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Transcripts of talks given at seminars held at the King's Fund Centre between June 1973 - June 1974.

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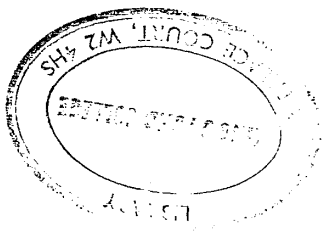

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NHS AND EEC - NETHERLANDS

Papers given at the seminar held at the King's Fund Centre on 5 June 1973, by:

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A) Professor J.B. Stolte

1 Preliminary remarks

The Netherlands is a small flat country (41 160 sq. km.). Communications by road, railway or waterway are excellent. Its highly urbanised population, totalling about 13.3 million (making Holland a very densely populated country) is distributed over 11 provinces with about 900 municipalities. The population is still growing but the rate of growth is rapidly diminishing. Approximately 10% are 65 years of age or older. The expectancy of life at birth is 71.0 years for men and 76.4 years for women; the death rate is 8.4 per 1000; the birth rate 17.2 per 1000 (in 1971).

Net national income (against market prices) was ƒ105 billion in 1971. The GNP was ƒ130 billion (ƒ 1, - being about 1/8 of £1). Because of steeply progressive income tax there are no startling inequalities in disposable income. Because of this and because of an extensive system of social security, there are virtually no really indigent people. The country is heavily industrialised, but has now entered the phase of being a service-rendering society (eg 8% of the working force is concerned with agriculture and fisheries, 42% with industry and 50% with services). There has been almost full employment for the last 25 years. Strikes have been few and far between. About 25% of married women are gainfully employed.

The population is fairly healthy. Perinatal mortality(death at birth + deaths within the first week) was 17.6/1000 births in 1971; the death rate from tuberculosis has become the lowest in the world; deaths from contagious diseases have dropped below 7 per 100 000 inhabitants.

2 Health care costs

The amount of money spent on health care has increased steadily, both absolutely and in relation to the GNP. It is now estimated at about 6.5% of GNP or almost ƒ7. billion. More than 85% of it goes into curative care.

About 70% of the population is insured through non-profit making sick funds against virtually the whole cost of health care, particularly in the curative field. Compulsory insurance covers all people over the age of 65,

NHS AND EEC

Introduction

It is probably true to say that European countries are reasonably well-informed about Britain's National Health Service, but that NHS staff in Britain are not so well-informed about health services in Europe.

With Britain's entry into the Common Market in 1973, the King's Fund Centre decided to join with the International Hospital Federation in arranging a series of one-day seminars to promote better knowledge and understanding of European Health Services. Thus between June, 1973, and June,1974, seven seminars were held at the King's Fund Centre at which English-speaking representatives from EEC countries were invited to talk about the planning and organisation of health services in their respective countries. The following pages contain transcripts of the talks given at each seminar.

Those attending the seminars certainly seemed to find them helpful - and entertaining. The speakers impressed us all not only by the depth of their knowledge and understanding of the health services of their own countries, but also by the elegance and wit with which they presented their papers and answered the numerous questions that followed them - all in excellent and idiomatic English. A truly impressive performance on each occasion.

March, 1975

Miles Hardie
Director

and all employees (and their families) whose income is below an agreed level - although this level tends to rise regularly every year. Hospitals and professional people are paid directly by the sick funds for the services they have rendered to the insurees. General practitioners receive a capitation fee; specialists are paid on a fee for services basis, either directly or through the hospital, depending on their relation to the hospital. The 30% of the population who are not covered by insurance through the scheme described above, take out insurance policies (mostly at a higher rate) either with the same sick funds or with commercial insurance companies. These refund the bills the insuree gets from the hospital and/or the doctors.

Hospitals may not make a profit by law. They are only allowed to cover their costs. In only a few cases do local authorities or the government subsidise a hospital.

The sick fund insurance repayments cover the total cost of curative health care and in most cases this applies also to the commercial insurance schemes. Patients have freedom of choice of doctor and hospital and this applies also to the consultants.

Hospitals borrow money on the market for improvements and they may get it at a slightly lower rate of interest when the state, the province or a municipality guarantees redemption and payment of interest. Capital costs are included in the hospital's tariff, with the exception of rent on own capital and writing-off on more than historical costs (writing-off on replacement-cost is not accepted). Hospital tariffs are set by a semi-official body, consisting of delegates from the hospital organisation and from the sick-funds and insurance companies, presided by three prominent citizens elected by both parties. They are subject to approval by the Minister of Health.

3 Government control

Hospital building is subject to approval by the Minister of Health under the Hospital Act. This covers special services (dialysis, open-heart surgery etc.) also. The Health Inspectorate exerts a certain control on quality of services. Most salaries are settled through a Board of Labour. Doctor's fees, included in (all-in) hospital tariffs are subject to the approval of the Board for Hospital tariffs, and, secondly to that of the Minister of Health and the Minister of Economic Affairs. The other fees are set by the Sick Fund Council in so far as sick-fund insurees are concerned. Fees for private patients are free in principle; the Dutch Medical Association protects the patient against exorbitant fees; nevertheless the Minister of Economic Affairs has recently deemed it necessary to establish rules for doctor's fees.

4 Organisation

4.1 Public and preventive health

The central authority responsible for health services is the Department of Health and Protection of the Environment. It runs a public health laboratory and there is a network of public health inspectorates, mostly designed along provincial lines. Advisory councils at national and provincial level furnish the authorities with scientific advice. The local operation of the public health services is partly in the hands of the municipalities (particularly the larger ones), but most of the work is taken care of by voluntary organisations (so-called Cross organisations),

these being rather heavily subsidised by government. The (diagnostic) School Health Service is in the hands of the municipalities. Undertakings with more than 750 employees have to establish an industrial medical service by law. Many of the smaller ones have a joint service.

4.2 Curative health care

For the most part curative care is delivered by private agencies. First line or primary care is provided by general practitioners and district nurses. Secondary care is delivered primarily by medical specialists and hospitals, either as ambulatory care or as inpatient care. Tertiary care (rehabilitation and long term care or 'reactivation') is provided by medical specialists, physical therapists and similar professional people and institutions (rehabilitation hospitals and so-called 'nursing homes' for the ailing aged, the chronic and the incurably sick).
The general practitioners are entrepreneurs, virtually all of them being in solo-practice. A few attempts in the direction of group-practices and health-centres have been made but without much success. Most specialists also are entrepreneurs. Quite a few, however, are employed by the hospitals where they work. This is particularly the case in psychiatric hospitals and in the municipal hospitals. Most hospital beds (about 75%) are in the hands of private organisations, most of them sectarian. The (sectarian and voluntary) Cross organisations provide home nursing to about three quarters of the population.
Curative care is characterised by an almost complete dichotomy between primary and other care. The dichotomy is stressed by the way doctors in the curative field are paid by the sick funds. General practitioners get a capitation fee, medical specialists are paid a fee for service. Sick funds and insurance companies will only cover expenses for curative care by specialists when the patient has been referred to the specialist by the general practitioner.

> It is estimated that of any 1000 inhabitants about 35 are under medical treatment each day: 20 are under the care of a GP, 10 under the care of a specialist (about 1/3 as in-patients in general or special hospital); 5 are in a mental hospital or an institution for mental defectives. Slightly less than 60% of confinments take place at home with either the GP (45%) or the midwife (55%) in charge. The results are very good.

Dutch general hospitals have never been real 'acute' hospitals, patients with long-term illnesses always being cared for among the others. In the last 15 years, however, many special hospitals ('nursing homes') have been erected for them, where facilities for nursing, treatment and rehabilitation or 'reactivation' are designed to meet their special needs. There are two kinds of these 'nursing homes', one for mentally deteriorating old people and one for those patients who are suffering from long-term physical illnesses. Community care for the old and handicapped in their own homes is gradually developing. The burden of home nursing is born mainly by the Cross organisations.
The number of adopted houses is increasing fairly rapidly, so that more old people can remain relatively independant. The day-hospital-movement has just begun. The need for this provision is perhaps not very urgent because of the extensive programme of home-nursing and home-help.

Much psychiatric care is provided in out-patient departments of general hospitals or in their own offices by psychiatrists, of whom there are not nearly enough. While admission to psychiatric wards in general hospitals does not require special formalities, the law requires that each hospital in which more than two mental patients are cared for, should be approved by the Inspectorate, and be subject to its supervision.
Patients may be admitted to psychiatric hospitals on a voluntary basis (more than 80%) or on certification. Boarding out of patients is practised by some hospitals, mostly on a rather small scale. As everywhere else the patient turnover has quickened substantially in recent decades. After care of discharged patients is mainly in the hands of the psychiatric social service, whose network covers most of the country. It may also remain with the psychiatric social service of the hospital itself. The psychiatric day-hospital is just emerging. Because of the existing network of extramural care its part will probably remain a relatively modest one.
At the end of World War II there was a terrible backlog in the development of the hospital service. Because of the economic situation the government nevertheless had to put restrictions on hospital building. In order to establish priorities and grant permission to build in the hospital field, a departmental commission was set up to advise the Minister of Health in respect of plans subjected for approval. This commission designed a few rules of a rather crude nature ('norms') to evaluate hospital building plans of all kinds. In this way a start was made to get a more adequate dispersion of hospital facilities over the country.
Two years ago a law was passed in which a scheme of regionalisation was embodied, the Province being taken as the planning unit. The law takes into consideration only hospitals and no other part of the service. However, another law is in preparation to establish a coordinated regionalised system for the entire health care service. It has, however, been shown already that to establish a good planning scheme on the lines of regionalisation is a difficult job, even when only hospitals are taken into consideration.

5 Management of hospitals

Most hospitals are private, non-profit corporations, run by a board of trustees, consisting of prominent citizens. Most boards are self-perpetuating. Membership is unpaid. The board lays down the general policy of the hospital and appoints its major officers and the members of the medical staff. It approves the budget both in respect of running expenses and capital investment. It acts as the final court of appeal within the organisation. Lacking expert knowledge, its members depend upon their officers for guidance, particularly on matters of development and planning. Through the technique of the discerning question, however, and by calling on external advice if necessary, they are able to assure themselves that the final decision, which is solely theirs, is the right one.

Only very few members are doctors and none of them work in the hospital for which the board is responsible. The day to day running of the hospital

either in the hands of an executive body, called the 'directie' (=board of directors), or those of a director. The troika principle increasingly prevails, the executive body consisting of a medical director, an administrative director (usually an economist) and the matron.

In the majority of cases the matron is considered to be of a slightly lower status than the other two members. In a few cases the executive responsibility lies with a (non-medical) 'general' director. It is the duty of the 'directie' to run the hospital within the general policy set out by the board, and in accordance with the approved budget.

It has to put plans for the future before the board. It has to watch over the functioning of the hospital and to safeguard its continuity by sound personnel and financial management.

Training for hospital (and health services) management as such does exist. There is a part-time course, taking about 600 hours in an academical year for people who are already in the field. It takes about 30 participants each year and has been running for 12 years now. Plans for a full-time post-academic course have not yet got to the stage of realisation.

TABLE I

HOSPITALS IN THE NETHERLANDS (BY 1971)

		beds (total)	beds 1000 inhab.	estimated shortage
General and special ('acute') hospitals	254	68.527*	5.15	-0.2
Psychiatric hospitals	39	26.782	2.01	-0.2
'Homes' for mental defectives	113	17.500	1.32	1.3
Hospitals for epileptics	6	1.400	0.11	-
Sanatoria for TB	5	700	0.05	-0.02
Nursing homes	206	22.495	1.69	0.4
Other institutes**	10	2.500	0.19	0.05
		139.904	10.52	

N6

* 2750 cots not included

** institutes for the blind and for the deaf, for maladjusted children etc.

TABLE II

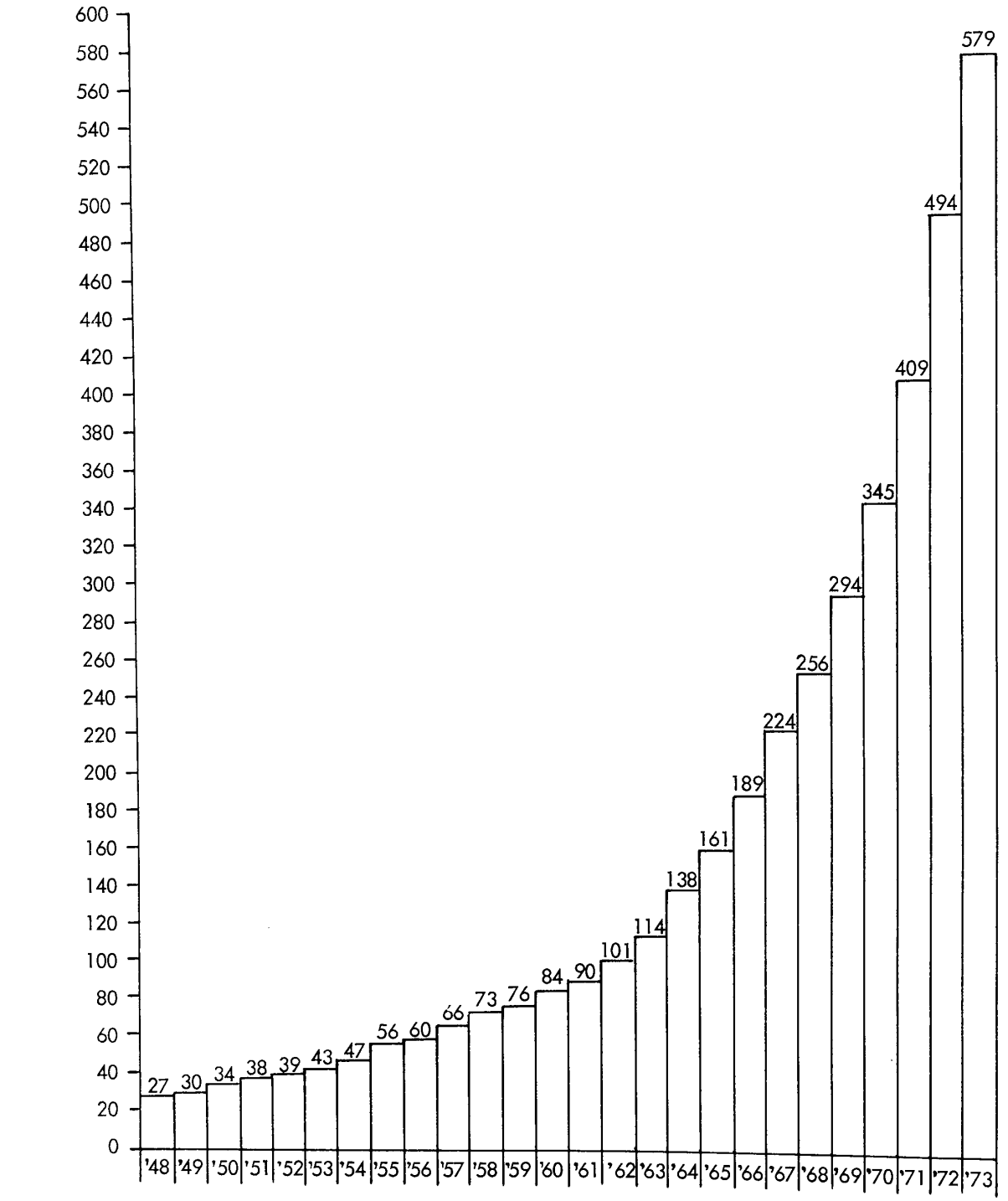
Health care personnel per 100 000 inhabitants (by 1972)

General practitioners	34	131
Specialists	45	
Other doctors*	52	
Dentists	26	
Midwives	7	
District nurses	27	
Other nursing personnel**	516	

* many of them are trainees in various specialisms

** including pupils and practical nurses

TABLE III



Costs per insured person with the compulsory sick fund insurance from 1948-1973 (figures for 1971, 1972 and 1973 are estimated) in guilders per year.

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B) Dr. J.C.J. Burkens

1 Staffing

Staffing problems exist mainly as far as technical paramedical personnel, nurses and some categories of doctors are concerned.

The shortage of paramedical personnel, which is not very serious, is caused (as is the case in many industrialised countries) by the steep increase in services required from industry and research. As to nurses, there is a shortage of practical nurses; the reasons being the growing demand for institutional care of the aged and infirm, and the fact that, contrary to expectations when the training was put on an official footing, many practical nurses are attracted to hospital work.

There is neither a shortage nor a surplus of student nurses, but there is a shortage of registered nurses. Women on the whole are tending to marry at a younger age, and certainly nurses are no exception. This shortage is more pronounced in the case of registered nurses with special technical skills. For this reason more and more clinical assistants from outside the nursing profession are being trained and used in hospitals.

Marriage by age of partners

The percentage of all marriages contracted between the ages of 15 to 49 years, the female/male partner being younger than:

	20 years	25 years	30 years
1961			
female partner	12	67.5	88
male partner	3	40.5	82
1970			
female partner	17	81	92
male partner	4	62	89

In the Netherlands, there has always been strong resistance to married women having a job while children are at home or at primary school. This is changing and more married women are now going out to work. Their numbers are proportionately lower than in many other European countries however, and for mothers of young children to have a job is still unusual.

The patient/nurse ratio varies according to the type of medical service, but it is generally accepted that in general hospitals it is 1 : 1.8 (including both registered and student nurses); and the ratio of registered nurses to student nurses varies at present between 2 : 3 and 3 : 4; but this is changing with the new training schemes.

It is less difficult to say whether there is a shortage of doctors at the moment than to predict what the situation will be in ten years' time. Because of the constant social and technical changes in medical practice, prognoses tend to be wrong, but even so the Hospital Institute is once more trying to make a prediction. The actual situation depends on the speciality. There is a shortage of G P's especially in the larger cities where working conditions are difficult. In recent years a new trend has developed whereby more medical students are choosing to become G P's and more preferring to settle outside the towns.

There are approximately 4500 medical specialists working in 290 general hospitals.

Number of general practitioners, medical specialists, public health physicians and other physicians (including retired) :

	Total	G.P.	Spec.	Public Health phys.	Other phys.
Jan. 1, 1970 Population: 12.957.600					
Number	15.664	4.492	5.460	1.029	4.663
Percentage of total	100	28.7	34.9	6.6	29.8
Jan. 1, 1972 Population: 13.269.563					
Number	17.381	4.504	5.909	1.081	5.887
Percentage of total	100	25.9	34.0	6.2	33.9

There tends to be a surplus in specialities like general surgery and general medicine, and a shortage in such specialities as anaesthesiology (where the UK and some other countries give valuable assistance by exporting anaesthesists to us), urology, radiology and other. This situation will probably have changed within a decade however, by which time we may have a surplus.

Some socio-economic data which may be useful, are as follows. In the Netherlands, there is a minimum wage, fixed by law and reviewed every year by parliament. At the moment it stands at Fl. 11.825, that is £1.822, a year, for adults. It is compulsory for wage-earners to join a sick-fund if they earn Fl. 23.200 or £3.569 a year or less; this figure is also fixed and reviewed by parliament every year. Self-employed people earning the same amount can insure themselves voluntarily in the same way by the same sick-funds. For the aged this figure is Fl. 26.750 or £4.115. 77% of the population fall within these brackets. The figure is somewhat uncertain as the last actual figures are from the year 1967 but probably the percentage has not changed much. As you have already heard this morning approximately 70% of the population is voluntarily or compulsory insured by sick-funds or comparable schemes.

Wages and sick-fund insurance as per Jan. 1, 1974

	Fl.	£
Minimum wage for adults	11.825	1.822
Ceiling of income to enter sick-fund	23.200	3.569
for aged	26.750	4.115
	(£1 = Fl. 6,50)	
% of population with income up to ceiling	77%	
% of population insured in sick-fund or comparable	70%	

Salaries for registered nurses (not staff nurses) vary from Fl. 1.139 or £175 to Fl. 1.555 or £239 a month* Salaries for student nurses vary from Fl. 695 or £107 to Fl. 956 or £146 a month. Resident nurses or student nurses receive their board and lodging relatively cheaply. For comparison: salaries for laboratory assistants (with a 3-year training) vary from Fl. 1.232 or £190 to Fl. 1.739 or £267 a month; salaries for social workers (4-year training) vary from Fl. 1.415 or £218 to Fl. 2.221 or £341 a month.

Salaries on a monthly basis

Student nurses	107 - 146	695 - 956
Registered nurses (non-staff)	175 - 239	1139 - 1555
Laboratory assistants	190 - 267	1232 - 1739
Social workers	218 - 341	1415 - 2221

There can be a certain difference in social contributions to be paid, and the relation between the part paid by the employer and that paid by the employee differs somewhat for different social contributions. On the average the total of all social contributions, at the moment, is 42.3% of the gross wage (it is not included in the wage) with the employer paying somewhat less than 2/3, and the employee paying somewhat more than 1/3. In 1971 19% of the national income was used for social contributions.

* Currency exchange rates vary. Here the relation pound-guilder = 1:6,5 is used.

2 Training

Until recently nurses received in-service training in the hospital where theoretical classes, training at the patient's bedside and actual nursing were freely mixed. There can be no denying that this system gave good practical results, but the question arose as to whether the theoretical level was high enough to keep pace with modern developments in medical work and techniques, and whether it could satisfy the younger people with a higher educational level who were coming into nursing.

The block system was introduced and then schools of nursing were opened, but the majority of nurses still receive in-service training in accordance with the block system. Generally speaking, it can be said that nurse training is developed to a higher and more modern standard in the UK and the USA than in the Netherlands (where standards of actual bedside nursing seem to be as good as in the UK), but developments are following the same trends as in those countries. The resulting gradual disappearance of student nurses as a labour force in the hospitals will, of course, have financial and staffing consequences.

Training of medical students is the task of the universities. Formerly it was done only in the teaching hospitals, but as their capacity is not increasing at the same rate as the demand, non-teaching hospitals are becoming affiliated with the universities for this purpose. This creates problems for any attempts at coherent hospital planning.

Medical specialists are trained according to a specified scheme and for a specific number of years (varying, of course, according to the speciality) both in teaching and recognised non-teaching hospitals. The situation is unique in Europe in that the regulation and supervision of specialist training are done jointly by the Dutch Medical Association and the university medical schools ; the Minister exercising only very general supervision. The professional medical organisations (comparable to the Royal Colleges in Britain) have some influence but play a much lesser role than your Colleges do.

Within the Common Market countries there are very considerable differences between the national training schemes although more for medical specialists than for G P's. The Latin countries for example do not always have full-time training; there is an examination at the end; and many sub-specialities are recognised. In the non-Latin countries, there is full-time training with the trainee (attached as an assistant to a specialist who is specially recognised as a teacher) under supervision and working in a recognised hospital, according to a fixed training scheme. There is no final examination and often the variety of sub-specialities was less. These differences made it impossible to have the free exchange of doctors which is one of the aims of the Treaty of Rome; but after years of negotiation, a common training scheme has been approved, on more or less non-Latin lines. Now with the entry of the UK and Ireland into the Common Market, new negotiations will have to be started. In the Netherlands as in the UK, the G P is beginning to be recognised as a specialist in his own right with his own training scheme.

3 Planning

Until a few years ago, planning in the hospital field was rather haphazard, even chaotic, and this was still the case after a number of research projects had been undertaken. The reason for this, if we compare it with the British situation, was that there is no national health service and no great foundations such as the King's Fund and the Nuffield Foundation. In 1970 a new hospital law was passed which changed the situation. The law is based on three principles.

The first is that it lays down that a national hospital plan must be drawn up, but this will probably become a national health service plan under a new law which will probably be put before parliament this year. This national hospital or health services plan will be made up of eleven provincial plans (there are eleven provinces in the Netherlands, comparable to your counties) drawn up by each province and combined - doubtless after considerable change - into one national plan. The responsible authorities in the provinces are assisted by advisory committees on which hospitals, both public authority and private, paying agencies, doctors, public authorities, nurses and other interested organisations are represented and can have their say. A new council, on which an even greater number of interested bodies is represented, with the hospitals and the paying agencies as the biggest partners, is responsible for drawing up this national plan from the provincial plans and submitting it to the Minister, who takes the final decision. Naturally there is provision for appeals. This process must be repeated every five years and can be reviewed in the meantime. This same council deals with applications for building, rebuilding, extending or changing a hospital.

The second principle is that the hospital plan will not deal only with hospital building; it will also cover medical and other important services and expensive equipment. When the health services law comes into force, it will deal also with extramural services. Hospitals will have considerable latitude in initiating action but not unrestricted freedom. In my opinion, this will be the most important change since it is becoming clearer and clearer to all planners that every good plan must be based not on beds or on buildings, but on services.

The third principle is that of having a system of permits - not only for building but also for expensive equipment and for the organisation and provision of certain services which will be laid down by the Minister, who must consult certain advisory bodies beforehand. The law lays down that a permit may be refused, on the one hand because the application does not fit in with the national plan (here the provincial authorities are consulted) and on the other hand because the building or service in question is inefficient, because it contains elements or provisions which are not a necessary part of the hospital or because the building or the introduction of the service or equipment would give rise to unacceptably high costs and charges to the patients. The whole system applies to private and to public authority hospitals, but the university hospital and the military hospitals are excepted although the former must still fit in with the national plan.

During the drawing up of the provincial plans, a number of fundamental planning decisions will have to be taken. For instance, there will have to be what we call regionalisation; that is the division of the country into territories where the population must be provided with a certain package of medical and other services. In our present situation we are interested in those areas in which and for which a complete package of medical services can be provided and which would have a population of one and a half to two million. We are even more interested in the areas where an extensive but incomplete package of medical services must be offered and where we envisage a population of 300,000 or more. The determination of the actual package is a major problem, especially in a country with small distances and a network of smaller hospitals that are already fairly highly developed, and often too highly developed. Taking well-founded dicisions here will be one of the most difficult tasks, as will interfering with existing conditions.

Another problem is whether, in such a territory, or district, or area, or region, or whatever we decide to call it, we should aim at having one central hospital (probably comparable with your district general hospital) with a number of satellite hospitals, or several medium-sized hospitals tightly organised together and providing the disired package of services in collaboration. The one central hospital has considerable advantages, but will it not be farther away from and less approachable by the workers at home care level, and will it not be more difficult for the hospital to provide support at home care level ? And what will be more important in the future ?

How many beds should new hospitals have in relation to the population they serve ? For the simple reason that we have nothing better at present, we are still using the old planning rule which states that you need four general hospital beds per 1000 inhabitants in agricultural areas, four and a half per 1000 in semi-urban areas and five per 1000 in urban areas. It is probable that when the medical and medico-social services are organised in a more satisfactory way at home care level, then these figures can be reduced. But much more important is the fact that the whole method of determining hospital building by the yardstick of bed/population ratios is certainly wrong; the determining factor should be the number and variety of medical services a population needs under given circumstances. We are trying hard to work this out but it is not easy, on the one hand because we lack certain relevant statistical elements and on the other hand because at the operational level it will be difficult to enforce new methods in existing situations. In this context the well known problems of the difference between demand and need and of the methodology to determine need have not yet been solved. But we cannot be content to leave them unsolved.

We have discovered - perhaps somewhat later than you did - that for health care planning, and that means even for hospital planning, first-line medical care and planning for it are the most important things. It must not only be developed but also reorganised, and we are thinking, as you are, of health centres. But we shall also probably have the same initial period of resistance by the medical profession that you have experienced in the UK and Ireland. This is important not only for the work that can be done in these centres rather than in the hospitals, but

also for the support that the hospital and especially the hospital personnel can give to this first-line care on the spot. In other words, it is important to find out whether the normal one-way traffic between G P and hospital doctor, and between hospital doctor and university staff, can be developed into a two-way system. Closely connected with this cluster of problems is the need for integration of somatic, psychological and social care both in home care and in hospital care; although this integration of disciplines must not confuse the particular and specific tasks of each discipline. This is also a problem of great importance in determining the future task of the doctor and more particularly of the G P and the nurse. Everyone agrees that extramural and outpatient care must be developed and intramural care reduced, but the duration of illness and absence from work must also be considered.

I am sure that you have all these problems too but I mention them to give you an idea of what is going on in Dutch minds. I think it is understandable that the hospital planning law is being expanded to become a general health services law.

4 Research

Hospital research is being done by smaller foundations (which are often short of funds and find it necessary, therefore, to look for paying clients); by governmental organisations, to a certain degree; by commercial organisations and consultants; by university department (which in most universities are beginning to develop this work); and in the last four years by the National Hospital Institute. This Institute meets its costs not by working for paying clients nor by receiving subsidies, but from a certain amount of money, approved by competent authority, which is added to the daily rate in every hospital. This is a very satisfactory system of financing. As in many countries, research findings are scattered and co-ordination is often difficult. The Hospital Institute sees a task for itself here, but we still lack a definite centre where all research findings would be registered. The Institute is developing close relations with other hospital institutes and their documentation centres in Europe, particularly at present with the King's Fund here, Belgium, Sweden, and Germany, where we are making a first experiment with some computer linkage.

5 Main Problems at Present

These are quite similar to those being faced in other countries which are fairly highly developed, quite highly industrialised, and which have the character of a welfare state. I mentioned earlier that our problems have a special colour due to the fact that our country is small and overpopulated with a very high degree of public welfare (not as high as in Sweden but higher than in England, if I have understood correctly from my daughter who is working in London as a social worker). Many quite basic problems within the social and health care field in fact are only just coming to the fore and to public attention.

We are frightened by the steeply rising costs, particularly as far as building is concerned, so much so that at the moment most hospital building has been stopped to create a breathing space. This does not apply to health services, but in general subsidies are not increasing in proportion to rising costs. Until now health has had almost absolute priority, but it is clear that this is no longer the case and that priorities must be defined both within the health care field and between health care per se and other essential fields. The relation between health care and general well-being is the subject of much discussion.

It is obvious that we cannot go on with the haphazard kind of development we have had in the health field in the past. Planning and control are necessary, but they are never easy, particularly in a country where the people are firmly attached to the individual approach to problems and decisions and to private enterprise. However, everyone now acknowledges the need for them. As in the UK, historical development has been without any serious breaks or revolutionary changes, and this, combined with our national preference for private initiative, has given rise to many organisations in the field of social welfare. Some of these are excellent but their work often overlaps, it is impossible to keep them under supervision, and really the time for such a loose system is past. Another defect is that very often there is more planning than actual strict control over execution and follow-up.

I have already mentioned such things as intramural versus extramural care and the relation between preventive and curative care. Financial restrictions make it necessary to decide in given situations money and manpower should not be devoted to the first at the expense of the second. Human considerations, as against technical and organisational ones, in medical, nursing and health care, are becoming more and more central to our discussions. You will not be surprised to learn that problems such as abortion, euthanasia, management of the dying and of old age, and the participation of the patient in decision-making, are claiming increasing attention.

I could go on with many more items, but I feel sure that any problem you care to mention that you have here, we are also facing in the Netherlands.

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King Edward's Hospital Fund for London

King's Fund Centre

NHS AND EEC - BELGIUM

Papers given at the seminar held at the King's Fund Centre on 25 September 1973, by:

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A) Professor J.E. Blanpain

This paper intends to describe and comment upon certain aspects of the health care scene in Belgium with emphasis on organization, management and planning. Like all health care systems, the Belgian health care industry has been greatly influenced by historical, cultural, economic, scientific and religious forces. In order to understand certain characteristics or even peculiarities of the Belgian health care system it is necessary to review briefly a number of characteristics of the country relevant to health care.

1. Belgian profile

1.1 General statistics

Belgium is a small densely populated country. With its surface of 30.513 km^2 it is, second to Luxembourg, one of the smallest members of the enlarged European Community. With 317 inhabitants per km^2 it is with the Netherlands the most densely populated country of the Community (Table 1).
It has a rather low birth rate of 14.7/1000 pop. and one of the highest death rates in the EEC with 12.3/1000 pop. Life expectancy at birth is 67.9 years for males and 74.3 years for females (Table 1). Infant mortality, maternal mortality and mortality in the age group 1-4 years compares favourably with the figures available for the other EEC members. (Table 2). As in all industrialized countries the leading causes of mortality are cardiovascular diseases and cancer with accidents rapidly increasing as a major cause of death. More than 13% of the Belgian population is over 65 years, confronting the country with tremendous problems in the fields of housing, health care, welfare, catering and provisions for leisure time (Table 3). An increasing amount of the Belgian population, nearly 10%, are immigrants from other EEC countries, from North Africa, Greece or the Middle East compounding the already complicated socio-cultural set-up in Belgium and introducing specific health hazards and health education problems. The EEC is very sensitive to this situation which calls for an EEC wide social programme to integrate 'guest workers' and to stop blatant discrimination in housing, education and other social opportunities.

1.2 A history of foreign occupation

Belgium can look back on an unusual record of occupation by invading armies.
Sitting as a buffer between two major cultures Belgium has been for many centuries a favoured battlefield. The terrain, particularly in the northern part of the country with its plains and small hilltops seemed perfectly suited to manoeuvring armies and commanding generals. This history is reflected in the administrative structure of the country and in the behaviour and mentality of the Belgian as a citizen. In order to guarantee survival during prolonged periods of war and occupation, local authorities were bestowed with important duties and powers also in the field of health care. The number of local authorities was kept large and unchanged for many centuries, confronting undersized local authorities with the problems of modern times. The average Belgian distrusts central authorities. Having learned to cope with foreign occupation he is reluctant to give information and inclined to distort it. This may explain the general lack of reliable vital statistics in Belgium.

1.3 Influential role of the church in health care

The catholic church has a long standing commitment to education and health care in Belgium. This is reflected in the structure of the health services as will be discussed later on.

1.4 Multi-lingual country

Belgium houses three language groups related to three different 'reference' cultures: Flemish in the north, French in the south and German in the east. Belgium is notorious for the tensions between these sub-cultures. This is now interfering in the process of regionalization which is taking place all over Europe as a movement to strengthen the intermediate level of Government.

2. Organization of health services

The main characteristics of the Belgian health care system are:

a. mixed venture of solopractitioners, public institutions (mostly local authority) and voluntary non-profit institutions;

b. loose, non structured and non-integrated system;

c. numerous duplications and shortages as a result of spontaneous developments mainly dominated by the supply of providers.

The main components of the health care system are:

1. Solopractitioners

Belgium has a medical density of 157 per 100.000 population. This amounts to some 15,000 M.D.'s of which 50% are general practitioners functioning on a private solo-practice basis combining office-based practice with home visits. The development of group practice, although highly advocated in circles of medical education, is negligible at this point of time.

The remaining 50% of the M.D.'s are, with the exclusion of doctors in administrative positions, specialists with hospital privileges. Full-time hospital commitment exists only in certain teaching hospitals and in a limited number of non-teaching hospitals; the rule being that the consultant shares his time between his office-practiceand one or more hospital appointments where he also functions on a private basis. This is related to the small average size of hospitals (see below). Belgium ranks high in the EEC with its density of physicians and of pharmacists. With Ireland it has the lowest density of dentists (Table 4). The importance of solo-practice in the Belgium health care system is responsible for the limited degree of organization of medical care. Staffed emergency services, departmentalization of medical staff, balanced bed-distribution, medical record systems, medical staff committees, referral policies etc. are virtually non-existent, reflecting a medical care philosophy in which facilities like hospitals are viewed as doctor's workshops where each doctor tries to function as independently as possible.

2. Institutional care

2.1 Preventive medicine

Programmes of maternal and child health, school health, industrial health, mental health, TB prevention etc. are offered either in separate settings or combined in so-called 'health centres' restricted to preventive care. Indicated sections of the population are invited or requested (if the programme is enforced by a special law) to submit periodically to certain screening procedures. These programmes are mainly staffed by part-time physicians, GPs or consultants have a qualification for industrial health, school health, TB, mental health etc.
These programmes are viewed by the medical profession as redundant with their role in office practice and do not create much enthusiasm.

2.2 Outpatient clinics

Immediately after World War II Belgium witnessed the creation of a number of out-patient clinics separate from hospitals under the impulse of health insurance funds. These funds were concerned about their membership still facing financial barriers in their access to ambulant specialist services. Reimbursement of a fixed amount being the principle of the insurance for these services, consultant fees were not related to this reimbursed amount and mostly out of reach for low-income groups. Also in certain areas ambulant specialist services were simply not available. The health insurance funds managed to retain a number of contractual consultants in a network of out-patients clinics rapidly spanning the whole territory. This has been a very controversial issue between health insurance funds and organized medicine which considered it as an attempt to 'nationalize' medicine. Since 1963 consultants' fees are to a certain degree under control; also the distribution of consultant practices has improved so that lately the creation of new out-patient clinics and the related controversy have been abandoned.

2.3 Hospitals

Hospital data are summarized in table 5.
There is a severe shortage of facilities for extended care and rehabilitation. Belgian hospital facilities are unevenly distributed with higher densities in the north of the country and in metropolitan areas.
Hospital sponsorship or ownership is divided between local authorities and private, mainly non-profit organization (see table 6). Private hospitals in Belgium have reached like in some other EEC countries the position of 'public service' institutions. They are entitled to the same financial allowances as public hospitals and are submitted to the same controls. Thus the difference between private and public disappears as far as resources and public accountability are concerned but remains in administrative structures and procedures. This has resulted in an unusually dynamic voluntary sector prodding the public sector into competitive behavior. This public sector is rapidly losing its identification with legislation for the poor and sharing with the private hospitals a cross-section of the population.

