treatment for at least a year with resultant inability to do things in life which give him great pleasure.

The Commission has also been concerned that the person requiring treatment should not suffer financially. Two separate types of case are in issue here. First, the Commission has been prepared to meet the costs of private hospital treatment where the patient has not been advised of the financial implications of entering a private hospital and the Commission considers that it would be unjust, or that financial hardship would result, if the patient or his relatives had to meet the costs themselves.[70]

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(69) Review Hearing No 75/R0392.

(70) See e.g. Review Hearings: No 75/R0065; No 74/R00317.

Secondly, the Commission has been prepared to meet such costs to alleviate the economic hardship on the patient which has resulted from his diminished earning capacity.(71) The other aspect to this category of case of course, is that the Commission is very aware of the fact that if the waiting time involved for public hospital treatment is too extended there is the possibility that the earnings related compensation which would have to be paid in some cases would far outstrip the costs of the private hospital treatment. In these cases it is obviously to the advantage of both the Commission and the patient that the patient receive treatment in a private hospital, at the Commission's expense, so that the patient can be restored to full earning capacity.(72)

The weight given to any of these factors often depends on the status of the applicant himself. For example, whether he is an earner or a non-earner:(73)

> In hernia strains suffered by earners, particularly those engaged in manual work, where the hernia is not immediately serious, the case for accepting responsibility for meeting private hospital costs, while public hospital services are unable to cope, is not in question. With non-earners, however, a reasonable period of waiting for a vacant bed is not so vital, if repair of hernia is not a matter of urgency.

The age of the applicant also appears to be a relevant factor. In several Review decisions(74) involving geriatric claims the

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(71) See e.g. Review Hearings: No 75/R0768; No 74/R00321; No 75/R0831.

(72) see e.g. Review Hearing No 75/R0462.

(73) Review Hearing No 75/R0165.

(74) see e.g. Review Hearings: No 74/R0368; No 75/R0180; No 75/R0256.

Commission has accepted liability for the costs of private hospital treatment on the circumstances of the particular case and has expressly stated that no precedent should be taken from the decision. A large proportion of these cases relate to the Auckland Hospital Board's practice of transferring geriatric cases from the public to private hospitals, a problem which will be discussed later in the paper.(75) However, obiter by Blair J. in an early Appeal Authority decision(76) supports the view that the age of the applicant is a relevant consideration.

In that case, the applicant, aged 77, had suffered a hernia and entered private hospital for his operation. There were two questions for consideration: First, was the incapacity brought about by the hernia "personal injury by accident" within the terms of the Act; secondly, if so, in the particular circumstances of the case, were the private hospital and surgical expenses compensatable by the Commission. The conclusion, both at the Review Hearing and on appeal, was that the evidence did not support the contention that the incapacity resulting from the hernia occurred as a result of an accident. Therefore, the question of whether the Commission would meet the costs of the private hospital treatment did not have to be answered.

However, in the early stages of the dispute liability was declined, not on the grounds that in the particular circumstances there was no "accident", but on the grounds that the appellant should have waited for his operation until the public hospital could take him since there was no urgency for the operation. Blair J. disagreed with this and felt moved to comment:(77)

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(75) Post. p. 67

(76) (1976) 1 N.Z.A.R. 45; Accident Compensation Appeal Authority Decision No 3.

(77) ibid 47-48.

> Had this case been fought solely on the initial ruling the appellant might well have succeeded. Anything I say on this point is of course obiter. My own impression ... is that if it was a fact that the appellant would have been required to wait for a long time for his operation in the public hospital (and there is quite strong evidence as to this), then <u>because of his age</u> it might have been reasonable to make arrangements for an early operation. A man of 77 years has a limited expectation of life and unlike a younger person cannot afford to wait a lengthy period for surgical treatment.

The Commission will also take into account any special characteristic of the particular applicant's case which may have a bearing on the question of whether it will accept the liability for private hospital treatment. For example, the Commission has been prepared to meet these costs in a situation where it was felt that public hospital treatment would not be conducive to the welfare of the patient because she had undergone a traumatic experience on a previous occasion when she had attended the same public hospital.(78) Similarly, the Commission has been prepared to meet these costs in a case where an elderly patient had transferred herself from the public to a private hospital because "she believed she was going to be done away with".(79) The Commission considered that this genuine fear of euthanasia warranted special consideration.

A recent Review Hearing(80) considered the question of the Commission's liability for the costs of medical treatment outside New Zealand. That case concerned a patient who was totally paralysed in an accident, losing the use of all his faculties.

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(78) Review Hearing No 74/R00242.
(79) Review Hearing No 74/R00198.
(80) Review Hearing No 76/R0786.

He was discharged from the public hospital into his wife's care. Over a year later the wife took the husband to Australia for a visit but as a result of travelling and airport delays the husband contracted pneumonia and had to spend 11 days in hospital in Australia. The Commission's liability for such treatment is governed by section 111 (8) and (9).[81] Under subsection (8) the prior approval of the Commission is a prerequisite unless there are special circumstances that, in the opinion of the Commission, justify payment being made. The Commission has an unfettered discretion as to whether it will meet the costs or not. The Hearing Officer thought there were strong grounds for saying that the Commission's financial outlay on hospital treatment should not be increased beyond what it would have been in New Zealand because of the voluntary withdrawal of the claimant from the benefits of the New Zealand hospital system. However, mindful of the fact that there was no cost-free hospital treatment available to the patient in Australia, the Hearing Officer allowed the claim for two reasons; first, the wife's personal sacrifices in the interests of her husband had lessened the Commission's financial obligations; secondly, it was considered that the tragic circumstances of the case justified a measure of liberality.

Two final points are worthy of mention here. First, it appears that where the Commission has already paid part of the costs of the private hospital treatment (for example, where the bill for the specialist's services has tended separately, apart from the

(81) As enacted by the Accident Compensation Amendment Act 1975 section 16.

hospital bill itself, and paid), it has considered this to be a factor in support of payment of the rest of the bill.(82) Secondly, in only one of the Review Hearing decisions surveyed did the Commission express doubts as to the reasonableness of the actual monetary amount charged on the bill for the private hospital treatment and on that occasion the fees were paid anyway "in the special circumstances of the case".(83) These are significant observations because they support the general conclusion reached later in the paper that the Commission follows a policy of either accepting the costs of private hospital and associated specialists fees in full or not at all.(84)

Summary

It does appear therefore that in practice the Commission's policy has been applied as it was intended to be applied - namely, in a "flexible and co-operative" way, with "the welfare of the patient being regarded as paramount". In reaching its decision, the Commission has been prepared to approach the question of its liability for private hospital treatment on three interacting levels: first, the policy guidelines themselves as set out in the Medical Handbook; second, the general status of the applicant; third, any special characteristic of the particular applicant's case. However the Commission has been aware of its "responsibility for the proper disbursement of funds compulsorily contributed by the public", and has properly balanced the above considerations against the general proposition that the public hospital system was intended to be the point of first referral under the Act.

