proposal was that the Provincial Councils, which the Bill aimed at setting up, were to take over the whole question of hospital administration. In other words, twenty-four Provincial Councils were to take over from forty-five Hospital and Charitable Aid Boards.

85. As we recommend the establishment of new hospital districts covering considerably larger areas than at present, it is essential that there should be satisfactory administration. We have recognized that a Hospital Board selected by the electors of the eighteen larger districts could not be expected to give that personal control and administration to the hospitals which is necessary if efficient and economical management is to be achieved. For instance, the representatives of the new larger districts who do not reside in the base town would not be available for committee work. The idea incorporated in the Local Government Bill of 1912 could, with advantage, be adopted, and we suggest that the Boards could be elected as at present, but, instead of the representatives forming a Hospital Board, they should elect an executive committee, whose members should all be resident in or near the base town so as to be available for service as a committee of management.

86. As to the actual management of the hospitals, we believe that the combination of hospital administration and medical treatment of patients is not in accordance with the best principles of hospital management. It is, however, the system generally in force in New Zealand outside the metropolitan areas. The Medical Superintendents are rarely qualified as, and should not be expected to be, business managers for the Boards. Their duties are usually confined to the medical side of administration, while the Secretary attends to the administrative side. Owing to this division of the duties and responsibility, the real management often devolves upon the Chairman, which appears to be undesirable.

87. While referring to the duties of the Chairman, it should be remarked that the Chairmen are in receipt of honoraria limited by statute to £250 per annum, and in some cases at least the amount of the honorarium is out of proportion to the size of the Board and its district. We do not believe that there is any justification for the continuation of the payment of honoraria to the Chairmen of the Hospital Boards beyond perhaps a purely nominal amount.

88. **We consider that a competent non-medical administrative officer should be appointed for each of the new hospital districts** to carry out the policy of the Board, as it is rarely possible to secure a medical officer who can successfully combine the duties of both Medical Superintendent and general manager.

89. We are of opinion also that the salaries at present paid to the secretaries and other officers of Boards are in some cases comparatively higher than those paid in the Public Service for somewhat similar positions, and generally there is not that system of uniformity of grading which should exist in what is practically a national service. Incidentally, a system has grown up of allowing free houses and other perquisites to officials of the Board, and the aggregate value of these perquisites appears to be very considerable. We consider this an undesirable system, which should be abolished, and an inclusive salary paid to the officers concerned.

90. It should perhaps be made clear here that we do not suggest that the number of hospitals in the Dominion should be confined to eighteen. It will be necessary for some of the new hospital districts to have district hospitals and/or cottage hospitals, but these would come under the direct control of the Manager of the Base Hospital District. These district hospitals would, in turn, be controlled by a local Manager, and cottage hospitals would be controlled by the Matron. The eighteen hospital districts would then be served by :—

(1) One base hospital in each of the centres of population :
(2) District hospitals where necessary within the base hospital district :
(3) Cottage hospitals in lesser localities.

91. Such a system would be more economical and more efficient than the present system whereby forty-five general hospitals, many of them with equipment and staff more than sufficient for the needs of the district, are maintained.

92. As to the medical administration, it is undoubtedly true that a great deal of the expenditure in hospitals depends on the efficiency or otherwise of the medical administration, and to secure the best possible results combined with economy it is essential that this should be subject to adequate supervision, which appears to be lacking to some extent under present conditions. In the main hospitals the qualifications for membership of the senior surgical staff are high, but, on the other hand, in many hospitals in the Dominion there is not sufficient supervision over the medical work, and no minimum standards of qualifications and experience requisite for the position of surgeon or physician are laid down in the by-laws. We are of opinion that this system should not be allowed to continue.

93. Furthermore, in many hospitals adequate records are not kept of the medical and surgical treatment of patients. We understand that this shortcoming has to some extent been remedied, but it is still a definite weakness and is mentioned by Dr. MacEachern in his report to the New Zealand Branch of the British Medical Association. The lack of adequate records may result in costly duplication of laboratory and X-ray examinations and in unduly prolonging the stay of patients in hospital. As to the medical administration of the base hospitals, there is no need for a medical officer senior to a Registrar or Resident Medical Officer, who should have the requisite qualifications and experience for such a position. We do not suggest that a high salary be paid for this position, which should be regarded as an opportunity for gaining further practical experience rather than as a career for life. With proper organization, we think that this end could be achieved, and that the best class of medical officer, who in later private practice would derive considerable benefit from his hospital experience, would be obtainable. The functions of the Resident Medical Officer would be to supervise the work of the House Surgeons, to do emergency surgical work as required, and to see that the nursing service and all the services for patients were satisfactory from a clinical viewpoint.