3. Management of health services

At the national level policy-making, guidance and control of health services is diluted over the Ministries of Health, Social Affairs, Labour, Public Works, Defence, Agriculture and Education. Through its control of health insurance (the main financing of health care), the Ministry of Social Affairs has a great an impact on the policy level as the Ministry of Health. The functions of these ministries are mainly regulatory : determining the conditions under which health care should operate and can be financed, with controls on the implementation of the regulations. Actual operations and their related management decisions are left to the local agencies which have a high degree of independence within the allocated resources and prescribed regulations.
So the actual management of health services is located at the individual hospital level (solo-practice being outside any managerial influence). Since 1960 health care institutions have started to strengthen their managerial backbone. The private hospitals have created boards representing the community and appointed hospital directors preferably with specific training in medical care administration. The local authority hospitals have created special hospital committees within the elected public assistance council to administer hospital affairs and to have a governing body working in close relationship with the hospital managers (lay-medical and nursing). Hospitals through their hospital associations have ventured in sharing services for purchasing, linen services and computer service. Even full mergers are under way, particularly in towns where several small hospitals see the need to grow into one larger institution thereby meeting the needs of the community for specialized care. The universities have responsed to the need for trained administrators. Three universities have offered since 1960, masterdegree programmes in medical care administration. Leuven University has also since 1963 a substantial development programme intended to keep hospital administrators and trustees updated. Some 600 health care managers and trustees attend yearly this Leuven University development programme.

Planning of health services

Manpowerplanning is virtually non-existent. Every attempt to introduce manpower planning has been thwarted by the fear that it would be used to exclude certain population groups from access to the health professions. A surplus of physicians is being announced given the 15,000 students enrolled in the medical schools : a net increase of 100% since 1965. This enrolment would lead to an increase in the medical density to ± 234/100,000 population in 1980 (1). This figure seems out of balance with the health care resources, both physical and financial and the current rewards available to physicians. All these considerations are bringing pressure on universities to limit their enrolment. It is starting hesitantly and without any assessment of the manpower needs for the future. Nursing has always been approached with a perception of shortages. Action has always been directed towards increasing the schooling capacity with little effort devoted to diminishing attrition during and immediately after training; to influencing working-conditions or financial rewards to retain married nurses in the active labour force; or to curbing the rapid personnel turnover to which the health services and the social system at large have insufficiently responded. Several studies have shown (2) that nurses are poorly utilized in a way that could, with imagination, be easily turned into a nurse surplus.

Physical planning has, until very recently, been indirect and mainly hospital-bed oriented. By granting or withholding building subsidy (60% of the building costs for local authorities and 50% for private non-profit organizations) the Ministry of Health has tried to develop hospital services within a national hospital plan in which different bed/population ratios were established for rural, semi-rural and urban areas for a number of given types of care like obstetrics, paediatrics, internal medicine, surgery, infectious diseases etc. This planning through the subsidy mechanism did not manage to indicate hospital localizations and catchment areas for hospitals within a regional set-up of balanced and hierarchical hospital services. It also failed to guarantee the prescribed bed population ratios in the first place because of the limited funds made available yearly in the budget. In the second place certain agencies moved ahead without the need for subsidy or managed through political influence to overrule a negative decision on the subsidy aspect. On July 6, 1973 parliament voted substantial changes in the legislation concerning hospitals (3). Physical planning of hospitals now becomes a direct responsibility of the Minister of Health whose permission to create or change hospital facilities will be required within a national hospital plan. A national planning council emanating from three regional councils will advise the Minister and establish the criteria to guide the elaboration and the updating of the plan. A special Health Facilities Fund

(1) DELIEGE-ROTT, D., Le ras de maree en Medecine. Halte a la croissance ? Bruxelles, 1973;

(2) BLANPAIN, J., BRUYLANDT, N., MEULEPAS, E., PRIMS, A., QUAETHOVEN, P., ROGGEN, H., TRAPPENIERS, F., VAN KORDELAAR, M., Studies van de werkverdeling van verplegenden in de Belgische ziekenhuizen. Acta Hospitalia 7 : 97-118, 1967.

(3) Notulen van de zittingen van de Belgische Sentaat. 1972-73 - 13 juni 1973 : Ontwerp van wet tot wijziging van de Wet van 23 december 1963 op de ziekenhuizen.

will be created to finance hospital construction which will be entitled to issue bonds and to receive government allocations permitting the Minister to establish long term planning. The effects of this radical change in the legislation will be felt only after a number of years. One can speculate however that this will rapidly result in a substantial renovation programme for existing hospitals and construction in priority areas such as extended care and mental health. A better distribution and an increase in average size are also likely to result within the next decade.

4. Problems

The Belgian health care system is beset with all the problems that confront health services in industrialized countries; spiralling costs, uneven distribution of services, unavailability of certain services like extended care, geriatric care, home care, and insufficient assurance of quality care.

The problems are compounded by the loose and non-integrated nature of the Belgian health care system resulting from the lack of a firm organizational base and the absence of a national health care policy. The problem produced by the lack of an overall set of goals and choices of alternative solutions to meet these objectives is being raised by all parties involved - health authorities, the health insurance funds and the medical profession. They are divided however in their approach to this problem and in particular in their underlying philosophies (4). Basically it goes back to a clash of diametrically opposed philosophies. The health authorities together with hospital boards, and the health insurance funds perceive health care as a societal function and pursue a more organized health care system with clear objectives not only in the field of restorative care but also in the fields of preventive medicine, rehabilitation and health care education. Organized medicine fights rearguard actions seeing health care as a responsibility of the individual that can be met in direct personal encounters with the medical profession. Thus the profession opposes every move towards strengthening the organizational grip on its membership. The strong bargaining position of the medical profession has made advancements towards even distribution of services, availability of services in space and in time, quality assurance and cost containment a very slow and sometimes distressing process.

(4) PRIMS, A. & L. DELESIE, Gezondheidsbeleid in Belgie. Kontakten, 1 : 3-32, 1973.

TABLE 1

DEMOGRAPHIC SITUATION IN EEC COUNTRIES

1970 or in the last year for which figures are available

	Population	Popul. per km^2	Birth rate	Death rate	Expectation of life M	W
BELGIUM	9.676.000	317	14.7	12.3	67.9	74.3
DENMARK	4.921.000	114	14.4	9.8	70.6	75.4
GERMANY	59.554.000	240	13.2	11.9	67.7	73.9
FRANCE	50.775.000	93	16.7	10.6	68.6	76.0
IRELAND	2.994.000	42	21.8	11.5	69.0	73.4
ITALY	53.667.000	178	16.8	9.7	68.4	74.0
LUXEMBOURG	340.000	131	13.0	12.1	66.3	72.7
NETHERLANDS	13.019.000	319	18.3	8.4	71.3	76.8
ENGLAND & WALES	48.988.000	324	16.0	11.7	69.0	75.3
SCOTLAND	5.199.000	66	16.8	12.2	67.4	73.7

Source: Health planning and Organization of Medical Care, Public Health in Europe 1 : 1, 1972.

TABLE 2

MORTALITY IN EEC COUNTRIES

	Infant mortality 1970	Mortality 1 - 4 y. per 1000 1969	Maternal mortality per 1000 1968
BELGIUM	20.5	0,9	0,18
DENMARK	14.8	0,8*	0,18
GERMANY	23.6	0,8*	-
FRANCE	18.1	0,8*	0,32
IRELAND	19.2	0,9	0,36
ITALY	29.2	1,1*	0,70
LUXEMBOURG	24.9	0,7	-
NETHERLANDS	12.8	0,9	0,26
ENGLAND & WALES	18.2	0,8	0,24
SCOTLAND	19.6	0,6	0.10

* 1968

Source: Demographic yearbook 1970, United Nations, 1971.

TABLE 3

AGE DISTRIBUTION (%) IN EEC COUNTRIES

1969 or in the last year for which figures are available

	Age in years						
	0-14	15-24	25-34	35-44	45-54	55-64	65 +
BELGIUM	23.8	14.5	12.2	13.7	11.1	11.6	13.1
DENMARK	23.8	16.5	12.8	11.7	12.2	11.2	11.9
GERMANY	24.9	12.6	15.3	12.7	10.5	12.2	11.7
FRANCE	23.7	16.1	12.0	13.5	10.2	11.1	13.4
IRELAND	31.2	15.7	10.3	10.4	10.9	9.7	11.3
ITALY	24.4	14.9	14.5	14.0	11.1	10.7	10.3
LUXEMBOURG	22.2	13.7	13.5	14.5	11.4	12.3	12.3
NETHERLANDS	27.5	17.6	13.1	11.8	10.6	9.2	10.1
ENGLAND & WALES	23.6	14.5	12.5	12.0	12.4	11.9	13.0
SCOTLAND	26.2	15.2	11.8	11.4	11.7	11.6	12.1

Source: Health planning and Organization of Medical Care, Public Health in Europe 1 : 1, 1972.

TABLE 4

HEALTH CARE PROVIDERS PER 100.000 POPULATION IN EEC COUNTRIES

Country	Year	Physicians	Dentists	Pharmacists	Nurses
BELGIUM	1970	157	23	67	102
DENMARK	1968	145	68	42	452
GERMANY	1969	170	51	38	221
FRANCE	1969	130	40	33*	258
IRELAND	1966	104	21	57	574
ITALY	1969	179	-	-	-
LUXEMBOURG	1969	103	32	49	234
NETHERLANDS	1968	119	25	8	369
ENGLAND & WALES	1967	117	26*	33*	304*
SCOTLAND	1969	133	24	57	395

* Approximate data

TABLE 6

HOSPITALS BY OWNERSHIP

General hospitals	41% local authority (public assistance) 59% voluntary (mainly non-profit)
TB hospitals	29% public 71% voluntary non-profit
Mental hospitals	27% public 73% voluntary non-profit

TABLE 5

HOSPITAL FACILITIES IN BELGIUM

General hospitals including isolated maternities	4.74 beds/1000 population
TB hospitals	0.24 beds/1000 population
Mental hospitals	2.74 beds/1000 population
Single speciality hospitals	0.24 beds/1000 population
Number of general hospitals	354
Average size of the general hospital	111 beds
Admission rate (1968)	100/1000 pop./year
Occupancy rate of general hospitals (1968)	82%
Average length of stay in general hospitals (1968)	14 days

B) Dr P Quaethoven

This lecture will deal with four aspects of health services organization in Belgium: financing, staffing, training and research. Most attention, however, will be paid to the financing of health services.

I. Financing

I will not limit myself to a description of the existing methods of financing. Therefore, the evolution of the cost of medical care and the influence of social security on these costs, will be taken into account.

I.1 Evolution of the costs of medical care

The lack of sufficient statistical material about the total cost of health care, forces one to attempt an overview of the costs of medical care of the Social Health Insurance. A description of the Belgian Social Security-system becomes necessary.

The vast majority of the Belgian population is covered by compulsory health insurance (more than 98%). In this insurance a distinction must be drawn between the position of the employees and that of the independent workers.

All employees of industry, commerce and public bodies are subject to compulsory insurance. They have to join a sick fund or else they are registered officially with a public institution, which also supplies health insurance.

Independent workers (professionals, businessmen, craftsmen and farmers) are also compulsorily insured, but in their case the insurance only covers certain specific medical costs : operations, hospital care, deliveries, and the treatment of cancer, mental illness, poliomyelitis, tuberculosis, and the care necessitated by congenital diseases and deformities.

Under Belgian compulsory health insurance retired workers are covered by sickness insurance, so it is not felt necessary to establish a special insurance fund for the elderly. However retired persons (over 65 years for men and over 60 years for women) have a special status within the insurance scheme.

The retired worker, or the widow of a deceased worker, enjoys free insurance if his or her pension is the result of at least 15 years of work; if not, a monthly premium is payable of frs. 50 (for employees) or of frs. 20 (for independent workers). This premium is increased by half if the retired person or widow has the charge of one or more dependents. Whereas the normal members of the insurance scheme have to pay part of the fee and of the price of drugs and appliances, retired persons and widows receive free care. The same applies to invalids and orphans.

Free care is, however, only given to these people if their income does not exceed frs. 75,000 yearly (frs. 60,000 for invalids). This sum is increased by frs. 15,000 per person dependent on the insured one. Since 1 July 1967, the compulsory sickness insurance has been extended to cripples and disabled persons and their families receiving allowances (insofar as they are not under compulsory insurance already). These beneficiaries are exempted from the usual patient's part of the cost in the same way as retired persons, widows, invalids and orphans.

They have to pay a premium of frs. 50 to frs. 75 a month, exactly like retired persons and widows, according to whether they have the charge of any family. Only disabled or crippled persons over 65 years of age (60 for women), their widows and orphans receive sickness insurance completely free.

By the act of 27 June 1969 health insurance has been made compulsory for students, domestic staff, members of religious orders etc. All other inhabitants can voluntarily join the compulsory insurance. In the whole of the compulsory sickness insurance the Government supports 95% of the cost of the so-called "social diseases" : mental illness, tuberculosis, cancer, poliomyelitis and congenital disease and deformities (see below).

The recent legislation on the social rehabilitation of handicapped persons permits all handicapped persons suffering from an incapacity to work of 30% (20% for the mentally handicapped) to receive free medical care such as rehabilitiation, prostheses and appliances, if judged necessary or useful for their readaptation to normal life. A committee examines each individual case and gives advice on the care that will be necessary in that specific case.

If these provisions fail to protect some persons, the law on public assistance will provide all necessary medical care, mostly by offering accommodation in hospitals and other medical institutions run by public assistance committees. This relief is financed by the local communities, except for the cost of mental illness, care for handicapped children, care for disabled or crippled persons and for the cost of tuberculosis, cancer and other diseases. These costs are covered by a national "special relief fund".

In general, Belgian health insurance shows a semi-public and semi-private pattern. It is governed at the top by public institutions and administered at the base by private organizations, the latter being as a rule mere executives of the former's decisions.

At the level of the public institutions a distinction is made between the general scheme and the scheme for independent workers. At the base, these two branches of the compulsory insurance system are administered by the same sick funds.

Under the compulsory health insurance scheme for employees contributions are collected by a central public institution collecting and distributing contributions for all branches of social security. The contributions for the health insurance sector are sent by this institution to the National Institute for Health and Invalidity Insurance. This institute divides the money between its two sections; the medical care costs insurance and the sickness benefit insurance.

The medical care costs insurance sector finally divides the contributions between the five national confederations of sick funds and the public sick fund, according to the number of contribution-vouchers each of these organizations can produce.

Regarding independent workers, the pattern of organization at the top is the same; contributions are paid to an official institution, which collects the contributions for all branches of social insurance for independent workers. Contributions for sickness insurance are directed by this office to the section for medical care costs insurance of the National Institute for health insurance and from there the money follows the same channels as in the insurance of employees.

At the base, the general scheme and the scheme for independent workers are administered by sick funds. They are only recognized to participate in health insurance if they belong to one of the five national confederations of federations of sick funds that existed in 1945 when compulsory health insurance started. The three main confederations (85% of the insured) are closely related to the three so-called "national" political parties and the three important trade unions. The two other confederations are only open to certain professional groups. To guarantee free choice by the consumer a public insurance institution was established.

Except for complementary insurance ; the sick funds cannot determine the rights of their members and neither can they decide on the contributions or premiums to be paid. They have only a very limited financial autonomy. As a result compulsory health insurance in Belgium has lost much of its private nature and its finance has become in effect publicly controlled.

Let us get back to costs.

In five years' time (1965-1970) the expense for medical care in Belgium has practically doubled; from 18.601 millions in 1965 it has grown to 32.060 millions in 1970 (according to the Ministry of Social Insurance, data for the general regime and the regime of the independent workers together).

TABLE I

Evolution of expenditure for benefits of social security 1965 - 1970 (in millions of Franks)

	1965			1966			1967		
Health care	17,933.0	100.0	22.2	19,655.7	109.6	21.7	20,663.3	115.2	20.9
Sickness benefits	9,842.7	100.0	12.2	10,831. 5	110.0	12.0	11,277.7	114.6	11.4
Unemployment	4,330.9	100.0	5.5	4,662.3	107.7	5.1	6,695.6	154.6	6.8
Pensions	24,094.3	100.0	29.8	27,635.6	114.7	30.5	29,271.3	121.5	29.4
Family allowance	20,445.6	100.0	25.3	22,754.4	11.3	25.1	24,522.8	119.9	24.8
Industrial accidents	3,880.1	100.0	4.8	4,398.3	113.4	4.9	4,582.5	118.1	4.6
Occupational diseases	206.2	100.0	0.3	618.7	300.0	0.7	2,048.0	993.2	2.1
TOTAL	80,732.8	100.0	100.0	91,556.5	112.2	100.0	99,061.2	122.7	100.0

	1968			1969			1970		
Health care	23,584.7	131.5	20.5	24,843.3	138.5	20.1	30,186.1	168.3	21.8
Sickness benefits	12,332.4	125.3	10.7	13,112.1	133.2	10.6	14,244.1	144.7	10.3
Unemployment	7,502.5	173.2	6.5	6,731.5	155.4	5.5	6,351.3	146.7	4.6
Pensions	36,765.9	152.6	32.0	41,027.6	170.3	23.2	46,798.3	194.2	33.7
Family allowance	27,102.2	132.6	23.6	29,095.0	142.3	23.6	31,617.8	154.6	22.8
Industrial accidents	4,910.1	126.5	4.3	5,426.3	139.8	4.4	5,824.7	150.1	4.2
Occupational diseases	2,772.0	1344.3	2.4	3,240.4	1571.5	2.6	3,650.4	1770.3	2.6
TOTAL	114,969.8	142.4	100.2	123,476.0	152.9	100.0	138,672.7	171.8	100.0

The medical care portion of the whole of the expense of social security has remained the same during the whole period 1965-1970: nearly 20%. The growth rate for medical care has even been lower than the average for all branches of social security. The index number (1965 = 100) for medical care in 1970 equals 168.3 while the same index number for the whole of social security equals 171.8.

So one cannot say that the growth rate of the expenditure for medical care by social insurance in Belgium is too high, without applying a similar qualification to the growth rate of the total expense of social security. It is clear for instance that the growth has been much more rapid in the area of old age pensions. The increase in the expense of medical care in the social insurance is caused in part by the extension of the compulsory insurance to new groups of the population. The number of insured people has increased from 5, 138, 102 in 1960 to 6,889,246 in 1965 and to 9,524,694 in 1970.

TABLE 2

Evolution of the expenditure per insured person of health insurance 1958-1971 (general regime)

Year	Total expense (in million Fr.)	Expense per insured person in Fr. ; index number (158 = 100)	
1958	5,421.9	1,083.54	100.0
1959	6,038.5	1,188.04	109.6
1960	6,336.3	1,233.20	113.0
1961	6,743.1	1,289.24	119.0
1962	7,482.6	1,399.45	129.2
1963	8,971.9	1,637.82	151.2
1964	9,101.5	1,585.27	146.3
1965	17,717.8	2,739.61	252.8
1966	19,426.7	2,727.27	251.6
1967	20,497.5	2,825.97	260.8
1968	23,469.9	3,193.24	294.7
1969	27,720.2	3,702.81	341.7
1970	29,173.8	3,863.41	356.6
1971	37,369.9 (a)	4,819.62	444.8

(a) previsions in the budget

The increase of expenditure for medical care cannot be explained only by the extension of the insurance to new groups of the population; the expense per insured person has grown too. In twelve years, the cost per insured person has been multiplied by 2.5.

This phenomenon can only be explained through a detailed analysis of the evolution of the costs for the different types of care (see Appendix). Such an analysis shows an important increase in medical consumption for such types of care as surgery and specialist consultations. The increase of drug consumption is also very clear. For general practitioners consultations and for hospital care, on the contrary, the rise in hospital tariffs and in doctors' fees explains largely the overall increase. Expenditure on care given to retired people is rising for all types of care. Expenditure on care given to the non-active popluation varies according to the type of care involved.

1.2 Influence on health insurance on the cost of medical care

At this point it seems necessary to give some more information on the system of distribution of health care, as far as costs and expenditure are involved.

The technique of the "franchise" (fixed amount up to which the hazard is not taken by the insurance) is not used in Belgian health insurance. The "ticket modérateur" (part of the cost to be paid

by the insured person himself) is used for current types of medical care (general practitioner and specialist consultations, dental care etc.). For all these types of care the insurance covers 75% of the official tariffs.

In principle the same rule applies to hospital care; the insurance only pays 75% of the day-price in hospital . But the other 25% do not constitute a "ticket modérateur" since they are paid directly to the hospital by the Ministry of Public Health, which also pays the supplement to the fixed day-price which may be charged by teaching hospitals.

Certain groups of persons are exempted from the "ticket modérateur" - retired people, widows, orphans and invalids, whose income does not exceed a certain limit.

Generally speaking, medical care in Belgium is not entirely free. Official hospital tarifs may be exceeded if the patient chooses to be treated in a private room; doctor's and dentist's fees usually exceed the reimbursement from the sick fund; part of the costs of protheses is left to the patient, and so on .

These problems are linked with those of the nature of the insurance benefits. On this point a distinction may be drawn between the fields of drugs and hospital care on the one hand, and all other types of care on the other hand.

For drugs and hospital care the insurance payment is generally operated directly between the insurance institutions and the supplier of care. The insured person only pays the "ticket modérateur" or the supplement.

For all other types of care, the suppliers may use the same form of payment. In fact, doctors are mostly if not always paid directly by the patient who gets reimbursement afterwards.

Drug prices are set in a different way according to their nature. Industrial drugs are subject to general price regulations; drugs made by the pharmacists themselves are subject to an agreement.

The price of a day's stay in hospital is determined by the King (the minister of public health). A separate price is fixed for every type of hospital department. For each type of department the price is the same throughout the whole country, except for the teaching hospitals where a considerable supplement may be charged.

The number and the nature of departments being different from one hospital to another, an average price per individual hospital may be calculated for the use of the health insurance on the basis of the prices for its various departments.

"For particular and exceptional reasons" the minister may permit a hospital to charge a certain supplement for a limited period of time. But it seems in many cases that there are "particular and exceptional reasons" all the time.

The day-price in hospital covers all expenses for boarding, nursing and delivery of magistral preparations for the patient in the common ward. In a two bed war a supplement of 50% may be charged, on the condition that at least half of the number of beds of the hospitals are available at the official price. For a private ward the hospital has freedom to fix its own tariffs.

1.3 Financing

The reform of the Belgian health insurance in 1963 has provided separate management for health care and for sickness benefits within the same insurance institute. Each sector has its own government subsidies, 65% of the budget for health care is financed by contributions of the insured persons. The fixation and the payment of contributions are made in a completely different way for the various groups of insured persons, even within the same regime. One must distinguish between social security contributions (which are part of the system of financing of social security contributions are due from all employees of industry, commerce and agriculture, by all civil servants and by all independent workers.

The contribution is determined by law. It is divided into two parts contributed by the employee and the employer, both calculated as a percentage of salary before deduction of taxes. The employee's part of the contribution is deducted from his salary by the employer, who pays it, together with his own part, to the insurance body.

The contribution is calculated on the gross wage ($\pm$6%), up to a given limit per month.

For independent works the contribution equals $\pm$ 1.5% of their income as it is assessed for income tax, but corrected according to the evolution of the price-index. It is calculated on a yearly minimum and maximum.

Higher income groups have to pay an additional contribution. Payments are made by the insured person himself to a public institution which distributes the money.

Contributions in the form of lump sum payments must be paid by different groups of persons to whom compulsory insurance has been extended in recent years; eg handicapped persons and students.

Those who are not compulsorily insured can voluntarily join the social health insurance. The premiums for these insured are set by the Minister of Social Security as a defined sum per month. Members of the compulsory insurance scheme can take out voluntary complementary insurance, by paying premiums to the sick funds. For the independent workers this complementary insurance will provide cover for general medical care, and for employees it will give additional benefits such as preventive open-air care in Switzerland, free transport in ambulances etc. In addition to this it must be mentioned that most employers guarantee their employees subsidation of heavy medical care costs, in so far as they are not covered by compulsory insurance. Some 20% of employers have taken out private insurance to cover this supplementary risk. Most of the others have initiated a special fund in their enterprise to meet these costs.

The country's largest insurance company has started a health insurance plan conceived as an additional insurance to compulsory health insurance. It covers the extra cost for care by specialists charging more than the official tariffs and the supplementary cost of first-class accommodation in hospitals.

Retired people and widows are in principle insured without contributions, but in certain circumstances they are also called to pay reduced contributions.

On the pensions received by civil servants a deduction of 1.5% is made with a minimum and maximum limit except for very small pensions. It is paid to the health insurance. Independent workers who have reached the age of retirement may be free from contribution if their income does not exceed a given maximum per year.

Special contributions, the subsidies by the government are assessed and paid in the same way for all regimes and for all groups of insured persons. This government intervention is focussed primarily on the so-called "social diseases" (mental illness, cancer, tuberculosis, poliomyolitis and congenital diseases and deformities).

The cost of these illnesses is paid for 95% by the government.

For all other expenditures of health insurance the government grants a general subsidy, equal to 27% of the previsions of the budget.

Not less important a subsidy is given by the Ministry of Public Health (the former subsidies were given by the Ministry of Social Insurance) and it covers 25% of the normal price for hospital care as well as the price-supplement which may be charged in teaching hospitals.

Finally the government also accepts responsibility for the contributions which are owed by unemployed workers. This subsidy equals the average daily amount of the contribution of each of these unemployed workers during the period before his unemployment.

1.4 Special Fund

There is one more, and a brand-new instrument for financing the health services - the "Fund for the Construction of hospitals and socio-medical institutions". This Fund, attached to the Ministry of Public Health is created in order to help finance (subventions, loans) the construction, modernisation and equipping of the hosptials and socio-medical institutions both public and private, on condition that the proposals have been approved by the Government.

The Fund also deals with the purchasing of property, needed for the construction or modernisiation of state-owned psychiatric hospitals and with the costs, involved in the construction and equipment of these hospitals Research in the field of hospital building design and equipment can also be paid from Fund money.

Subsidies from Government and revenues from loans form the Fund's own financial means. Donations form a minor part in this respect.

1.5 Comments

Several important organizations expressed their concern about the way health care is organised at present in Belgium.

The largest sick-funds propose:-

1. to enlarge the financial contribution of the insured

2. to enlarge the contributions of the Government

3. to close the gap between the cost of both a medical act and a day's stay in hospital, and the price to be paid.

4. to reduce the profits on drugs.

The Socialist Trade Union supports the fiscalisation of the present system. The League of Belgian Industry is thinking along the same lines, as far as so called "great risks" are concerned. The medical profession does not want care to be free; on the contrary, it wishes the patient to pay for his own care.

2. Staffing

It is hard to give exact figures on the number of different categories of professionals.

At the end of the year 1972, the number of specialists was estimated at 7,450; some of them being speciality. Therefore the number of accreditations (8,040) is slightly higher

than the number of specialists. Quantitatively, surgery (918) and internal medicine (909) rank first and second. Together with pediatricians (678), psychiatrists (629), radiologists (571), gynaecologists (548) and ophthalmoligists (500), they form the majority of specialists. At the other extreme there are only 3 physicians, specialized in thoracic-surgery, 6 specialized in surgery of the blood-vessels, and 14 specialized in surgery of the abdomen.

At the end of the same year, there were approximately 2,500 dentists, 5,600 physiotherapists, 3,000 opticians, almost 17,000 nurses and over 1,800 midwives.

So far, staffing problems are mainly in the fields of hospital nursing and midwifery. Legally, there should be one skilled nurse or midwife for every 30 or 24 hospital-beds. However, the Minister of Public Health, i.e. his administration, aims at 10 to 12 nurses for the same number of beds. Presently, 70% have to be qualified nurses and 30% may be nursing aides. It is hoped to increase the proportion of qualified nurses from 70% to 80%.

Public hospitals, generally, try to get more nurses, which means that they are asked by the Administration to review their recruitment policy. Private hospitals, on the other hand, act differently; they try to get less nurses than 10 to 12 per nursing unit.

As in most other countries, there is said to be a shortage in nurses. It is hard to prove whether this is true since we do not have standards to tell us how many nurses exactly are required; how much nursing time an average patient needs; or how the overal work can be divided among different categories of nurses. We do know, however, that even highly qualified nurses spend only one third of their time in both direct and indirect care. The solution therefore seems not necessarily to attract more nurses, but first to ensure that those we have undertake the right sort of tasks.

There are no standards as to the number of physicians, necessary for a given number of patients. For two medical services only, both in the field of psychiatric care, it has been decided that 1 physician is needed for 30 - 120 patients according to the nature of the care to be given.

3. Training and research

This part of my paper will be very short.

There are obviously specific trainingfor doctors, nurses, hospital administrators etc. but I will not attempt to describe these here.

It might be of some interest, though for you to know that a specific training in hospital administration does exist. As a matter of fact, there are three such programmes in Belgium, all at graduate or even post-graduate level. A specific training at the same level for nurses does not exist, although some nurses can enter the Schools of Hospital Administration after one preparatory year. The Leuven University School of Hospital Administration has an enrollment of ± 50 students. The yearly number of students in hospital administration is estimated at a total of ± 100.

Continuing education seems to be of utmost importance. A large number of physicians, nurses, hospital administrators, pharmacists etc. show their interest in this respect. This continuing education is organised mainly by the Leuven University School of

Hospital Administration and by the Catholic Hospital Federation. The first continuing education prgramme alone, has an enrolment of approximately 500 people, who for a 3-day period isolate themselves from hospital business in order to refresh their minds.

Research has been done at several levels, mainly, however, at the University level. For obvious reasons I will not comment on clinical research, but restrict myself to research within the broader framework of health services studies. Most research has been commissioned by the central government (Ministry of Public Health, Ministry of Social Affairs) and by the Catholic Hospital Federation. Research Units, generally, are linked to the Schools of Public Health. Areas of main interest, so far, have been : manpower (especially nurses and doctors), organization and administration, and health economics (especially in recent years). Recent research topics include medical consumption; systems analysis applied to nursing units: medical staff organisation: costs, organisation and personnel of selected hospital departments.

These are only a few examples, but they might give an impression on what is of concern to "health people" in Belgium.

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TABLE 1

Evolution of expenditure for consults and house visits of general practitioners and specialists for insured persons entitled to primary benefits and the members of their household (1965 – 1970) in million Fr ;

	1965	*1966*	*1967*	*1968*	*1969*	*1970*
consult general practitioner	491,6	505,5	550,5	601,3	703,7	843,2
house visit G.P. (a)	507,5	524,7	561,7	648,0	718,7	771,8
consult specialist (a,b)	454,2	488,3	503,3	538,4	609,3	634,6
house visit pediatric (c)	13,0	9,8	9,7	10,3	9,5	11,7

(a) without transport ;
(b) without specialists of internal medicine, neuropsychiatrists and pediatrics ;
(c) house visits of other specialists are not paid for by the insurance.

TABLE 2

Evolution of expenditure per insured person for
· general medicine consult of specialists,
· dental care and nursing care 1956 – 1970.

Year	*expenditure per insured person (in fr.)*	*index (1966 = 100)*
1965	746,7	98,8
1966	755,7	100,0
1967	795,7	105,3
1968	873,4	115,6
1969	980,3	129,7
1970 (a)	1.047,0	138,5

(a) prevision in the budget.

TABLE 3

Evolution of expenditure per insured person for surgery 1956 – 1970 (without social diseases) ;

Year	*expenditure per insured person (in Bfr.)*	*index number (1966 = 100)*
1965	130,3	97,8
1966	133,3	100,0
1967	136,5	102,4
1968	145,4	109,1
1969	162,2	121,7
1970 (a)	176,8	132,6

(a) prevision in the budget.

TABLE 4

Evolution of expenditure for heavy and light surgery for insured persons entitled to primary benefits and members of their households

	1965	*1966*	*1967*	*1968*	*1969*	*1970*
light surgery	199,4	210,6	215,0	229,4	260,6	285,7
heavy surgery (number in nomenclature between 75 and 300)	255,0	263,4	267,8	281,2	305,4	323,4
heavy surgery (number in nomenclature exceding 300)	18,5	28,1	37,2	43,2	56,5	72,9

TABLE 5

Evolution of expenditure per insured person for special care 1965 – 1970 (without social deseases)

Year	*Expenditure per insured person (in Fr.)*	*Index number (1966 = 100)*
1965 (b)	338,0	91,4
1966 (b)	369,8	100,0
1967 (b)	384,5	104,0
1968 (b)	444,6	120,2
1969 (a)	489,1	132,3
1969 (b)	566,54	153,2
1970 (a)	504,1	136,3

(a) prevision in the budget ;
(b) real figures.

TABLE 6

Evolution of the type of special care for the insured persons entitled to primary benefits and members of their household (1965 – 1970) (in millions Fr.)

	1965	*1966*	*1967*	*1968*	*1969*	*1970*	*1971*
special care generally	66,5	70,4	76,5	85,7	96,8	82,9	125,2
stomatology	57,6	64,9	71,6	80,9	96,9	85,0	131,3
radiodiagnosis	707,5	754,0	763,6	855,5	1054,1	901,9	1349,3
radium- and radiotherapy	33,2	39,7	44,1	66,5	64,4	54,5	81,2
internal medecine	202,6	223,8	244,2	268,7	344,9	269,9	467,3
dermatovenereology	2,7	2,4	2,6	2,9	3,2	2,7	4,0
fysiotherapy	168,9	177,1	163,8	161,1	178,9	136,8	184,4
clinical biology	423,7	518,1	554,8	700,2	1007,0	970,5	1637,2
emergency technical acts	13,9	19,2	21,0	23,2	28,7	25,3	39,1
TOTAL	1676,6	1869,6	1942,2	2244,7	2874,9	2555,6	4019,0

TABLE 7

Evolution of expenditure for dental care, including protheses for insured persons entitled to primary benefits and the members of their household 1965 – 1970 in millions Fr.

	1965	*1966*	*1967*	*1968*	*1969*	*1970*
dental care	448,8	514,6	546,6	582,3	654,9	682,9
dental protheses	164,2	144,2	134,1	127,0	131,9	126,6
TOTAL	613,0	658,8	680,7	709,3	786,8	809,5

TABLE 8

Evolution of expenditure per insured person for hospital care in general hospitals, sanatoria and psychiatric institutions 1965 – 1970

Year	*General hospitals expenditure*		*Sanatoria*		*Psychiatric hosp.*	
	Expenditure (in Fr.)	*Index (1965 = 100)*	*Expenditure (in Fr.)*	*Index (1966 = 100)*	*Expenditure (in Fr.)*	*Index (1965 = 100)*
1965	349,9	100,0	29,3	100,0	65,1	100,0
1966	374,5	107,0	29,5	100,7	85,1	130,8
1967	374,7	107,1	27,7	94,4	90,8	139,5
1968	348,5	128,1	27,6	94,3	103,8	159,4

TABLE 9

Evolution of the expenditure per insured person for drugs 1965 – 1970

Year	*Expenditure per insured person in Fr.*	*Index number (1966 = 100)*
1965	717,8	110,3
1966	650,6	100,0
1967	702,3	107,9
1968	798,6	122,7
1969 (a)	722,7	111,1
1970 (a)	927,0	142,5

(a) prevision in the budget.

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King Edward's Hospital Fund for London

King's Fund Centre

NHS AND EEC - FRANCE

Papers given at the seminar held at the King's Fund Centre on Wednesday, 14 November, 1973, by:

Monsieur J-P Dunand
Director
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Monsieur P Aurousseau
Hon Inspector General
L'Assistance Publique a Paris

A) Monsieur J-P Dunand

1 Finance

In health economics, medical consumption means the demand for medical services or goods made by households as the units of consumption; most of consumer decisions being taken at this level.

Medical consumption consists of goods on the one hand and services on the other. Among the former are pharmaceutical medicaments, spectacles and so on, bought by patients outside hospitals. Among the latter are the care given by physicians, dentists and nurses at home or in outpatient departments, and finally the care given to the inpatients of public or private hospitals.

Out of our 532,000 beds, 66% are in general hospitals and 34% in specialized hospitals (ie, those for psychiatry or for the physically handicapped . . .). This means an overall rate of 10.3 beds per 1,000 inhabitants; the rate for general hospitals only being 6 beds per 1,000.

By the standards laid down by the French VIth Plan, such a rate is held to be sufficient. This is the reason why the Government emphasizes the need for bringing beds up to date rather than increasing their number. Stress is being laid more and more on quality rather than quantity.

Out of the 350,000 general hospital beds, one third are private and two thirds public. Most of the private beds are profit making institutions. Voluntary non-profit hospitals amount to 23% only of all private beds, and as they operate on a similar basis to that of the public hospitals, may be assimilated with them.