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(82) See e.g. Review Hearings: No 74/R00178; No 75/R0308.
(83) Review Hearing No 74/R00317.
(84) Post. p 56.

The Appeal Authority

Under section 162 (a) of the Act there is a general right to appeal against a decision given on the hearing of an application for review. The appeal is made to the Appeal Authority which is a judicial body exercising a judicial function. Section 164 (1) provides that every appeal shall be by way of rehearing and the Authority has the right to rehear any or all of the evidence under/sub. section (2) and (3).

In Re Harvey(85) Blair J. looked generally at the role of the Appeal Authority. He said:(86)

> ... when an appeal comes to the Appeal Authority by way of rehearing, the Authority must judge the appeal not as an appeal coming from a Court of Law but as one evolving from a review of an administrative decision.

The power conferred on the Appeal Authority under section 164 raises the interesting but difficult question of the Authority's power to exercise the discretion conferred on the Commission under section 111 (1)(b). It is beyond the scope of this paper to examine in depth the state of the law on the general question of appeals from the exercise of a discretion. Suffice to say at this point that the various authorities indicate that "there is no single precise answer as to the extent of appellate review of the exercise of a discretion".(87) The paper will however examine the more specific question of how the Appeal Authority has viewed its role as the appellate body from the Commission's

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(85) (1976) 1 N.Z.A.R. 166.

(86) ibid 171.

(87) K. J. Keith, "Appeals from Administrative Tribunals: The Existing Judicial Experience", (1969) 5 V.U.W.L.R. 123, 151 and see generally pp.134 et seq.

exercise of the discretion conferred on it under section 111 (1)(b).

In Re Manthel Blair J. referred to two cases dealing with the attitude of the respective appellate bodies to the decisions of specialist tribunals. In R v National Insurance Commissioner, Ex parte Michael(88) there was an application to quash a decision of a Commissioner appointed by Statute to deal with internal disputes. The main issue before the Commissioner was one of fact which he had decided against the appellant. May J. who delivered the judgment of the Court commented that he might have reached a different conclusion. However the Court refused to interfere. It was said:

> Where a real error of law is shown then this Court will interfere but it would in my opinion be wrong by gradual erosion of the basic principle to set up this Court as in effect a Court of Appeal on fact from decisions of the specialist tribunals.

Similarly, in the earlier case of R v Industrial Injuries Commissioner Lord Denning M.R. expressed the view that it was a mistake to interfere too much with the decisions of the arbitrators to whom the legislature had entrusted the administration of compensation.

Blair J. distinguished these authorities on the ground that they concerned certiorari applications, and turned to the decision of the New Zealand Court of Appeal in Hammond v Hutt Valley Milk Board.(90) In that case it was said that where a

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(88) [1976] 1 All E.R. 566.
(89) [1966] 1 All E.R. 97, 101.
(90) [1958] N.Z.L.R. 720.

statute has conferred a right of appeal with expressed powers to reverse, vary etc. the decision appealed against,(91) "the appellant tribunal is bound to form an opinion of its own as to the merits of the matter and is entitled to substitute its opinion for that of the administrative body".(92) Blair J. considered that this decision covered the situation which arose under the Accident Compensation Act concerning appeals from the Review Hearing decision to the Appeal Authority.

However, in the Hammond case the Court of Appeal considered that the appeal provision under consideration, "of necessity calls for a hearing afresh for the purpose of determining the merits of the matter ... because there has been nothing in the nature of a formal hearing by the Board, there are no reasons for its decision and there is no record of the proceedings for examination on appeal".(93) This is clearly different to the situation which exists in the appeal structure under the Accident Compensation Act and Blair J's. reliance on the Hammond decision in Re Manthel shows some inconsistency with his reasoning in a later decision - Re Sharland.(94)

In Re Sharland counsel for the applicant pointed out that section 164 provided that appeals should be "by way of rehearing" and submitted, with reference to some Town and Country Planning cases,(9 that the Appeal Authority should in each case carry out an investigation de novo and should make its decision unfettered in any way by the earlier decision of the Hearing Officer.

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(91) c.f. section 164(7) Accident Compensation Act.

(92) [1958] N.Z.L.R. 720, 728.

(93) idem.

(94) (1977) Accident Compensation Appeal Authority Decision No 48. (Unreported at the time this paper was written - reference No 85/77).

(95) See e.g. Wellington Club v Wellington City [1972] N.Z.L.R. 698 Ross v Planning Appeal Board [1976] 2 N.Z.L.R. 206.

Blair J. considered that the hearing by the Appeal Board in the Town and Country Planning Act was the exercise of an original jurisdiction and not a second step in some form of judicial process and that therefore there was really no comparison with the appeal situation existing under the Accident Compensation Act as between the Review Hearing and the Appeal Authority. The learned Judge said:(96)

> I accept, as I have said in an earlier case, that the Review Hearing is not a judicial hearing. It is, as the name indicates, a review or a fresh look at an administrative decision already made by the Commission. However, the procedure at a Review Hearing is entirely different to that operating at local body level in the Town and Country Planning legislation. The Review Hearing is conducted by a Hearing Officer specially appointed by the Chairman. Generally he has legal qualifications. In practice the evidence and submissions are meticulously recorded. The applicant or his representative is entitled to be present and all relevant evidence that the Hearing Officer has must be disclosed. Examination and cross-examination are carried out though the proceedings are deliberately conducted in a fairly informal way and are inquisitorial in nature to enable an applicant (particularly if not represented by counsel) to bring out such evidence as he thinks fit. In due course the Hearing Officer gives a written decision with reasons and the Commission is bound to give effect to the decision ... It is true ... that all Hearing Officers are officers in the employment of the Commission and that on occasions their decisions may be controlled to some extent by administrative rulings. However, they are senior officers and of course their primary duty when appointed under section 154 is to administer the statute. Their decisions are subject to scrutiny and appeal up to the Court of Appeal level and accordingly there is little chance of bureaucratic administration ...

(96) Re Sharland (1977) Accident Compensation Appeal Authority Decision No 48 (Unreported).

Blair J. then went on to say:

> Because of the terms of that Act and the operation of procedures carried out at Review Hearings, I do not think that the Appeal Authority is required to hear appeals de novo ... the Appeal Authority can in an appropriate case come to its own opinion on the merits as well as the law but this is something which should be done with some circumspection.

The fact that in the Hammond decision it was held that the magistrate's power on appeal from a decision of a milk board allocating milk rounds obliged him to determine the matter de novo on the merits,(97) whereas it has clearly been established that under the Accident Compensation Act the Appeal Authority is not required to hear appeals de novo, suggests that perhaps Blair J. was mistaken to rely on Hammond's case in Re Manthel.

