apportion it among medical practitioners of their district on a basis decided by the majority. Owing to the absence of sufficient information as to the working of any such systems, the Committee considered it was not in a position to make any recommendation.

FEE-FOR-SERVICE SYSTEM

18. Particular attention was necessarily directed to the existing General Medical Service Scheme introduced under sections 2 to 11 of the Social Security Amendment Act, 1941, which provide two alternative methods of payment from the Fund—namely, a direct payment to the doctor or a refund to the patient. Reviewing the administrative procedures involved in these two methods, the Committee came to a general agreement that there should be one method only of claiming against the Fund.

19. The Committee recommends that in lieu of the present alternative fee-for-service methods of payment from the Fund (namely, (i) direct payment, and (ii) refund) there be adopted only one method (namely, one by which the medical practitioner shall be required to claim on the Fund on behalf of the patient the appropriate amount payable from the Fund for the service and apply that amount in full or part settlement of his charge for the service).

The recommendation that the claim be made in this manner—*i.e.*, on behalf of the patient—rather than directly as is at present provided by section 4 of the Social Security Amendment Act, 1941, is made to meet the desire of the profession to preserve the doctor-patient relationship to the fullest extent. It is a matter of common knowledge that, on account of the widely held view that a direct claim by the practitioner on the Fund infringed this principle, a large number of practitioners have declined to make direct claims upon the Fund.

20. A suggested form of claim was discussed and while the Committee recognized that the actual detail and form of the claim would be a matter for further discussion and settlement, a draft of the form considered by the Committee forms an appendix to this report as an indication of what is considered necessary.

21. *Verification of Claims.*—It was agreed that the present invariable practice of obtaining a certificate from the patient, parent, or guardian as to the dates, &c., of attendance has only limited value. With the adoption of the system recommended in paragraph 19 it is recommended that certification by patients, &c., be discontinued.

It was recognized, however, that with the discontinuance of certification by patients some alternative method for checking the claims made by practitioners would be necessary. It is accordingly suggested that the Department devise a system of verification of service as an alternative to the patients' certification, as, for example, postal inquiry from a proportion of the patients of each practitioner. In addition, it is recommended that all practitioners be required to maintain adequate medical records of their patients in support of all claims made and that these records and daily diary sheets be subject to inspection by medical practitioners duly appointed for that purpose.

22. *Amount of Payment from Fund.*—The Committee recommends the following scale of payment from the Fund in respect of general practitioner services:—

(*a*) For an attendance at the doctor's place of residence or surgery or at a private hospital, up to 7s. 6d.:

(*b*) For an attendance elsewhere than at the doctor's place of residence or surgery or at a private hospital, up to 10s.:

(*c*) For an attendance between 9 p.m. and 7 a.m. or on a Sunday or on a public holiday in response to an urgent request at those times, 12s. 6d.:

(*d*) Where any attendance extends beyond a half-hour, 5s. for every additional quarter-hour:

(*e*) For telephone consultations in certain rural areas approved by the Medical Officer of Health, up to 5s.