All health services and goods make up medical consumption which amounts to 6.5% of the French gross national product. But a major point to be emphasized is that medical consumption goes up by more than the overall consumption of households. If both equalled to 100 in 1959, ten years later the index of the former was 368, of the latter 269. The following table gives further details.

Medical and overall consumption of households from 1959 to 1969

	1959	1965	1966	1967	1968	1969
Hospitals	100	228.9	253.5	278.6	312.1	441.4
Other services	100	211.5	240.3	267	294.1	330
Medicaments	100	212.2	241.6	276.5	303.1	333
Medical consumption	100	217.5	245.1	273.9	302.9	368.6
Overall consumption	100	174.5	188.4	202.8	222.2	269.2

These are value indices, but should volume indices be used in order to make up for the difference in relative prices, the trend would be obviously the same. Moreover all studies (1) show that medical consumption rises faster than overall consumption and hospital consumption still faster than the other components of medical consumption. Medical consumption is due to grow by something between 8.3% and 10.5% per annum in future. Hospital consumption now rating 41% of medical consumption will rate 44% in 1975.

Most of medical consumption is financed by social transfers since compulsory insurance means a re-distribution of income operated by law for social ends. Compulsory insurance indeed is very similar to taxes. Nevertheless the two systems work in a basically different way. Though regionally operated, the NHS is fully State controlled whereas our system still leaves some initiative to local boards and people are left free to choose their own family doctors. Yet, except for the family doctor choice, private local enterprise and personal initiative is less than it would seem and declining - as M Aurousseau will bring out when dealing with Government control.

The regular rise of medical consumption is a particular problem for social insurance which covers 75% of all health expenditure. In fact 96% of French people are protected by social insurance, but in a few cases a certain amount is left to be paid by the patient or a private insurance. As a result, the balance of social insurance is jeopardized by the growth of medical consumption. In 1968 the deficit amounted to 24,000,000 FF and in 1971 to 462,000,000 FF. Yet, as has already been said, it is very doubtful whether the growth of medical consumption can be lessened in years to come, since it is consequent upon scientific progress which entails innovations in medical techniques, which in their turn meet potential demands.

The secondary growth of hospital demand is accounted for by the fact that in the health field, as in any other service, consumer and producer should remain in touch. As a result highly technical means have to be geographically widespread - an expensive business.

The following table shows the role of social insurance in hospital running costs. Nearly 80% of all running costs are paid by social insurance either at a rate of 100% (58.2%) or 80% (21.3%).

(1) particularly those made by Doctor ROSCH through the CREDOC

Payment of hospital days in 1970 according to debtors

Social insurance					
100%	With patient or private insurance	With State reliefs	State reliefs 100%	Patients 100%	Others
Percentage					
58.2	14.9	6.4	12	2	6.5

The resources of social insurance come from premiums paid by employers (66%), employees (17%), State (10%) other (7%). In fact only the first and second groups pay premiums, the State's contribution being an aid to cover the deficit and the remnant transfers. Should the State's contribution increase too much, there would be a serious threat to the insurance systems; for should it one day go bankrupt, no bulwark would be left against nationalization. The French would not readily accept such an outcome eventhough their present system practically achieves the same aims as a NHS. Rightly or wrongly our system is thought to bring less pressure on health producers and consumers; but only time will tell whether the social insurance system can survive.

As for capital expenditure, the State helps to build new hospitals with subsidies of up to 40 per cent of the total cost. A further 30 per cent is lent without interest out of a special fund of social insurance, while the remaining 30 per cent is usually borrowed from savings banks, and more recently from the ordinary financial market. The interest is always paid out of running costs. Within two or three years the hospital's running costs amount to the original capital cost, and in the revenue budget staff account for 60 per cent of the total.

The day rate of hospital costs is proposed by the management and assessed by the prefect whose decision puts the rate into force for one year. The annual day rate increase is controlled by the Government. A reform of day rate reckoning is now under way in order to make sharper the cost of illness per patient, and the cost of medical care itself apart from accommodation and food costs. The continuous growth of hospital running costs makes it a necessity to get clear-cut measures of all factors involved and of their combination into healing.

2 Management

When considering management, French hospital classification must be borne in mind. According to the basic hospital law of 1970 and the decrees passed in pursuance, there are in summary three sizes of hospitals.

i) simple medical units called local hospitals

ii) general hospitals providing a wider range of care for a wider area

iii) general hospitals which are called teaching general hospitals because they provide for the training of medical students as well as for a still wider range of care including research.

These are ruled by a board of trustees on the one hand and a manager (or director) on the other hand. Moreover they are liable to State supervision.

a) The board of trustees

The board consist of 9 members in local hospitals, 14 in general hospitals, 22 in teaching general hospitals. Let us look in more detail at the board of a general hospital.

Representatives of the community. The mayor always sits on the board as chairman, as well as two town-councillors. A member of the Department council (the Department is a French territorial division) also sits on the board. The aforesaid four members represent the public interest in the hospital, since all of them have originally been elected by the community.

Representatives of social insurance. They are four members. Social insurance is by far the major debtor to hospitals, as it has already been said. This is the reason why its representatives have increased.

Representatives of medical staff. Three doctors chosen by their fellow doctors are allowed by law to sit on the board.

Representatives of non-professional staff. One employee is proposed as a trustee by the hospital staff unions.

Members appointed by the prefect. Finally two members are appointed by the prefect on account of their interest in hospital matters, one of them being a general practitioner.

Thus, the 1970 law intended to achieve a balance between representatives of the various bodies involved in hospital running. As a decentralized body, the board is entitled to rule over such matters as budget and accounts, day rate proposals, buying and selling of property, loans, planning of building and main repairs, rules and regulations, deciding which kind of care should be developed or reduced, and staff establishments.

b) The director

All other matters lie within the director's competence. He is first entitled to carry out the general policy settled by the board. In addition he has been given particular powers - appointing all staff (physicians excepted) and signing all orders for expenditures. Practically speaking, the director is wholly responsible for general management. For the last ten years, there has been a trend towards increasing the director's powers, as the skill needed to co-ordinate the activities of a large and varied staff, and control a vast budget, has been realised. Hospitals actually come out first among all other employers in two when staff is rated. As to the budget, it amounts to millions of French francs (25,000,000 FF in a 300-bed hospital). Moreover the director is the standing authority whereas the board is summored only six times a year or so.

The question used to be posed - should the director be a physician or a layman? It does not arise any longer. Management is definitely lay. It has been suggested that a medical management would be something like running with the hare and hunting with the hounds. In other words we think that to practice good medicine and good administration at one and the same time is too much for one man. A medical manager would either become less and less of a physician or a poorer and poorer manager. At least this is the French standpoint. Nevertheless the incompatibility is only a gentleman's agreement, for the law does not forbid a physician to become a manager, providing he follows the required training.

Hospital directors are trained in one national health school in Rennes (Brittany). The school belongs to the Health Ministry. Directors to-be are trained in law, finance, industrial psychology, hospital needs assessment, economics and statistics, and organisation and methods. The training course programme bears witness to the change undergone here within a ten years span during which the very word management has been more and more used to define the director's role. The training puts special emphasis on the search for the highest efficiency at the lowest cost in the use of means in order to achieve the goals that have been set. Students entering the school are mostly licentiates holding a master's degree in law, economics or arts. Evenso, their entry depends on their passing an examination. The training involves one year at school and two years on probation in a hospital as assistant to the director.

When the three years are over, the brand-new director is appointed in a 300-bed hospital or in a bigger hospital as deputy-director. Appointments are made by the Health Minister. So far hospital directors have been assimilated with civil servants, which has been a hindrance to recruiting students because of insufficient salaries when compared with the managers of private profitable hospitals. There is therefore still a lack of directors and deputy-directors at the time when their responsibilities and duties are widely acknowledged to be much more businesslike than ever.

Directors' salaries according to the hospital size

Assistant	2,250 FF per month
Director (200 to 500 beds) and deputy-directors	From 2,620 FF to 4,080 FF per month
Director (500 to 1,500 beds)	" 3,250 FF to 4,700 FF " "
Director (over 1,500 beds)	" 4,290 FF to 5,300 FF " "

c) The advisory committees

The medical advisory committee whose advice is taken on all medical matters consists of the whole medical staff. Though it is given details of the costs of medical care, unfortunately it does not act as a medical audit committee. There is hope that it will do so in future as younger physicians are being trained to understand the economic consequences of hospital care. The hospital joint committee, on which representatives of staff and board sit, is consulted about labour relations and organisation.

d) State supervision

The board's resolutions are liable to State approbation and control which is wielded by the prefect.

3 Staffing

Under this heading comes the most critical problem of hospital management - the shortage of skilled staff and particularly of nurses.

a) Nursing staff

By the end of 1971, 11,000 nursing licences had been issued. At the same time there were 250 nursing schools and the training duration was two years, now extended to two years and four months. The student nurse enters the school at the bachelor's degree level (baccalauréat), either holding it or passing an equivalent examination. Figures show that more degree holders enter schools than formerly.

In 1971, 94,000 registered nurses were in office, that is nearly 200 nurses per 100,000 inhabitants. The number of male nurses is about 5 per cent of the whole figure. In spite of an increase of nurses between 1965 and 1971, the shortage is still crucial. It may be ascribed first to the regular progress in care techniques which entails more skilled and more numerous nursing staff (intensive care units, resuscitation units for instance) for the patient's safeguard. At the same time nurses are less and less inclined to put up with labour conditions (being on duty overnight or on Sundays) incompatible with home life, and as a result tend to choose other occupations.

The vicious circle must be broken by drastic action. The Government and particularly the Health Ministry is definitely determined to tackle the problem and has already taken preliminary action to this end -

- a rise of salaries (or at least of starting salaries) will be granted. A nurse now earns from 1,500 to 2,230 FF per month, a sister from 1,900 to 2,460 FF, a head nurse from 2,100 to 2,700FF.
- a part-time work will be allowed to nurses in hospitals where surprising though it may appear, there was none.
- payment of a pre-salary to students in nursing schools providing they pledge themselves to work a number of years in hospitals.
- auxiliary nursing staff to be helped to advance.
- progress in hospital nursing organisation is helped when a matron is in charge of all nursing staff. Posts of matrons must be created in future.

Undoubtedly the main challenge for health authorities in the next few years comes from the need to train sufficient nursing staff of the high quality required in modern hospitals.

b) Medical staff

Doctors in public hospitals in 1971

Total	Full-time	Part-time	Consultants	Substitutes
23,380	5,102	8,864	8,217	1,197
1965/71(%)	+178	-3	+150	+31

The table shows a regular shift from part-time to full-time doctors. The trend is certainly steady, though 80% of full-time doctors work in teaching general hospitals. Nevertheless in general hospitals doctors work more and more on a full-time basis. A great change has occurred in attitudes, chiefly among younger doctors, who no longer shrink from full-time hospital jobs but think it better to work in a team inside a newly equipped hospital. This trend is fully backed by health authorities because full-time doctors are thought to increase care productivity, while part-time doctors bring about a waste of highly technical means.

Number of doctors in France from 1960 to 1972

	1960	1965	1970	1972
Population (millions)	45.5	48.5	50.5	51.5
Doctors	44,954	54,764	64,873	71,039
per 1,000	0.98	1.12	1,28	1.38

Full-time doctors working in hospitals are paid as follows:

- Teaching general hospitals	Professor head of ward	170,000 FF per year
	Professor	99,000 FF to 140,000 FF
	Assistant	50,000 FF to 56,000 FF
- General hospitals	Head of ward	78,000 FF to 130,000 FF
	Assistant	39,000 FF to 96,000 FF

In addition, full-time doctors may be granted private beds (up to 5 percent of the ward beds) and private surgery hours (twice a week). In either case they receive fees directly from the patient. These additional fees have been allowed to encourage doctors to accept full-time posts.

The accounting process is a bit more intricate. For each medical act given in hospital fees are paid by social insurance, in addition to the day rate. The doctor's salary is always paid even if the fees obtained from social insurance are lower. In this case the difference is provided by day rate. As it is not necessary for the fees yielded by medical acts to make up for the salary paid, there could be the risk of the full-time doctor being slack. As a matter of fact only a few drawbacks of the kind have happened, most doctors being both aware of their duties and industrious.

In order to favour full-time activity, the fees of part-time doctors have been limited to 80 per cent of the lowest salary of a full-time head of ward doctor, even if higher fees are obtained according to the aforesaid process. Therefore in a general hospital, a part-time physician working six half-days may earn up to 62,000 FF per year as a maximum. In addition the part-time doctor receives fees from his outside hospital practice. The practice can yield 80,000 FF a year on an average for a general practitioner and more for a specialist. Nevertheless, some part-time doctors should be kept in hospitals (chiefly small local hospitals) subject to a clear delineation of their duties and responsibilities.

B) Monsieur P Aurousseau

I. Government Control

The President of the French Republic concentrates in his hands all executive powers. That is the characteristic of the fifth Republic, under the principles initiated by General de Gaulle.

The Ministry of Health and Social Security is one of our ministries. Its attributions and title vary from time to time according to the politics of the day. Some years ago, it was the Ministry of Social Affairs and before that the Ministry of Labour and Health.

What is the Government's control of new constructions? It must be to distinguish between institutions with and without beds.

i) If the institutions contain beds, be they public or private, they must be authorised by the Government, i.e. the Minister of Health, and this authorisation is given or refused in conformity with the "carte hospitalière", an hospital map, which we will explain later. When a hospital is to be built, the cost of the construction is divided between the State 40%, the " Sécurité Sociale" (Social Insurance) 30%, and the town and hospital which provide the remaining 30%; (although the question is now being considered as to whether the state's contribution should be reduced to 30%). The financial contribution on the State implies a certain measure of control, especially in regard to the planning stage.

The structure of our Ministry is as follows:

a) The Minister is assisted by les Directions (Regional & Departmental Offices), Santé Publique (Public Health), Hôpitaux (Hospitals), Sécurité Social (Social Insurances)

b) The territory of France has been divided, since the French Revolution, into "départements", of which there are currently 94. For the last 10 years we have also had a division into regions, each of them grouping a certain number of departments.

c) At the head of each region, the representative of the Government is the "Préfet régional". At the head of each department, the representative of the Government is the "Préfet" (a kind of Governor).

d) In each region, for health affairs, the Préfet regional is assisted by a "Directeur régional de la Santé" and a "Médecin Inspecteur régional" - MIR (i.e. medical officer for the region).

e) In each department, we find the same organisation; the Préfet is assisted by a "Directeur départemental de la Santé" (DAS) and a "Médecin Inspecteur départemental".

f) So the channel by which demands have to travel is from Direction departementale de la Santé, (with the advice of his medical officer) to the Direction régionale de la Santé, (with the advice of his medical officer), to the Ministry. This is still true for teaching hospitals. For the others, it is suggested, since the new Law on Regions was introduced, to give power of decision to the Préfet but within financial limits fixed by the Government.

ii) If the institutions contain no beds, the private hospitals are free to do what they like (for example, polyclinics or sheltered workshops), of course as long as they abide by the usual laws of architecture and construction. Private hospitals, by the way, divide into profit making institutions and non-profit making institutions - the latter being charitable organisations, the majority of which belong to Catholic communities, Trade Unions, or corporative societies ("les Mutuelles"). The public hospitals are subject to the same constraints as we have already mentioned.

2. Quality Control

As to the control of quality of service, this is the same for public and private hospitals.

At the Government's level, it does not operate regularly, only when there is a serious incident of some kind, brought to light by the Press. In this case, the Regional officers intervene and also the Inspectorate of the Ministry (Inspection Générale du Ministère de la Santé). The only exception was that of l"Assistance Publique à Paris. The hospitals of the city and of its surroundings were regularly visited by Inspectors.

But of course, near the end of the year, when the hospital asks for the authorisation of its daily rate (le prix de journée) for the coming year, the regional health officer controls its accounts. But the control relates more to the figures than to the quality of treatment or services.

On the other hand, as far as salaries and fees are concerned, Government control is very strict. In public hospitals, like all branches of public administration in France, there is, for the employees, a very rigid salary scale that it is impossible to avoid. All this is regulated by the Government, especially by our Ministry of Finance. There is, in each hospital, a civil servant (le Receveur, "the Bursar") who is an employee neither of the hospital nor of the Ministry of Health, but of the Ministry of Finance, and he pays and controls the salaries of the staff.

At a higher level, there is another control and indeed a very efficient one. In each Ministry, in each great Administration (for example it is the case for the Assistance Publique de Paris), there is a civil servant of high grade, belonging to the Ministry of Finance, and called "contrôleur financiez". He examines, checks and controls all the expenses of Ministries and administrations; he controls before expenditure is made, not afterwards.

3. Organisation

Public health sectors coincide with the administrative divisions.

As for hospitals, since last year we have had a new definition of public hospitals, with only three categories of institutions:

i) Les centre hospitaliers régionaux (regional hospital centres), i.e. general hospitals which are also our teaching hospitals (centres hospitaliers universitaires) abbreviated to CHU. Each region has at least one CHU, but some have two, three or more. Paris for example has eight teaching hospitals, each of them consisting of a certain number of institutions, generally one great hospital and two or three smaller ones.

ii) Les centres hospitaliers (hospital centres) which are general or specialised hospitals, large or small, from 200 to 1,000 beds, the largest being sometimes ambitious to become a teaching institution, especially in areas with growing populations.

iii) Les unités hospitalieres (hospital units) which are little units, medical centres with or without beds, the maximum of beds being 40 in the rural institutions (les hôpitaux ruraux) - cottage hospitals sometimes with a little maternity, but without any surgical facilities.

We also have another category, the psychiatric hospitals. But French psychiatry is now undergoing a kind of revolution. Since our law of 1832 (and it was the first time a nation tried to be more humane with mentally ill people), we have built large and often very large mental hospitals in rural areas, far from towns. Now we have instituted psychiatric sectors (70,000 to 100,000 inhabitants) and we try to cure the maximum number of patients in day centres or home. So the need for psychiatric beds is diminishing. On the other hand, we are trying to integrate psychiatric units into general hospitals, and undoubtedly in due course the psychiatric hospitals will come in this category.

With our spirit of free enterprise (what we call l'esprit libéral, le liberalisme) - we have no family doctor service. In France, general practitioners and specialists are free to open and run a surgery (un cabinet) either alone or in what we call "cabinet de groupe" (group practice). Almost a third of French doctors have chosen the second system.

The social services are not grouped in one organisation. Each of our hospital or social institution has its own social workers which are independent of one another. For example, we have social workers belonging to hospitals, to municipalities, to schools, to factories, and so on. That is to say, social services are not unified in sectors (but, of course, the social service of each institution is unified).

As for geographical regions, there is now a trend in France towards a better geographical organisation with public health sectors. We are just at the beginning and la carte hospitalière (literally, "hospital map") will be the framework of the new organisation. This map indicates what institutions we have to suppress, to keep or to create according to the needs of the present and the near future (i.e. up to the year 1985). The map indicates private as well as public institutions.

Is there any degree of coordination of services? At this moment the characteristic of our hospital system is rather one of total independence. But the recent law on hospitals has created "les syndicats inter hospitaliers" grouping several hospitals together in order to optimise the use of facilities such as laundries, catering services, computers and so on, and to encourage cooperation between public and private hospitals.

We must also add that many institutions are independent of the hospital system. For

example, the cancer centres (CAC - centres anti-cancéreux) have their own budget and separate administration, even when they are located near a hospital. The same applies to the blood banks, even where they are within the precincts of hospitals.

As for coordination between general practitioners and hospitals, this again is greatly encouraged by the Government. Our last Minister said for example that he hoped that every GP would have his own gown in the hospital, and post-graduate teaching now being organised is creating new links between hospitals and doctors.

Is there a recognised channel through which the French patients travel to get health care? In France we have no such organised channel. A patient or would-be patient may go:

- to his family doctor or to any other private surgery;
- directly to a private specialist;
- to the specialised out-patient department of a public or private hospital.

4. Planning

Let us first give you some figures:

- in 1975, our population will be 52 million inhabitants, 13.5% of them over 65
- in 1980, 7.5 million will be over 65 and the working population will be 40% of of the total
- life expectation is 68 for men and 75 for women (many explanations have been given for this difference, too many to find the truth)
- infant mortality (by which we mean death under one year old) is 19.7 for 1,000 children
- in hospitals, the average length of stay is diminishing; 15 days for France but 10 days or 11 days for large towns and teaching hospitals
- number of doctors: 124 for 100,000 inhabitants
  number of nurses: 200 for 100,000 "
  (that is to say: 2 nurses for 1,000 inhabitants). We think like WHO that we need 3 nurses for 1,000.
- increasing rate of activity:
  labs 20% every year
  X ray 15% every year
- and of course the total cost of health increases every year, by 12% to 14% (or 9 to 10%, taking into account the decreasing value of money).

What is the structure of planning for health services in general and of hospitals in particular?

We have almost no health centres and no general organisation of preventive medicine at the national level (with some exceptions of course, such as vaccinations, médecine scolaire - school medicine - and so on). Until recently, we had no planning, no "numerus clausus" for our students. But facing an unexpected rush towards medical careers, we are obliged to fix for each Faculty of Medicine a determinate number of students.

But we have had for many years, planning arrangements for hospitals. We plan for five years at a time and the work is done at the local, regional and national level. Needs are known at the local level. The demand is made by the "Conseil d' Administration", is examined by the Préfet at the regional level, and is compared with other needs and other demands coming from the region (until last year the demands went directly to the Ministry). Assuming that all is in conformity with the "carte hospitalière", the Préfet agrees, and the demand goes to the Ministry of Health where it undergoes a final examination. Assuming once more that the Minister agrees, the demand (together with an estimate of cost) joins the great bulk of other demands coming from all regions of France.

For the former Plan, the sixth Plan, the amount of all demands authorised by the Ministry was 30 milliards of francs. The plan of the Ministry of Health is referred, as are the plans of other Ministries for consideration by the general committee for National Plan (le Commissariat general au Plan). It is a kind of arbitration tribunal, and of course, the Government plays a very important role in the final judgment of the Committee.

To give you an example, the Ministry of Health asked 30 milliards of francs for the sixth Plan and finally obtained 12.6

At the end of the present year (next year being the last of the sixth Plan) we have completed 77% of the Plan for the teaching hospitals, 73% for the other hospitals, 56% for the psychiatric hospitals.

Have we a final goal which should have determined an optimum bed-population ratio? Our average figures are now 2.7 for medicine (2.38 in public hospitals; 0.32 in private institutions); 2.07 for surgery (1.05 in public hospitals, 1.02 in private institutions); 0.68 for obstetrics (0.35 in public hospitals, 0.33 in private institutions). The burden of medicine (less profitable than surgery) is carried by the public hospitals. In psychiatry, our average number is 2.3 - mainly in public hospitals.

Generally speaking, we think that we have enough beds for our needs. But we still have old wards to be rebuilt. The rule in France is to have no more than 4 patients in a room and we have still (though less and less) large wards with 15 to 20 patients together. On the other hand, we have too many little institutions. For example, almost 50% of public hospitals have less than 100 beds and 60% of the private profit-making institutions (cliniques) have less than 40 beds. Indeed 5% of public hospitals contain almost 50% of the total public beds.

For mental diseases, we are experimenting with a new system. Instead of assessing our bed numbers according to the old general ratio of 3 beds per 1,000 inhabitants (which is the WHO ratio) we are organising our country into sectors of 67,000 inhabitants, each sector

with 150 psychiatric beds and 50 places (i.e. in day and night hospitals, sheltered workshops and so on). These are for adults (i.e. over 20), while for children, there is one sector for 190,000 inhabitants, with the same number of beds and places as before.

We have also another reason to be careful about the number of beds to be built: the development of the home care programme. In the city of Paris, the home care system takes the place of one hospital with 700 beds, and we still have far to go in this direction.

5. Research

A few words now about research, that is not purely medical. Medical research in France is performed essentially by the INSERM (Institut national de la recherche médicale), by the CNRS (Centre national de la recherche scientifique) and by the universities. The other kind of research may be called "recherche hospitalière"(research about health and hospital matters).

One important institution is the CREDOC "Centre de recherches et de documentation sur la consommation". It undertakes very accurate research of all kinds of health expenditure always comparing it with French expenditure in other sectors. It has noted a very rapid growth in the health sector in comparison with the whole of the French economy. The growth of expenditure is 10% each year, twice as rapid as the national growth rate .

Another important and specialised research centre is the medical demographic society. Its role is to enquire about doctors (their number, their regional and local disposition, the number of GPs and specialists, their sex (very important, for many female doctors don't practise any more), the number of students, the common market problems and so on). We have also, for general demographic problems, so important for a good health organisation, the INED "Institut national d'études démographiques" which depends on the Ministry of Health.

L'Association des Hautes Etudes hospitalieres has undertaken interesting research on hospital architectural and technical details, such as windows, floors, walls, fire security, lifts, noise disturbance, laboratories, operating rooms, etc.

Our universities, especially our Medical, Law and Medicine Faculties, are also beginning to participate in health research. We may quote for example the Law Faculties of Paris (Pr. Guitton), of Aix-en-Provence and of Bordeaux. Here however, according to their vocation, research workers are mainly interested in management problems, economy and administration of hospitals.

6. Problems

And now, what are for us the main problems at present? In discussing this topic, I am somewhat apprehensive, for I may be obliged to be somewhat critical about present systems in France. But it is only in Utopia, a country not represented in the Common Market, that there is no problem.

First of all, we have to put into use in fact rather than just in words, our new law giving new facilities and new powers to the regional boards and authorities. There is always a tendency for Ministries (at least for French Ministries) to stick to their prerogatives and their habits of centralisation.

Then we think that in a hospital just as in the State itself, there must be (because that is the law in democratic countries) a legislative power and an executive power. The first is and must remain in the hands of the "Conseil d'Administration". But the executive power is not so firmly established in the hands of the Director. This power ought to be greater than now.

We have too to realise one of the goals of the Law on hospitals is to group them in syndicates and regional unions, without destroying their individuality in the process. In the text of the law there is only one representative of these new bodies, a general secretary. There are, of course, general assemblies, once or twice a year, but there is no committee working between the sessions; which is why these new arrangements are so slow in their implementation.

Another of our main problems is the existence of what we name "le secteur privé" that is to say the private profit-making institutions grouped as are the public hospitals in one Federation. As I have mentioned, they manage half of all surgical beds in France, and up to now, have tried to escape the two heavy additional loads which public hospitals carry - emergency work and teaching. The cost of a good emergency unit(where so many residents, surgeons, doctors, specialists and nurses are on duty) is very high. This unit is not, as we say, "rentable" or profit earning. It does not pay; and you cannot teach medicine without causing some problems for your patients. Our problem is to integrate private institutions in our planning arrangements for emergency work and teaching.

But I think that the Main Problem, with M and P in capital letters is that of our ever growing health costs. And I do believe that it is the main problem for all the developed countries, even the richest, if I am to believe what I read in the American and Swedish newspapers. Up to now we have accepted that health, that a man's life, is invaluable. Doctors feel quite free to make prescriptions according only to their patiets' interests. In France we make a distinction between the "ordonnateur" i.e. the person entitled to pass accounts, and the "comptable" the accountant who keeps the books. In the health field, the real "ordonnateur" are the doctors. For example, in an hospital, who defines the needs, who asks for a new X-ray apparatus, for an additional technician or nurse? The doctors. The great problem is how to build a dyke to stem the overflowing health costs.

7. Future Trends

And now let us examine what are, for our country, the main future trends. The future? I don't know how to read tea leaves, what we call "lire dans le marc de café" - or as you say: I am not an expert in crystal-gazing. Together then, let us try.

Mr. Dunand has explained the leading part taken by social insurance in the financing of our health system. Social insurance is a very important organisation, almost a state within the state. Trade Unions easily put pressure upon it.

For some weeks now it has been rumoured that health expenditure may be supported directly by taxes. Taxes, in our country as in yours, are gathered by the Ministry of Finance. Well there is a universal rule "celui qui paie, commande", which translates something like "he who pays, orders". I would not pledge my word that this is the beginning of nationalisation, but it may be. The expenses being so important, I should not be surprised that the Government, one day or another, tries to get a hold on the whole business.

As I told you, when we have to build a public hospital, the state gives 40%. But I think (as I have already mentioned) that in the future this will be only 30%. Social insurance will continue to give 30%, which means the quota for the town and hospital concerned will be 40% in place of the current 30%. Many hospitals and towns however find it difficult (if not impossible) to collect the necessary sum of money. We think that they will be very soon authorised to borrow from private banks, just like manufacturers and tradesmen. Of course, the interest payable will then have to be included in the price per day ...

And what about the future trends for manpower? As I told you, we have enough doctors; this is not a problem for us. We have indeed a lack of doctors in certain specialities, such as anaesthetics and psychiatry, but this difficulty will soon be over.

But we have not enough trained hospital administrative directors. We have a good Health Public School in Rennes (Brittany), some of you know it. But more than 300 hospitals (most of them small) have no manager. It is a question whether one school is enough. In my own opinion, it would be better to have another Health school, but not so far from Paris or Lyon.

As for our everlasting shortage of nurses, I think you know the story of the Danaides, those girls of Greek mythology trying for centuries to fill a bottomless barrel. Year after year, we are building new nursing schools for more and more students; and after two and now three years of school, more and more are graduating. But on average four to five years later they give up, they leave the hospitals.

What are the remedies? Are there remedies? We have increased nurses' salaries, given them many social advantages. But I think, f rom my own experience, that is the same problem all around the world. I have found it in developed and in undeveloped countries, in socialist and capitalist countries, under dictatorial and liberal forms of government. Even in young nations, with a brand new spirit, even in nations where it is easy to recruit young enthusiastic soldiers, I have found the same shortage of nurses. I found it in Cuba, in spite of Castro's eloquence, and as I wondered above the cause, they answered "our girls prefer to be typists".

I think that it is a problem of civilisation, a world wide problem. And perhaps the final solution may be an obligation for young girls to serve the hospitals for several years, as it is an obligation in many nations, for a young man to do his military service. It is, I know, quite a romantic idea and you may smile. But, welfare being more and more common, and good citizenship less and less common, I think that nations cannot during the years to come avoid the horns of the dilemma. They must either do this or leave their patients without the aid of nurses.

I have given you my personal view of what is right and what is wrong. Very often that view also represents the opinion of our Federation of Public Hospitals. But I remain, we remain, optimistic. Between 1960 and 1970, 100,000 beds were built or rebuilt, a third of our total number of beds in France. By the end of 1980, 80% of that total number will be built or rebuilt. So we are confident in the future.

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NHS AND EEC - FEDERAL REPUBLIC OF GERMANY

Joint paper prepared for the seminar held at the King's Fund Centre on Tuesday, 8 January, 1974, by :

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1 Facts about health and hospital services in the Federal Republic of Germany (F R G)

1.1 Demographical statement

The area of the Federal Republic of Germany - including West Berlin - was inhabited in 1971 by about 61.5 million people. The ratio of males to females was 100 : 109. In an area of about 248,000 kilometres 2 the population amounted to 246 inhabitants per kilometres 2.

In 1971 there were 7.3 marriages, 14.8 births and 12.2 deaths for every 1,000 inhabitants. The infant mortality per 1,000 inhabitants amounted to 23.2 (i.e., died during the first year of life). Taking into account the births and deaths there is a total increase in births of 2.6 per 1,000 inhabitants. 9.7% of the population are children below the age of six, 13.5% are children from six to 15 years, 63.8% are persons of employable age from 15 to 65 years, and 13.0% of the population are persons of 65 years and above.

1.2 National Income and Expenses for Health Services

The health services as part of the social services are sub-divided into the areas prevention, disease, occupational accidents - occupational diseases, as well as invalidity.

The total costs for health services amounted to 61,267 million DM in 1971, this is 32% of the total social budget (191,277 million DM).

Information on the trend in health expenditure may be gained from table 1. According to this health's share in the gross national product has increased steadily as well as the amount of expenditure per head of the population. The social benefit quota (percentage of the social budget of the gross national product) has increased from 24% in 1965 to 25.3% in 1971 ; a social benefit quota of 26.4% is forecast for 1976. A survey of the costs of health is given in the tables 2 to 5. According to these about 70% of the total expenditure falls to the area of diseases. Of the different types of benefit available, material benefits (re: repayment in cash, goods and services supplied) amount to about 50%, and income benefits (re: continuation of salary/wage payments, sickness benefits) to about 42%.

If grouped according to financing institutions, about 47% of the expenditure fall to social health insurance, about 22% to other institutions of social insurance (annuity insurance, accident insurance, civil servants' insurance), about 23% to continuation of salary/wage payments by public and private employers in case of disablement, and the remaining 8% to other financing institutions of health services (above all social assistance and social services).

As far as the costs of material services of particular importance to health are concerned, the cost of medical care outside hospitals dominates (general practitioners, specialists and dentists) which in total accounts for about 37%. Then comes the cost of hospital care at about 31%, and cost of medicaments at about 24%. The rates of increase of these material services have been much in excess of the average in the recent past,due to a heavy increase in the doctors' fees and in the prices of other services and goods which are used in the health service. However, it is expected that costs in the area of material services will become normal again in the future.

1.3 Type and Number of Health Personnel

On 31st December, 1970, 99,654 physicians and 6,322 medical assistants, so-called "Medizinalassistenten" were working in the Federal Republic of Germany (see table 9). While the average numbers of inhabitants looked after by one physician was 675 in 1960, by 1970, this figure had dropped to 622. The physician density in the large towns is relatively favourable, but in the country and on the outskirts of larger communities increasing difficulties are expected in replacing general practitioners.

By the end of 1970 free practising physicians had to look after 1,222 inhabitants on the average, 11% more than in 1960. The number of physicians working full-time in hospitals on the other hand, increased by about 58% in the same period. A heavy increase in the number of specialists was also noted.

A recent investigation of the age range of doctors showed that 74.2% of practising physicians, and 53.4% of specialists are 50 years of age and above.

Personnel employed by the 493 public health departments on 31st December, 1970, can be seen in table 7. The number of physicians working there, inadequate for a long time, has even so decreased slightly since 1967 - the calculated shortage ranging from 22% to 63%.

Because of the unfavourable age range an enormous decrease in the number of working dentists has to be faced in the near future.

20,866 pharmacists were working in 11,526 public pharmacies and 308 hospital pharmacies in 1970. The number and the staff of these as well as the permanent non-pharmaceutical assistants can be seen in table 8.

The total of health service staff is listed in table 9 according to their professions as at 31st December, 1970. From this it can be seen that the number of nursing staff amounted to 199,457 in 1970; in comparison with 1960 it shows an increase of about 57,600 (i.e. 31%).

The number of fully trained hospital male and female nurses, and nurses for infants increased during the same period from about 117,100 to 140,000 (i.e. by 19.5%) ; the hospital male and female student nurses (including student nurses for infants) increased from 25,000 to 52,047 (i.e. by 108%).

1.4 Hospitals, hospital beds and hospital performances

The number of hospitals in Western Germany including West-Berlin amounts to 3,601 with a total of 677,695 hospital beds. Thus the rate of hospital beds per 1,000 inhabitants is 11.1.

54.6% of all hospital beds are in public hospitals, 36.7% in non-profit private, so-called voluntary hospitals and 8.7% in profit making private hospitals. The number of hospital beds in public hospitals has reduced somewhat during the past few years, whereas the number of hospital beds in voluntary hospitals and in private hospitals has increased.

Looking at the classification of hospitals by bed capacity the point of main emphasis is on hospitals of 100 to 200 beds (17.3%). They are followed by hospitals of 200 to 300 beds (15.6%) and by hospitals with 300 to 400 beds (12.6%). 18.5% of all beds are in hospitals with more than 1,000 beds (university hospitals, larger municipal hospitals, tuberculosis sanatoria, mental hospitals and homes, etc.,). As regards public hospitals 49.5% of all hospital beds are in hospitals with 500 and more beds. With voluntary hospitals the concentration is in hospitals with between 150 and 600 beds (61.6% of hospitals beds). 55.3% of all private beds are in hospitals with 100 beds or less.

The interesting point is that compared with previous years the number of beds in smaller hospitals decreased and in larger ones increased. The most outstanding thing of all is in the increase in the number of beds in hospitals of 200 to 500 beds. The average bed capacity is one of the hospital problems in the Federal Republic of Germany. Bearing in mind that there are 3,600 hospitals with a total of 677,000 hospital beds, the average bed capacity amounts to 188 beds. The optimal average bed capacity should be 450 to 500 beds, which means that initially we only need 1,450 hospitals instead of 3,600.