In spite of this apparent conflict however, the learned Judge has taken a consistent view of what he considers is the correct approach of the Appeal Authority. The same conclusion Blair J. reaches in Re Sharland (above) is also expressly set out after his consideration of Hammond's case in Re Manthel:(98)

> (a) The Appeal Authority should interfere if of opinion that an error of law has been made or the decision reached by the application of wrong principles.
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> (b) It may interfere where the decision relates to the exercise of discretion or to a finding of fact provided that the Appeal Authority has reheard the evidence or permitted the introduction of fresh evidence which has thrown fresh light on the matter in issue so that the Appeal Authority is in as

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(97) See K. J. Keith, supra n.87 pp.143-45.
(98) (1976) 1 N.Z.A.R. 69, 73.

good a position as the Hearing Officer to form a fresh opinion.

(c) Subject to the above the Appeal Authority should be circumspect in overruling a decision based on the original evidence and which amounts to the exercise of a discretion.

There have been eight appeals before the Appeal Authority where the question of the Commission's liability to meet the costs of private hospital treatment has been in issue. These represented about 16.5% of all appeals decided by the Appeal Authority up until the end of July 1977. Six of these appeals were dismissed with the Appeal Authority supporting the decision made at the Review Hearing and in one case the question did not have to be answered because a preliminary question was decided against the applicant.(99)

It is useful to consider the Appeal Authority's approach in the other case. In Re Turner(100) the patient had been involved in a ski-ing accident. An orthopaedic surgeon who was contacted by telephone considered early surgery desirable and advised that a private hospital would be preferable to a public one. The Hearing Officer declined liability for the payment of the private hospital costs on the ground that the Commission's policy was well known to those persons who would be most affected by the decision made by the Commission and there was no evidence to suggest that the care and treatment in the public hospital would have been inadequate in any way.

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(99) Ante p. 44

(100) (1976) 1 N.Z.A.R. 7; For the Review Hearing decision in this case see Review Hearing No 74/R00157.

On appeal to the Appeal Authority, Blair J. examined his function and said:(101)

> My task as the Appeal Authority is to decide whether in the circumstances of this case the Commission should have declined to pay the private hospital expenses and surgical fees. I am conscious that the decision of the Commission through the Hearing Officer was to a considerable extent an exercise of a discretion and an appellate tribunal will not lightly interfere in such circumstances. However, under s.164 it is provided that the appeal shall be by way of rehearing. In effect the Appeal Authority hears a new case with a right to hear additional evidence. Under these circumstances I do not think I can shrink from expressing my opinion on the facts and submissions which I heard which may well have differences from those presented to the Hearing Officer. My duty, I think, is to look at the whole case do novo and give my opinion as I see it.

In the light of after ascertained facts, the learned Judge found that the patient could have received proper treatment in the public hospital, but felt nevertheless that:(102)

> ... in the circumstances it would be proper for the Commission to agree to make a compromise payment which on the one hand recognises that in the light of present knowledge a claim for private hospital treatment could not be sustained, but on the other hand accepts that the decision to send a patient to a private hospital was an understandable error for which there was a degree of justification.

The matter was accordingly referred back to the Commission for it to fix the amount as the Appeal Authority was empowered to do under section 164 (8).(103)

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(101) ibid 11.

(102) ibid 12.

(103) For the Commission's final decision on this matter see Post. p. 58

On the particular facts of this case therefore the Appeal Authority did feel competent, after hearing new evidence, to disagree with the decision of the Hearing Officer. Because of the presence of the new evidence it is submitted that this decision is not inconsistent with the decision in Re Manthel. In fact Re Turner was distinguished in Re Manthel on the grounds that it was a case "where the injury was more serious and where the decision to go to the private hospital was influenced by a mistaken belief that there would be delay in getting treatment".(104)

(104) (1976) 1 N.Z.A.R. 69,73.

VI. SPECIAL PROBLEMS

This section of the paper will consider three specific areas which have caused the Commission some concern in the application of its policy regarding its liability for the costs of private hospital treatment. Hopefully this examination will indicate to some extent how the Commission has been willing to modify its position and adapt its policy in situations which require special consideration.

The Amount to be Paid

The Commission has always had the attitude that under section 111 (1)(b) it will pay either the full amount claimed for the private hospital treatment or nothing at all. It has not, at the Review Hearings, entered into a discussion of the merits of the particular case in order to determine how much of the bill should be paid by the Commission. Rather, its policy has been that if, after a consideration of the various factors set out in the Medical Handbook (of which, "the actual cost of the private hospital treatment" is one), it considers that in the circumstances of the particular case it was reasonable to incur private hospital treatment, then the cost of that treatment will be paid in full by the Commission.

In Re Turner[105] however, Blair J. considered that a different approach might be more appropriate. In that case the learned Judge found that although adequate public hospital facilities were available at the time, the surgeon was nevertheless justified in admitting the patient to a private hospital in view of the urgency of the case. This, the learned Judge considered, put the

(105) (1976) 1 N.Z.A.R. 7.

Commission into something of a dilemma because to decline payment on the grounds that, in the light of after-ascertained facts, the patient could have received proper treatment in a public hospital had he elected to do so, would be a too rigid and narrow approach and would disregard "some particular and peculiar features of the case".

After considering the words in section 111, Blair J. concluded: (106)

> In applying subs.(1) of the section the Commission is acting in an administrative way which involves the exercise of some discretion and the Commission has itself acknowledged that its policy should be flexible. Inevitably there will be occasions when the Commission will be confronted with claims for payments under s. 111 which are neither entirely meritorious nor entirely without merit. In such circumstances the duty to pay an amount which "is reasonable by New Zealand standards" permits in my opinion the Commission to fix an amount which is less than the costs actually incurred. It seems to me that it would be artificial in such circumstances for the Commission to be obliged to pay either the full amount claimed or nothing at all. I believe para. (b) bestows a measure of discretion which enables the Commission to deal realistically with such situations and allows it to award an arbitrary amount which it thinks is reasonable in the circumstances by New Zealand standards. Such an award would recognise that while the claim is not wholly meritorious there is an element of merit which warrants a partial acceptance of the claim ...
>
> The general purpose of para. (b) read in its context is to enable the Commission to pay a reasonable amount for claims for medical treatment and in my view entitles the

(106) ibid 12.

> the Commission to reduce a claim to a figure which is commensurate to what it thinks is the justice of the case taking into account the circumstances under which the medical costs were incurred.

Blair J. accordingly referred the matter back to the Commission for it to fix the amount pursuant to section 164 (8) of the Act. However, while in this particular case the Commission did make a "compromise" payment, it has not accepted Blair J's. recommendation as a general principle of policy.