68.5% of all hospitals in the Federal Republic of Germany are general hospitals. They include in each case several special departments (surgery, internal medicine, gynaecology/maternity, and departments for throat, nose,ear and eye diseases, etc.,). The special hospitals account for 31.5%. They are either specialised in the treatment of certain kinds of diseases, or groups of kinds of diseases (surgical hospital, lying-in hospital, orthopaedic hospital) or in special methods of treatment (observation hospitals, sanatoria). In terms of beds the proportion is as follows : general hospitals 67.0%, special hospitals 33.0%. (Table 2 shows the breakdown of hospitals according to their functional classification)

Approximately 9.3 million in-patients were given treatment in 1970 and the number of hospital days amounted to about 200 million. For each 1,000 inhabitants there are some 149 hospital admissions and some 3,600 hospital days. Every hospital bed on average was occupied for 325 days, the average occupancy thus being approximately 88.9% and the average length of stay 25.3 days. The high average length of stay is due to the very long admission period in some special departments (particularly tuberculosis, psychiatry and orthopaedics). The general hospital service shows an average length of stay of about 18.6 days.

1.5 Hospital staff

The hospitals in the Federal Republic of Germany employ about 45,500 doctors, 38,600 full-time physicians and about 6,900 part-time physicians so-called "Belegärzte". They work both in hospitals and in their own surgeries. Furthermore there are 2,200 dentists and other doctors as well as about 5,750 medical assistants, so-called "Medizinalassistenten". The number of nursing employees totals 175,800 plus 52,000 nurses under training.

Keeping in mind the average rebuilding costs of our hospital 47,000 people are working in the diagnostic and therapeutic departments, 178,000 in supply-services, and 41,000 persons in administration. The total number of personnel engaged on our hospitals amounts to 547,300.

1.6 Economic importance of hospital services

The description of the hospital system of Germany must include a short survey of its costs. Exact statements as to the financial and economic importance of hospitals in Western Germany are not available - neither the total expenditure, the turnover, nor the fixed assets. 75% of our hospital beds are over 20 years old, which means that they were built before 1950 - usually before the second world war. Only 25% have been built since 1950, most of them since 1960. Taking the average rebuilding costs of our hospitals we can estimate the value of the capital invested in the hospital system at 50,000 million DM.

The annual turnover exceeds 17,000 million DM, which means - the economic position of hospital services is similar to that of the Federal Post-Office, the Federal Railway and of heavy industry.

Investment costs per bed vary between 100,000 and 150,000 DM, and for hospitals now being planned about 150,000 - 170,000 DM (1950 : 15,000 - 20,000 DM; i.e. an increase of about 800%). This increase is partly due to rising costs but mainly, however, to the increase in the building-volume (1950 - 150 - 200 million3 per bed; 1971 - 200 - 350 million3 per bed).

About 55 to 60% of the operating costs are accounted for by staff. The cost of material goods (medical requirements, food, water, power, laundry requirements, other requirements and administrative requirements) amount to about 23 to 30% of operating costs. Of these, the costs of food and of medical requirements, each of about 10 to 15%, are of greatest importance. About 15% of the total costs involve investment costs (depreciation and maintenance). The costs of financing amount to 1 to 2%. Since 1950 the hospital costs have increased considerably, by about 500% and more. Particularly striking is the large increase in salaries and wages and the increase in costs for medical requirements (intensification of treatment and nursing - shortening of the period of stay).

1.7 Panorama of Diseases

The panorama of diseases has changed immensely during the last 100 years. The end of the previous century was marked by severe epidemics of cholera, typhus, and smallpox. In addition other not quite so dramatic infectious diseases played a decisive role in neonatal and childhood morbidity - e.g. diphtheria, meningitis, tuberculosis, and the large group of intestinal diseases.

Due to the work of hygienists and bacteriologists the dangerous infectious diseases were conquered, and the decrease of infectious diseases had its effect mostly in a decrease of the death rate particularly in baby and infantile mortality. In consequence decade by decade more and more people now reach an age where quite different diseases are in the foreground. Furthermore, increasing industrialisation, mechanisation and urbanisation have posed new threats to human health which may collectively be called 'illnesses caused by modern life'. Hereby circulatory diseases and cancer now head the list of causes of death these illnesses caused by modern life threaten to outweigh the benefits of a prolonged life-span by premature invalidity and early invalidism.

Comprehensive surveys of the state of health of the entire population in the Federal Republic of Germany have not yet been carried out. The only data available is that concerned with notifiable diseases and with the state of health of certain groups of the population.

2 Present structure, organisation and financing of medical services in the Federal Republic of Germany

The whole system of medical and nursing care can be divided into the following stages from the organisational aspect : health education; out-patient, semi-hospitalised and in-patient preventive medicine; general practitioner care (also known as community medicine); out-patient, semi-hospitalised and in-patient rehabilitation; in-patient care of the aged and needy; home care of the aged and needy; and other medical welfare measures (e.g. general public health inspection).

In principle medical efficiency and the effectiveness of the whole range of medical and nursing care for the people depends to a critical extent on whether and how far all these individual areas are integrated into a complete system or remain independently of each other.

Typical of the present form of medical organisation in the Federal Republic of Germany is the separation, as regards organisation, personnel and finances, of the various stages of care, above all the division between in-patient treatment and the treatment of non-hospitalised patients. One striking feature is the way hospital facilities are limited to the treatment of in-patients; with hospital activities in the out-patient and semi-hospitalisation fields being of very little significance at the present time. The following facts throw light on the present situation

2.1 Administration of health and hospital services

The Federal Republic of Germany is a federative government. In the field of the health service including hospital service all executive power is assigned to the "Länder"ie Lands or Provinces. The Federal Republic is only in charge of legislation as far as the following tasks are concerned: measures against diseases of human beings and animals either infectious or dangerous to the public; permission for medical or associated professions; control of medicines, drugs, anaesthetics and poisons; protection in handling food; public welfare, including the public health service, and since 1969, measures safeguarding the financial position of the hospitals.

The Federal Ministry of Youth, Family and Health is responsible for the health service of the Federal Government.

In the "Lands" the interests of the health service are in each case taken care of by the Ministry of Work and Social Welfare. The health departments of the "Lands" are supervised by a Chief Medical Health Officer and the hospital departments by a departmental chief. Both are directly subordinated to the responsible Minister. Both departments prepare the Land Acts concerning health and hospital affairs, give instructions as to their execution and ensure that they are carried out in accordance with the law.

The local boards of health are affiliated to the city and rural districts, and are the lowest administrative health authorities. The boards of health are supervised by a medical health officer. He is in charge of the following medical offices : sanitary inspectors; public health instruction; school health service; child-welfare centre, and the care of those suffering from tuberculosis, venereal disease, physical handicap, chronic illness and addiction. To these duties may be added further voluntary tasks in the field of the public health service. As part of their compulsory duties, the boards of health also supervise all hospitals.

2.2 Health Insurance - Social Insurance

The character, organisation and structure of the medical services outside hospital and the hospital services themselves are determined by the so-called "social insurance". Social insurance is a special form of social security - in which insurance principles and the needs for social adjustments are brought together. A further distinguishing mark of social insurance is its compulsory character. It arises from the social insurance acts of 1881 and includes social health insurance, accident insurance, pension insurance, unemployment insurance and unemployment relief, children's allowance and pension insurance for farmers.

The bodies responsible for social health insurance - which is our prime concern here - are the public health insurance and also the insurance institutions of the "Lands" in respect of those tasks which are executed jointly for the district of a "Land" e.g. psychiatry, tuberculosis.

German social health insurance is based upon a compulsory insurance scheme. According to the present law all who are actually employed, previously employed (pensioners), being trained for employment, (apprentices, etc.,), or are temporarily unemployed, are compulsorily and automatically insured. Manual workers are insured irrespective of the size of the wage packet, but staff employees only if their salary is below a maximum, which has now been made "dynamic". In 1972, it was raised from 1.400 DM to 1.575 DM per month. Employees whose salary exceed these limits are however entitled to continue their insurance voluntarily, and the same choice is available to employees who were not previously eligible for public insurance.

The administration of the scheme is extremely decentralised and is in the hands of 1,800 separate and highly autonomous insurance funds for different categories of employees, localities, etc., thus providing a fair amount of choice for the insured. In Particular, the individual funds are free to determine - within regulated limits - the contributions which they levy. It has been estimated that at present these compulsory contributions average about 8.6% of earnings up to the prevailing dynamic maximum. Half of this amount is paid by the employer, who under recent change of the law has to make similar contributions to the voluntary insurance of the more highly paid employees. For the unemployed and retired, contributions are made by the respective public insurance funds. There is no subsidy given by either Federal Government or regional authorities to the health insurance scheme. In total, health insurance expenditure amounted to 25.050 million DM in 1970, representing about 19% of the whole social budget. About a quarter was used for cash payments in lieu of earnings lost through sickness, whereas about 18,900 million DM were paid out to hospitals for treatment of in-patients, to doctors and pharmacists.

It should be noted that there are no deductions of hospital costs or doctors' fees, which the insured has to pay himself. As far as prescription charges are concerned, the insured has to pay 20% of the costs with a maximum of 2.50 DM. Including family-members who participate in the insurance the social health insurance includes approximately 87% of the population of the Federal Republic. The other 13% are those who are entitled to a total or partial refund of their treatment costs by the state or the welfare authorities by reason of different legal claims for medical treatment. Finally there are those patients who take out private health insurance (about 6 to 8%).

The right of the insured to medical care outside hospital is guaranteed by the social health insurance scheme through qualified medical practioners (and dentists). Apart from treatment in urgent cases not all qualified medical practitioners are allowed to look after medically insured people but only those who are granted a licence by so-called "licensing committees". Although the provision of hospital treatment is legally only "Permissive", in practice the insured person claims it as a right. The social health insurance funds grant their insured members hospital care in hospitals of their own choice. As a rule the social health insurance funds conclude general contracts with the hospitals. The charges of the hospitals, agreed upon in these contracts, are paid by the social health insurance funds directly to the hospitals instead of being reimbursed to the insured persons.

2.3 Suppliers of medical services

a) Out-patient care

It is the duty of those doctors in private practice to take care of non-hospitalised patients, whether as general practitioners or as specialists. Doctors in private practice are grouped in associations under contract to a social health insurance fund. These associations have to ensure that there is an adequate supply of general practitioners and specialists in private practice and they also take over responsibility for the payment and clearing of fees for all services by doctors in private practice un der the social health insurance scheme.

With a few exceptions, hospitals are not licensed as institutions to treat non-hospitalised patients. Specialists on the hospital staff are only called in for non-hospitalised patients if in the area concerned (town or district) there is no appropriate specialist in private practice (e.g. radiology, laboratory doctor). In such cases patients with social health insurance cannot consult the hospital doctor directly, but must be referred to him by a general practitioner or specialist in private practice.

All doctors in private practice are self-employed and work as "medical contractors". The doctors working in hospitals are on the staff. Medical superintendents of hospital are allowed to take direct payment for the treatment of private patients.

b) In-patient care

The duties of hospitals are limited to in-patient care. Facilities for semi-hospitalised care - day or night hospitals - are found only for psychiatric treatment. The out-patient work of hospitals is insignificant.

The ownership of German hospitals 3,600 of them with some 677,000 beds - has not been affected by the prevailing public insurance systems. They continue to be partly owned by regional and local authorities, by voluntary associations, in particular religious bodies, and to a small extent by profit making organisations (cf. section 1.4).

c) Physicians-doctors services

A survey of the total number of working doctors, classified according to their functions, is given in Table 1. This shows that about 51% of all doctors are in private practice, about 39% are on the resident medical staff of hospitals and about 10% work in public health, administration and research. Allowing for the fact that some of the doctors in private practice also work in hospitals about 46% of all working doctors have some professional connection with hospitals.

About 42% of all doctors are specialists. There are no exact figures available for the number of general practitioners. However, it can be assumed that the non-specialist doctors in private practice - i.e. about 27% of all working doctors - are general practitioners. Non-specialist doctors working in the hospital - about 22% of all working doctors - are doctors in training, (or housemen). About 54% of all specialists are in private practice, about 38% on the resident staff of hospitals and about 8% in public health administration and research. Considering once again that some of the specialists in private practice and also consultants in hospitals, then about 51% of all specialists have a professional connection with the hospital.

d) Health education and preventive medicine

The functions of health education and preventive medicine were originally restricted solely to the public health service. Today, however, it can no longer cope with the comprehensive duties involved, particularly as the public health service has too few doctors and in many areas has inadequate facilities and insufficient equipment available. As a result, a large proportion of preventive medicine is today carried out by doctors in private practice.

e) Rehabilitation

The restrictive attitude of the social health insurance scheme to the duration and aims of medical treatment has led to a specifically German interpretation of rehabilitation as a supplement to hospital treatment - so-called "medical rehabilitation. The majority of rehabilitation measures are carried out in general hospitals for in-patients. There are also rehabilitation measures financed by pension insurance schemes which are carried out in the special hospitals of the statutory pension insurance schemes. Occupational and social rehabilitation is not adequately covered. Local authorities are responsible for this. It generally depends on the inititative of the practising doctor or factory doctor whether sufficient use is made of the relatively limited facilities for occupational and social rehabilitation.

f) In-patient care and home care for the aged and those needing nursing

In-patient care of the aged and those needing nursing is in the hands of either the local authorities or voluntary associations, with the latter predominating. The social services of the local authorities are responsible for financing this form of care and similar conditions apply to home care. Home care however is not yet sufficiently developed.

g) Other medical welfare measures (e.g. public health inspection, police department responsible for public health matters).

All other measures of health welfare, primarily the police department responsible for public health matters, public health inspection, special welfare work (e.g. for those suffering from tuberculosis or venereal disease, the physically handicapped , the incurable and drug addicts) are the responsibility of the public health service.

2.4 Financing of medical care and medical welfare

The various treatment stages are financed as follows :

a)	Care of patients who are not hospitalised	Social health insurance through the associations of doctors under contract to a social health insurance fund.
b)	In-patient treatment	Investment costs and depreciation by taxation - running costs by social health insurance.
c)	Health education and preventive medicine	Health education fully financed by taxation. Preventive medicine both by social health insurance and by taxation.
d)	Rehabilitation	Social health insurance and pension insurance; to a minor extent taxation.

2.4

e)	In-patient and home care of the aged and those needing nursing	Predominantly taxation.
f)	Other medical welfare measures	Taxation

2.5 Services and communication with patients in the field of medical care

Because the information on the Federal Republic of Germany health and hospital system is insufficiently quantified, there is a lack of corresponding figures on the connection between treatment of patients in and out of hospital. According to regional analyses of patients referred by general practionters, these doctors referred a total of 11.1% of their patients, of which 4.7% went to practising specialists for diagnosis, 0.33% to hospitals for diagnosis as in-patients and 1.28% to hospitals for in-patient treatment.

The general practioner therefore treats about 89% of his patients himself. On the 11% that he refers, 85% go to practising specialists and only 15% to hospitals.

2.6 Disadvantages of the existing isolation of the hospital in the general system of medical care

With the present organisation of medical care, the duties of the hospital are almost exclusively limited to in-patient diagnosis, treatment and care in the field of cruative medicine. It is primarily the financing arrangements for the various stages in the general system of medical care that have led to this restriction of the functions of the hospital.

The disadvantages of this lack of integration in the general system of medical care are primarily as follows :-

a) The lack of integration results in an excess of personnel and equipment both in the hospital and in private practice. This becomes obvious if one considers that with the introduction of the five-day week in the hospital, its facilities for diagnosis and treatment are generally only used in the mornings on five days of the week (except for casualties).

b) Because of the shortage of personnel, it will not indefinitely be possible to tolerate a situation in which the specialist potential in private practice is not available for hospital treatment as well, especially as there is a considerable shortage of specialists in hospitals. Considering also that with increasing specialisation the group of patients referred to a specialist or superspecialist will become smaller it may justifiably be claimed that it is unreasonable to have two such specialists with duplicate equipment and assistant staff, one in private practice and the other on the hospital staff.

c) The quality of diagnosis and even treatment is known to increase with the number of patients seen. Quite apart from the duplication of personnel and equipment involved, there are also medical arguments against too great a splitting up of the group of patients. Each doctor needs a specific routine if he wants to ensure optimum diagnosis and treatment and if he wants to obtain the necessary experience. This is only possible if he treats a large enough group of patients. However, this group of patients will not be available to him if the specialist treatments, for which the numbers of patients are already relatively small, are further split up into out-patients and in-patients.

d) For automation of diagnosis and treatment, a certain minimum number is essential : only then does automation "pay its way". In addition, only large establishments automated in this way allow institutionalised control in the execution of diagnostic services (e.g. laboratory tests, ECGs).

e) The present system, which separates in-patients and patients who are not admitted to hospital, necessarily involves double investigations for diagnosis purposes. This does not help to make the diagnosis more thorough, as would be desirable, but merely amounts to a duplication of the tests made. Such duplicated tests represent a considerable burden not only from the financial and staffing aspects but also on the patient.

f) The separation of in-patients and patients not admitted to hospital increases the number of in-patients and extends the time they spend in the hospital. At present patients must be admitted to hospital for diagnosis and treatment and "put to bed", even though out-patient or semi-hospitalised treatment in day or night hospitals would be adequate.

Moreover, if the facilities for out-patient or semi-hospitalised treatment in the hospital were extended, the time spent in hospital could be reduced since part of the preliminary diagnostic work and follow-up treatment for which the diagnosis or treatment facilities of the hospital are required could then be handled on an out-patient basis or by semi-hospitalisation in day or night clinics.

The consequence of this isolation of the hospital from the general system of medical services is that there are too many hospital beds in the FRG, which consume too much capital and abort too many staff.

3.0 Future development in structure and organisation of the health services.

3.1 Basic Principles for the structure of the hospital market.

When considering the claims of the people for health, welfare and medial services, the government has a justifiable interest in seeing that needs rather than just demands are met. Medical institutions which help to meet such needs and which are primarily financed from public funds, should therefore be seen as part of a total health service, which in its turn is a part also of the social and economic infra-structure of the whole country as well as of each region.

Health needs should be balanced against other social requirements - housing, education and recreation - and should be fitted into a capital development programme geared to the country's economic situation. Regional requirements may differ, and regional planning is necessary in a cost-benefit basis to try to ensure that medical services are equally available to the whole population.

In spite of the logic of this approach it appears unlikely however that the state will in future extend its activities in the appropriation of funds for medical institutions beyond the hitherto existing scope. Medical care for in - and out-patients will it seems be left, as before to private initiative and to voluntary and non-profit self-help. The state will only act as offerer of medical services in cases where voluntary self-help and private initiative is sufficient.

Should the state, however, decide to meet its responsibility for ensuring hospital care for the entire population under equal terms and available at any time, have to face the problem of providing such care in a form easily accessible to everyone and yet not unduly expensive. While we are able here to consider the financial implications of such a proposal, the question of how near to their "clients" various hospital services need to be, is essentially one to be answered by medical planners. Health financing as it is practised by those concerned with the social insurance funds at present, means merely paying for the most extensive services possible within the funds available. Health planning on the other hand demands control of outline planning at national level and regional implementation of the national plan in detail locally according to local circumstances.

3.2 Development tendencies within the hospital and health service as background for necessary structural changes.

The development of the hospital service can be articulated as follows :

a) - Increasing use
at linear extrapolation of the conditions in the past, there are 155 hospital transfers per 1,000 inhabitants to be expected for 1985 (1970 : 132).

b) - Further increase of costs for hospital constructions and for hospital management.

If one looks back on the development in the past then one has to expect for 1985 costs for hospital contruction, which may amount to approximately DM 320,000 to DM 350,000, --- per hospital bed.

The operating costs per day of hospital care are predicted at DM 200, --- inclusive of the allowances regarding a day of hospital care.

If the constantly rising health care costs of the FRG are to be controlled therefore, it will be necessary to transfer as much as possible from hospital wards to other parts of the health service less demanding of capital and staff - preferably to the areas of out-patients and semi-hospitalised care.

When considering the necessary structural changes in the entire organisation of medical and nursing care of the population in the Federal Republic of Germany the development trends in medicine cannot be ignored.

Future development in the organisation of medicine and medical treatment will be determined by specialisation, mechanisation, and the rapid advance of scientific and technological medical knowledge. According to one estimation this knowledge is likely to double in amount during the next six to eight years. Such doubling has happed in the past over rapidly decreasing periods of time.
E.G. 1800 - 1900; 1900 - 1960; 1960 - 1970.

As a result, and as more and more doctors study in smaller and smaller areas of this field of extending knowledge, medical specialisation is bound to increase a pace. Even today it is no longer possible fully to command a subject of science, thus it will not only come to a distribution - according to special branches - within the individual subjects of science in future, but beyond this to a further specialisation and super-specialisation within each part of the special branches. Even those possibilities in connection with Electronic Data Processing of accumulation of knowledge and the information accessible at any time about this, cannot stop this development, but can only keep it within reasonable limits.

The practical work of doctoring, using modern methods and techniques, will also increasingly demand special knowledge, and in addition a command over equipment and instruments which will exceed the capacity of every physician.

Diametrically in contrast to these tendencies towards specialisation, are the unconditional demands that are likely to be made for "comprehensive" treatment of the patient.

A solution to this problem - specialisation on the one hand, and comprehensive treatment on the other hand - can only be found in a close co-operation of specialists. Here such a co-operation will become necessary partly because of the need to integrate the special knowledge of these numerous individual specialists, and partly also because of the requirements of automation which will necessarily affect the instrumentation modern medicine requires.

The result of this development will be that the individual physician will no longer work by himself in future, but will be forced to co-operate, using centralised diagnostic and therapeutic facilities.

3.3 Integration as structural principle for the health service.

The entire object of all service levels and of all institutions of the health service is to provide continuous and co-ordinated medical and nursing care of the sick so as to restore them as far as is possible to health and to rehabilitate them both at work and in society generally. In addition, preventive medical measures and early recognition of illness, provide advisory assistance in the maintenance of health. The aims and objects of each individual service level has to be balanced with those of other service levels and also with the aims of health welfare and medical care generally.

The medical efficiency and the economical operation of the entire field of medical and nursing care of the population, depend decisively on whether and how far all these partial spheres have integrated to a self-contained unit, or whether they continue to operate independently. Looked at solely from the viewpoint of providing medical and nursing care for the people we must be careful to define what we mean by integration. On the one hand the term may be used to describe the action of bringing a number of service elements together to form an inter-connected group with each element independent yet complementary to its fellows. The separate services in other words are integrated one with another, the service may not be.

On the other hand the term 'integrated service' may be used to denote a single service containing no independent elements. In this instance, the different uses - as with the term 'organisation' - produce no contradiction but merely express a different point of view.

When one uses the term "integration" in this sense, the integration phenomenon in the entire sphere of the health service can be described most explicitly only with the help of terms from the system theory.

Under "integrated medical welfare and medical care" a specific form of linkage of all working elements in the service of health - persons, materials and facilities - to one system is understood. Thereby this system is to be structured in such a way that the numerous elements classify themselves to sub-systems, the combination of which is determined by the specific grouping features.

If one classifies the persons, materials and facilities in the service of health with the term "kind of care" then the sub-systems correspond with the service levels of the entire system. Here the precondition for the efficiency and the economical operation of the entire system is, that the structural set-up of the individual sub-systems as well as the relation between the sub-systems are aimed to a total system, i.e. to an optimum medical welfare and medical care sensibly limited to the necessary staff and material expenditure.

3. Integration of medical care for hospitalised and non-hospitalised patients.

a) Possibilities of improving the integration of medical care for in-patients and patients not admitted to hospital.

The best way of improving the integration of out-patient and in-patient medical care would be for the majority of specialists to be active both in hospital and in private practice so that the patient does not need to change specialists when he is admitted to hospital.

It would be conceivable for the diagnosis and treatment of non-hospitalised patients to be carried out by means of community facilities by the practising doctor and for the patient to continue to be treated by the same specialist when admitted to hospital. Such a solution would be similar to a modified form of the "part-time" hospital consultant, a specialist who has a private practice and also works in the hospital.

When one considers that diagnosis and treatment of in-patients in hospital require to a large extent the same facilities as would have to be available in the surgeries of specialists in private practice, it appears desirable to make far more use in future of the highly technical and automated facilities in hospitals, which are not used to anywhere near their full capacities, for out-patient and semi-hospitalised treatment. This would be possible if the majority of specialists, as in the Netherlands, were connected with the hospital and worked with the hospital facilities for out-patients, semi-hospitalised patients and in-patients. In private practice there would then be mainly general practitioners only, apart from specialists in certain disciplines and in special situations.

With an organisation of this kind, the general practitioner refers the patient to hospital for specialist treatment. In the hospital it is decided whether the specialist diagnosis and treatment should be carried out on an out-patient, semi-hospitalised or in-patient basis. In this way, the preliminary diagnosis and follow-up treatment could largely be organised on an out-patient or semi-hospitalisation basis. It would, however, first be necessary to expand the out-patient and semi-hospitalisation treatment facilities in the hospitals, and especially to set up day and night clinics.

With this form of treatment it would not by any means be a question of the "anonymous out-patients department" so often quoted. It would rather be a question of the patient visiting in the hospital a specific specialist whom he could select himself if there were more than one specialist available in the same discipline.

This integration of all facilities for non-hospitalised, semi-hospitalised and hospitalised patients will in future be faciliated by the possibilities offered by data banks in Electronic Data Processing systems. In this way complete information will be available for all doctors in the field of prophylaxis and treatment in and out of hospital and of rehabilitation. Any doctor in private practice, on the hospital staff or in other establishments will on request have the complete case history of the patient available on his screen from the computer in seconds. This thorough information, combined with a concentration and increased quality in the field of diagnosis, will help to avoid duplicate tests and examinations, unnecessary admissions to hospital and unnecessarily long stays in hospital.

b) Advantages of improved integration of medical care for hospitalised and non-hospitalised patients

An improvement in this integration is accompanied by an increase in medical efficiency and economy in health matters, particularly in the following ways :-

a) Reduction in the number of in-patients
A not inconsiderable number of patients who have to be treated in hospital today could be treated as out-patients or semi-hospitalised patients.

b) Reduction of the length of stay in hospital and hence better utilisation of existing hospital beds
Practical experience has shown that the establishment of semi-hospitalisation facilities in the form of day clinics would help greatly in this respect.

c) Avoidance of duplicate tests and examinations for diagnosis - purposive introduction and continuation of treatment - smooth transition to rehabilitation.

d) Avoidance of unused capacities, as regards both specialist potential in private practice and the facilities and equipment in hospitals and in private practices.

e) Professional qualifications of medical hospital work.

c) Pluralistic forms of medical care

Extending the functions of the existing hospitals in the form of out-patient and semi-hospitalisation activities is not the only way to eliminate the current division between private practice and hospital work. An exhaustive analysis of the organisation and techniques for the treatment of hospitalised and non-hospitalised patients will show that there are a number of ways whereby integration may be improved by re-organisation.

The existing community facilities of practising specialists could be associated with semi-hospitalisation and in-patient treatment facilities. In addition, centres for out-patient diagnosis and treatment could be set up which would not only cover preventive medicine and out-patient care, but would also be associated with convalescent homes, so-called "hostels" and operate in close co-operation with hospitals. Finally, consideration could also be given to the extension of smaller hospitals with a view to out-patient and semi-hospitalisation work. This would increase the scope of the small hospital and enable it to attach the minimum acceptable capacity on medical, nursing and also economic grounds. A pre-condition for this, however, would be close regional co-operation between the small hospital and the larger and more efficient hospitals in the region.

Even profit orientated institutions could have a suitable role in the provision of medical care, as long as they came within the scope of the generally accepted aims and objectives, and so did not disturb the balance of the entire system of medical welfare and medical care.

A consequence of these new types of operation would be the development of other types of hospital ownership. The existing non-profit-making hospitals owned by public authorities or by charitable associations could be supplemented by hospitals operated by doctors on a co-operative basis. Hospital ownership of this kind would eliminate one of the basic ills of the current types of hospitals - the conflict in aims that is bound to exist between the hospital as an institution on the one hand and the hospital doctors responsible for the hospital work on the other.

3.6 Planning and co-operation within the health service

There are two decisive reasons why - in the long run - regional planning must not be limited to the province of hospital service, but has to be extended to the entire province of the health service including all medical institutions :

a) If the claims on medical services of all sections of the population are to be met, then all necessary services must be made available, not only the hospital services. From this follows the demand for services readily available to all which makes regional planning essential in the entire field of the health service including all medical institutions.

b) The mutual dependence of the various sub-systems of the health service - not only in the field of out-patient, semi-hospitalised and in-patient special medical care, but also within and between the other maintenance levels - demand the production of a balance and co-ordination of the services offered by all medical institutions according to kind and extent.

If one further considers that the number of staff and the financial capacity available to the health service is limited, then the planning of resource allocations within the entire province of the health service is seen to be essential.

1) Example : the kind and extent of out-patient and semi-hospitalised diagnostic and therapy facilities available in hospitals influence considerably the number of hospital beds. The number of hospital beds is further dependent on the kind and extent of care for persons in need of care, either at nursing homes (homes for the sick) or domiciliary care, and further on the kind and extent of general medical or also special medical domiciliary care.

If one considers the different high costs of the various service levels and service institutions of the entire system of health welfare and medical care, then it becomes obvious that the problem of integration does not rest simply on the provision of regional planning. Just as important is continuing co-operation between the medical institutions of all service levels with the aim of bringing the patient to his/her level of care adequate to the type and seriousness of the disease. Insufficient care will not allow the provision of adequate medical treatment, while more care than is required creates unnecessary costs. Such a controlling process will require the supply to all services institutions of complete information about all patients, a demand which can be realized by making use of Electronic Data Processing and the possible installation of regional medical data banks.

In addition it depends on the understanding and acceptance by all physicians taking part in the service of the need to lead the individual patient to the expedient service institution according to the type and seriousness of his illness. A sensible, controlled price policy for medical, nursing and general out-patient, semi-hospitalised and in-patient service can here be of effective support. With such alterations in the fee structure for medical services the mistrust prevailing in the public mind, that guaranteed incomes for those working in the health service do not always achieve a sensible medical service structure, could well be abolished. The efficiency of the health service depends thus not only on systematical regional planning but just as much on a continuously operating co-operation of all the various medical elements which make up the service.

If one considers the health service as a part of the social infra-structure then the necessity arises for the State to ensure that an optimum, efficient and econmic cover of the demand for medical service of any kind is available at any time. That, however, means that in the long run the State becomes the responsible body for planning within the entire province of the health service, and is ready to organise the necessary continuous co-operation, if the entire system of the medical institutions formed by the health welfare and the medical care will not merge by themselves into a regional planning and operational association.

1) Uniform principles throughout the Federal Republic of Germany for kind and extent of "necessary" medical care developed and fixed in co-operation with the State and the Lands, self-management of hospitals, the physicians and the bodies for social services.

2) Uniform standards throughout the Federal Republic of Germany for construction, installation and commissioning of medical institutions developed and listed in co-operation of the State, Lands the self-management of hospitals, the physicians and the bodies of the social services.

3) National regional planning on Lands basis, in the form of Lands' outline planning worked out and listed in agreement with the self-management of hospitals, the physicians and the bodies for social services. In connection with this, ascertaining the total resources graduated according to service levels and operating units necessary for the individual region of service.

4) Particularisation and carrying out of the national out-line plans by regionalisation in the form of regional planning and working communities of medical institutions (in the form of self-governing bodies) on the level of service regions or service areas together with the government of the Land and social service bodies responsible for the health service.

Such a regionalisation of medical planning is at the same time an essential precondition for the necessary participation of the entire population in the planning of their health service. Here the necessity of such a right of codetermination by the patients arises, because no longer is it accepted that doctors have the exclusive right to dictate health care policy. The doctor-patient relationship is changing and, the patient is increasingly less prepared to comply without hesitation to doctor's decisions on fixed aims and on achieving these aims in the matter of planning and organisation of the hospital and health service. In addition the problems of staffing and costs force those who plan hospital and health services increasingly to take account of economics as well as medical criteria in their planning. Although the difficulties connected with such a co-operative necessity should not be underestimated, it is, however, only possible to create the preconditions for maintaining a liberal structure of the health and hospital service in the Federal Republic of Germany by making use of voluntary regional planning and co-operation well organised from top to bottom.

4 Future development in structure, organisation and financing of hospital services

4.1 Adaptation of hospital operation and hospital structure to the changed position of the hospital in the general system of medical care.

Against the background of the trends towards the integration of medical care within and outside the hospital, the hospital will increasingly acquire a central and dominating role in the general system of medical care. In addition, it appears advisable as far as nursing is concerned to have as far as possible a central organisation and arrangement of the various types of nursing at the different stages of integrated medical care. The hospital is the obvious control point. From the aspect of both medical and nursing care, the hospital is becoming a centre for medical welfare and the care of the sick.

The resultant consequences for hospital operation and structure are described below :

a) System and work-intensive orientation of the organisation of the hospital

The replacement of today's individual specialists by tomorrow's team of specialists will mean that the existing departmental organisation of the hospital will be replaced by a more flexible division, adapted to the constantly changing patient structure, and determined primarily by the type of diagnosis and treatment and the intensiveness of the nursing required.

b) Specialist qualifications in the medical service

With the increasing concentration of medical care in or around the hospital, far more highly qualified specialists will have to work in the hospital in the future than today. However, this will only be possible if these specialists are allowed to work independently in accordance with their high capabilities and if they are ensured of adequate incomes that must not depend solely on the ability or willingness of private patients to pay them.

c) Organisation structure of the medical service

The existing vertical structure of the medical service will be replaced by a more horizontal structure, typified by a number of specialists of equal status on the same level. This will mean that a leading specialist will see fewer patients than he does at present. As far as in-patients are concerned, the senior consultant, supported by his medical colleagues (three to four medical colleagues depending on the specialty) will treat 40 to 50 patients depending on the department, or sometimes even fewer. On the other hand, however, he will have varied and comprehensive duties in the field of out-patient and semi-hospitalisation treatment.

d) Administration of the medical service

The effectiveness of the medical work depends not only on the professional skill of the individual doctor but also to a great extent on the co-operation between doctors, the medical services and the other hospital services. Consequently the planning organisation and control of the medical service will be of greater importance in the future. The problems concerning the payment of fees for this work should not result in the medical organisation function being sadly neglected, as it often is at present, to the disadvantage of the total organisation of the hospital.

e) Changes in the operating and structural organisation of the hospital

Whereas diagnosis and treatment have primarily been oriented towards hospitalisation until now, they must in the future lie at the boundary between out-patient and in-patient care. The services that are to be given greater scope depend on the type and extent of the additional duties and need to be investigated in each individual case. For some services, the reserve capacities as far as time is concerned will be sufficient to cope with the additional burdens on the hospital imposed by out-patient and semi-hospitalisation diagnosis and treatment (including prophylaxis and rehabilitation). It is certain, however, that there will be extensive automation of diagnosis and treatment, particularly in the field of basic diagnosis and the compilation of case histories. The traditional sphere of treatment of the general hospital will thus be further developed to make it a diagnostic and therapeutic clinic attended and used by out-patients, semi-hospitalised patients and in-patients.

In addition, semi-hospitalisation facilities will be extended, i.e. day and night clinics where the patients look after themselves to a great extent. These establishments can take patients before their actual stay in hospital starts or after it is ended and greatly help to relieve the in-patient hospital services. They would also be available to out-patients for a stay of some hours. It would be conceivable to combine these semi-hospitalisation or short-term nursing facilities with minimum nursing as far as organisation and premises are concerned.

A central element in the future hospital operation will be the diagnostic and treatment clinic, combined on the one hand with the elements of full accommodation facilities for in-patients or intensive, normal and long-term care, and on the other with elements of semi-hospitalisation facilities for minimal and short-term care - the so-called "hostel". It will be the task of the medical and general care, communication and information to integrate all these individual elements with the complete system, the "hospital".

4.2 Financing hospital services

For about 87% of the population associated with social insurance, the sickness-funds take over all costs for hospital stay. About 5% of the population has a legal claim for other kinds of medical treatment (e.g. public welfare, armed forces etc.,). The remaining 6 to 8% are self-paying persons, i.e., they have to bear the costs of hospital treatment themselves. The greater part of these patients are members of private health insurance schemes. The social health insurance funds take over the costs of hospital stay for 78 weeks. If the financial position of the patient makes it necessary, the public welfare will meet the hospital bill after termination of treatment. The number of patients has steadily increased over the years and last year reached nine million.

For patients insured by health insurance the hospital receives a refund of its costs in the form of a global daily charge. Hospital costs in Germany, as in all Western countries have increased over the years - it is claimed there was a veritable cost explosion. If these costs were to be fully refunded to the hospitals by the social health insurance it would become necessary to increase the contributions payable to the health insurance by the insured to a much greater extent than hitherto. To prevent this the Federal Government issued regulations in 1954 limiting the extent of the daily charge.

The difference between the actual costs and the returns resulting from daily charges was covered by means of unsystematic contributions by the owners or public authorities, as well as by means of private contributions or through withdrawals from the hospitals' real assets.

This in turn had brought about a chronic deficit on the part of the hospitals which, as estimated, had reached over 10% of their total expenses. Naturally enough the hospitals were extremely dissatisfied and they blamed both the social health insurance schemes and the government for their losses. The patients as such have not been affected by this dilemma.

The only realistic possibility of re-organising the system of financing hospitals was proposal two - government intervention.

After years of protracted discussion and recriminations in the press and in parliament the Federal Government in July 1972 finally submitted a bill of law intended to safeguard the financial position of the hospitals and regulate the daily charges which could be levied by the hospitals on the health insurance scheme. Broadly speaking the aim of the law is to divide hospital costs between those directly incurred by the individual patient, i.e. staff costs, medicine, food, etc., and investment costs, (buildings, equipment, etc.,). Whereas the former are now charged in full to the health insurance the latter are provided by the public authorities, (the federal, regional and local governments), out of taxation. Such a grant-in-aid, however, depends on the conformity of requested investment contribution to a Regional hospital plan.

It is as yet too early to assess what possible effect the law might eventually have on the financial position of the hospital system. Even if the State took over the total investment cost, we have to keep in mind, that the cost of investment, amortisation, and interest amounts only to a small percentage (15%) of the total costs of a hospital, notwithstanding the high construction cost. This means that health insurance should be obliged to cover the full running costs - 85% of the total costs.

The main reason for splitting financing the hospital services into two parts i.e. investment costs, depreciation and maintenance by the state out of taxation, and operation costs by the patients or their health insurance, was the need to intensify, to qualify, to improve regional hospital planning.

For medical and nursing reasons and also on economic grounds it appears advisable not to provide certain special equipment and specialist beds everywhere, in view of the comparatively low demand, but to concentrate them centrally in a few places. It is therefore not sufficient, when calculating bed demand, to determine the extent of the demand for hospital services in the specific area. It is just as important to distribute the necessary bed capacity correctly to the various types of hospitals (basic service - regular service-central service) in order finally to achieve an optimum hospital service for the population and a well differentiated and graduated hospital network.

Adhering to the principle of voluntary self-help there was no governmental regional planning in the Federal Republic of Germany. The planning was left to the individual hospital and to the regional planning groups of several hospitals. Thus the individual hospital had to come to terms voluntarily with neighbouring hospitals. Up to now, this voluntary conformity and classification of the various hospitals within this general hospital service network was but unsystematically supervised and supported by the government. In the case of financial applications, the "Länder" subsidised the construction of new hospitals out of taxation with public funds, with the contribution by the "Länder" amounting to 30% - 90% of the total building costs. The health authorities as a rule examined the question of requirement and suitability in relation to the whole network of hospital service.

The new law regulates not only the financing system but also the questions of regional hospital planning. The plans of the individual hospitals must fit into the framework of the regional hospital plan. This hospital plan is given by the Government to each "Land" and provides a very general estimate of the necessary number of hospital beds and their regional distribution. The Government examines in each case whether the individual planning of the hospital fits expediently into this general framework. Hospitals cannot get money from the "Land", to finance depreciation or maintenance costs of an existing hospital or to finance the investment costs of a new-planned hospital, if they are not included in the regional hospital plan. In all these matters of regional hospital planning the "Länder" work closely together with the hospital association and the association of the health insurance; and both institutions participate in the "Lander's" regional hospital planning.

4.3 Problems of Hospital Management

Business administration as an academic discipline has concerned itself until now, both in theory and practice, chiefly with profit-making enterprises, while other types of enterprise, including non-profit-making concerns, have only been given occasional attention. This applies particularly to the hospital, and yet business administration plays an increasing part in the hospital of today.

If the hospital of the past was administered by the owner, the hospital of today is a highly technical, complex and very sensitive organism which can no longer be administered in this simple way. The continually increasing opportunities to improve every aspect of hospital care and also the continually increasing costs of running and building hospitals compel careful consideration of how the hospital can best fulfil its task with the personnel and finance which are available. It has been increasingly realised that the rational application of the discoveries and experiences of business administration can be of great help in the management of hospitals. Solutions to hospital problems can also sometimes be usefully applied in business.

Within the framework of this broad objective the individual hospital decides on its own medical and nursing objectives, thus the authority or organisation that owns the hospital decides on the type and number of specialities, on the facilities for diagnosis and treatment to be provided, on the organisation of medical, nursing and other services and on the employment of the hospital management.

In the modern hospital the individual can no longer be left to decide how the work should be done. In future all procedures in the diagnostic and treatment departments as well as in the nursing and other departments must be centrally planned and organised. This can only be done if administrative authority is clearly defined between the hospital owner and hospital management; if it is recognised that management is essential to the hospital; if the hospital management is instituted as a board of directors or, alternatively, as one qualified hospital director responsible for medical, nursing and economic aspects; and if the middle-management is qualified and is given incentives to function efficiently.

The authority owning a hospital must be clear that a modern hospital can no longer be administered as a dependent department, and because of the nature of its task, must be given a substantial degree of autonomy. The hospital can only fulfil its tasks to the best of its ability if a hospital management is given effective authority in the following areas :-

Day-to day management (planning, organisation and supervision) in the fields of diagnosis and treatment, nursing and general management, within the framework of the medical and nursing objectives laid down by the hospital owner;

Personnel management within the framework of the employment policies laid down by the hospital owner;

The operation of a management information and accounting system within the framework of the general accounting system of the hospital owner.

This far-reaching delegation of authority to the hospital and the hospital management gives rise to the danger of tensions between the hospital authority and the hospital management. This danger can be averted by clearly and unequivocally defining the authority of a hospital owner and of the hospital management. The effective day-to-day management is carried out by the hospital management, while the hospital owner reserves the right to make the fundamental decisions (objectives, planning of building, further development, forms of organisation, employment of staff, financing) and also to undertake certain supervisory functions.

In order that the hospital owner can rely on the hospital management to operate within the framework of policy laid down, there must be a complete identification of the hospital management with the ideas of the hospital owner. It seems obvious that an effective hospital management must be appropriately qualified. In order to achieve this aim there must be a structure of basic and specialised training and further education for people holding positions of responsibility in hospital management. For this reason a number of programmes of training and further education have been introduced - particularly a two week comprehensive management course for leading hospital professions.

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NHS AND EEC - ITALY

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1 Planning

Planning is at a very early stage in Italy. It is included in the machinery of the Hospital Law but it is not limited to the hospitals because it is foreseen that other health establishments will also need to be included. Planning procedures are concerned mainly with public hospitals and university departments, but on a regional basis the representatives of private hospital can also be included in the advisory bodies. No new building, merging, or institution of new hospital administration is allowed if it does not come within the regional plan.

National Plan :

This is proposed in a Law which is linked with the economic 5-year plan, and aims to establish :

the number of new hospital beds both for patient care and teaching
- distribution among the different specialities
- regional distribution
- the criteria to be applied in order to quantify the different needs in relation to social, economic and urban planning
- the criteria for co-ordinating the different health institutions
- the funds on the Government budget for building repairs and equipment

the Plan is promoted by the Ministry of Health on the advice of a National Committee comprising the regions, which has set out the details whereby the law may be implemented.

Regional Level

Planning at this level is under the complete autonomy of the region as far as administrative procedures are concerned. The starting point is always the national Law under which most finance is provided. Regional Law however is restricted only by few general constraints and can be heavily influenced by the trends of a single region (for instance the building of a new Psychiatric Hospital has been banned in Venice because of the current belief that such hospitals should be replaced by psychiatric wards in general hospitals).

Until now the main work of the planning machinery has been devoted to the recognition of the different types of old hospital, while the Ministry of Health has ordered a provisional hospital plan (which has not yet the strength of a Law) and which foresees :-

Beds for maternity cases and acute treatment	5-6 per thousand
" for chronic illness and convalescents	3 " "
" for TB cases	0.5
" psychiatric cases (in addition to bed places in intermediate institutions and so on)	3

In Southern Italy there are provinces which currently have no more than 3 beds per thousand while in other areas (eg Veneto) there is the risk of a proliferation of hospitals. Almost everywhere it is difficult to close down non functional hospitals and proceed to the merging of different institutions. The frequency of hospitalisation is also increasing : in 1961 it was 10.9 per hundred while in 1972 it has risen to 15.3%.

There has been an increase of beds in the last ten years particularly in the southern regions but new hospitals do not always attract people who are used to the sort of help traditionally found in large regional hospitals. So occupancy rates vary sharply (from 50 to 100 or more in the overcrowded wards of the Roman and Neapolitan hospitals).

Past and present situation : (beds per thousand inhabitants)

	1961	1971
General hospitals	4,2	5,7
(average length stay	16 days	15,2
Specialized hospitals	0.56	0.67
	20 days	16 days
Sanatoria	0.95	0.62
	136 days	114 days
Psychiatric Hospitals	1.96	1.72
	211 days	167 days
Private Hospitals		
General hospitals	0.76	1.2
	11 days	10 days
Sanatoria	0.36	0.19
	154 days	136 days
Psychiatric institutes	0.32	0.41
	138 days	136 days

Health personnel of public hospitals :

	in 1961 for 386,813 beds :	in 1971 for 474,283 beds :
Physicians	24,000	38,000
Professional nurses	22,000	32,000
Nursing Aids	29,000	72,000
Midwives	1,600	3,100
Orderlies, technicians	72,508	124,809
Clerks	10,151	20,000

It is easy to see how the numbers of unqualified nurses and clerks have increased compared with qualified personnel.

Almost 30% of beds are occupied by chronic patients who are in hospital solely for social reasons (lack of home care) and because the number of long-stay hospitals is very small. There is a lack of clear definition of a hospital for long-stay patients which tends to be confused with a geriatric hospital. (ie hospital for acute patients in old age). The objective of 3 beds per thousand for psychiatric hospitals appears to most people to be already outdated even if the decree indicates "beds or other non institutional place".

In the field of rehabilitation there are around 340 institutes - half with beds and half as day centres (the law favouring the second type) with an average of 60,000 newly admitted crippled and handicapped people (40% being mentally subnormal). At present responsibility for this form of treatment and for the provision of appliances remains with the Ministry of Health.

ORGANISATION

Italy has been submitted in the period 1970-72 to a real revolution as far as management of health services is concerned, due to the establishment of the regions (15 plus 5 which were special regions and were formed after the war) and the passage of responsibility and powers from the Ministry of Health to the Regions. It is not an administrative delegation of tasks but a political competition. Regions have the authority to decree Laws and enforce them, with the Government only able to oppose such Laws if they are contrary to the constitution or against the "framework laws of the State". In the former case offending regional Laws may be annulled or suspended, but in the latter the procedure of opposition is more complicted. At present hospital law can only be considered as "a framework law".

Regions try to stress their independence and to develop a new kind of management avoiding heavy bureaucratic machinery. In fact in many areas of the health and social services fields Regional Laws are far in advance of older State regulations (eg for aged people priority is given to day centres, foster homes, domiciliary services; and in the kindergarden network the educational valuer under the custodial role is stressed). In other fields such a trend towards independence can create problems. Control of infectious diseases submitted to international quarantine eg remains with the Ministry

of Health, although its implementation has been delegated to Regions owing to the lack of health officers of the Ministry of Health. When cholera cases were notified in Naples the Ministry with the support of the central advisory body suggested limiting vaccination to the surrounding areas and to exposed personnel and intensifying epidemiological surveillance and research. But regional authorities under the pressure of local opinion chose mass vaccination and devoted all their effort to the organisation of the vaccination campaign.

The more critical point is the fact that while most of the powers and tasks of the Ministry of Health have been transferred to the Regions, the network of Insurance Institutes (Sickness Funds) has remained under their own separate and centralised organisation. Also the Maternal and Child Welfare Agency (which is under the control of the Ministry of Health) has remained unchanged, so that there is a gap in the real ability of a Region to develop a co-ordinated health policy. In spite of this many regions decided to integrate health care given by some Sickness Fund for farmers and tradesmen, including the provision of drugs, which was not previously comprised in the insurance. From the point of view of law it is a borderline regulation and at the same time tends to increase drug consumption at the expense of prevention and the better organisation of hospital care. Such a trend stresses the urgency of a reform whose out lines have already been deeply discussed and laid down. There is danger that if the law is delayed in Parliament, Regions could establish their own Health Services. But any movement from the present stage of Compulsory Insurance to the establishment of a real National Health Service requires the initial grouping of the various sickness funds (200 in total, with 7 being the main ones and caring for 80% of the population with the aim of producing Local Health Units).

Government : Ministry of Health	Min. P. Works	Ministry of Labour	Various Ministries
General Planning		Control over Insurance Institutes	Army medical corps
Distribution of funds for hospital equipment and internship payment.			medical service
National plan for kindergardens.			minor local services
Payment of fees and appliances for handicapped and crippled persons.	Financing of new hospitals (For the South there is a special national agency)		
Drugs registration.			
Food and drinks regulation.			
Requisites for health professions.			
Quarantine services.			
Ecological services.			
Control of infectious diseases submitted to compulsory vaccination.			
General oversight of Child Institution Red Cross and some Scientifical Institutes.			

Regions

(5) The oldest ones at present have minor powers because their birth was not accompanied by a decentralized trend. So now it is necessary to await the Law of Reform in order to fill the gap with the newly established regions (15).

Regional borders do not always parallel industrial and traditional socio-cultural areas.

The main regional health tasks are the provision of hospitals and medical care (although they have no control over the Insurance Institutes and the Maternal and Child Institutes). They finance, with the aid of governamental grants and the local taxation, the preventive services (school health services, vaccines, training of health auxiliary personnel) and distribute the funds to hospitals which have been assured by the government. Most of these activities are delegated to the Provinces and Municipalities.

The Province (94 in all Italy) has no political power, even though it is an elected administration, but its main task is to provide all those health and social services which municipalities are unable to manage by themselves. In many fields its role is shared with the municipalities through the old system of compulsory or voluntary association (consortiums). Its continued existence is also being debated but it would be necessary to change the constitution before provincial administrations could be abolished - and the trend is to avoid any enlargement of operative tasks on the part of the Regions.

The main present tasks of the Province (now under the control of the Region) are :-

care of psychiatric patients.
management of P Health Laboratories.
care of illegitimate babies.
prevention of TB through clinics, mobile units, vaccinations and payment of sanatoria fees for people not insured.
expenses of vaccination (acquiring and maintenance)
premises and executive personnel for maternal and child welfare.
provincial agencies (which are headed by the President of the Province, the administration being always centralised).

Municipalities (8.900) have the more direct task of delivery of preventive services, the responsibility for sanitation, ecology, housing control and at the same time vaccinations (through public health doctors, municipal doctors, PH nurses) school health services (which cover only a minority of school children and can be partially financed by the Region) and clinics for municipal doctors (medici condotti - around 9,500) midwives (3,000) and veterinarians (3,000). Municipal doctors are salaried (approx 250,000 lire monthly) in order to assure free of charge treatment for people registered in the poor list (whose hospital confinements and drugs are also paid for by the Municipality). But in many municipalities the number of poor people is almost nil, so that the local administrations tend not to replace municipal doctors when they leave. On the other hand, some

administrations believe that the assurance of the continued presence of a qualified doctor, appointed by public competition, (particularly in more rural and dispersed areas) can represent an important encouragement to local people. Municipal doctors may be employed as school medical officers and as part-time Public Health Officers but such work is very much less remunerative than the fees obtainable through practice with Sickness Funds. Preventive and public medicine is not therefore very popular. In the municipality the Public Health Officer shares overall power with the Mayor but cannot order anything involving expenditure.

Hospitals are independent public agencies whose governing boards are formed by representatives named by municipal, provincial and regional councils according on a proportional basis. When it is impossible to constitute a board the region can temporarily manage the hospital through a commissioner (this happens when provinces or municipalities do not succeed in forming local governments and new elections are ordered). Hospitals are divided into regional, provincial and local according to the number of services they provide, rather than the number of beds. Local hospital should assure a minimum of services, provincial ones must have additional services, while regional hospital are staffed with hyperspecialized personnel and equipment.

Members of boards of governors are not salaried, but receive a modest monthly reimbursement, while accounting is assured by a team of state officers. Administrators being political men are linked with the community, but, at the same time tend to accept the demands of local staff, since quite often the hospital is one of the main sources of work for the local population, and there are electoral implications in enlarging paid unqualified staff or even in increasing (through local agreements) the standstill fixed on national basis.

The mechanism of the daily fee avoids an active managerial role as is explained in the financial section. At the same time the corporate existence of hospitals has many disadvantages and therefore in any future reform local hospitals should become the responsibility of the Local Health Unit, with major ones the direct responsibility of the regions-management being participative with maximum delegation.

One of the principles of the last law on hospitals (1968) is the right of any person to emergency admission to hospital and the duty of the hospital to give a reason for its refusal and to provide transportation to another hospital if it has no vacancy. In case of refusal the patient can make use of his right to appeal to the Health authority, which may produce unnecessary admissions as the doctor on duty may worry about the side-effects of his refusal. Nevertheless it is a guarantee for the citizen and it reduces waiting lists.

Often a patient has to undergo in hospital the same examinations which have already been made as an outpatient in one of the Social Sickness Fund clinics or health centres and the same can happen when a patient is moved from one hospital to the other.

The connection between hospitals and other health structures are provided for by the Law, but the existence of a separate administration and the impossibility of exchange of personnel between different institutions makes it very difficult to put these principles into practice.

Computers are popular in hospitals but their main utilisation is in the administration (not in the management) and for laboratory data processing. There is a cultural obstacle in introducing evaluation of the quality of medical care such as medical audit, peer review or even T-committees.

Private hospitals (94,000 beds) are generally partnerships with shareholders who very often have a high proportion of doctors among them, though many of these hospitals belong to religious orders. There are in practice two main classes : "high class" private hospitals with residential luxury facilities, attended by well known surgeons; and "ordinary" private hospitals whose main income derives from agreements with the Sickness Funds particularly for deliveries and minor surgical operations. Their daily fee is usually lower than that of public hospitals since they have the possibility of a more rational use of beds and are not subject to the strict rules of public hospitals as far as minimum staffing and the provision of infectious diseases and emergency wards are concerned.

At the moment a new regulation order is under study whereby some of these advantages will be reduced and a standard level of care ensured for private hospitals which often do not provide any better qualitative care than other hospitals (excepting, perhaps, a greater freedom of visiting). The general policy is not to encourage private hospitals imposing standards for the sake of the care of patients and applying the hospital law which from 1975 foresees the prohibition of private practice in private hospitals by public hospital doctors whose presence at present represents the best advertising for these private institutions.

It should then be possible to reduce the competition between public and private hospitals and to select among them those organisations which can truly provide an alternative to public hospitalisation.

Sickness Funds

94% of the population is covered by some sort of compulsory health insurance which reduces from 9 to 15% of salaries. There are about 200 different Funds but the main one is INAM which covers 45% of the Italian population. Six other agencies provide care for another 35% with the remaining being spread among small Funds. Sickness Insurance assures for workers in private industry, agriculture and trade, the payment of daily allowances which are given by Public authorities to their employees. Insurance against working accidents is managed by a special Institute which deals also with workmen's compensation for occupational diseases ; while TB is insured by the same Institute which provides for ordinary old age and invalidity pension.

Usually sickness funds assures total payment of hospital fees for not more than 180 days each year, apart from some chronic disease of old age. They also assure direct payment (only for a few categories reimbursement to the insured person) of general practitioner's and specialist's fees. Drugs are provided freely by most Agencies and now (as previously mentioned) for the farmers artisans and other independent workers, Regions are trying to integrate the pharmaceutical care, not currently available to them.

INAM obliges insured people who require an expensive drug (which is not comprised in a long list of nonproprietary drugs covering practically all registered products,) to pay themselves a small percentage of the cost (around 300 lires).

The increase in drug consumption is one of the main causes of exponential increase in the output of a Sickness fund (with hospital fees).

When a person has completed his 180 days of illness each year he can :

- apply to the Region if he is affected by a crippling condition requiring rehabilitation and appliances (the money is given by the Ministry of Health)

- apply to the Municipality in case he can show that he has a very low income

- apply to the Public Welfare authorities when Municipalities are unable to provide for him.

The treatment of VD and of infectious diseases for which confinement is compulsory, in the responsibility of Regions.

The Health Insurance agencies in recent years have been obliged by law to contribute to preventive medicine. This happens for TB immunisation for the financing of kindergardens. There are also indications in some statutes such as that of INAM, of going further than the simple treatment of union's interest justifying the controlling role by the Ministry of Labour but national Trade Unions now agree that they should gradually disappear from the field of medical care.

Criticism of this system is unanimous - duplication of diagnosis; tendency by physicians to overuse the system; lack of co-ordination and linkage with other structures; competition between Sickness Fund clinics' and outpatients' departments of Hospitals; need for the Treasury to intervene because of the constant deficit of the Agencies. From the political point of view the Sickness Fund became an important part of the so called "under-government" or "a typical centre of power" resulting in bureaucratic policies and in rising costs of administration.

The citizen even if he enjoys a virtually unlimited access to treatment (apart from dental prosthesis because of the insufficient number of dental clinics within the sickness fund) tends to identify "insured medicine" with a low-degree medicine. He makes recourse to it mostly to obtain financial benefits, drugs and certificates, and doctors are evaluated according to their willingness to yield to pressure. The time given to each consultation is very short and prevents a suitable doctor patient relationship, even though the number of general practitioners assures an average of one doctor for every 700 insured people.

As the services provided by the Health Insurance agencies are not in great esteem, private practice is flourishing with fees on the high side (particularly for dental treatment).

Antenatal clinics, paediatric clinics, kindergardens, maternal schools, school health services, immunisations, cytological smears, dispensary visits for chest diseases consultations at Mental Hygiene clinics, screening visits in industry and in some centres of Preventive Medicine are totally free of charge but attendance is not good and there is no linkage with Sickness Fund, which makes follow-up rather difficult.

Within the insurance system the normal practice is for specialist visits to be authorised by family doctors but very often it is a simple formality and group work between GP and specialist is not popular. The same applies to "health centres" and groups of doctors working in the same premises have in common only their sharing of rent and secretary.

MANAGEMENT

Before 1970 there was a network of medical authorities because in each province the Medical Health Officer (a state employee) was the major health authority with autonomous power but not with direct managerial responsibility - his tasks being more of control and promotion than of administration. In the municipality power was shared between the Public Health Officer and the Mayor, the first being the representative of the Ministry of Health in the municipality.

Lay administrators have always dominated the Ministry of Health in the sense that in the decision-making positions they have outnumbered physicians. Usually lay administrators have a legal training and have no experience in the field of social services.

There is now a modern school of Public Health but only post-graduate courses in Hygiene and Public Health with an overwhelming trend in the classic sanitation and bacteriological fields (still necessary owing to the poor conditions in much of Italy).

Only in Hospital is there a "medical manager" - the medical director who plays an advisory role with the lay director (administrative director) in the meetings of the Board of Governors. He is responsible both for hygiene (sanitation, prevention of cross infections, food) and for personnel (service, admission of patients, shifts, statistics, training and so on). In the Sickenss Fund, physicians have a controlling role over the practising physician but virtually no administrative tasks.

It has been questioned during the present debate - WHO WILL DIRECT THE FUTURE HEALTH UNIT OF MEDICAL SERVICES? Most probably he will be a community physician with training in managerial systems. This idea has gained popularity in the last months even in absence of any serious experience of training in this field (apart from the industrial initiative). There is no separate management of the nursing service and this is one of the reasons why there is a shortage of nursing personnel.

All the experts in health education are aware of the need to address an important part of their effort towards the health education of administrators particularly lay administrators (although physicians are not excluded). Currently because of their negative attitude towards health problems they take decisions which are not positive. For example, they tend to overstress the confinement of some patients presumed to be contagious, give priority to any kind of expense for cancer, and refuse to treat leper patients - who in Italy have to be named in official records "person diseased by Hansen diseases" in order to avoid a social stigma. Reduction of contact with other countries and the so called "provincial outlook" are mainly responsible of the old-fashioned system of administration. In addition, however, the rigidity of the laws and regulations represent an important obstacle and the active administrator is obliged to go against the strict observance of the law risking penal sanction almost every day!

FINANCE

It is very difficult in these last months to approximate a calculation of present and future cost of health services in relation to GNP. It is estimated (1971-72) a total of 4,500,000 millions of lires was spent on Health services which is approximately 6% of the GNP.

These expenses can be summarised as follows (1972) :-

1 - SICKNESS FUND : Input through compulsory insurance : 2,310,764 millions

Output only for health and economic care 3,049,237

Deficit: 738,000 covered by the Government
94% of population is covered by compulsory insurance. Participation of insured people is minimal because hospital GP and specialists, drugs and most part of appliances are covered.

2 - Budgets of Ministries, Regions and Local Authorities : around 700,000 millions taken through general taxation (there is no particular taxation for health services)

3 - the present mechanism of financing the running costs of hospitals is based on the "daily fee" established by the hospital and approved by the Region on the basis of the average number of patients in the previous year and the total costs comprising :

- salaries, stipends and so on (from the 60% to the 70% of the total cost)
- pharmaceutical expenses, equipment, food and running of services
- expenses of amortization up to a maximum of 40%

Most administrations also includes the cost of interest on the loan caused by the delay in payment by the Insurance Institutes. The various Sickness Funds do not accept the daily fee because they are chronically in deficit and they do not have any say in how these fees are determined.

In five years the main daily fee passed from 8,000 to 23,000 lires mainly due to increasing salaries. Private patients pay also for surgery and drugs while non insured patients who are cared for in the common ward are only charged the daily fee covering all their care. Insurance institutes pay a higher fee for intensive care treatment, major surgery and so on. Usually for the ordinary fee payment comes from :-

- in part, the municipalities for the poor patients cared for in the year
- in part, the Sickness Fund with a partial involvement, in the sense that no more than 75% of the fee is paid. The difference is covered by the Government in its periodical research work for the deficit of sickness fund, but more than the 6% of the hospital cost is linked to new loans made necessary by the urgent need to pay salaries and stipends.

Money for new hospital buildings come from the Government and from Regions but at the same time, Hospitals can obtain very advantageous loans provided that any new building is approved as part of the regional plan.

A simple calculation of the increase in expenses met by Sickness Funds gives a clear idea of the problem :

Year	Hospital admissions	Ambulatory care	Physicians fees	Drugs	Others
1967	501,967	80,899	270,017	373,339	73,339
1971	1,170,735	222,883	414,835	547,971	49,104

Newly insured people account for only on 4.5% of this rise while increase in salaries is responsible for the 83.5% of the major expense.

Government has no power to control hospital salaries but one way it could do so would be to restrict loans to hospitals to national limit when administrators increase stipends,such negotiations are not directed by government but it can be called in as peacemaker.

It has been calculated that delay in the reform of health services will increase the deficit in sickness fund to 1,200,000 millions in 1974. Such reform could reduce increasing costs because :-

- any cost of controlling the patient's insurance status will be abolished.
- cost of administration of the large number of existing agencies will be sharply reduced
- personnel will be in a single regional group and differences in financial treatments will be abolished
- a central and regional computerized file will reduce overuse of doctors and doctors would be paid on a capitation fee basis
- hospitals will be managed according to new criteria decided by managers, with calculation of costs for services and co-ordination of similar services and one on a regional basis (associations for common services, common purchasing and so on)
- A system of anticipation will be substituted for the current one which involves chronic delay in making payments - thus reducing the need for loans
- the trend towards hospitalisation will be reduced with greater emphasis placed on health centres, family practice and prevention.

Different Budgets:

Ministry of Health (1974)	202 billions plus 56 billions for care of crippled people
Local Authorities : (1973)	540 billions : but it is difficult to separate budget for welfare services and budget for health services
Sickness Funds (1973)	2.130 billions of which around 400 comes not from premiums on salaries but from the Treasury (for the independent categories half of the budget is assured by the Government)
Intervention of Treasury	To meet the deficit : from 6-700 billions; but at present the deficit is more than 1,000
Private expenses :	voluntary insurance for health is almost non-existent, but there are items such as dental care, and private care chosen for preference which account for around 500 billions of private expenses

There is an important controversy as far as computation of health budget is concerned - experts in favour of reform stressing the high incidence of expenses for administration, while defenders of the present situation claims that no serious effort is made to divide between welfare intervention and health care expenses.

In the Hospital management the inputs from rents of buildings, estates and so on have been sharply reduced and on a total of 2,314 billions of inputs (1971) represent only 15 billions.

In the hospital budget :

Running costs amounts to 2,252 billions
capital costs amounts to 234 billions

In the health services there is no experience of financement through money borrowed in the market, although such a measure has been proposed many times (obligations for building of new hospitals). Usually the money to meet the deficit comes from :

- the relative flexibility of the State budget (the Constitution obliges it to find additional sources for any new expenses although there are many tricks to avoid the imposition of unpopular additional direct taxation. As everyone knows in Italy indirect taxation is heavy and increasing, when taxation produces more gains it is easy to obtain further finance for deficit.

- the transfer of funds from more active budgets (like that of insurance against working accidents and pension) to a passive one Some activities like kindergarten building and functioning are partly financed through the increase of some compulsory premiums on pension, but in periods of unemployment it is difficult to reach the amount foreseen in normal periods.

Control and Accounting

The State budget is submitted to the control of Parliament and every expense is registered by a special Court.Control is mainly formal in the sense that the expense or the grant must correspond to the aims of the single title of the budget. Grants are given to local authorities only when in the local budget there is a corresponding sum or at least a partial participation. Regional budgets are approved by the regional parliaments and submitted to a more flexible control by regional Courts.

Provincial Municipal and Hospital budgets are submitted to the administrative control of the Region. Control is not always limited to ensuring that the expenditure comes within the laws and regulations and the border between formal and substantial control is very confused. It happens that in some places non-compulsory expense of local authorities are not approved while in other regions they are encouraged.

Accountability of the State, Regions, Provinces and Municipalities is the responsibility of the same court through a detailed examination of the expenses and a report to the Court which then transmits its observations to Parliament. Usually observations of the Court are not fully taken into account. When the Court finds some irregularity the officer responsible can be charged and fined to repay the sums.

In hospitals the role of the accounters is not defined in the sense that they have no right to interfere with the mechanism for approval of expenses. When a decision coming from a Hospital reaches the regional authority, if no observation is made within 15 days the decision is considered as approved.

Why with such a controlled system is there so large a deficit? Because it is impossible to reduce the delivery of care which is considered a right like hospital care, pharmaceutical care and rehabilitation for crippled people (12% of the appliances are represented by equipment for the deaf).

The increase in drug consumption is relevant : 1965 : 12 prescriptions per year
1971 : 16 prescriptions per year
the number is reduced (10) when the doctor is not paid for service.

Some Statistical Data on the Health of Italian People

Population

census 1971 : 54,025,000. 96,4 males per 100 females
10.9% up to 65 years
23 2% up to 15 years
Yearly increase in the period 1961-71 = 0.65%
Mean composition of each family : 1961 =3.6
1971 =3.3
Percentage of population active (in working activities) 34%
of 100 persons working 17.7% still work in agriculture
(in 1961 the comparable percentage was 29%)

Marriage rate

7.4% (1972) constant in the last 30 years
Mean age at marriage : Males 28.14 Females 24.29
Median " " " " 26.61 " 22.91
The age at marriage has been subject to a slight decrease : in the southern regions values are a little lowered for females (around 23.0)

Birth rate

16.5 (1972) Slight decrease from 1961 (17.7)
Range : from 21.2 Campania (Naples) to 12.2 in Liguria. The difference was greater 10 years ago, due probably to the relevant migration of families from South to North which has helped to narrow the diffence, producing a slight increase in the northern birth rates. Of every 100 mothers delivered in the period 1968-70 only 1.7% were under 18 years and 4.8% 40 or over. Among the deliveries for the same period 15.8% were of babies of 4th or more order of birth. In the southern regions, particularly in Campania and Calabria the comparable percentage is 25% or more thus raising the risk of perinatal mortality.

Illegitimate birth rate	out-of-wedlock births have been reduced from 38% of births in 1950 to 22% in 1972. (38.7% - 22%) In the South the rate has always been lower (8% in Basilicata) probably for cultural reasons : for the same inverse reasons in the northern region of Trento the rate is 50% (full acceptance of out-of-wedlock babies are well accepted in this region).
Death rate	9.5% (1973) constantly under 10% since 1961. In the South rates are lower even after their standardisation for age. The main cause of death is cardiovascular diseases (4.5%) followed by cancer (1.8%) respiratory diseases (0.7%) digestive tract dis. (0.6%) accidents (0.5%).
Infantile mortality	27.0% in 1972 There has been a considerable decrease in late infant mortality (ie after the first month of life). It was 20 per thousand live births in 1951 while it reached 7 per thousand live births in 1972. However, the number of babies up to the first month of age who die because of enteritis in the first year of life is still almost double that in other Western European countries. The incidence of infantile deaths due to accidents is the only one which is much lower than in other countries possibly because of the persistence of the custodial role of the mother (or other female relatives).

Neonatal mortality (during the first month of life) is 20 per thousand and has decreased only slightly ; it is linked mainly to insufficient ante-natal care and lack of adequate intensive therapy equipment and qualified nursing personnel in paediatric wards for the treatment of premature and high-risk babies.

90% of all births take place in hospital. In 1961 the figure was 65% but still on the agricultural population the 20% of confinements are at homes with rates around 45% in some southern regions (always among the rural population).

The figures for miscarriages (150,000 per year) is within the limits of the percentage of 15-20% of births suggested by WHO. Italian Law does not allow therapeutic abortion, except in cases where the mother's life is at risk.

There are no data on how widespread is the use of contraceptives. The figure of one to two million illegal abortions per year which has been quoted, appears to be over estimated since if correct should be accompanied by a more sharp reduction in general fertility (it is quoted that sterility follow in 10% of abortions). Maternal mortality (1970) is around 6 per 10,000 total births (toxaemia accounts for 1.9).

Infectious diseases

Particularly in the South, typhoid fever and brucellosis are persisting, while diphtheria has considerably diminished and polyomielitis has almost disappeared. Infectious hepatitis had its maximum development during the period 1967-69 with outbreaks in all the regions, but prevalently in the North and Centre and in school -age children.

In the regions where in Sept-Oct 1973 an outbreak of cholera happened, the strict local measures of sanitation and personal hygiene have contributed to reduce to half the mean number of cases of typhoid fever and hepatitis in the last three months of 1973 and first two of 1974, even though the trend of the first 8 months of 1973 had shown remarkable increase.

Venereal diseases do not appear on the increase, not even in the figures concerning cases among army personnel, though the problems of prostitution and the lack of sexual education are serious.

Education

In the period 1961-71 an important increase in number of schools, teachers and students has taken place. While in 1961 the total number of pupils from elementary to secondary high schools represented the 13.7% of the total population, in 1971 it was the 18.0%. The relative explosion of universities is characterized by the percentage of students in the population : 1961= 0.5% 1971=1 3%
Compulsory education continues until 14 years (5 years of primary schools plus 3 of obligatory schools of the secondary order).

Medical Faculties

Because access to Medical Faculties is free to all graduates from secondary high schools (even from technical and professional high schools) the increase in medical students during the decade was parallel to the general increase in the University population ; with a trend towards even greater increases :

1961 : Total	288,000	1971 :	750,000 Total
Medicine :	25,000		97,000 Medicine

In 1973 the total number of medical students was 110,000.

STAFFING OF HEALTH SERVICES

Physicians

At present the number of practising doctors is 107,000 of whom :

10,000 are dentists (the proposal to have a separate training has not yet been introduced to Parliament)
40,000 are hospital doctors of whom more than half are full-time
9,000 are municipal doctors living also in small villages who are paid for treatment of poor people (4% of population) but who enter into private practice within Sickness Funds
9,000 are army doctors, Public Health Officers, medical directors of hospitals, medical administrators of sickness funds

The specialist in Italy does not have ordinarily the same functions as the English consultant or as a secondary care physician but is more akin to the American specialist, as he is a part of a group of doctors providing primary care (paediatricians, gynaecologist heart specialist).

Specialist training takes place in University schools and can last from 3 to 5 years; a full-time training is often quite theoretical, but will have to be introduced after the EEC directive becomes operative. An open problem is that of the salary to be given to doctors during their specialist training and the trend is now in favour of their introduction into Regional Hospitals and University Depts, as "extraordinary assistants" (registrars). We can produce numbers of post-graduate diplomas which can be obtained after 3-5 years of academic study with examinations and a final thesis. An important number of paediatricians, chest physicians, dermatologists and cardiologists work both as general practitioners and specialists owing to the different variety of Sickness Funds. Specialist work is done mainly in clinics at the Sickness Funds ambulatory network ; about 40% of hospital doctors are specialists but post-graduate degree is required only for perfoming anaesthetics and radiological work. While, as pointed out before, access to university is free, admittance to a specialist school is restricted in almost all the post-graduate schools.

The number of diplomas shown that while the total numbers of paediatricians (6,000) gynaecologists (2,000) surgeons (2,000) and cardiologists (4,000) are reasonable there is a shortage of radiologists (1,000) and particularly of anaesthetists (less than 1,000).

The Medical Faculties are in crisis : compared with more than 100,000 students there are 1,100 full-time professors and around 12,000 assistants of whom 3,500 are part-time (voluntary assistants).