In a Technical Information Circular distributed after the Re Turner decision, the Commission made it clear that:(107)

> Normal Commission policy will continue to be that, after consideration of the factors set out in the Medical Handbook the cost of private hospital treatment will be either accepted in full or not accepted at all. In other words the Commission believes that, in almost every case, it is impossible to place a percentage on the level of merit and accordingly pay that percentage in cash.

The Circular does not exclude the possibility however that there may be occasions when the Commission, either on its own initiative or as a result of representations, will be prepared to offer a contribution towards the cost of treatment.

Private Medical Insurance

A related issue concerns private medical insurance. New Zealand does not have any compulsory health insurance per se (although the Accident Compensation Act can be seen to have that effect since part of the levies paid to the Commission are made available for hospital and other health expenses), but the establishment and growth of voluntary medical insurance

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(107) Technical Information Circular No T.208.

organisations indicates a dissatisfaction with the adequacy of the public sector in the provision of health services. For example, the largest society in the field today, the Southern Cross Medical Care Society, has consistently achieved an astonishing 50 to 60 per cent cumulative expansion rate since 1966 and its membership today is approaching the half million mark.

The approach of all such groups is broadly the same. For a fixed premium contributors could normally expect to get a refund of up to 80 per cent of their net costs (after Social Security deductions).

The question arose as to whether the Commission or the Medical Insurance Societies had first charge on the private hospital fees where the person injured by accident was a member of such a Society. This issue has not been of major concern in practice because usually in cases where the applicant has been covered by medical insurance the first charge has already been made on the Society concerned by the time the case comes before the Commission and the latter has only been faced with a claim for the difference between what the Society has paid and the net cost of the private medical treatment.(108)

Initially, the view taken by the Commission was that no account was to be taken of any medical society insurance which the injured person might have.(109) This was consistent with the Commission's attitude that if it agreed to meet the private hospital expenses then it would undertake the payment of the whole of those expenses.

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(108) See e.g. Re Stevens (1976) Accident Compensation Appeal Authority Decision No 21. Reported in the Accident Compensation Commission Report, May 1977 p.33; also Review Hearings: No 75/R0968; No 75/R0496; No 76/R1665.

(109) Technical Information Circular No T.188.

However the comments of Blair J. in Re Turner concerning the ability of the Commission to lay down a general policy relating to its liability to meet the costs of private hospital treatment, appears to have changed the Commission's attitude to the question of private medical insurance. In a memorandum issued in June 1976 the Commission's Chief Solicitor expressed the opinion that, in the light of comments made in Re Turner, the Commission could and should ascertain whether an injured person has a medical society insurance which would meet part of the net costs of private hospital treatment.

This therefore appears to be one area where the Commission may not necessarily pay the full cost of the private hospital treatment if it accepts liability for that cost.

The Attitude of the Medical Profession

The medical profession has always been a powerful lobbying force in New Zealand's history. In the 1930's and early 1940's when the first Labour Government was trying to implement its proposal to provide a comprehensive State health service available free of charge to the citizens of New Zealand, it was forced to concede several principles to the medical profession as a result of the pressure put on it by the New Zealand Branch of the British Medical Association (now the Medical Association of New Zealand).(110)

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(110) see generally, W. B. Sutch, The Responsible Society in New Zealand Christchurch 1972; New Zealand Department of Health, A Health Service for New Zealand, Govt. Printer Wellington 1974; Medical Association of New Zealand, Review of Medical Services: Preliminary Report, Dunedin 1967; Department of Health, The Medical Services Committee Report, Govt. Printer, Wellington 1948.

The area of primary concern to the profession has been its means of remuneration. There has been a continuing concern at increasing State involvement in the country's health services and the profession has reacted strongly to any move which has suggested that it might become in essence a salaried servant of the State. In 1940 the Social Security legislation provided for doctors to be given a salary in country areas and in hospitals, and other medical practitioners to be paid an annual "capitation" fee on the basis of fixed lists of patients. However, general dissatisfaction on the part of the profession led to a series of modifications to the method of remuneration until the "schedule" system, which, together with the "refund" system, operates today, was adopted.

Over 90% of general practitioners use the "schedule" system under which they charge the patient a fee for service and claim the medical benefits directly from the Department of Health. The method of remuneration by item of service is traditional in private practice and has always had the support of the medical profession itself.(111)

In the public hospitals however, (as well as for a small number of general practitioners in the more remote areas of the country), a salaried system continues to operate. Consequently doctors and especially surgeons have built up private practices and personal income on a fee for service basis by working part-time in private hospitals while also holding a salaried position

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(111) Under section 111 (1)(b) of the Act the Commission is responsible to pay that portion of the doctor's fee not covered by the health benefit under Part II of the Social Security Act 1964, so far as the Commission considers the amount it pays is "reasonable by New Zealand standards". The Commission's policy on this question is also set out in the Medical Handbook at pp.17-22.

on a "sessional" basis at a public hospital. Unfortunately, this is not an entirely satisfactory situation. As one commentator has pointed out, "so long as consultants are employed in public hospitals on a part-time basis they are unlikely to pursue policies in their salaried hospital role which could jeopardise that part of their living which they derive from fees in private practice".(112)

The Southern Cross Medical Care Society, in their submissions to the Board of Health Committee on Private Hospitals, report on a survey that they conducted among a number of surgeons in Auckland in 1970. "It showed that while, on average, they gave almost half of their working time to Public Hospital service, the rewards from that work accounted for only 20% of their income, the other 80% coming from private practice undertaken during the remainder of their time."(113) Given the trends in the number of people taking out voluntary health insurance there is no reason to doubt that the situation has changed at all.

It is understandable therefore that many in the medical profession were disappointed when the Accident Compensation Commission would not agree to accept automatic liability for the payment of private hospital treatment under section 111, since this would have meant a higher income from increased number of patients entering private hospitals. Generally speaking though, it is fair to say that the majority ofthe medical profession has accepted the Commission's attitude and the policy guidelines set out in the Medical Handbook.

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(112) R. J. Latimer, Health Administration in New Zealand (1969) p.11.

(113) Southern Cross Medical Care Society, Submissions to the Board of Health Inquiry into Private Hospitals. 1972 (mimeo.) p.8.

However in some instances particular doctor and specialists have persisted in admitting their patients to a private hospital without obtaining the prior approval of the Commission, while still expecting the Commission to meet the costs of such treatment. This has been one of the main reasons for the high number of Review Hearings in this area.