It is difficult to have data on the number of students dropping out of medical schools in the last few years because now students have greater freedom in the selection of courses they wish to attend. Previously the school failure rate was around 22%, but even so in 1975-76 the number of 130,000 doctors will be reached and surpassed.

There are 27 Medical Faculties with Hospital departments staffed by university (State) and guested mostly by Hospitals: the relationship between University and Hospital is regulated by specific agreements and the whole problem of a better utilisation of beds and hospital staff with the aim of contributing more to the training of medical students is one of the central issues of University reform. Researchers and medical scientists tend to stress the unity of the process of medical education and feel that too close a professional link with hospital and Health authorities might endanger the cultural aspects of university training. Some university professors would tend to prefer a direct dependence from the Ministry of Health as this would lessen the effect of the introduction in the University of the single category of teachers. The young hospital doctors are in favour of the way of introducing a "single hospital doctor" category so as to overcome the present hierarchical situation.

It must be noted that from 1974 onwards newly trained doctors after their 6 years of university training will have to spend a full year of hospital placement either in a Regional hospital or in a University department, and their salary will be equal to one third of the ordinary salary of the first assistants. There are proposals for increasing the length of this probationary period (which is followed by a State examination) and including in it placement in local public health services in order to overcome the disadvantages of a training based entirely on hospital experience.

In the Italian situation there is a great need to improve training and orientation in the field of preventive medicine in order to obtain a future doctor able to cope with prevention and treatment at the same time. What is the number of doctors required? The reply to the question is a very difficult one. The objective of 130,000 doctors will be easily reached and was indicated by the first economic plan of the Government (1968-72).

The trend towards a system of unified services with the prevalence of the local district team GP/Nurse should reduce the present overlapping and the multiplication of useless tasks. But there is always the risk of the introduction of new types of institutions staffed separately and at present one of the more important topics of discussion is the needs of preventive services versus the trend towards a full integration. The same discussion is taking place with regard to rehabilitation services.

One of the main difficulties in calculating the present income of physicians is the lack of a central file of doctors and patients, so that distribution of clients and income is uneven. Each Sickness Fund has its maximum number of patients allowed to register to each doctor registered in the authorised list, but it is easy to work for more than one Sickness Fund. The same difficulty affects the calculation of the real need for GP and specialist services, being on average the number of visits paid yearly for persons increasing each year (at present around 12 in the system of fee for service payment).

Treatment, Careers and Perspectives of Medical Professions

All public positions in Italy should be won through public competition with written, practical and oral examination and evaluation of career and scientific titles strictly fixed by the law and almost automatically evaluable.

For hospital doctors there are double competitions: one on national or regional ground for obtaining the "suitability" or the access to a further competition to obtain the hospital position. The first examination is a written one with 5 subjects to develop on a list of around 150 published yearly according to different degrees and specialities. The marks obtained in this written examination (which is under the responsibility of the Ministry of Health) can go from 0 to 7 and are counted for in the further competition for a position in the single Hospital (the total of marks for career and title is around 60 and every year of previous service is valued at 1 point, so that older surgeons of small hospitals have more marks than young university assistant professors).

Each hospital has a fixed number of positions and should be obliged to open a competition when a position is free. Owing to such a complicated mechanism of double competitions however,(begun in 1968 and introduced to overcome the prevalence of local interests and of University professors in the selection of hospital doctors), many hospitals have been compelled to fill their empty positions with physicians "charged" (who should possess a minimum of titles). At present, Parliament is examining a bill to allow some sort of moratorium for these hospital doctors (around 10,000).

Work and payment of general practitioners and specialists within the Sickness Funds are negotiated between the Funds and the Medical Associations. Stipends and working conditions of hospital personnel is also under the same system, even if hospital doctors are considered as public civil servants. On the other hand Public Health doctors, local doctors (medici condotti) and insurance companies doctors' salaries are fixed by law and not submitted to negotiation.

Medical Associations are half/public and half/private; registration is compulsory for practising and they have disciplinary powers in case of penal or professional offences but also when doctors refuse to strike or accept conditions which are considered as contrary to professional dignity by Medical Associations. The organisation is provincial and the governing body is elected every 4 years. The Ministry of Health can dissolve the Association in case of irregularity. Such a mixed situation is submitted to heavy criticism particularly for the power given to a semi-private institution against the freedom of work of physicians. There is an interesting trial of a group of doctors who refuse to accept the orders of the Association-registration in which is compulsory as far as minimum fees and condition of financial agreement with Sickness Funds are concerned. Minimum fees for GP's and specialists are fixed by the Law but do not apply to work within the Sickness Fund being considered in the free profession. There is no maximum fee and Medical Associations usually tend to justify very high fees required by some university professor.

AGP or a specialist who wants to work with a Sickness Fund requires registration through the Medical Association. The number of positions for GP's is unlimited but in rural areas priority is given to local municipal doctors. Positions for specialists are usually limited with the Fund practising the system of paying specialists for the number of hours of service in Insurance clinics. Clients are entitled to choose their physicians on an individual basis and can change even during the same episode of illness. Physicians are paid according to four systems :

Per service (fee for each visit divided in domiciliary and in the same doctor's clinic with a plus for night calls and holidays service)

Per capita (divided into different categories according to age, residential area of clients)

with a mixed system (an experiment for young doctors)

according to the number of hours of service (for specialists)

In each province Medical Associations negotiate with Sickness Funds the prevailing system and try to improve the same pattern in all physicians. Usually a certain choice is possible between the two main systems (fee per service and capitation) and there is some sort of fifty/fifty division between the two ways. The more recent trend is to negotiate on national grounds and with all the Sickness Funds together in order to avoid so many different procedures.

The average number of visits/per year in the fee per service system is almost double (12 against 7) and the number of pharmaceutical prescriptions/per year/client is 15 against 9. On the other side there are difficulties in the exact and well-timed calculation of the number of clients in the capitation system, particularly in the areas of large population mobility.

The Physician's Income

This is a ground of debate. Trade Unions, affirm that it has increased sharply due to the enlargement of Sickness Funds medical care in the last ten years (lately, for instance, the State Employers' Sickness Fund passed from the system of reimbursement to patients, to one of direct payment to the physician. The reimbursement per service is restricted to few categories - approximately 2-3% of the insured population and while doctors can claim official fees, Sickness Funds give the patient a reduced amount). The flow of new medical students is assumed to be produced partly by the promise of high and uncontrolled gains (in a country which is at the beginning of a rational taxation system). Dividing the expenses of Sickness Fund for payment to doctors (family doctors, arithmetical main is (1971) around 6,500,000 lires yearly.

Hospital

Monthly stipend (13 stipends yearly)		Full time	Part time
Assistants	from	428,700	273,700
		955,450	601,200
First Assistants	from	843,450	531,200
	to	1,202,950	756,200
Consultants	from	1,187,200	746,200
	to	1,427,450	896,200

Full-time is chosen by the same doctor after approval by the Hospital administration and means 40 weekly hours and no private practice apart from some activity within the hospital itself. Part-time means 36 hours weekly and the possibility to private practice but not in private hospitals (at present but only until 1975 it is allowed provided that the hospital is not concurrent with the public one).

Overtime is well-paid and there are additional gains from clinic activities and paying clients in separated rooms, fringe benefits, night duty and indemnity for being on call. The two terms for each category are the minimum and the maximum treatment, with fixed periodic increases according to length of service.

Passage from assistant to first assistant and from first assistant to consultant (head of division) is linked to the winning of a competition. Every position is life long till 65 years (70 for consultants and medical directors; this last category may comprise of non-treating doctors with responsibility for sanitation and personnel).

For psychiatric hospitals and for University Departments the monthly stipend is partly given by provincial authorities and by Universities and it is linked to the Government's officers while the amount necessary to reach the level of corresponding hospital personnel is assured by the Government. From 1967 to 1971 the expenses for hospital treatment have passed from 100 to 240, the increase being almost exclusively due to the new stipend of medical and paramedical personnel.

Public Health Officers

Government positions are half empty and paid according to the same level as other civil servants without any possibility of further gain being forseen (reimbursement to the Government even of the fees for participating in examining boards and so on). Monthly stipends (13) are from 180,000 to 500,000 (medical general inspector) and the career is linked to internal examinations and periodical title evaluations.

The Army medical corps try to overcome their shortage of doctors by offering free and paid training during medical studies in a particular Academy in Florence but the results do not seem to be encouraging. Army doctors are allowed to practice and have some privileges (like the right to sign medical certificates for driving licences) but can be submitted to frequent transfers.

Regions at present are building up their medical staff who in any case should be restricted owing to the prevailing pattern to planning and promotion more than to direct management. They should align with State parameters and usually have introduced the principles of "everything in the stipend" without any possibility of extra earnings.

Local authorities assure stipends for Public Health Officers and municipal doctors, school health doctors, psychiatric hospital personnel and medical personnel of P H Laboratories. There is no national stand-still because stipends are determined by every authority individually, but submitted to control by the Region (and partly by the Ministry of Health). Negotiation between the association of local authorities and medical associations has not the same official value as for Hospital personnel. The main point for P H officers is the amount of extra gains from visits and inspections in the interest of private patients and so on. At present there is a trend towards a overcoming of legal restrictions (no more than $\frac{1}{3}$ of the stipend). In some large cities the P H officer can gain more than 1,000,000 monthly solely from extra earnings (stipends are more or less similar to governamental ones).

Doctors working as administrators in Sickness Funds (6,000) earn from 400,000 to 700,000 lires monthly and sometimes are allowed to practice with clients of other Funds. They have experience only in the field of control of medical acts and are more addressed toward forensic medicine than prevention and management. One of the subjects of discussion is who will direct the future local health unit; and the category of insurance medical administrators is much more numerous than that of P H officers (around 1,000).

Nursing Personnel

The shortage of professionally qualified nurses (since 1971 both sexes are trained at the professional level) is related to the persisting status of "auxiliary personnel" in which this profession has been kept. The same control of nursing schools and the responsibility for their deployment in hospitals is practically in the hands of medical directors and the nurse head of the school is restricted in her authority. The last hospital law has introduced the nurse head of nursing staff in hospital but there is still confusion with the inspectors of aid-nurses and with the simple task of controlling working hours and shifts.

There is a vicious circle of shortage of qualified applicants to professional training. Trade unions pressures on the part of the nurses' aids have resulted for a period of moratorium in their being allowed to attend the last year of professional schools and they now push for a new extension of this. There is also a tendency to consider the role of the nurses as consisting of just a set of techniques to be learnt and therefore to dismiss the importance of good nursing, and of course there is a failure to meet the shortage of 40,000 qualified nurses for hospital service and 20,000 for home care, in spite of an important increase in the number of nurses' training schools (120 in 1968, 290 in 1973. Yearly output 3,000 in 1968 - 8,000 in 1973 plus 2-3,000 aid-nurses promoted professionals).

Some experts are in favour of abolishing nurses' aids and establishing a single type of nurse in order to avoid too many categories of personnel crowding around the hospital bed. All seem to agree on the need to develop the extra-hospital and domiciliary care role of nurses, including the task of health educators; this would imply a shaft from an almost entirely hospital centered training to a training taking place in schools at the level of higher schooling. There have been proposals for the establishment of secondary schools termed "Health technical schools" accessible to school leavers (after the first 8 years of compulsory schooling) and with courses of 5 years duration followed by short practical training in hospitals. This type of training would have the advantage of giving all the para-medical professions a common basis both cultural and professional. On the other hand this trend runs counter the more accepted idea of reducing the number of professional secondary schools and stressing instead a comprehensive education; professional training should, from this point of view begin only after the basic secondary high school diploma.

At the moment access to a professional nurses' training school managed by the Red Cross or hospital administration begins after 10 years of basic schooling. The courses are two full years and there is no longer the obligation of residence. After first diploma one year further training can lead either to qualification for becoming a ward sister (head nurse) or to specialisation such as health visitor, midwife (a further two years) paediatric nurse, surgery (scrub nurse) anaesthesia. There are three university schools for directors of nursing services and teachers in nursing schools and WHO tends to encourage these programmes giving technical assistance. In this field Regions have a responsibility which overlaps with the State's and in some cases have adopted their own measures following abstract criteria (eg schools for children's nurses have been surpressed on the basis of the desirability of a "single type nurse"; courses for head nurses are threatened on the grounds of the trend against any kind of hierarchy and so on).

After 8 years of compulsory schooling aid nurses follow a one year course in hospitals; they are allowed like professional nurses to practice in private having a lower set of tasks and responsibilities; there are around 60,000 aid nurses against 35,000 professionals but the number of courses is reducing. Professional nurses have their association which has the same tasks of Medical Association but much less effective power. There is no Nursing Office in the Ministry of Health or in the regional offices.

Midwifery is a separate auxiliary profession with c separate association; there are about 24,000 midwives with a rather elevated averaje age. After the request of the nursing degree before entering into the midwifery schools (which are directed by professors of obstr/gynec of University Dept.) the numbe- of students has decreased but the trend began a little earlier owing to the decreased number of domiciliary deliveries. It is becoming increasingly difficult to cove- vacancies in hospitals while municipal midwifes (3,000) in fact are seldom employed in helping births at home and according to some municipal authorities, are in fact bec>ming a useless expenditure. Midwives tend to be used in preventive medicine tasks (vaginal smears collection) and in giving advice about child nursing. In this last field there are professional nurses with special training, but also children's nurses (nursery nurses) who should only look after healthy children.

Physiotherapists are somewhat scarce and their dip oma is not yet officially recognized. There are schools offering three year courses which can be attended by young people qualifying for University entrance. These schools receive grants by the Ministry of Health and their academic position will be soon regularized. The estimates give a need for 7,000 physiotherapists against 2,000 existing; also in this area sectional pressures are very strong, especially on the part of the masseurs of different training and qualifications. It is very important to resist these pressures pointing out the need for a cultural qualification needed for team work.

X-Ray technicians are trained both in three year courses given in large hospitals and in technical schools and requiring 8 years of schooli ıg. It is estimated that within 5 years the present shortage should be made good. Labo-atory technicians partly come from hospital training courses of varied duration, partly cre trained in chemistry in professional schools through 4 year courses and undergo further training in hospitals. Opticians and dental technicians are trained in vocatior al schools offering four year courses. As said before some of the auxiliary medical professions have their own register (association) with their own elected Board similar to mecical registers (nurses, midwives, X Ray technicians).

It is very difficult for a foreigner to be accepted for registration in Italy even with such a severe shortage, as this would require reciprocal agreements on the part of the country of origin (according to the law dealing with all the registered professions). At present we are still at a very early stage of the free movement of professionally qualified people advocated by the EEC. The EEC directives are quoted by several experts as a means of inducing Parliament to introduce qualitative legislation in this field.

Research

Research other than purely medical is not widespread in University Departments. Most inquiries in the field of costs, organisation and evaluation has been performed by private Agencies financed by the electronic industry. The same Ministry of Health do not possess a staff for research and it is obliged to finance private Agencies which are at the beginning of their involvement in the health field and do not possess sufficient knowledge of national and international health matters.

Economic Departments of Universities, on the other hand, begin to be interested in managerial games and an important part of the budgets for research of local authorities is devoted to the calculation of cost/benefit particularly in the field of social services. Psychology departments are interested in research on personnel motivation and the dynamics of personnel relationships among health staff. For the moment most research is at the stage of the survey of the existing facilities and the comparison with the situation of other countries. Sickness Funds have more experts than State and Local Authorities and provide a lot of papers in their own magazines.

FUTURE TRENDS

The reform of Health Services is a sort of myth in Italy but, nevertheless, it is quoted in plenty of official documents and even in some recent Laws such as that for rehabilitation of disabled people which postpones the settlement of whether or not there should be regional involvement in the administration, until the "reform of health services".

The outlines of the reform have been drawn up as a result of a long period of debate and consultation with trade unions, professional associations and experts. For some years some Trade Unions leaders favoured the maintenance of Sickness Funds because their representatives sat on the governing board, but now, at least in their speeches, these organisations support a global National Service. The Medical Associations are unhappy about the present situation but claim a more powerful role for physicians and declare that no Health Reform could be really implemented without the support or against the advice of the doctors. Regions and a relevant group of experts point out the need to increase participation at all levels of the service and one important point of discussion concerns the size of future Health Units - the prevailing view being now from 50,000 to 200,000 people.

In any case the structure of the Local Health Units and the particular ways of administration should be fixed by Regional Law, the Reform Law being a "framework Law" or "Law of trends" rather than an operative Regulation.

These are the present outlines which represent an agreement between the Political Parties, Trade Unions and Ministries of Health and Labour.

1 Tasks and Role of the National Health Service : Not only prevention, diagnosis and treatment of diseases but also :-

hygiene and sanitation of environment;
promotion of health and health surveillance in work place schools and any kind of collectivity
protection of mothers, children, the elderly and disabled; mental health;
rehabilitation comprising social and work rehabilitation;
drug, foods and beverages control;
veterinarian services (control of zoonoses, control of animal foodstuffs
health education-planning of training of medical and paramedical personnel and their permanent education;
establishment of a complete information service with retrieval, linkage and data bank, both central and regional.

The Service at the Central level will be represented by the Ministry of Health with an Advisory Body with power to make proposals composed of four regional representatives (3/4) and representatives of Ministries(1/4). The Council will have direct responsibilities for planning and the distribution of funds, while the existing Superior Council of Health will play only a scientific role. The Ministry will operate directly the prophylexis of infectious diseases, the control of drugs and other tasks. It will establish directives for the subjects delegated to the regions and will propose to the Cabinet (council of ministries) the trends and the co-ordinating operations for the health activities run by the Regions when they involve national interest, international agreements and particularly patterns of National Economic Development. Relationships between Regions and the State are mediated through the Cabinet and the Minister of Health, yet at present, have only a slight possibility of contact with Regions apart from technical subjects.

The Region will stress its present role of being a political centre for health planning with the active participation of Local Authorities and a link with the "social forces". It will have the task of promoting the permanent education of all the health personnel. An advisory body will have, in due proportion, the same tasks of the National advisory body and will be formed by representatives of the Local Authorities.

Each region will control the organisation of the Local Health Units which in any case should comprise :-

a comprehensive health maintenance system covering under a single administration all the primary services and most of the secondary ones
The present Hospital administrations will be dissolved as independent bodies and independent bodies and the majority of hospitals will be administered directly by part of the Local Health Unit Regional Hospitals.
a guarantee of democracy and accountability : the LHU will cover from 50,000 to 200,000 people and will be administered by an Assembly composed of the representatives of the Municipalities included within the boundaries (of course the preferred solution is to unify the two boundaries) - In the large cities the borders will be that of the districts which are at present virtually autonomous. The Assembly will elect an executive council . Real participation will develop at the level of the health districts which will be not administrative but functional units covering an average of 10,000 people and assuring the primary health services (GP nurses, school and working places medical schools). In each district there will be a health council named by all the families of the district and dealing with all the health problems of the area (advisory body with ability to make proposals.

The administrative direction of the Unit should be given to an administrator with managerial training while a committee of physicians should assure by rotation the chairmanship to ensure that any directive position is temporary (in order to avoid conflicts among different categories).

All personnel will be attached to the same regional administration, so that mobility will be assured in a system which currently suffers from a pletnora of different groupings of personnel, who can only pass from one hospital to another as a result of open competition. The financial treatment of all the personnel with full-time functions and employed as civil servants will be negotiated with negotiated Ministries and Regions, extending in such a way the present situation existing for hospital personnel.

Primary care or medical activities for diagnosis and treatment will be operated by physicians (and nurses) who subscribe an agreement with the National Health Service. They will be obliged to live in the area to fulfil some tasks of first aid, rotation of holidays and no private practice shall be allowed in the same Health Unit (but apparently no opposition will be made to part-time activity outside the boundaries of the Health Unit).

Free choice of physician will remain one of the characteristics of the system, while fees will be based on the capitation system. Financing will be assured by a National Fund included in the budget of the Ministry of Health, divided into running costs and capital costs and distributed to the Regions according to parameters established by the National Committee for the Economical Planning (a committee of ministries) after advice from the National Health Council and with the aim both of assuring a baseline level of health care in all the Country and of reducing the existing differences between Regions.

For a provisional period of two years :

- all the economic benefits given by the Sickness Funds will be transferred to one Social Security Fund which at present is responsible for old age pensions.
- the health structures of the Sickness Fund will be managed by Commissioners charged with the gradual disappearence of the Funds as such, and then merged with the National Health Service.
- all the procedures for doctor's payments will be unified and a local file of doctors will be established. In the same way the present time limit of 180 days of care/yearly will be abolished.
- all the activities of the Maternal and Child Welfare Agency and the health activities of the Red Cross will be transferred to the Local Health Units.
- global planning for the mortgage of the goods of the Sickness Funds.
- the mechanisation and the unification of all the budget and accounting procedures in order to allow grouping on a regional basis of the administration of hospitals and other institutions.
- the contributions for Sickness Fund actually paid for by the owners and workers will be revised and unified; they will pass at the end of the two year period to the National Fund together with the existing financial contribution made by the State, and Local Authorities.
- A distinction should be made between drugs necessary for life and treatment which will be free of charge, drugs useful but not indispensable with a partial charge and drugs to be paid for completely by the patient.

The brevet will be introduced while a public Agency will deal with tasks of research and competitive production; all the prices will be revised and the list of drugs to be given freely will be restricted.

The veterinary services will maintain a certain autonomy it being difficult to conciliate the realities of animal rearing with the problems of human communities.

One problem which is still submitted to debate is the transfer to the Ministry of Health of a relevant part of the tasks of the Ministry of Education as far as training and education of medical and paramedical personnel is concerned. Also no general agreement has yet been reached in the distinction of tasks between State and Regions in the field of prophylaxis for infectious diseases.

PROBLEMS OF HEALTH CARE DELIVERY IN ITALY AND OF ORGANISATION OF MEDICAL SERVICES

1st - The tendency towards a global approach may tend to overstress the philosophy of health services and to dominate the debate with thesis often preconceived. For instance, the affirmation that psychiatric diseases are mainly due to the present structure of the capitalistic society and that psychiatric Hospitals represent one of the forms of dominancy by one class may engender the feeling that only through a social revolution could it be poosible to change the situation.

2nd - The model of participation might be confused with the trend of giving to the trade unions and to the representatives of the personnel much more power in matters dealing with financial treatments and the discipline of personnel. Such a trend has created areas of privilege and particularly has reduced the task of most administrators to long and fatiguing participation in endless meetings.

3rd - Regions/State. On one side old-fashioned bureaucrats hope that everything will come back to the times in which they had absolute power. On the other, regions try to control every area (regardless of convenience) to build up their authority. The infectious disease problem is one example .

- bureaucrats claim that "Public Health" considered in a napoleonic way of thinking is "suprema lex" and police measures should be implemented from the centre.

- when a train coming from Naples in September 1973 was stopped north of Rome because a lady in the dining care was suffering from vomiting, Lazio regional authorities did nothing but simply isolate the lady. Toscana authorities in Florence stopped the train and submitted all the passengers of the dining car to the compulsory administrations of long-acting sulfa drug. Only by a last moment and strong intervention on the part of the Ministry was a mass vaccination avoided in Bologna (another region).

the idea of substituting old measures with an active role (epidemiological surveillance, monitoring of the antibodies and of the circulation of pathogens in the milieu) is not matched by people who lack a modern training in Public Health methods.

4th - How is it possible to change the present unsatisfactory relations between physicians and patients from a superficial approach without reciprocal esteem to a real co-operation? And how to modify the growing trend towards an increase in drug consumption? The total of drugs could be substituted? Health education in such a way could be addressed also towards administrators, politicians and so on?

5th - How to introduce gradually into the Hospital a system of medical audit and how to affirm the autonomous role of the nursing personnel?

6th How to profit from increasing relations with the doctors of the other European countries in order to establish a new role for the physician avoiding the easy criticism which risks to lower the functions and to menace the privacy of the relationship between physician/patient but, at the same time, overcoming the trend towards a professional dominancy in the field of medical organisation.

King Edward's Hospital Fund for London

King's Fund Centre

NHS AND EEC - DENMARK

Papers given at the seminar held at the King's Fund Centre on Tuesday, 30 April, 1974 by:

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1 Introduction

The human body is the same all over the world - except for a few slight differences, such as pigmentation. It is therefore only natural that those who are engaged in preventing or curing sickness or in the care of patients will usually be interested in learning how their colleagues in other countries go about solving problems similar to those which they face in their own daily work. Such studies will usually be rewarding, because of the very fact that the human body does not differ from one country to the other.

One, therefore, might easily be led to believe that comparative studies of the health service systems of various countries might be equally rewarding. Without denying that such studies may eventually turn out to be of value - at least as a means of opening one's eyes for deficiencies and drawbacks in one's own system - it should be pointed out that such studies are infinitely more complicated and difficult than they may appear to be on the surface - if, that is, you want to use them as a basis for sound conclusions.

The organizational pattern of any given country's health service will usually be so closely bound up with a host of other social phenomena, specific to that country, and determined by traditional, historic, economic, political and probably a lot of other factors, that such comparative studies become an almost hopeless affair. This applies particularly, when provision of health services - as in Denmark - have developed to become a government concern rather than being left to the forces of free enterprise. In this case a true description of the health service system and how it works will necessarily require a description of how and why the whole governmental system works.

And when we start to look at the financial aspects of health, how can we obtain a true and real picture of conditions in another country without knowing something about that other country's general economic conditions and the web of factors involved in any discussion about economics. Differences with regard to distribution of income, the tax-systems, the pattern of occupation and trade, to name a few, may blur the picture. So may the differences that we meet, when we start to look at the variations among educational systems from one country to another - and this applies not only specifically to differences in the educational system of the medical and related professions but also to differences in the elementary and secondary educational patterns as well.

Finally we run into difficulties when we try to examine what is actually meant by the term "health services". We will soon discover that even this simple concept varies from one country to another. Several measures which in one country are labelled as part of the health service system, in other countries will be considered as belonging under "social services" and vice versa.

In Denmark such measures as cash benefits during sickness or provision of homes for the aged are usually considered social services rather than health services, while on the other hand institutions for alcoholics and narcotics addicts - not to mention institutions for detention of dangerous criminals, who are diagnosed as mentally ill - are considered as belonging to the health services.

Admittedly there seems to be a general and apparently global tendency to view social and health services as but two sides of the same coin and accordingly to integrate and amalgamate the two services administratively, so that the border-line between the two becomes more and more vague, eventually one day to vanish.

In the meantime, however, we shall still maintain the traditional distinction. Therefore, what is said in the following pages pertains primarily to the Danish health services in the traditional, more narrow sense.

But even if we stick to this concept of "health services", comparisons at the international level may be dangerous. For instance, the concept of what kind of institution is covered by the term "hospital" actually differs from country to country. In some countries - such as for example, in Denmark's close neighbour, Sweden - the hospitals usually provide an extended polyclinical out-patient service in the so-called "open ward". In Denmark on the other hand the hospitals have traditionally left ambulatory care to the general practitioners so that normally no-one will be dealt with in hospital (except for emergency cases) unless he has been referred for admission by a general practitioner. Interestingly enough, there seems at present to be a tendency towards limiting the ambulatory functions of the Swedish hospitals and the opposite tendency towards extending the ambulatory services in Danish hospitals, so that maybe one day the term "hospital" will mean exactly the same in Sweden and in Denmark. We may even reach the point one day, where the word "hospital" has the same meaning all over the world. But so far, it has not.

Also it should be mentioned that when we in Denmark talk about hospitals, we usually do not include under this term such institutions that rather have the character of convalescent homes and sanitoria, even though such institutions may and do provide some measure of medical and nursing care.

Finally, it should be mentioned that there are certain kinds of services that may be provided under the term "health services" in one country, but which may not even be available in other countries. For instance, in Denmark we do not have - and do not want to have - such a thing as homoeopathic hospitals, which are to be found in Great Britain. Neither do we accept the need for institutions of the kind that are found in abundance in Central Europe, employing therapies based on miraculous mud or on wells producing mineral or other kinds of "healthy" water.

Let it be added that these introductory remarks are not designed to discourage anyone from studying the health services of other countries. They have rather been made in order to point out a few factors, which must be borne in mind, when one engages in such studies.

2 General Description

The Danish population now numbers a little more than 5 million people, the vast majority of who live under urban conditions. The birth rate has been fairly constant during recent years, at 14.5 - 15 per 1000, while the death rate also remains constant at about 10 per 1000. Infant mortality however shows a decreasing rate, now being down to a little more than 13 per 1000 live births.

The number of admissions to hospitals per inhabitant has been constantly increasing by 3% per year and now amounts to some 750.000 admissions annually, corresponding to 15% of the total population. Also the number of ambulatory examinations and treatments at hospitals has been constantly on the increase - at the rate of 7% annually - and now amounts to approximately 2 million a year. In addition, the average number of consultations with general practitioners now amounts to roughly 6 consultations per citizen per year. It is estimated that approximately half of all hospital beds are occupied by patients of 65 years of age or older, and the average life expectancy now is 71 for men and 76 for women.

The health services proper, apart from institutions for mental defectives, epileptics, disabled and a few other minor groups (but including the primary health services) employ altogether some 100.000 persons (in whole-time equivalents) or 2% of the total population. As many of the personnel - and that applies particularly to the nursing profession - are actually employed only on a part-time basis, the actual total is somewhat bigger, amounting to approximately 120.000 people. Of these, 75% work in hospitals, while the rest, who work in the primary health service, are distributed almost equally between medical practice, dental practice, the pharmacies and what we might call the "outgoing" services,

i.e. midwives, mother and child health nurses, domiciliary nurses and practising physiotherapists.

More detailed data on the Danish health services may be found in the annex.

3 Organization

As in most other highly developed countries the organization of health services in Denmark certainly does not present a clear and logical picture. The present organizational set-up is a product of a constant process of evolution and progress, aimed at improving and extending the health services that are available to the population, combined with an ever-growing tendency towards letting the type, the extent and the management of the health services be determined through the ordinary democratic channels of the governmental system - on the national as well as on the local level. That is to say that provision of health services - through this evolutionary process - has almost entirely come to be looked upon as (and by law constituted to be) a government concern and responsibility. At the same time the financing of these services has almost entirely come to be based on general taxation, rather than on payment from the individual patient, his insurance company or his employer."

These responsibilities are shared between the three levels of government, the national government, and the two levels of local government, the "amtskommuner" (which for the sake of convenience we may translate as "counties") and the "kommuner", (which we may translate as "municipalities"). The country is divided up into 14 counties, each of which has a population of 250.000 to 500.000, while eachcounty is divided up into a number of municipalities, each with a population of between 4.000 and 6.000 in the rural areas, and of course many more in the urban districts. Each county and each municipality is headed by a council, the members of which are elected at general elections every four years. These councils are empowered - within certain limits - to levy taxes on land and on income (according to a proportional scale) and, in addition, they receive certain blanket grants from the national government, which in its turn also imposes customs duties, sales taxes etc., as well as levying taxes on income on a progressive scale.

Parliament determines by law which services must be provided by each level of government and also often determines the general framework within which each service must be provided, producing norms and standards etc., which are binding upon the local governments. For example, the Hospital Act of 1969 provides that each county is under an obligation to establish and operate a sufficient number of hospitals and convalescent homes for the population of the county and to offer hospital services free of charge to that population. The same act provides that the county government must prepare a plan for the operation and future development of its hospital service, which has to be submitted for approval by the national government. Until such plans have been prepared and approved, any schemes of new constructions or of new specialized departments must be submitted for approval before execution.

Yet another act, provides that each municipality must employ a sufficient number of mother and child health nurses as well as domiciliary nurses, and a further one prescribes that the municipalities must establish and operate dental clinics to provide preventive and curative dental care to all school children, etc., etc.

This division of power between the three levels of government is nothing new, but what is new, is the size of the two kinds of local districts (the county and the municipality) which form the basis for the various activities of the local governments, including the health services. The present pattern was established only in 1970 through a local government reform, by which the number of municipalities was reduced from some 1200 rural municipalities and 90 city municipalities with a special status, to 217 in all; and the number of counties from 23 to the present 14. It should be mentioned, that this reform, however, did not include the city of Copenhagen and its neighbouring municipality, Frederiksberg, both of which for more than a century have had a special status.

As a result of the local government reform the number of local governments responsible for providing hospital and certain other health services for the local population within the district was reduced from 111 to 14.

The primary purpose of this reform was to give the local governments at both levels a better foundation - populationwise and thereby also tax-wise - for providing and managing those services, which according to tradition and to the general political philosophy in Denmark, should be left to the responsibility of the locally elected councils.

When we take a look specifically at health services, and bear in mind the general idea that there should primarily be a local government concern, it is obvious that the organization and planning - not to mention the financing - of a modern, specialised hospital-service requires quite a number of "customers". The responsibility for providing this service therefore must be vested in the counties, while other health services, such as mother and child health-nurses, school dental health and domiciliary nurses are of such nature and have such a close relationship with the social services that their management and planning should be a responsibility of the smaller communities, the municipalities.

In fact, when aiming for a division of Denmark (outside of Copenhagen) into 14 counties each with 250.000 - 500.000 inhabitants, the committee which prepared the local government reform, actually based its recommendation on the idea that a population of this size is required to satisfy and to motivate the degree of specialization within the hospital service, which - at the present stage of development in the field of medicine - is desirable, from the point of view of the patients as well as that of the medical profession.

The pattern of local governments as created by the local government reform of 1970 constitutes the organizational framework within which all health and social services that at present are, and in the future will be, provided to the population will eventually be based. But as indicated above, the picture is not, as yet, as clear and logical as one might expect. The national government, which in the new local government framework, should be left with the role of initiator, policy-maker and supervisor vis a vis the local governments still delivers various of the health services, either through institutions, established, operated and financed directly by the national government or through institutions, originally established and still operated by private associations, but financed 100% and heavily controlled by the national government. This is true as regards psychiatric hospitals, institutions for the care and rehabilitation of the handicapped, mentally defective, mute, blind and deaf as well as for institutions for the care and treatment of epileptics and alcoholics. As a first step towards leaving the new counties with all responsibilities in the hospital field - thereby promoting the integration of these special services into the general, somatic hospital system - it has been decided that the responsibility for providing psychiatric care as well as care for the handicapped should be transferred from the national government to the county governments as of two years from now. At that time the psychiatric hospitals as well as the orthopaedic -surgery wards and hospitals, heretofore operated by the national government, shall be transferred to the counties, in which these institutions are actually situated. It should not be difficult to imagine what problems this decision raises, especially as the standard and size of the psychiatric and orthopaedic hospitals vary considerably from place to place, and as the staff of these institutions are at present national government employees and may have no wish to become county government employees.

The next step will be to transfer the responsibility for treatment and care of epileptics and alcoholics from the national government to the county governments, and the same applies to various other measures that in Denmark are considered to be on the borderline between health and social services, i.e. rehabilitation services and the special agencies for advice and assistance to single mothers.

This expected development eventually will leave the national government with the responsibility of operating just one hospital, namely the university hospital of Copenhagen, which is Denmark's largest and most specialised hospital. It might also be worth mentioning that the national government - in spite of the general trend of transferring its operational responsibilities in the hospital field to the counties - for quite a long time to come will probably still be in charge of serving the county-hospitals with clinical microbiological services. The national government since the turn of this century has operated the "State Seruminstitute" in Copenhagen which is a combination of a factory for sera, vaccines and blood-products, a central public health and clinical microbiological laboratory and a research centre in these fields.

As the need for microbiological assistance in the clinical field has gradually extended during the last decades, the institute in collaboration with the county hospitals in question has established local branches so far attached to a total of 8 major county hospitals. Even though these local laboratories of clinical microbiology geographically form an integrated part of the hospitals in which they are situated, it has been felt that the day to day operation and management requires such close co-ordination with the management of the central institute, that they should be organized as branches of the State Seruminstitute under its direct supervision and instruction rather than being managed by the hospital administration of the county government. Thus one might say that the clinical microbiological service is organized as a national government responsibility in the general, local government hospital system.

The strong tradition of local government's responsibility for providing a hospital service of the right size and standard to meet the needs of its population; combined with a deliberate policy on the part of the local and national governments of keeping the fees for admittance to the government hospitals at a low level, has resulted in there being virtually no private hospitals left, with those that there are having to rely heavily on economic support from the national government and the local governments. It is no exaggeration to state, that all remaining private hospitals - and the same is true of convalescent homes - have been more or less forced to depend upon and co-operate with the local government hospitals, and have thus become an integral part of a totally public or socialized hospital system.

This development must be seen - and may only be comprehended - in the light of the evolution, which has led to the abolition of the former fee-system in the health area, and accordingly the abolition of the former health insurance system.

Previously only very few services in the field of health were offered free of charge. In principle only certain preventive measures, such as certain vaccinations, TB and VD examinations and the like were offered to everybody free of charge, this being another responsibility of the county council. Most other services - whether it was admittance to a hospital, midwife-assistance at childbirth, or consultations with your general practitioner etc. - in principle involved the charge of a fee. As for the local government hospitals, the local government in principle decided the level of the fees, but before implementation these decisions had to be approved by the national government, which thereby came to exert quite a heavy influence on the contents of the fee-regulations of local government hospitals.

In reality the fees for health services in most instances, however, were paid for the patient by the public health insurance scheme.

The health insurance system which was supported quite heavily by the national government had developed in such a way that the vast majority of the population were members. By law, membership had been made compulsory to everyone whose annual income was below a certain level, the so called "A-members", as opposed to the "B-members" i.e. those, whose income was above the fixed level. The level however was fixed at such high amount that some 80% of the population were A-members. Being organized more or less as private associations with local boards of trustees elected by and from the members, one association in each municipality, the health insurance scheme levied a fixed annual membership-fee per capita. Members, who were in arrears with their membership-fee, were denied the benefits.

The health insurance scheme paid the fees for hospitalisation in government hospitals which, as mentioned above, were kept artificially low - the fee being the same whether the patient was an A- or a B-member. As for private hospitals the health insurance scheme only reimbursed its members an amount corresponding to the humble fee of the local government hospital. In this connection it may be worth mentioning that by virtue of its supervision and control of the local government hospital fee system the national government ever since the turn of the century has seen to it that the government hospitals charged only an all-inclusive fee to in-patients, regardless of the services rendered to the individual patient, except that a supplementary fee was charged for a private room, which was not required because of the patient's condition.

With regard to services from health personnel in private practice - general practitioners, specialists in practice, dentists, midwives and practising physio-therapists - the amount of the fee for each kind of service, delivered to A-members was determined by general agreements between the central board of the health insurance scheme and the respective medical and paramedical associations - or maybe in this connection one should rather use the term "trade unions". According to these agreements the members of the "trade unions" in question were under obligation to deliver their services to A-members of the health insurance scheme at the fees that were settled in the general agreements. These fees were reimbursed 100% by the local health insurance office, to the effect that the A-members received their health services virtually free of charge. On the other hand, the A-members in order to enjoy the benefits of the health insurance scheme, had to register with one particular, general practitioner in the local community and stick to him for at least a year at a time of fees for reimbursement. Consultations with a specialist or treatments by a practising physiotherapist was dependent on the patient being referred by his general practitioner.

B-members were not under these restrictions, but then the doctor, midwife etc., were under no obligation to stick to the fee settled in the general agreement, and were free to charge the B-patient a mutually agreed fee - in other words an entirely free enterprise system. The benefit which the B-member enjoyed from the health insurance scheme - apart from full reimbursement of hospital fees - was the right to get a refund from the health insurance scheme of an amount equal to the amount which the health insurance would have had to pay to the doctor or dentist etc., if the patient had been an A-member.

The health insurance reform, which was introduced as of April 1, 1973, did away with the local health insurance associations - and thus with membership-fees - and transferred the responsibilities of the former health insurance associations to the county councils. At the same time it made it obligatory for the counties to provide hospital services including stay in convalescent homes, free of charge to everyone permanently resident in the county. Concurrently parliament enacted a law, whereby midwifery services were so to speak socialised, as it was made an obligation for the county-councils to employ a sufficient number of midwives to provide the local population free of charge with the necessary examinations etc. before and after delivery, preferably in conveniently located centres of 4-6 midwives. In addition the county governments are now required to provide facilities for deliveries, preferably in obstetric hospital wards or otherwise in special clinics.

As for the services of the practice sector, the pattern of fees and reimbursement etc., is more or less the same as before, except that the negotiations with the medical association and the other trade unions on fees and services are now undertaken - on behalf of and binding upon all the county-councils - by a special committee, elected jointly by the county-councils (and the city council of Copenhagen and Frederiksberg). As a consequence of the reform, all residents of any county (or in other words all residents of Denmark) are automatically covered by the new health coverage scheme, and no one is deprived of cover even if he or she is in arrears with the local taxes. The new scheme, however, has not abandoned the system of the population - still called "the members" - being divided into two groups - according to annual income - with different status and benefits. The national government, however, is at present considering another reform, which will either give all citizens, regardless of income, the same status as the present A-members, or entitle every citizen - again regardless of income - to choose between status as A-member or B-member. The Danish medical association favours the latter solution.

The major effects of the health insurance reform - apart from the administrative simplification which stems from the abolition of hospital fees - has been, that the expenses of medical care are no longer shared by the population on a per capita basis but are shared mainly proportionately according to income, because the new scheme including the costs of hospital operation, is financed via local government taxation.

As the financial responsibility of the former health insurance associations has been placed on the shoulders of the county councils, who are also responsible for the hospital service, another effect of the reform has been a somewhat closer relationship between the responsibility for providing secondary care and for providing primary care. Even so, it must be admitted that each single county council has only little power of influence on where and how the personnel of the non-socialised part of the primary health services is performed. It remains to be seen, whether the present arrangement leaves the county councils with a satisfactory instrument for fulfilling their responsibility for providing ample and co-ordinated medical care to the local population inside and outside of hospitals, a task in which the county councils under all circumstances will need the benevolent co-operation and assistance of the medical and the other professions in the health field.

Now a few words about the organization on the national government level with respect to health. The Minister of the Interior, who is traditionally the minister entrusted with supervision of local governments, including local taxation and finances, is also responsible for matters pertaining to health. Legislation on hospital management and planning, on preventive health measures, on the medical and related professions as well as on the whole pharmaceutical field is enacted by the Ministry of the Interior. Also the operation of the State Seruminstitute, the psychiatric hospitals and schools for medical and related personnel, outside of the universities, are the responsibility of the Ministry of the Interior.

Because of the historic background of the health insurance scheme as a social insurance set-up - originally closely connected with the sickness cash benefit system - health insurance reform was undertaken by the Minister of Social Affairs, who is also in charge of the operation of institutions for mental defectives, mutes, blind, deaf and handicapped.

Neither of the two ministries, however, employs persons belonging to the medical profession or for that matter to any of the related professions. The professional advice, which of course is essential to both ministries, is provided by a central agency which in English translation we have chosen to call "The National Health Service". It is headed by a medical doctor, who is appointed by the Minister of the Interior, who also approves the budget of the agency. Apart from that, this agency is considered not to belong to the normal hierarchical set-up of the national government. By law, any national government agency, which needs medical advice in the performance of its functions, is under obligation to consult with the National Health Service, and also this agency has managed to play an important role as the advisor of local governments in matters concerning the planning, organization and management of the local hospital service and other health services. The National Health Service is the supreme authority of all medical and related personnel and exerts its control and supervision primarily through its local field officers, some 50 medical doctors employed by the National Health Service on a full-time basis. This field service has contributed considerably in guiding the build-up of the local health services, not to mention the development in the field of environmental sanitation.

It should be mentioned, that this dissertation does not deal with the health services of the Faroe Islands and Greenland.

4 Finance

According to a rough estimate the Danish population in the fiscal year 1971/72 spent more than 7.000.000.000 Danish kroner on health. There seems to be various different methods of calculating the gross national product, but if one employs the method, usually followed in the U.K., the Danish gross national product of 1971 amounted to 128.000.000.000 Danish kroner. The health expenses of Denmark in other words amounted to more than 5.5% of the gross national product. This figure, however, must be taken with several reservations - especially when used for comparisons with health expenditures of other countries - partly because the definition of what belongs under the term health services, especially as opposed to social services, is awfully difficult and partly because accurate figures simply are not available. For instance, it may be possible to state very accurately the total retail sales of the pharmacies, but it is not possible to get accurate information on what part of the total sale was medicine or medical remedies and what part of the total sales were other articles for cosmetic or other use. And even if such sub-division were possible we would meet a host of problems of definition, where e.g. should one place tooth brushes and tooth paste in this connection?

Since the health services available to the Danish population, however, are to a very large extent provided by - or at least financed by - public funds, it might be of greater interest to demonstrate the total government expenditure on health services.

This is done in table 1, which also shows the rate of growth during the five year period 1966-71.

Table 1. National and local government expenditure on health services, fiscal year 1971/72.

Running costs	Million Danish kroner	Rate of growth 1966-71
Primary health services		
Medical doctors in practice +)	730	15
Dentists in practice +)	250	16
Medicine +)	340	17
Preventive Services	100	12
School dental health	110	
Home visiting nurses	110	
	1.640	15
Institutions for medical care		
General hospitals	3.600	16
Psychiatric hospitals	520	13
Somatic specialized hospitals	180	12
	4.300	16
Running costs, total	5.940	
Capital costs		
Construction of hospitals	870	26
Hospital equipment	120	21
Capital costs, total	990	25
Public expenditures, total	6.930	17

+) Expenditures of health insurance scheme, from 1973 taken over by local government.

As mentioned previously, the fees that medical doctors, dentists and physiotherapists in practice may charge, are determined by general agreements between the professional unions and the public health coverage scheme. It can be seen from the table, that the total expenditure of the scheme which relates to payment of the fees of A-members of the scheme and to refunding the doctors' bills of the B-members in 1971/72 amounted to 730 million Danish kroner. It has been estimated that the B-members' own expenses, that is, the part of the doctor's bill that goes over and above the amount refunded from the health insurance scheme, amounted to approximately 60 million Danish kroner.

One might actually simplify the picture of health financing by stating that the financial relations between the services of the medical profession outside the hospitals and the B-members are the only example of really free enterprise in the Danish health field. Of course, the pharmaceutical industry, if you want to include that under the term "health service", also bases its activities on the principle of free enterprise, but when it comes to the retail distribution of medicine through the pharmacies, we have a system which lies somewhere between free enterprise and a socialised order with the national government controlling the number and geographical distribution of pharmacies. The owners of each of these pharmacies are appointed by the national government and they are entitled to a pension when they retire, in common with the rest of the pharmaceutical staff of the pharmacies. By law it is provided that medical remedies may only be marketed in retail sale by one of the total of 360 pharmacies, and what is even more important in this connection, the national government through the National Health Service not only closely supervises the pharmaceutical activities of the pharmacies but also determines the price at which each remedy must be sold. The national government is thereby, more or less, in a position to control the income-level of each pharmacy. Attached to the whole system is a central fund, which by act of Parliament is empowered on the one hand to levy special fees or duties on pharmacies whose total sales exceed a certain level, and on the other to pay subsidies to those pharmacies, whose income is below a certain level. The central fund is responsible for payment of pensions to pharmacists and also provides loans to pharmacists for new constructions or remodelling of old pharmacies.

What has just been stated does not apply to the 12 hospital pharmacies which are operated and financed as integral parts of the hospitals to which they are attached.

Particularly as regards the subject of hospital finance it might be of interest to mention a few items.

As mentioned before, it is a basic principle that each county council is obliged to provide proper hospital services free of charge for the residents of the county. As the hospital-system - or at least one of the hospitals of each county - has developed to become fairly well specialized, the general practitioners of the area will usually refer the patients to one of the local hospitals. In fact it is a more or less tacit agreement between the general practitioners and the hospitals, that when the general practitioner estimates that the patient needs hospitalisation, he must refer the patient to one of the local county hospitals. Considering that each county

will have an average population of only 300 - 400.000 inhabitants, it is evident that there are certain specialised departments or functions, such as neurosurgery and plastic-surgery, transplantations etc., which you will not find in each and every county. Such specialised departments will usually only have been established in the 3 university hospitals, i.e. in Copenhagen, Odense and Aarhus, and in a few other places. If and when the patient's diagnosis indicates that he must be referred to one of these specialised departments, his local hospital will make the reference, and by doing so will automatically be liable to defray the actual costs of the treatment to the receiving hospital. The Hospital Act explicitly provides that a local government hospital, which receives a patient, who does not have residence in the county in question, but who has been referred by another local government's hospital, shall be entitled to have the actual costs of the treatment reimbursed by the latter local government. In principle the same system applies if a patient for one reason or another prefers admittance to a hospital in a county, where he does not belong. If his home county, however, does not want to give its consent and to pay the costs of the treatment, he may still be admitted to the desired hospital, if this hospital is willing to take him, and the patient is willing to pay an all-inclusive, daily fee of 100 Danish crowns - equivalent to 6 British pounds. It should be mentioned in this connection that every county government by law is obliged to receive acute patients free of charge - regardless of the patient's residence inside or outside of Denmark.

As mentioned before, the university hospital of Copenhagen is operated and entirely financed by the national government and, like the local government hospitals offers its services free of charge to the patients who are referred to it, provided they are residents of Denmark. The hospitals that serve as university hospital for the two provincial universities, in Odense and Aarhus, are operated by the respective local governments, which receive a special subsidy from the national government to cover the expenses of the extra staff, who are required for the teaching and research in this connection. But if a patient is referred from another local government hospital for some highly specialised treatment, which may only be provided by one of the three university hospitals, the two local government operated hospitals in Odense and Aarhus - according to the payment system, described above - will have to charge the patient's county government for the full expenses of the treatment, while the university hospital of Copenhagen - being operated and financed by the national government - will receive the patient without charging anybody, either the patient or his local county council. It has been pointed out that this system implies the risk that local governments will feel tempted to order their hospital administrators and others preferably to refer the patients to the free services of the university hospital of Copenhagen rather than to one of the two other university hospitals where the patient's home county has to pay, thus depriving the two other university hospitals of patients, who might be "interesting", from a teaching and a research point of view. Nobody is actually able to evaluate whether this fear is justified or not, but the fact is that the government is at present seriously considering the introduction of a system, whereby the national government will charge the counties with a rather heavy fee per day for

each of their residents referred for admission to and received by the university hospital of Copenhagen. The professors and the rest of the medical staff of the university hospital of Copenhagen - as might be expected - are very much opposed to this idea.

As regards the financing of research activities in a mainly local government dominated hospital sector it might be well worth mentioning that for quite a number of years, a special arrangement - originally proposed by the medical association - has been in force, according to which each county council sets aside a fixed annual amount for each doctor in the establishment of its hospital service. These funds are then appropriated for general research purposes or specific research projects on the recommendation of a special research board for each county or region, the members of which are appointed from among and by the heads of departments of the hospitals in the area.

Apart from this, a considerable, but unspecified part of the national government's annual appropriations for the university hospital of Copenhagen is meant to cover research activities, performed at the hospital. In addition the national government annually appropriates an amount of approximately 17 million Danish kroner, or little more than 1 million British pounds, to be used by the National Medical Research Board for initiating or supporting medical research projects.

5 Management

Before the local government reform, when responsibility for the operation of the local government hospitals were in the hands of some 90 city-councils and 23 county councils, and where several of the hospitals outside the Copenhagen metropolitan area were established and operated as a joint enterprise between the local city government and the county government, it was quite common that each hospital - big or small - was governed by what you might call a board of trustees, the members of which were appointed by, and often from the members of the city and county councils in question. The need for overall co-ordination in the planning and operation of the various local hospitals was primarily taken care of by the "Hospital Association" and by the National Health Service - both of which, however, had no executive power and therefore could only fulfil their co-ordinating role in an advisory capacity.

One of the most important effects of the local government reform has been the simplification and the strengthening of the hospital management side. The reform, which divided the country (outside of Copenhagen) into 14 counties, made the county government the owner of all local government hospitals in the county and made the council directly responsible for the management of these hospitals as a whole. This acknowledged the fact that no hospital as such may be considered an entity in its self, but that each hospital - big or small - is rather just a part of an integrated hospital services system. Instead of one governing board for each hospital, the political responsibility of the county council is now exerted by one body, the "hospital committee" of the county council. It is not too early to state

that the idea of all hospitals in the county forming an integrated entity is a good one, but unfortunately it could not be said that the idea has swept the country and caught on. There is still a lot of local patriotism to be taken into consideration. As citizens and patients we all want the most highly developed technical services to be available right next door. Therefore, of course, it requires political courage from our local politicians to live up to the idea that the hospital system of each county should be considered, organised, planned - and therefore managed - as an entity. This system, of course, favours the trend towards concentration of the hospital services in larger medical centres and the abolition of the smaller hospitals. So far, we may still be optimistic. All of the county governments have appointed a county hospital manager, an administrator, who while responsible to the hospital committee of the council, is in charge of the management of all hospitals in the county.

We find ourselves in a period of transition and development. It is not possible therefore, to say at present, which of two differing points of view is likely most to affect our thinking in the future. Whether that which believes in the rationalisation of services and allocation of finance in accordance with the community's total needs, will have more influence in the long run, than that which considers optimal treatment and care solely from the point of view of the individual patient, remains to be seen.

B) Dr C Toftemark

1 Further views on the health-care system in Denmark

Denmark is a small country of only 43,000 square kilometres its' total population is a little less than 5 million.

It is consequently densely populated: approximately 115 inhabitants per square kilometre. In spite of ever-increasing urbanisation and industrialisation there is still a fairly even distribution of the population over the country. Because of this fact it should be fairly simple to distribute and manage a medico-social system giving fair and equal benefits to any citizen anywhere in the country.

The expectancy of life at birth is 70.3 years for men and 74.5 years for women.

The population is growing at a rate of nearly one per cent per year. 23.7 per cent of the population is between 0-14 years of age, 61.6 per cent between 15-64, 14.7 per cent 65.

The total number of persons working is approximately 2 million, of which about 560,000 are women.

The population is said to be fairly healthy - many of the traditional measures being in accordance with that point of view. Yet in spite of this, there has been a constant cry for services, facilities, and manpower in the medico-social system, which has taken personnel from industry into these services.

Approximately 15 per cent of the total population are admitted to hospitals yearly, which means about 750,000 admissions. Of these 50-60 per cent are casualty/emergency cases - the others being selective. A little less than half of patients in hospital are in the age-groups above 65 and constitute the majority of long-term patients.

A pressure for more medical services seems evident and can be illustrated among other things by a cry from overworked medical and dental practitioners, and waiting lists for non-acute cases at all hospitals. Whether this situation results from a quantitatively diminishing effort by the profession, from growing need or simply from increasing demand is open to discussion. There is an old Danish saying 'the appetite grows when you are eating' which to a certain extent may hold true here, but quite a number more or less valid causes for pressure for more medical services can be enumerated : -

1) a population growth of nearly 1 per cent

2) a relative and progressive preponderance in the older age groups which means that persons 65 years old to-day comprises 15 per cent of the population

3) rapidly increasing urbanisation and industrialisation

4) increasing road traffic with consequent accidents

5) a wider knowledge about what can be achieved through medical care. Popular information spread through radio, television, and the press - occasionally as a propaganda campaign - has its effects

6) the methodical medical examination of pregnant women and babies, schoolchildren, apprentices and soldiers

7) the cost free access to medical care

8) an increasing part of the population is covered by insurance against loss of wages caused by illness

9) regardless of improved living conditions in the so-called Welfare State (money, food, housing, etc., etc.,) the population seems to be in greater need of medical consultation and advice. People are no longer satisfied to await the onslaught of a serious illness before they want to see the doctor, but seek advice at an earlier stage - want a certain form of health-control.

2 General Practitioners

For a great many years the general practitioner in Denmark was a sacrosanct figure. He met the primary prophylactic, diagnostic, and therapeutic requirements of the population. He was really the family doctor ensuring a certain stability in the patient/doctor relationship. Due to the advances in medicine and technology he gradually lost prestige, and the weight shifted more and more to the acute hospital component resulting in too many admissions and a disproportionate growth of this very expensive and more and more personnel-consuming component of the medico-social system. This was certainly not a fortunate trend. It is now generally recognised that the above-mentioned advances have not resulted in the sort of healthy and happy population that the WHO defines. Instead they have created a changing pattern of morbidity consisting of chronic degenerative and progressive diseases, with mental and nervous disturbances and states of stress causing maladjustment and occupying an increasing part of the doctors' time.

We still have great confidence in the G.P. as a central person in the provision of primary care, but there is a trend to change the pattern of primary care, with general practitioners working together in group practices, or even better working together with different groups of medical, paramedical, and social welfare personnel. The prevalence of mainly chronic diseases and states of disability and handicap following severe accidents, the heavy burden of pathological states belonging to the psycho-somatic group of diseases, neurotic and psychiatric diseases, and also a wide variety of problem patients with mainly social and/or nursing care needs, calls for a new way of thinking.

It is completely relevant to handle a very large proportion of the patients in such a system using the general practitioner - working no longer as solo doctor but as a member of a group practice from doctors' premises (or still better from comprehensive health centres) in close collaboration with other professional groups, performing some fairly simple diagnostic X-ray or laboratory work, and quite simple medical and surgical procedures not requiring the large apparatus of the specialised hospitals. Dentists, midwives, health nurses, home nurses, social workers, and also less skilled ancillary personnel are required to complete the team.

It is believed that as many as between 80-90 per cent of the total number of patients may be dealt with in a rational manner using only the above-mentioned team.

10-15 per cent only of the population coming in contact with the medico-social component really need the facilities, the top-level care, and the general and specialised treatment of the hospitals.

It should be mentioned that apart from the emergency patient-section Danish hospitals in general do not operate out-patients departments proper. Out-patient care is primarily in the hands of the G.P. (and practising specialists) who may however refer patients/or X and laboratory examinations in the public hospitals.

In order to become a G.P. nowadays you have to have a regular 2 years hospital rotation training inclusive of a certain number of theoretical post-graduate trainings - but it is the general rule that a G.P. will have had some 5-6 years in the hospital before settling down outside it.

The number of G.P.'s has been static for the last decade, but seems now to be increasing. There appears to be a growing interest in general practice among the young doctors perhaps in recognition of the fact that we may have a surplus of doctors.

We are at present contemplating making it compulsory for the young doctor before taking up a practice of his own, to serve as a sort of apprentice to a skilled G.P. for six months - very likely in group practice.

3 Hospitals

As modern legislation concerning the hospital service in Denmark has made it the responsibility of the local authorities to establish and run a requisite number of hospitals in places where the State has not provided for the necessary facilities, all but very few Danish hospitals are public ones.

Private hospitals are not forbidden, but have to be recognised by the Minister of Interior. If anybody should want to build a private hospital he has to get approval and he has to pay for it. Former catholic hospitals disappeared because of lack of money and nuns.

Within the hospital, there is only one kind of bed. It becomes more and more rare to have access to a single room on your own account, but they are freely provided for medical reasons. There are at present approximately six acute beds per 1,000 inhabitants which is considered to be too many as long as primary care, ambulatory and home care, etc., are available in a satisfactory degree.

4 Doctors

All doctors working in institutions as well as medical officers of the civil services are public, full-time, salaried staff.

The younger doctors undergoing post-graduate training undertake most of the professional routine-work under supervision of the fully educated and trained medical specialists. The younger doctors hold temporary posts while the institutional specialists are employees practically for the rest of their working-lives.

The specialists working inside the institutions are allowed to perform a limited amount of private practice. It is an advantage for hospital doctors to be full-time, salaried staff, with no opportunity of making extra charges of any kind, since they are thereby in no way affected by the financial status of their patients.

On the other hand, access to a limited private practice is of great value, as under these circumstances it is possible to create a confidence which otherwise is unobtainable and which certainly gives the doctor human experiences, which may be valuable in his daily routine work.

Doctors working in a hospital are not financially liable as far as their hospital work is concerned. The hospital keeps all its doctors insured professionally and will take care of liability problems if something untoward should happen. Naturally any doctor is professionally and ethically responsible for what he does, but very few problems have arisen in this respect through senior doctors delegating some of the workload to younger doctors while retaining legal responsibility for the absolutely necessary teamwork.

Up to now there has been little tendency to blame and sue the doctors for professional mistakes, but this may change in the years to come.

In a growing number of counties there are established planning, co-ordinating, and decision-making groups comprising participants from both the primary and secondary care system in order to insure proper communication inside the profession as well as a satisfactory patient flow.

Previously such local authorities as owned hospitals would appoint a hospital board, which was responsible to the local council for the management of the hospital. For this purpose the board was assisted by an administrator (inspector, director, or executive), who was responsible for the day-to-day administrative leadership.

After the recent communal reform the county council has become the owner of, and is responsible for, all hospitals within the county, and there is no longer a local management committee, although of course there is a local administrator.

5 Administrators

The administrator looks after the hospital's economic and central administration. He is in charge of the finance department, maintenance of buildings, furniture, and equipment, purchasing, personnel administration, and so on. Some of these matters are submitted through the county hospital manager to the council hospital board for decisions. The county hospital manager usually acts also as secretary to the hospital board. Records of the admission and discharge of patients as well as all accounts relating to their period of hospitalisation are handled by the administrator.

In addition to the above-mentioned duties, the administrator supervises the technical departments; the kitchen (management of which is in charge of a kitchen matron), the laundry, and the boiler and maintenance departments.

The established rule nowadays is for the administrator to be a non-medical man. The medical chiefs are co-ordinate, each one deciding on all questions concerning the treatment of patients within his own department. At the larger hospitals the medical chiefs generally constitute a medical committee. On medical matters of major importance the county hospital board or the administrator, as the case may be, obtains a statement from the medical committee, and on less important matters a statement from the medical chief concerned.

The administration and supervision of the nursing staff is carried out by a principal (matron) in close collaboration with the administrator and the medical chiefs.

No post as medical chief at a municipal hospital can be filled until a statement has been obtained from the National Health Services regarding the qualifications of the candidates for the post in question. The council is free to choose among all such candidates as have been considered as properly qualified for the job - not necessarily "the top-one".

On the other hand, local authorities are free to appoint any hospital administrator they may choose for their hospitals, provided , however, that the salary of the post is approved by the Minister of Interior - a condition applying to all comparable official posts.

An advertised vacant post of administrator at a major hospital will as a rule be applied for both by university graduates and non-graduates. The university graduate, however, is unlikely to be preferred unless his degree of Bachelor of Laws, M.A. (econ.), M.Sc. (econ.) or the like, is supplemented by a thorough, practical hospital training. The successful candidate will in most cases be a man who after a commercial training and a subordinate administrative position in a hospital has held a post as deputy chief. In doing so he will have acquired a varied training in the different branches of the administration and will have the requisite fund of theoretical knowledge by participation in various courses, studies at a commercial high school or possibly at a university.

The administrator is required to possess such a comprehensive technical know-how that it will hardly be possible for him to acquire the necessary knowledge anywhere else but in a hospital.

The Danish hospital administrators, who have formed a professional organisation, realised at an early stage that in addition to an all-round, practical training, a comprehensive, theoretical knowledge is required.

As early as 1925 a special theoretical training was suggested, but as it was and still is beyond the possibility of the hospital administrator's association to establish such training by its own means, the association has from time to time tried to make the financial central authorities as well as the Copenhagen School of Commercial Science interested in its plans. No final solution has been achieved so far.

Consequently, since 1934 the association has organised a series of courses. These courses have been called advanced-training courses and continuation courses, respectively, and have been arranged in the form of lectures and visits to institutions.

Among the subjects taken up for study during recent years may be mentioned :-

management - organisation

budgeting

transport systems

laundry

kitchen

near-democracy.

In addition, frequent visits have been made to institutions.

The committee on courses set up by the association of hospital administrators fully realise that the best arrangement would be if, in addition to a practical training, prospective hospital administrators could be given a specialised hospital training at an institute of higher education, but it will probably be necessary to face the fact that this solution is impracticable, since in Denmark five to seven candidates only will be needed per year.

In some cases candidates have studied at public health schools in the U.K. or U.S.A., and for the last 7 years a 2 month's course for hospital administrators has been conducted in Gothenburg, Sweden, as a joint Scandinavian effort, with participation by both lay administrators, doctors and nurses.

6 Nurses

The administration and supervision of nursing care and nursing personnel, including assistant nurses and student nurses, are the responsibility of a matron in close collaboration with the hospital administrator and the medical chiefs. In most hospitals she will be assisted by an assistant matron. In addition she is in charge of training of the staff, and will organise the practical work of the student nurses if the hospital is co-ordinated with a nursing school. All hospital nurses are invariably state-authorised nurses.

The matron is chosen from the group of experienced nurses with a post-graduate training from the Nursing Institute at the university of Aarhus. The training, which extends over one academic year, takes the form of lectures, seminars, etc.,

Nurses are scarce, partly because they are too attractive and leave active service to get married soon after they have completed their training. Some reappear as part-time helpers. Approximately 33 per cent of those who have finished their education during the last 20 years are permanently out of service. Further approximately 2,000 have taken up jobs outside Denmark, all of which leaves approximately 15,000 for work in general hospitals, 2,000 in mental hospitals, and 2,000 for home-nursing and social work - a work-field which in the future will need a higher proportion of the total profession.

The number of nurses employed in hospital work has increased nearly 100 per cent since 1950 and a similar growth-rate must be expected for the future. Efforts are made to concentrate nurses' work on nursing, leaving other people to perform duties which they are trained for and willing to perform at least just as well. A growing tendency to specialise within the nursing work-sphere is envisaged, special courses being arranged in order to increase nurses' responsibilities - for example training in blood transfusion. A system of progressive patient care is advocated as well as group-nursing.

7 Computers

A few words about computers in hospitals.

For several years electronic computer methods have been used as a daily routine in a fairly large number of hospitals for accounting purposes (payment of salaries etc.,).

A pilot study for a comprehensive system comprising statistical data concerning diagnoses, treatment, length of stay, status at admission, and discharge from hospital, and other pertinent information, has since 1965 been tried out at a number of major hospitals.

It has been found very useful for both clinical and administrative (local as well as central) purposes.

The system is expected to replace the compulsory yearly medical report, and should make a better central processing of these statistical data possible.

The programme has been developed jointly by the Danish Hospital Association and the National Health Services with due regard to similar studies in Sweden, U.K., U.S.A., etc.,

Finally, it should be said that there is a great demand for skilled technicians within this field and also a need for thorough education of doctors with regard to the vast possibilities within the computer area.

8 Regional Planning

As has already been mentioned the counties have now been made responsible for the total health care system within their boundaries.

They have to make both a short-term and a long-term plan for secondary care according to centrally issued guidelines, which first and foremost stress the necessity of creating a functional entity of the previous more or less independent hospitals in the area.

At present a plan for primary medical care is lacking, but the appreciation of the necessity for such a plan is increasing. It is a possibility that planning in primary medical care may be the result of a governmental request for guarantee of quality as a condition for approval of economic negotiations.

This new concept of a regional planning (and here I must remind you that a region in England may be even greater than all of Denmark - where we as mentioned before have 14 planning region-counties) has undoubtedly both positive and negative sides.

As advantages of regional planning may be mentioned that - :

1) regional planning at least ensures planning is undertaken

2) it implies planning by those authorities which have the major economic responsibility

3) it may furnish the prerequisites for a local co-ordination of primary and secondary medical care for the benefit of the consumer

The disadvantages of regional planning in contrast to central planning seem to be - :

1) local political issues may prevail over professional aspects

2) if hospitals become a subject of local political prestige duplication of efforts both economic and professional within narrow geographical limits may be the result

3) it precludes a national budgeting and distribution of means for various sectors of health services and between health services and other public services. This may turn out to be hard for the consumer as tax-payer.

Really effective regional planning requires at least - :

1) a definition of tasks

2) detachment from solely political issues

3) intellectually and educationally well equipped local planners (and they are hard to get)

4) open-mindedness among the professional medical personnel and an awareness of the necessity for defining economic priorities.

The optimal size of a region should vary according to the service planned. Most services could effectively be planned in a region of about 300-500,000 inhabitants in Denmark where transportation for example will rarely exceed 40 km (25 miles) and due consideration may be given to existing institutions.

For more refined types of health services (e.g. haemodialysis or heart surgery) a region of about one million inhabitants is the minimum. Smaller regions would allow for unwanted "duplication of efforts". Therefore collaboration among our "regions" is a necessity. But as our counties are political and geographical entities with a certain economic freedom and having the obligations to plan, furnish, and run the health care system, they seem to be the natural planners. Thus the Danish Health Service seems to have a rather fair relationship between ownership, economic, and professional responsibility.

It is, however, in some quarters felt that the national government through the legislation and the administrative authority of the ministries concerned - exerts a rather heavy influence even in those matters, which are formally left to be solved by local bodies. The legislation which empowers or directs the local governments to perform certain functions in the field of public health will often establish rather narrow standards to be followed by the local governments and leave only little space for the discretion of the local authorities. In several other respects it is prescribed that the local government's plans or decisions must be approved by a national government agency before they may be carried out, as in the case for example of all plans for construction, extension, or alteration of hospital facilities.

9 National Health Service

The ever growing variety of public health services and of agencies concerned with one or another aspect of public health - on the national as well as the local level - has obviously given rise to an increasing demand for co-ordination, while at the same time the availability of medical and technical knowledge has become increasingly indispensable for the agencies concerned.

To fulfil these needs, the national government already at an early stage in the history of public health in Denmark established a central agency, the National Health Service, headed and staffed by members of the medical profession and vested with the responsibility of advising all public and private institutions in the field of public health and being the supreme authority of all medical, pharmaceutical, and public health personnel in technical matters. The National Health Service has only few directly executive functions, being, as it is, outside the politically responsible hierarchy. But even in its advisory capacity the agency has a major influence in the policy-making process as well as in the day to day management of the regular government agencies in the field of public health.

While the staff of the ministries concerned with matters of health is almost entirely composed of members of the administrative or legal profession, the staff of the National Health Service is dominated by members of the medical, pharmaceutical, and nursing professions. When dealing with matters which require medical or pharmaceutical expertise the ministries or other government agencies are obliged according to the law to consult with the National Health Service, which thereby has most effectively established itself in a politically neutral central position in the field of public health.

As mentioned before, a special bureau of the National Health Service is in charge of advising the Ministry of Interior in evaluating all plans for functions, but also for construction, remodelling, or extension of hospital facilities. Such plans are prepared by private consultant engineers and architects, who are hired to do this work by the local government council in question. Most often the local council will set up a special planning and construction committee consisting of representatives of the medical and nursing professions, a hospital administrator and the architect in charge to supervise the planning and construction phases.

In view of the fact that all plans must be examined and approved by the Ministry of Interior after consultation with the National Health Service, it has not been found necessary to establish explicit legal requirements especially with regard to hospital construction, except for certain regulations concerning installation of X-ray equipment.

The cost of building is met by the authority which will be in charge of the operation of the hospital, i.e. either the local government or the national government as the case may be (the Ministry of Interior e.g. in the case of mental hospitals).

When the plans for new construction have been approved by the local government in question and the Ministry of Interior (the National Health Service), the local government will usually follow the same procedure with respect to the actual construction enterprises, i.e. the construction works will be open to contractors' bids. Normally the lowest bid will be accepted.

Studies are currently undertaken by the National Health Service, generally in collaboration with the Medical Association, the scientific medical societies, or similar representative organisations, on matters concerning hospital and health problems.

The results of such studies are usually published in a monthly bulletin from the National Health Service (Fra SUNDHEDS-STYRELSEN) but mainly in Danish.

Such studies also form part of the background from which the head of the National Health Service draws his conclusions as to future health policy. The Director-General has a right and a duty to advise both local and central government as to which measures within the medical sphere are advisable or even necessary.

It may also be mentioned that a comprehensive survey is published yearly by the National Health Service in The Medical Report for the Kingdom of Denmark. Part I is mainly concerned with an epidemiological report. Accidents, suicides, and poisonings are reported. Certain measures against diseases and preventive health control are dealt with as well as public hygiene measures, and the activities of the medical officers are described.

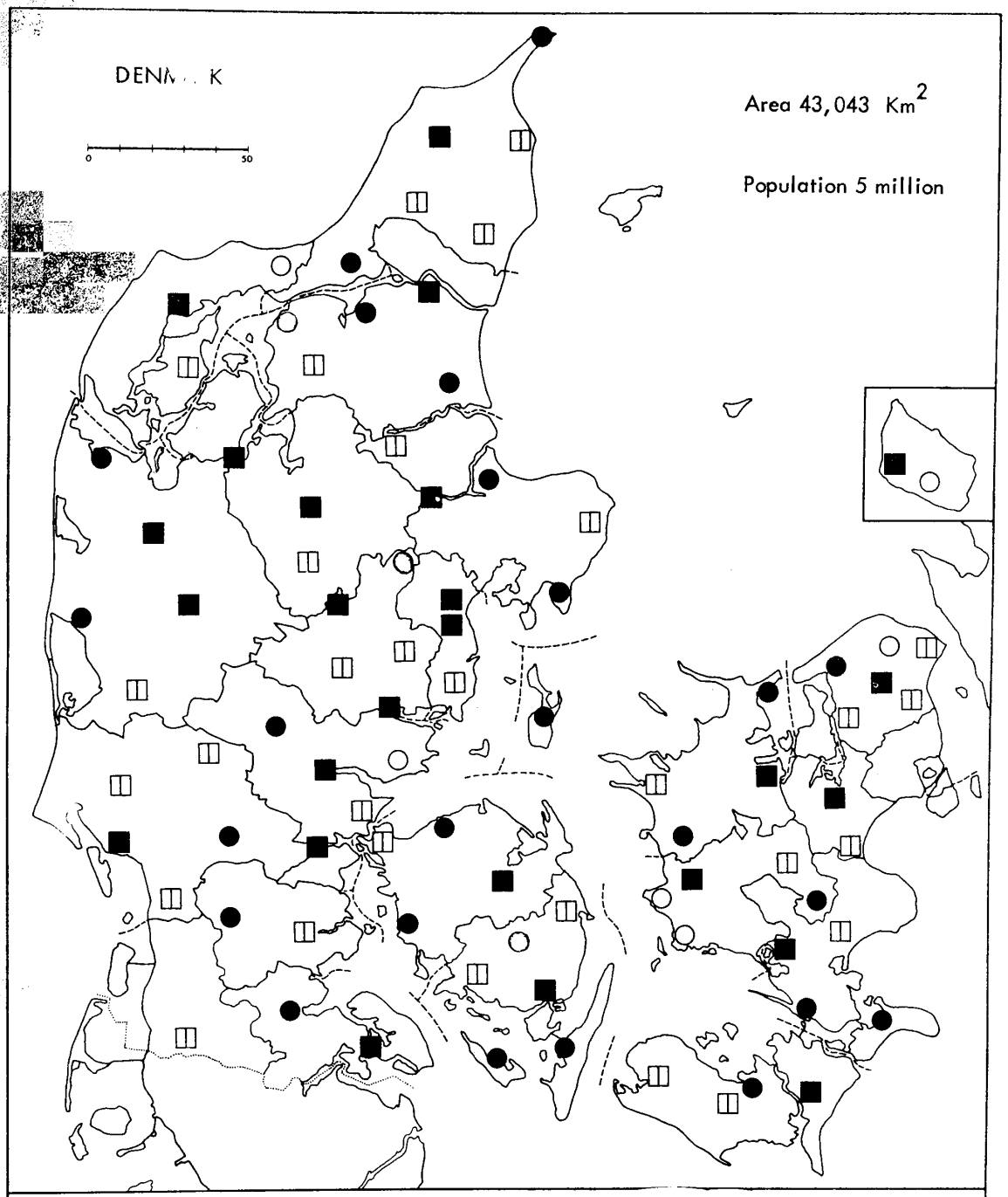
Part II is a report on hospitals and other institutions for the treatment of the sick throughout the country. It gives a description of each existing hospital and its functions; and provides tables giving number of employed persons in the individual hospitals, number of beds and occupancy, main diagnoses and operations for discharged patients in the individual hospital departments.