The more extreme attitude is illustrated by a classic piece of evidence given in a recent Review Hearing.(114) In this case the consultant surgeon concerned, question by the Hearing Officer as to why the patient had been admitted to a private instead of a public hospital, said:

> It didn't occur to me in any way. In the course of 24 years practice in this town as a surgeon I have not once referred a patient to the Public Hospital Outpatient Clinic and I have no intention of ever so doing ...
>
> I've been in practice in this town here for 24 years. It has a population of 39,000. My practice is known to everybody in this town. It is a private practice. Everybody who comes to my rooms pays a fee: that fee is my livelihood. If surgery is required they have that surgery in a private hospital for which there is a fee. Everybody in this town knows this ...
>
> I will send the patient to a private hospital because there I charge him a fee and that fee constitutes my livelihood. I shouldn't have to state this. This is self-evident. The question in the correspondence: 'Why did I send the patient to a private hospital?' is a silly question ...
>
> The patient was injured at work and attended my rooms. And if he did this again tomorrow he would have this done

(114) Review Hearing No 76/R0404.

> in a private hospital. If he said to me he wanted it done in a way in which I was not going to be in receipt of a fee I would take exception to his having come to my rooms. Because he knows perfectly well that I expect to charge him a fee.

Fortunately, not too many in the medical profession display such unyielding affections but there are "problem" practitioners who appear to be doing their best to thwart the Commission's policy in this area. An interesting example concerns an orthopaedic surgeon (a Mr G of Palmerston North) who has been involved in at least five Review Hearings[115] out of the fifty or so indexed on the Commission's files. In each case Mr G has neglected to obtain the Commission's approval prior to admitting the patient into a private hospital although in most of the cases it would have been possible for him to seek this approval. In each case Mr G has made a similar argument in support of his claim. His contention is that while suitable treatment has been available in the public hospital, there would have been no guarantee that he would have been able to conduct the operation in the public hospital. He has stressed the desirability of the initial surgeon seeing the treatment through and the fact that it would be unethical to delegate treatment to some other person after having accepted responsibility himself for proper treatment to be given. On some occasions it has even been suggested that the staff available at the public hospital might not be competent enough to treat the particular injury.[116]

At the Review Hearings the Commission has agreed to pay the costs involved in four of these cases. In two cases it has found that

(115) Review Hearings: No 74/R00334; No 74/R00317; No 75/R0062; No 75/R0308; No 75/R0912.

(116) Review Hearing No 75/R0062. see also Review Hearing No 75/R0671.

the treatment given has materially assisted in the rehabilitation of the patient[117] but in the other two cases the Commission has paid the costs reluctantly, considering that the surgeon in effect has presented it with a fait accompli.[118] In the fifth case[119] the Commission flatly refused to meet the costs for private hospital treatment. As the Hearing Officer in that casesaid:

> After two and a half years of experience in Accident Compensation the view is taken that the orthopaedic surgeon should have known that discussion with the Commission was necessary and this he failed to do.

The difficulty which the Commission faced in these cases was that more often than not no indication had been given by the surgeon to the patient that he might be liable for the private hospital expenses himself if theCommission's prior approval was not obtained. As has already been seen, the Commission has been reluctant to have such costs fall on the patient if it would result in economic hardship, which it invariably would.

Whether this last decision has resulted in a change of attitude by Mr G remains to be seen but it does indicate that the Commission might be prepared, in the future, to decline liability for the costs of private hospital treatment in order to bring the reality of the Commission's policy home to doctors and surgeons who have a duty to inform their patients of the financial implications of entering private hospitals without prior approval having been obtained.

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(117) Review Hearings: No 75/R0062; No 75/R0308.
(118) Review Hearings: No 74/R00334; No 74/R00317.
(119) Review Hearing No 75/R0912.

A recent Appeal Authority decision does indicate that the Commission's approach to the problem will be stricter in the future and that the doctor's responsibility to his patient will be more stringently enforced. Re New[120] involved the question of payment for private hospital treatment for an operation on a child who had fractured her nasal bones in an accident at school. Blair J. found that prior approval for private hospital treatment had not been given and that admission to the private hospital had been made at the initiation of the surgeon. There was evidence that proper treatment was available at a nearby public hospital without delay. The appeal was dismissed by the learned Judge, who said:[121]

> ... I feel obliged to comment that if the surgeon had had regard to the Handbook the parents of the child may not have been made liable for these hospital and surgical expenses as it is plain that there was no obstacle to the child being treated in the public hospital system. This case, and other cases that have come before me have demonstrated that the medical profession has a particular responsibility in accident cases to ensure that the patient fully understands the financial implications of a recommendation by the doctor that the patient enter a private hospital with its attendant costs. If adequate public hospital facilities are available the patient should be so informed and advised that if in these circumstances he elects to go to the private hospital then the consequent hospital and medical costs will be the patient's responsibility. In the usual pre-operation stage a patient is usually heavily dependent upon his doctor's advice and this gives an added responsibility to the latter to ensure that the alternatives are fully explained.

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(120) Re New (1976) 1 N.Z.A.R. 164; Accident Compensation Appeal Authority Decision No 13.
(121) ibid 166.

After offering these words of warning to the medical profession Blair J. suggests:(122)

> To avoid any misunderstanding between doctor and patient and for the doctor's protection in cases where the patient selects private hospital treatment in circumstances where public hospital treatment is available, it seems to me that it would be prudent for the doctor to ask the patient to sign a written form of consent which shows that the patient has been properly advised on the point and has elected to bear the cost of private hospital treatment.

As one commentator has said, this suggestion by Blair J. "clearly implies that in his opinion the expanding liability in tort for negligent advice may well encompass the situation with which he was dealing".(123)

Auckland Geriatric Cases

In 1974 the Health Department was transferring patients from the public to private hospitals and paying the costs of treatment of the patients transferred in three instances:(124)

(1) A Rest Home Scheme sponsored by the Health Department in Auckland and Christchurch under which age beneficiaries were transferred from public hospitals to private hospitals because the public hospitals needed the accomodation.

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(122) idem.

(123) G. W. Palmer, "Accident Compensation and Private Hospitals" (1977) N.Z.L.J. 50, 53.

(124) The Health Department considered that it was able to do this under section 78 of the Hospitals Act 1957.

(2) A scheme, approved by Government, under which public hospitals were able to contract for beds in private hospitals.(125)

(3) The Otago Hospital Board was transferring certain geriatric patients to a maternity hospital to relieve pressure on the acute wards.

In all of these cases the Hospital Boards were paying to the private hospitals concerned the difference between the Social Welfare benefits paid in respect of the patients and the cost of the treatment in the private hospital.

The Auckland Hospital Board was also in the practice of discharging geriatric and destitute patients into private hospitals for convalescence. The Board applied a means test to determine whether the patients could pay the private hospital costs and if not the Board paid them.

It appears that in the Auckland area elderly accident patients were being discriminated against in two ways: First, if possible, a public hospital would avoid taking in these patients; secondly, when the public hospitals did admit these patients they kept them in for only a fraction of the time for which the injury required hospitalisation, and discharged them into a private hospital as quickly as possible. The purpose behind these practices was to prevent the public hospitals from inheriting longstanding geriatric cases, in view of the probability that with elderly people an accident could lead to the necessity for hospital treatment for the rest of their lives.

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(125) This scheme was not fully operational at the time but Wellington Hospital did have a contract with Calvary Hospital for the use of 26 beds while repairs were done to one of the Wellington Hospital wards.

The Accident Compensation Commission was naturally concerned that these practices were occurring. If an elderly patient was not admitted to a public hospital, he or she would probably go to a private hospital and, subject to the Commission's discretion as to reasonableness, the Commission would be liable for private hospital fees under section 111. Similarly, if an elderly patient was discharged into a private hospital long before a normal patient suffering from similar injuries would have been sent home, and the public hospital did not subsidise the private hospital fees, the Commission could again be liable.

Because of the Commission's liability under section 111 therefore, the coming into force of the Accident Compensation Act presented the Hospital Board with the opportunity to shift the financial responsibility from the State health services to the Commission. The disturbing aspect for the Commission so far as the transfer of patients from the public to private hospitals was concerned, was that the public hospitals were not asking themselves when accident treatment ended and geriatric care began. Because the patients were being discharged while they were still accident patients a claim against the Commission could be supported, and once the Commission accepted responsibility for the cost of maintaining an aged accident victim in a private hospital, it could have been impossible to assess when accident treatment ended and geriatric care began. Consequently, the Commission could have ended up paying hospital fees for an extended period.

The Commission thought it unacceptable that this shifting of financial responsibility could depend on any of a number of factors influencing a Medical Superintendent of a hospital to

discharge an accident patient, and considered that there should be some other, more reliable, dividing point between State health financial responsibility and the Commission's financial responsibility.

In an Internal Memorandum issued in February 1975, the Commission proposed that, (apart from the services of private medical practitioners outside institutions), the State health services retain financial responsibility for institutional costs, and costs of medical treatment, for accident victims up to and until the time was reached when medical-cure treatment could no longer offer any reasonable prospect of further recovery or cure. At that point the responsibility of the State health services would cease, apart from such services as were available in the nature of District Health Nurses, or other standard public health practices.

From that time onwards the Commission would accept responsibility under section 121 (3) for the cost of institutional care of a person whose injuries by accident had left that person with such a disability that he could not reasonably return to his living environment prior to the accident or if for some other reason the disability justified institutional care.

The effect of this proposal was that the State remained financially responsible so long as medical-cure treatment was still underway; but once a chronic state was reached, which medical treatment could no longer improve, and institutional care was required, the Commission would become responsible. Consequently, the prevailing reasons why an accident victim was discharged from public hospital, and transferred to the

private sector would be irrelevant.

The Auckland Hospital Board however continued to deny liability for private hospital fees in this type of situation on the basis that once the patients had been discharged from the Board's hospital into a private hospital it was incumbent on the Commission to pay the fees under section 111, and therefore the Board had no further financial responsibility for them. It also argued that the adjustment made by the Health Department to the Board's financial allocation with the coming into force of the Accident Compensation Act did not cover geriatric cases.

Inquiries directed by the Commission to the Hospitals Division of the Health Department revealed that the adjustment made by the Department to the Board's financial allocation was to cover the Board's loss of revenue from accidents. However under the Department's Rest Home Scheme the Board was provided with funds to be used in paying private hospital fees for geriatrics transferred and the indications were that these funds should have been sufficient to pay for private hospital treatment of geriatric accident victims without any recourse being made to the Commission.

Faced with this situation, the Commission issued another Memorandum in September 1975 outlining a set of principles to be applied in all cases except those where special circumstances existed or where the principles could not be exactly applied. These principles were to be applied only in the Auckland Hospital Board area, and they were to remain in force until agreement was reached with the Board. Apparently no agreement has been reached and this policy represents the Commission's present

attitude to the "Auckland geriatric cases".

The principles laid down to a large degree implemented the proposals which had been put forward in the earlier memorandum although there were some modifications. The most significant parts of the memorandum are as follows:

> The Commission will accept payment of private hospital, rest home, convalescent home etc. charges by payment either to the hospital or by refund to the claimant, where the claimant has been transferred direct from public hospital, under the following conditions:
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> ...
>
> 2. Acute treatment, and attention or supervision by a specialist, must have finished, so that in the private hospital the only attention required is that which can be given by the hospital non-professional staff or by a general practitioner. If further specialist attention is contemplated, liability will not be accepted but the circumstances will be considered and a decision made on the facts of the particular case.
>
> 3. Establish that it is not reasonably practicable, in all the circumstances, for the patient to return to his former residence from the public hospital instead of going to the private hospital. The previous condition of health of the claimant, the domestic circumstances in the residence, the extent of nursing or other care required, and the mobility and severity of the injuries of the claimant are all relevant factors.
>
> 4. Payments will continue only so long as the patient remains incapacitated or disabled as a result of the personal injury by accident. Cases will require periodic review, so that payments will

> cease if the patient returns to the same state of health as he would have been in but for the accident, even though he remain in the private hospital for other reasons.
>
> ...

It is significant to note here that the memorandum also authorised a scrutiny of all relevant claim files and revisions to be made in accordance with these principles in order that there would be no discrimination between claimants who had applied for Review in respect of the Commission's refusal to pay for the private hospital treatment following direct transfer from public hospital, and those who had not.

It is interesting to observe how the Commission dealt with this specific problem. Obviously, it was not a situation which could be resolved by the application of the policy considerations set out in the Medical Handbook. The Auckland Hospital Board was in effect presenting the Commission with a fait accompli over the payment of private hospital fees for elderly accident victims. If both the Hospital Board and the Commission refused to accept liability for such costs, the patients themselves, by no design on their own part, would have to pay them. As has already been indicated, the Commission has been reluctant to see this situation develop, and therefore usually agreed to pay the costs because of the special circumstances involved in these cases.

The Commission however saw the danger that, if liability was accepted in the geriatric area, the Hospital Boards might extend the practice to accident victims generally. The Commission's fears may have been well founded if the evidence produced in a

Review Hearing[126] in late 1975 is any indication. In that case, the applicant, in support of his claim that the Commission meet the costs of private medical treatment, produced two letters sent to him by the Medical Superintendent in charge of the waiting list for the North Canterbury Hospital Board. The first letter read:

> In my opinion patients who cannot have their surgery in private are the patients who receive priority as far as the Public Hospital System is concerned. In other words, had I been asked to give a ruling on your particular case I would have said you did not warrant priority because as your hernia developed as a result of an accident, you could at least in theory had obtained surgery in private.

And the Superintendent is even more to the point in his next letter:

> I do not give priority to Accident Compensation cases on the routine surgical waiting list. On the contrary, I adopt the attitude that patients who could have their surgery in private hospitals should not have elective surgery in a public institution except in cases of emergency. If Accident Compensation cases are operated on in public hospitals, patients who have no option must be deferred.

Obviously, therefore it was essential that the Commission firmly establish its attitude to the payment of private hospital fees in these cases. According to one of the Commission's Hearing Officers, the principles laid down in the memorandum are working in practice to the satisfaction of all parties concerned and for the present time at least the problem appears to have been resolved.

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(126) Review Hearing No 75/R0462.

It is suggested by way of conclusion however that the type of situation which arose here might very well have been the type of situation which could have been better resolved by the Governor-General in Council exercising his power to make regulations under section 181. This was not a situation in which the Commission needed a flexible policy making procedure, it was situation which demanded a definite indication of which of two statutory bodies was liable for certain expenses in a particular situation. As it was the dispute between the Commission and the Auckland Hospital Board continued for almost eighteen months before it was resolved and, it is submitted, a more satisfactory solution would have been achieved if Regulations had been brought down under section 181 to regulate the situation which existed.

VII. CONCLUSION

The scheme of the Accident Compensation Act rests on the tripod of prevention of accidents, rehabilitation, and compensation. Given that the focus of the rehabilitation aspect of the Act is on the role of the hospital, supported by the medical profession, it was to be expected that the Act would reflect the nature of New Zealand's hospital system by imposing a liability on the Commission for the costs of treatment obtained in a private hospital, if the costs of treatment were to be covered at all. The Act does impose that liability subject to the Commission's discretion as to whether "the amount to be paid by it is reasonable by New Zealand's standards". This paper has been primarily concerned with the narrow question of how the Commission has exercised that discretion.

It has been useful to examine the Commission's policy in this area both at the general level and at the more specific level. At the general level, it has shown how the Commission, which has only been in existence for five years, has developed a general policy which it applies in the exercise of its discretion. In formulating this policy the Commission has had to make judgments on how best to utilise the country's health facilities and, ironically, in determining in what circumstances it would be preferable to make use of private hospitals, the Commission has had to take into account problems existing in the public sector which to a large extent have been caused by the perpetration of a dual hospital system.

In exercising its discretion, the Commission has found it necessary to balance many factors and the paper has shown that in instances where the general policy, as set out in the Medical Handbook, has not been able to satisfactorily resolve a particular situation which has arisen, the Commission has been willing and able to adapt or modify its policy to meet the particular contingency.

On a more specific level, the examination has shown how the Commission as an administrative body, has had to interact and operate alongside other people and organisations in the community at large. Quite apart from the fact that the Commission, by the very nature of its statutory functions, has to deal with the persons who have a claim under the Act, it has not been able to develop a policy and exercise its discretion in isolation. It has had to take account of the operations and views of such organisations as the Social Security Department, the Hospital Boards, the medical profession and the private medical insurance societies, who are also intimately involved with the successful operation of the Act.

The large number of Review Hearings in this area appears to have been the result of a "feeling out" of the Commission's policy by the various parties concerned. The Commission indicates that the number of such applications over the past nine months has dropped to a more realistic level and it is suggested that this is because the policy is becoming more widely known by those who were ignorant of it previously and is being adhered to more closely by those who chose to turn a "blind-eye" to it previously. Related to this trend, of course, is the fact that

the policy has gained a large measure of support in the decisions of the Appeal Authority.

In conclusion, it is submitted that the Commission's policy in this area is a sound and sensible one, providing genuine relief for those who have valid grounds for entering private hospital while, at the same time, ensuring that the role of the private sector in Accident Compensation does not reach unintended proportions.

APPENDIX

MEMORANDUM FROM CHAIRMAN

11 February 1975

MR FAHY
MR GRAHAM

PRIVATE HOSPITALS - POLICY

I attach some notes on the difficult question of transfer of patients from public hospitals to rest homes, convalescent homes or private hospitals.

Would Divisions listed below please offer comments by 28 February 1975.

K.L. Sandford
Chairman

Distribution : Chief Solicitor
Director of Compensation
Medical Division

Legal Division
Please consider and be ready to comment on this by 18/2/75

MEDICAL

Private Hospital and Rest Homes - Commission Policy

1. It is suggested that consideration be given to the following points when considering the proposed regulations under section 111.

2. Government policy agreed that Government funds (through the Hospital system) should pay for the public hospital treatment of accident victims. This extra cost to the hospital system (compared with the recoveries they previously made from insurance companies) is largely balanced by the saving to Government funds as a result of the Commission now paying for what previously the Social Security Department paid out in sickness and invalidity benefits to accidentally injured people.

3. It can therefore be assumed that (leaving aside private medical practitioner treatment) the cost of medical-cure treatment of accident victims is the responsibility of the State health services and not that of the Commission.

4. It is unacceptable that the shifting of financial responsibility between the State health services (the public hospitals) and the Commission can depend on the whim of, or prevailing circumstances affecting, a Medical Superintendent of a hospital. There might be any of a number of factors influencing a Medical Superintendent to discharge an accident patient. The moment of discharge from public hospitals surely cannot represent the dividing point between State health financial responsibility and the Commission. There should be some other more reliable dividing point.

5. It is proposed that (apart from the services of private medical practitioners outside institutions) the State health services retain financial responsibility for institutional costs, and costs of medical treatment, for accident victims up to and until the time is reached when medical-cure treatment can no longer offer any reasonable prospect of further recovery or cure. As at that point the responsibility of the State health services should cease, apart from such services as are available in the nature of District Health Nurses, or other standard public health practices.

6. From that time onwards the Commission will accept responsibility, under section 121(3) for the cost of institutional care of a person whose injuries by accident have left that person with such a disability that he cannot reasonably return to his living environment prior to the accident or if for other proper reason the disability justifies institutional care. This provision would mean that geriatric patients, left with a chronic irreparable fracture, and for whom the doctors can do no more, will be maintained in geriatric institutions at Commission expense.

7. The same rule could apply to transfers from public hospitals to other rest homes and to private hospitals. The State remains financially responsible so long as medical-cure treatment is still underway; but once a chronic state is reached, which medical treatment can no longer improve, and institutional care is required, the Commission will become responsible.

/ ...

8. Provisions such as the above will make it irrelevant what were the prevailing reasons why an accident victim is discharged from public hospital treatment, and transferred (either with or without the patient's consent) to a rest home, convalescent home, geriatric hospital, or private hospital. The Commission will not be concerned. But it will move in to pick up the financial responsibility at such a point as institutional care is still required, but medical-cure treatment can do no more.

K.L. Sandford
Chairman
10/2/75

ACCIDENT COMPENSATION COMMISSION

MEMORANDUM FROM CHAIRMAN

8 September 1975

DIRECTOR OF COMPENSATION
REVIEW & APPEAL SECTION

AUCKLAND GERIATRIC CASES

So that there will be no discrimination between claimants who have, or have not, applied for Review in respect of the Commission's refusal to pay for private hospital treatment following direct transfer from public hospital, a scrutiny is to be made of all the relevant claim files and revisions made in accordance with the following principles.

These principles will apply to the majority of cases. There will be other cases of special circumstances, or to which the principles cannot be exactly applied. These should be individually considered.

These principles will apply in the meantime only to the Auckland Hospital Board area, and will continue in force until agreement is reached with the Auckland Hospital Board on future cases.

The Commission will accept payment of private hospital, resthome, convalescent home, etc. charges by payment either to the hospital or by refund to the claimant, where the claimant has been transfer direct from public hospital, under the following conditions:

1. Establish that case is one accepted as personal injury by accident covered by the Act.

2. Acute treatment, and attention or supervision by a specialist, must have finished, so that in the private hospital the only attention required is that which can be given by the hospital non-professional staff or by a general practitioner. If further specialist attention is contemplated, liability will not be accepted but the circumstances will be considered and a decision made on the facts of the particular case.

3. Establish that it is not reasonably practicable, in all the circumstances, for the patient to return to his former reside from the public hospital instead of going to the private hospital. The previous condition of health of the claimant, the domestic circumstances in the residence, the extent of nursing or other care required, and the mobility and severity of the injuries of the claimant are all relevant factors.

4. Payments will continue only so long as the patient remains incapacitated or disabled as a result of the personal injury by accident. Cases will require periodic review, so that payments will cease if the patient returns to the same state of health as he would have been in but for the accident, even

though he remain in the private hospital for other reasons.

5. Payment is only in respect of the private hospital's account in excess of the social security patient benefit.

6. Refunds can be made to relatives who, by production of receipts or otherwise, demonstrate that they have provided the money.

7. After refunds have been made the future accounts from the hospital can be rendered to the Commission.

8. If the patient is still receiving "treatment of the person as a patient in any hospital" in respect of his accident injuries (section 111(2)(a)) the payment is made for medical treatment under section 111. For this purpose "treatment" includes hospital attention (not necessarily only from medical practitioners) that is designed:

   (a) To cure or reduce the injury.

   (b) To rehabilitate a patient in respect of his accident injuries.

   (c) To maintain a patient's condition which would, but for such attention, deteriorate further as a result of the injury.

   When "treatment" in any of those senses is no longer being supplied the case ceases to come under section 111, and payment under that section will then cease.

9. If, after "treatment" under section 111 ceases, the patient must still receive "constant personal attention" in respect of "necessary care" - and this attention and care is still the result of the personal injury by accident, the case transfers to one requiring consideration under section 121(3). But the Commission has a discretion as to whether it will make payments under this section, and (if it does) the amount thereof.

10. Reductions:

   (a) Payments made under section 111 will, in the case of a Supplementary Fund claimant, continue to be paid in full. If, however, the claimant is in receipt of earnings relate compensation, payments will continue in full for three months, but the file will then be referred to the Commissi for consideration of whether a reduction will be made unde section 129.

   (b) If a case becomes one of "constant personal attention" under section 121(3) it will be referred to the Commission to be considered in the light of its own circumstances. In general it is to be expected that the saving to the claimant of living costs will be reflected by his making a contribution from his own resources (not exceeding one-half of his pension) with the Commission paying the balanc Care will be required to ensure that the "constant persona attention" is required for the personal injuries by accide and not from reasons solely connected with age, infirmity, etc., which might have been applicable if no accident had occurred.

11. Some geriatric patients are returned, either direct from public hospital, or by way of a private hospital, to an institution where they had formerly lived, e.g., old peoples homes. Some of these institutions have a hospital wing. Even though a patient might formerly have been paying for accommodation in the home, admission to the hospital wing for either section 111 "treatment" or section 121 "constant personal attention" will still be dealt with under the above principles. However, in respect of section 121 cases, the amount that the claimant would in any event have been paying to the institution will be considered a relevant factor in deciding what contribution (if any) he should make towards the cost of the "constant personal attention".

K.L. Sandford
Chairman

c.c. Mr Fahy
Mr Graham
Medical Director

Accident Compensation Commission

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TECHNICAL INFORMATION CIRCULAR

CIRCULAR No. T 208

DATE 21st June 1976

SUBJECT: PRIVATE HOSPITAL CHARGES - PAYMENT OF AMOUNTS LESS THAN THE COSTS ACTUALLY INCURRED

FACTS: The Appeal Authority in issuing its decision in an appeal by E.D. Turner, relating to payment of Private Hospital expenses, commented to the effect that section 111 of the Accident Compensation Act confers a discretionary power on the Commission to determine to what extent (if any) it will accept financial responsibility for private hospital treatment.

In determining that question, the Appeal Authority recognised the propriety of the guidelines set out in Chapter 7 of the Commission's Medical Handbook to determine whether there are any circumstances present in a particular case which would justify admission to a private hospital so as to require the Commission to make full payment of, or a contribution towards, the cost of private hospital treatment.

If the claim is not wholly meritorious, but provided there are circumstances present which show some justification for obtaining treatment in a private hospital, the Commission may pay part of the cost of that treatment.

In considering the circumstances of each case, the Appeal Authority stated the Commission was entitled to look at the general structure of medical services in New Zealand and to ask itself whether it is reasonable by New Zealand standards that it should pay private hospital charges with their associated specialist fees, taking into account that "free" hospital and medical service is available under the Social Security Act 1964.

For the assistance of staff handling Private Hospital claims the Commission has issued the following broad guidelines:-

(a) Normal Commission policy will continue to be that, after consideration of the factors set out in the Medical Handbook the cost of private hospital treatment will be either accepted in full, or not accepted at all. In other words the Commission believes that, in <u>almost</u> every case, it is impossible to place a percentage on the level of merit and accordingly pay that percentage in cash.

(b) However, there will be some cases in which we must be prepared either on our own initiative or as a result of representations, to offer a contribution towards the cost of treatment.

Cont/d...

(c) With special exceptions contributions should be considered in the range of 50%, 66⅔% or 75%. Greater or less percentages do not seem to make sense. If one thinks in terms of less than 50% contribution, it is probable that the circumstances do not possess enough merit to justify any contribution at all. On the other hand, if the circumstances suggest more than 75% it is clear that the merit considerations are so strong as to justify total payment.

(d) Arrangements to make payments by way of contribution should be entered into only in rare cases, and pressure on the Commission to make that a regular practice should be resisted.

(e) It is emphasised that it will be only in rare cases claims will be dealt with in this way and under no circumstances during the handling of the claim should the claimant be led to believe that the Commission will as a matter of course consider meeting a proportion of the claim.

[illegible] Internal Distribution only

Signed .....
ADVISORY OFFICER

[illegible]e behind Provisional Interpretation S.111

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