The report is written in Danish, but with a summary in English in to which language also headlines etc., are translated.

Besides the staff attached to the National Health Service headquarters in the capital, the service is represented at the local level by a number of medical officers. They serve as a link between the National Health Service and both the local agencies concerned with public health, and the local medical and health personnel - thus performing at the local level, the advisory and supervisory responsibilities of the National Health Service. An important part of the district public doctor's functions consists of advice and guidance to the local health authorities, when performing their tasks in the field of environmental sanitation and food hygiene.

As a medium for creating close contact between the Ministry of Interior and the National Health Service on the one side and the interests of local governments on the other side with respect to all matters pertaining to further extension and improvements of the hospital service a supreme hospital board has been established by the Ministry of Interior, comprising representatives from the political parties, the Ministry of Finance, the Ministry of Interior, and the National Health Service.

It is the duty of the board to assist the National Health Service in obtaining a smoothly running, effective, and economic hospital service, especially concerning co-ordination and collaboration between hospitals, regardless of ownership and geographical location.



MEDICO-SURGICAL HOSPITALS OUTSIDE COPENHAGEN 1974

- ■ Central hospitals comprising several departments
- ⊟ Other hospitals comprising at least two specialities
- ● Minor hospitals comprising a mixed surgical-medical department
- ○ Long-term care hospitals

Health Services in Denmark — Annex

DATA SHEET

		1966	1971/72
1.	Percentage of G.N.P. for institutional Health Services :		
1.1.	overall percentage	3,8	5,3
1.2.	general acute hospitals	2,5	3,4
	psychiatric hospitals	0,2	0,3
	homes for the aged + nursing homes	0,5	0,9
	institutions for handicapped, i.e. institutions for the mentally deficient, epileptics, disabled, speech defective and word-blind, blind, and deaf	0,6	0,7
2.	Incidence of admissions per 1,000 population		
2.2.	general acute hospitals	122	140
2.3.	psychiatric hospitals	3,6	5,4
3.	Number of beds per 1,000 population		
3.2.	general acute hospitals	6,0	6,3
	- medicine & obstetrics		2,5
	- surgery		2,8
	- paediatrics		0,3
	- geriatric care		0,5
	- psychiatric care		0,3
3.3.	psychiatric hospitals	2,0	2,0
3.5.	homes for the aged + nursing homes	6,6	(1972) 8,2
3.6.	institutions for handicapped	6,0	6,3
4.	Use of beds		
4.1.	number of patients (1,000)		
4.1.2.	general acute hospitals	610	742
4.1.3.	psychiatric hospitals	19	27
4.1.5.	homes for the aged + nursing homes, i.e. number of residents	no inform.	39

		1966	1971/72
4.1.6.	institutions for handicapped, i.e. number of patients (clients)	29	31
4.2.	Number of hospital days (per 1,000 patients)		
4.2.2.	general acute hospitals	8,664	9,134
	medicine		2,415
	obstetrics		209
	surgery		2,627
	paediatrics		351
	geriatric care		248
	psychiatric care		318
	others		2,966
4.2.3.	psychiatric hospitals	3,797	3,960
4.2.4.	geriatric hospitals	no information	
4.2.5.	homes for the aged		
4.2.6.	institutitutions for handicapped		
4.3	Average length of stay		
4.3.2.	general acute hospitals	14,2	12,3
	medicine		16
	obstetrics		8
	surgery		11
	paediatrics		15
	geriatric care		53
	psychiatric care		23
4.3.3.	psychiatric hospitals	200	147
4.3.4.	geriatric hospitals	no information	
4.3.5.	homes for the aged		
4.3.6.	institutions for handicapped		

4.4.	Average occupancy			
4.4.2.		general acute hospitals	87 %	87 %
4.4.3.		psychiatric hospitals	99 %	100 %
4.4.4.		geriatric hospitals		no information
4.4.5.		homes for the aged	no information	96 %
4.4.6.		institutions for handicapped		no information
5.	Personnel engaged in Health Services			
5.1.		total physicians	7,694	8,114
5.1.1.		physicians authorised as specialists	2,741	3,046
		internists	393	419
		obstetricians (x) incl. gynaecologists)	256 x)	167
		surgeons	376	407
		paediatrists	91	95
		geriatrists	no information	101
		psychiatrists	243	304
		others	1,382	1,553
5.1.2.		general practitioners (incl. GP specialists)	2,579	2,600
5.1.3.		physicians in post graduate training	no information	1,500
5.2.	physicians/Health Services			
5.2.2.		general acute hospitals	3,100	4,525
		medicine		1,228
		obstetrics		
		surgery		1,863
		paediatrics		149
		geriatric care		217
		psychiatric care		170
		others		898

		1966	1971/72
5.2.3.	psychiatric hospitals	225	317
5.2.4.	geriatric hospitals		
5.2.5.	homes for the aged	no information	x)
5.2.6.	institutions for the handicapped		

x) 1972 : an existing resource-status is not adequately specified, as physicians are included in "other trained personnel"

5.3.	total nurses		
5.4.	nurses/Health Services		
5.4.2.	general acute hospitals	13,200	14,600
5.4.3.	psychiatric hospitals	1,650	1,750
5.4.4.	geriatric hospitals		no information
5.4.5.	homes for the aged	no information	2,750
5.4.6.	inst. for handicapped		no information
5.5.	total other paramedical personnel		
5.6.	other paramedical personnel/Health Services		
5.6.2.	general acute hospitals	17,700	25,900
5.6.3.	psychiatric hospitals	2,625	4.775
5.6.4. x)	geriatric hospitals		no information
5.6.5. x)	homes for the aged	no information	5,834
5.6.6. x)	inst. for the handicapped		no information

x) "other paramedical personnel" is here defined as : practical nurses, nursing home assistant nurses, deacons, and physiotherapists (but not incl. ergotherapists, etc.,)

	1966	1971/72
6. Costs	per patient	per day
general acute hospitals	3,800	310
psychiatric hospitals	2,000	133
	year/number of beds	
	1966	1971/72
homes for the aged	13,800	39,200
institutions for the handicapped	16,000	29,600

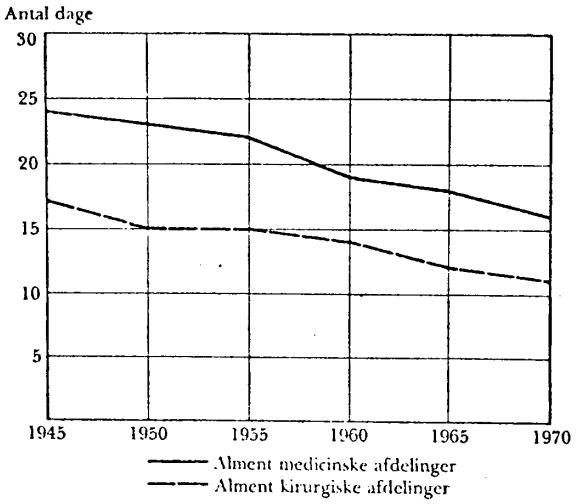
Cost for personnel in somatic and psychiatric hospitals in 1971 was approximately 72 per cent of total running cost.

7. Selected items compared with size (general acute hospitals only)

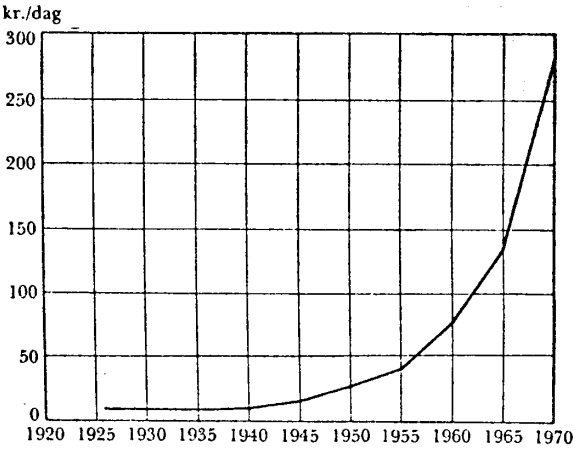
1971

items	number of beds				
	- 150	150-199	200-599	600 +	total
average number of beds	80	154	351	1,172	296
patients per bed per year	22	25	26	25	25
average length of stay	12	12	12	12	12
average occupancy	73,8	81,3	86,3	85	84,5
average cost per patient	2,800	3,000	3,350	4,650	3,800
average cost per patient day	230		280	400	310

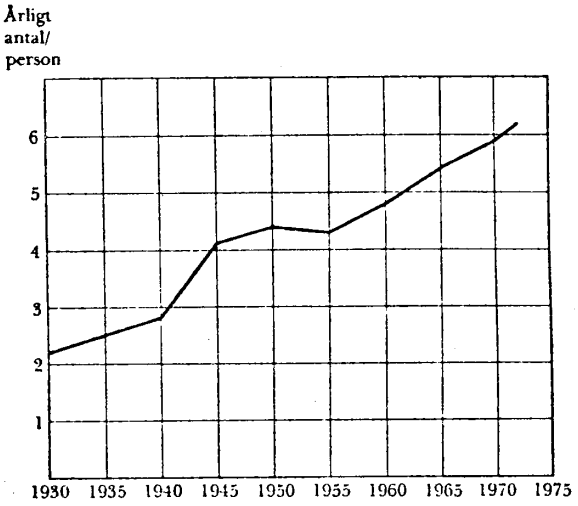
Average length of stay in danish hospitals.



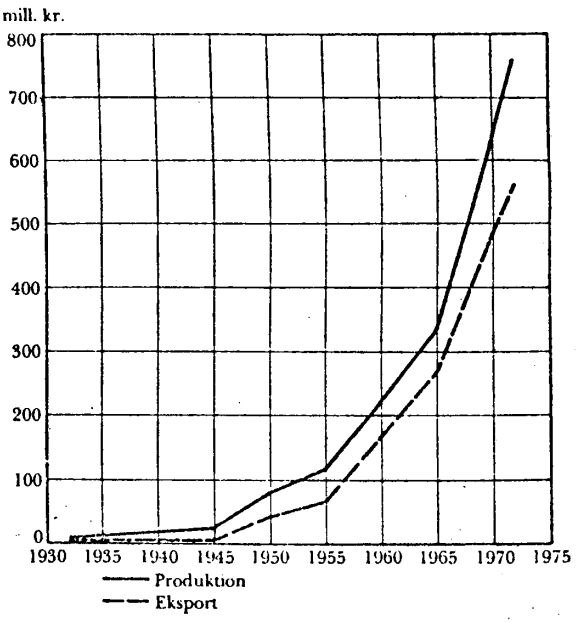
Gross-expenditure per day.



Number of prescriptions per person.



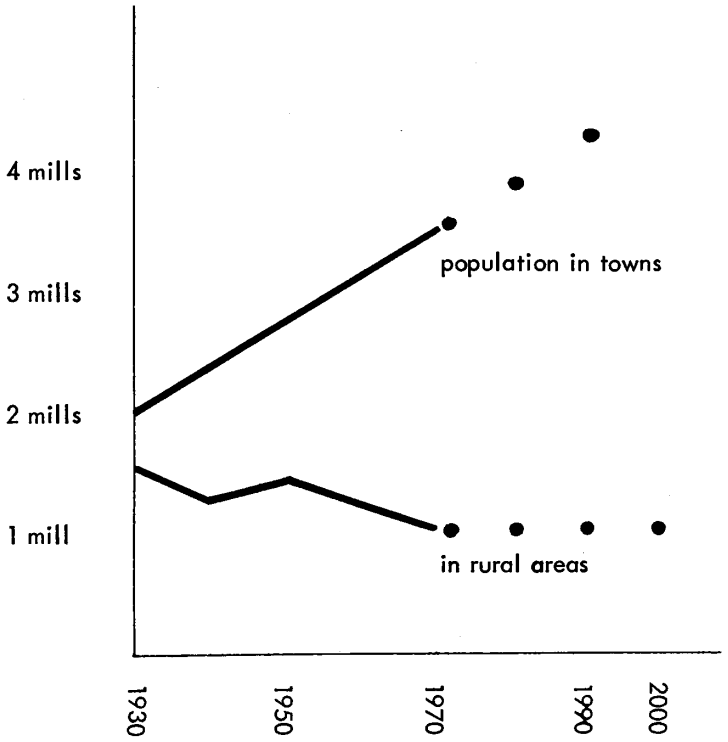
Danish industrial production of pharmaceuticals.



During recent years there has been a marked change in the pattern of the working population.

There has occurred a distinct migration from agricultural occupation into industry.

From 1930 to 1960 the active part of the population increased by 24 per cent, the active town-population increased by 50 per cent, while the active agricultural population diminished by 26 per cent.



The decrease in the agricultural labour-force in the period was around 200,000 men and women, mostly wage-earning persons, while the number of land-owners fell from about 200,000 to 185,000.

All groups in towns have had a considerable growth, 72 per cent or 670,000 persons in all.

Groups comprising education, health service and social welfare and other professional activities enlarged by 158 per cent, industry by 63 per cent, commerce by 50 per cent, and transport by 74 per cent. The number of women employed was more than five times as large in 1960 as in 1930.

An interesting feature is that while until recently most of the industrial growth took place within the capital, this has since 1960 been reversed and the expansion now takes place in the larger provincial towns, where there is easier access to space for one-storey factory-buildings (automation) and parking-areas.

It is presumed the above described tendency will continue during following years.

King Edward's Hospital Fund for London

King's Fund Centre

NHS AND EEC - IRELAND

Papers given at the seminar held at the King's Fund Centre on Thursday, 6 June, 1974, by:

Dr Brendan Hensey
Secretary
Department of Health
Dublin

Mr D Condon
Assistant Secretary
Personnel Division
Department of Health
Dublin

A) Dr Brendan Hensey

1 Introduction

This being the last of your series of lectures on health services in the EEC countries, I am sure that many of your listeners will have been concerned and, perhaps, bemused at the variety which exists in the organisation of health care within the different EEC countries. As you will have heard, most of these countries have systems very different from that in the United Kingdom and it may be a relief for you to have described for you a system of administration which is now strikingly similar to yours but which, I think, has sufficient differences to make its description interesting - if only because while we in Ireland have arrived at much the same kind of system as you have, we arrived by an entirel, different route.

Our system of health administration has been designed for requirements as they are seen to exist in Ireland and, perhaps, I should, therefore, start by giving you some significant information and statistics relating to our country. First, it has a population of just three million. This population is now increasing but, up to about 1970, we were unique among Western European countries in that our population had been falling steadily since the middle of the last century.

At the same time, there has traditionally been in Ireland a substantial excess of births over deaths - in 1973 the birth rate was 22.3 and the death rate 10.9. Emigration was, however, greater than the natural excess of births over deaths and hence we had this secular fall in population. Because most of those who emigrated were in younger age groups, the population which remained in the country had a uniquely high dependency ratio, probably the highest in Europe. Only 57.7% of the Irish population in 1971 was between 15 and 64 years, as compare to 64.6 in England and Wales. The high proportion of children and old people has presented especial problems in the development of the health services.

The area of Ireland - and here, I am of course, referring only to the Republic - is 26,600 sq. miles and the density of population is 112 persons per sq. mile. In the Western part of the country, the density is very much lower than this, because most of the population is on the Eastern side of the country, the Dublin area alone having about one-third of the entire population. There are few cities, Dublin and its suburbs being the only one which measures up to the scale of your cities and conurbations. Our gross national product per head of the population in 1972 was £750 which was about two-thirds of that for the U.K. However, this ratio was only about half in the nineteen-fifties. There continues to be a reasonable rate of economic development in the country. The proportion of the working population engaged in agriculture, which was traditionally very high, has now fallen to about one-quarter.

This, then, is a thumbnail sketch of the country whose administration I will describe. Quite disimilar from England but not too unlike Scotland, Wales or Northern Ireland. You will see, indeed, that our system of health administration is more like the recent systems which have been developed in those countries than the system which has just been installed in England.

Again, before discussing administration or planning, it is necessary to refer briefly to the scope of the health services which we have and to the philosophy behind their development. The kind of thinking which led to the introduction of a national health services in the UK in the 1940s was not then adopted in Ireland, one reason being the very practical one that the country was then far too poor to afford it. Since then, as we observed, the financial problems which in all countries bedevil the development of public health services, the approach in Ireland towards universality in cover for the services has been a cautious one, but in many of the services universality in cover is now achieved or near achievement. For the preventive services, including hospital care for infectious diseases there is no means test. Other hospital services are now available to about 90% of the population and their extension to the entire population is now a matter of Government policy. This extension is held up only because of a dispute with the consultants about how they should be paid under a universal scheme.

We have a fully free general practitioner scheme, based on payment by way of fee-per-item of service, for about one-third of the population and for the rest, while doctors' fees are not subsidised, the cost of general practitioner care is alleviated under a scheme whereby no family need pay more than £4 a month for prescribed drugs - a scheme which I might describe as the inverse of your system of prescription charges. Drugs for a number of long-term ailments and conditions are available for all entirely without charge.

In the case of dental, ophthalmic and aural services, the concentration within our health services has largely been on children and we have not yet got anything like the comprehensive cover which you have in the U.K. However, looking at the general pattern of our services, you will see that the organisation which I will describe is largely an organisation for services related to the needs of the whole population for health care.

Any system of organisation must be related to the resources available and I think I should here give you first a summary of the situation in Ireland as far as hospitals are concerned.

We have a relatively large number of hospitals and a good ratio of general hospital beds to population. One reason for this is, of course, that, except in some areas we have had no pressure from increasing population on the beds available. Many of the hospitals are small and they are well spread throughout the country. About half our hospital beds are in the ownership of voluntary bodies, most of these being concentrated in the Dublin area. (1, 2)*

As far as personnel is concerned, the situation in Ireland is that our five medical schools turn out about twice as many doctors as can be absorbed into our services so that, except in the case of some specialties, there is not usually much difficulty in recruiting doctors. The same applies to nurses, but not to dentists. But, over the whole gamut of health personnel, it has been possible in recent years to increase numbers fairly considerably.

2 Organisation

Now, I will turn to the main theme of this morning's discussion which is the organisation and planning of our services. In dealing with organisation, I will first speak of the change in recent years in the system of local administration and then with our central administration and the impact which the local changes have had on that. Finally, I will turn to the planning processes used and to be used in the re-structured administrative system. Before describing the present local organisation, I should perhaps refer briefly to the past. Until 1971, the responsibility for providing our health services resided within the local government system and, through mergers and adjustments within that system, a position had been reached whereby in each of 27 areas, one local authority had responsibility for the entire range of health services. We had not developed anything like your system of regional hospital boards, nor your system of executive councils for general practitioner care. Some of the local authorities responsible were, however, quite small (a few counties have populations of only about 30,000) and it was becoming clear by the early 1960s that modern health services required a larger scale of administration. It was also becoming clear at that time that the existing system of finance whereby health services were paid for out of local rates, subsidised by a 50% State grant, could not adequately cover the continually rising costs of health care.

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*The bracketed numbers here and elsewhere in the text refer to the tables on pages 1R-11 onwards.

I would not suggest that the logic of a change from the system which then existed immediately impressed itself on all interests but, from about 1960, policy towards a new system based on amalgamation of existing areas became more clear and more firm.

A White Paper issued in 1966 stated the intention to introduce legislation to transfer health administration from the existing local authorities to regional boards whose membership would, as was expressed in public paper, "represent a partnership between local government, central government and the vocational organisations".

The reasons given for the change were on two bases. Firstly, it was stated that the needs of hospital organisation required larger areas. (However, the merits within the existing system of keeping all the services under one body were recognised and it was decided that whatever bodies were set up should have comprehensive responsibility for health care). The second reason for the change was the recognition that the local authorities could no longer, from their sources of finance, pay for their share of the development of many services. The change in administration was accompanied by increasing State finance although it was not until last year that a final decision was taken that the cost of the health services should be removed entirely as a charge on the local rates and became almost entirely an Exchequer charge. (3)

Following consultations on the White Paper, a Bill was put before Parliament in 1969 and this became law in the Health Act, 1970. The new system of administration based on health boards, came into effect in April, 1971. The relative speed of this process of change, as against the changes made in the United Kingdom may have been accounted for by the fact that we in Ireland had, so to speak, only to break eggs to make our omelettes while you had first to unscramble a much more varied and complex system.

The Act of 1970 did not itself specify the number of health boards. This was done by regulations made subsequently, after wide consultation. This resulted in a system based on eight health boards for the entire country, the population covered varying from about 180,000 in the case of the smallest board to almost a million in the case of the Eastern Health Board, which includes the Dublin District in its functional area.

The pattern of administration is such that in each case the functional area of the Board is made up of a number of the existing counties and county boroughs,

A number of factors were taken into account in designing this structure. Existing inter-country arrangements for other services were borne in mind, regard was had to desirability of not combining too many counties in any one board, of not allowing the population to be served in any case to be much below 200,000 persons, and it not having any board covering too extensive an area. The areas covered by the boards varied from 1,800 sq. miles in the case of the Eastern Health Board to 5,000 sq. miles in the case of the Western Health Board. You will note the similarity in this pattern to those adopted later for Wales, where I think there are 7 boards, Scotland where there are 14 and Northern Ireland where there are 4 boards (for a population about half that of the Republic).

Turning to the membership of the boards, the Act required that at least half of the members should be nominated by the local authorities in the area and that the remainder should be made up of representatives of the medical and ancillary professions, elected by those practising in the area, together with some members appointed directly by the Minister. This pattern of membership is, I understand, rather different from that for your health boards and I think that the difference may not be unrelated to the pattern of organisation within our boards which I will describe later.

Membership of the health boards varies a little but a typical board would be made up of 16 county councillors, 7 medical practitioners, a dentist, a pharmacist, a general nurse, a psychiatric nurse and three other persons appointed directly by the Minister for Health, making a total of 30. An analysis of the occupations of all those appointed as first members of health in 1970 showed that, out of a total of 235 members, there were 61 medical practitioners, 44 farmers, 33 shopkeepers, 17 nurses, 10 pharmacists, 8 dentists, 7 teachers and 6 each of solicitors, trade union officials, clerks and company directors. Several other occupations were represented in the remaining appointees. Persons employed by a health board are not debarred from membership of it. except for those in certain senior administrative posts. (4)

Health boards, as conceived in Ireland, are not managerial bodies and this was an important consideration in deciding on the constitution of the boards. Each board is required to have "a person who shall be called and shall act as the chief executive officer to the Board". While major policy decisions are taken at the meetings of the board members the board itself is specifically prohibited, under the Act, from interfering in a number of managerial decisions, including those relating to the eligibility of individuals for services and the control of personnel (including the fixing of remuneration). The health boards have also recognised the need to delegate the day-to-day management of many other aspects of services on a considerable scale to their chief executive officer, while retaining ultimate control in their own hands.

The management structure is thus highly significant in our context. The chief executive officer has a very special statutory position and all other managers carry out their functions as his delegate. However, a system of delegation of authority on a considerable scale has been encouraged and evolved within the Boards.

3 Administrative structure

Now I would like to discuss some typical administrative structures in health boards.

Under the chief executive officer, the work of the Board is divided into programmes. In each case there is a community care programme a programme for general hospital care and one for special hospital care. Each has a programme manager responsible to the chief executive officer and the Board for planning and development work within the programme. The division into programmes is related to the financial structure for the Boards which Mr. Condon will be describing later today. There are also at headquarters level in the health boards, functional officers dealing with finance, personnel and planning and evaluation. (5)

What I have just described is, if you like, the central core of the organisation, which is there for the planning of the services for the whole area of a health board but responsibility for providing the services is, particularly in the case of the community services, devolved to the local level. There is a local advisory committee under the board for each county, including many members not on the health board, and community care teams are being evolved under the local county medical officer (who is being re-named director of community care). These will include the heads at community level of the dental and nursing and other health professions.

This devolution to the county level should not in future be such a marked feature of hospital organisation. Most health boards have, in fact, recently produced plans to concentrate acute care in fewer hospitals, so that each county would not aim to have a comprehensive service within its boundaries.

Perhaps I should refer here to the position of the professions in administration. First, none of the chief executive officers is in the medical or para-medical professions. This is probably because there has not been a great background of medical administration in Ireland. Indeed at the second level of administration, that of programme manager - only about one quarter are doctors. However, it should be noted that doctors form a considerable proportion of the membership of the health boards and those who wish to specialise in administration should have the scope to do so, particularly as directors of community care who will, of course, have opportunities to move up in the ladder of administration. While there are less well-cut opportunities for the other professions, they also are represented on the health boards and the local committees.

The health boards have now had the responsibility for providing the services for a little over three years but it is generally recognised that it is even as yet too soon to assess the real effects in the change in administration. There was a considerable "shaking down" period when counties were learning to work together and while the new administrative teams under the boards were being built up. With the help and guidance of management consultants, new procedures for the new structure were being evolved but we found that it was easy to be optimistic about the pace at which changes such as these could be made. Health administration being previously in the hands of fairly small all purpose local authorities, the field for filling top jobs in the new administration was somewhat limited.

We should hope however, that the teething troubles may now be coming to an end and we can see the value of the broader organisation in the form of comprehensive plans, based on the different programmes which have been produced by most of the boards and which are invaluable in the central decisions on the allocation of resources. However, much more sophistication in this respect will be needed and this is being worked on at present.

The health boards are the main agencies in providing our health services: they spend most of the money and employ or pay most of the personnel. Even where other agencies - such as the voluntary hospitals - are involved, the health board has a financial responsibility and the costs for people in its area are charged to its account. However the health boards are but part of a general system of administration - in our parlance, they are executive agencies working uder the Minister for Health who in turn derives his authority from the Government and the legislature.

To aid the Minister and the Department in policy-making, there are a considerable number of advisory bodies. Most of these are specialised but there is a general statutory advisory body, the National Health Council, to advise over the whole field of health care. Most of these bodies have strong professional representation, and, indeed, by statute, the main advisory body, the National Health Council, must have at least half its members nominated by the medical and ancillary professions. (6)

There are also a considerable number of executive agencies apart from the health boards. Most of these are bodies set up under an Act passed in 1961 which permits the Minister by order to establish corporate bodies for any health purpose. They include the Blood Transfusion Board, the National Rehabilitation Board the Medico-Social Research Board and the Drugs Advisory Board. Health boards also have authority to combine and form joint boards for specific purposes. This power was used to form a combined board for the organisation of a computerised system for paying doctors and chemists under the general practitioner service for the whole country.

As I said earlier, about half of the acute hospital care is provided through voluntary hospitals and other hospitals outside the direct control of the health boards. These hospitals and the health board hospitals, are being combined in a computerised management information system.

There is one other body in the structure which I should perhaps mention specially. This is Comhairle na nOspideal - in English the Hospitals Council. It was set up in recognition of the fact that many of our hospitals, including most of the important teaching hospitals, were in the hands of voluntary bodies and it was necessary to involve these and the medical consultants, in the general planning and control of the hospital service. Thus this Council, made up of twenty-three members, of whom twelve are medical consultants, has the statutory function of governing the number and kind of consultant posts in each hospital, and hence the location of medical specialities. It also has a wide function in advising the Minister on the hospitals services. It is, if you like, a body to which the Minister delegates some of his policy-making powers, rather than an executive body like the health boards. I have in these remarks tried to let you have a broad picture of the health administration of Ireland. It has not been possible to deal with all aspects of this administration but the later discussion may bring up some important points which I have missed.

4 Planning

To turn to my final topic, planning - better planning, execution and monitoring of services - was, of course, the whole aim of the changes in the administrative structures which I have described. By reducing the number of responsible executive authorities at the local level, it was possible to have stronger organisation at that level and this in turn permitted the Department to commence freeing itself of detailed controlling and monitoring work so as to concentrate on planning. This is an incompleted process at this point of time: installation of formalised planning processes could not fully coincide with the structural changes necessary for these processes. Therefore, what I will say about our planning processes will not relate entirely to the present but rather to the future when, now that the structural changes are largely completed at local and central level, we can begin to see the benefits of a more formal system of planning for services.

Planning in the health services is not, of course, a new thing in Ireland. We, in common with other countries, recognise the tremendous complexity of the problems facing the health services, the need to identify priorities for development, and to decide on a strategy for such developments. This kind of strategic planning, in which an endeavour is made to identify what are the needs of different groups of the population and how best these needs should be met, has been helped by a number of reports of advisory bodies which have been published in recent years. We have had reports on the mental health service, the services for the mentally handicapped, the general hospital services, the child health services, the care of the aged, the general practitioner services and the public health service. Each of these more or less indicated what changes should be made in the services for the category concerned. By and large, these reports have over the years been accepted as the bases for strategic planning. For example, that on the mentally handicapped recommended a considerable addition to the number of places for the mentally handicapped and the implementation of this recommendation is part of general policy. Similarly, a recommended change in relation to the care of mental illness whereby the numbers kept in mental hospitals would be reduced, with concentration on developing community services, is being steadily implemented. The number in mental hospitals fell from 19,000 in 1963 to 15,000 in 1973.

This kind of strategic planning is, one might say the raison d'etre of ministries of health throughout the World and it involves much of the attention of the medical and para-medical professions. This planning is involved with identifying the needs of all kinds of people for health care and with assessing broadly how this care can best be provided within the context of the changing pattern of medicine. However it is well-known that no country can hope to provide quick and ready answers to fulfil all the objectives of strategic planning. Subsidiary to the strategic planning, therefore, there must be built into the health administrative system, arrangements for tactical planning, to assess in the short-term what advances and changes should be made and to see that the practical arrangements for making these changes are carried through.

It is in this tactical planning that we see the greatest advantages to be derived from setting up the new system of administration. Perhaps the most important consideration in this regard is that the health board, at the local level, can look right over the whole field of medical care, both in hospitals and outside hospitals and evolve its priorities on where advances should be made within the overall strategic plan. A second advantage from the new system is that the similar and more sophisticated organisations in the boards allow the central administration to oversee tactical planning, in its allocation of resources, to take into account properly assessed needs of different areas.

The planning system which is being evolved is based on programme budgeting. Mr. Condon will deal with the financial aspects of this but, as far as planning is concerned, it is a system, based on the three main programmes which I have referred to earlier, i.e., community care, general hospital care and special hospital care. Each of these is divided into sub-programmes and activities. The same system will apply to all health boards and to the Department itself, so that planners will have access to comparable information and indices of achievement from all the main executive agencies. The plans based on this system will be projected for a period of five years and not on a simple annual basis.

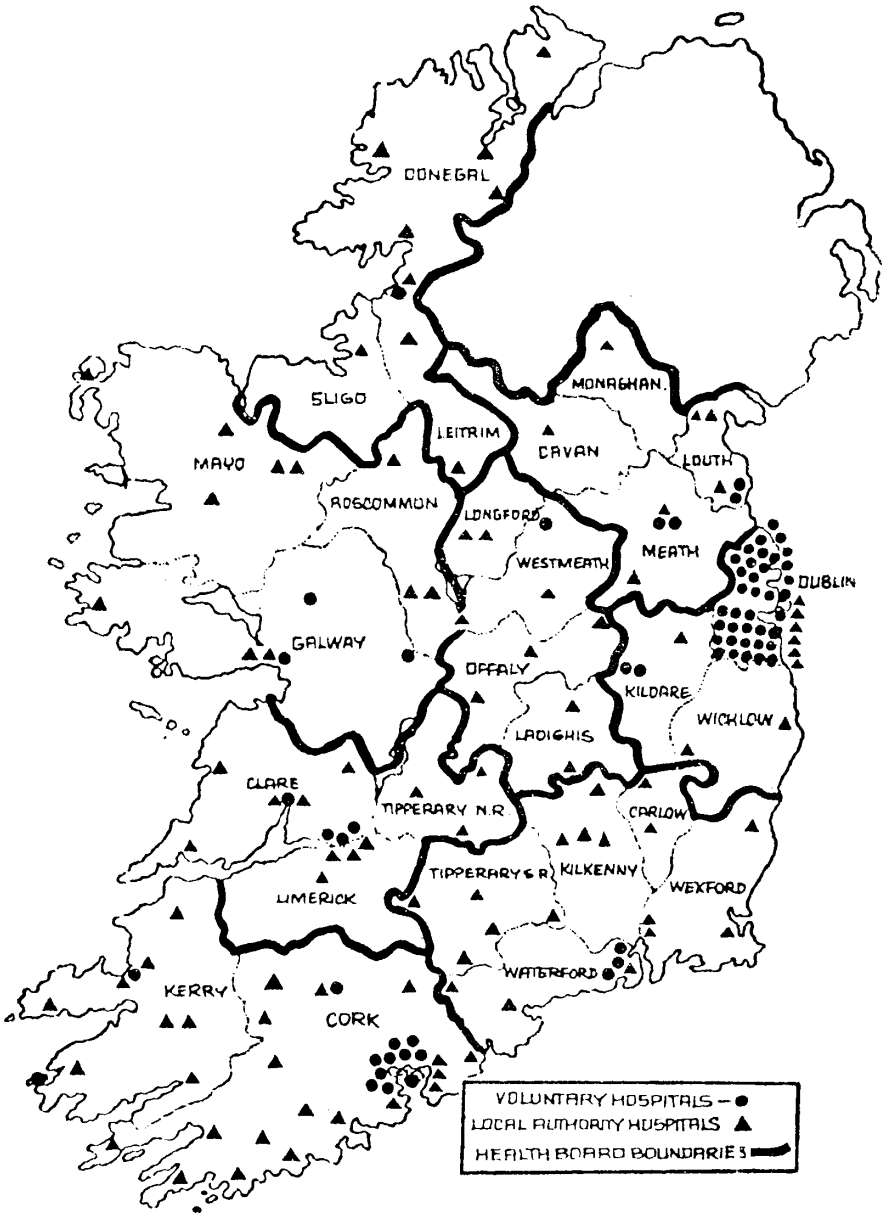
It is, of course, an essential pre-requisite for any system of planning that there is full and accurate information available on the services and the results which they are achieving. We are endeavouring to introduce m ore sophistication into the collection and processing of such information. I have already referred to the computerised process which we have for paying doctors and pharmacists under the general medical service. This gives us a very good facility for analysing visiting patterns and prescribing patterns by area, kind of patient, type of practice and so on. We are extending this kind of sophistication into other aspects of the services. A number of the health boards are at present linked in with the central computer operated by our Department of the Public Service and it is intended that all the boards will be so linked fairly soon. This will give them a facility for their accountancy work but will also be the basis of comprehensive and comparable management information for the boards and the Department of Health.

The information which comes from health boards is backed by studies carried out under the Medico-Social Research Board. These include an in-patient study which is being extended to all general hospitals and will provide information on the lines on that provided by studies in the UK on the user of hospitals, durations of stay, etc., Further studies under the Medico-Social Research Board relate to admissions to mental hospitals and the causes for stays in mental hospitals. In conclusion, may I say that in Ireland, as in most other European countries, the awesome problems being presented by the financing and organisation of medical care are fully recognised. The changes in administration and in planning processes which I have described cannot of themselves sovle these awesome problems. What we can hope is, however, that in the future allocation and spending of resources for health services, there will be better knowledge of the options and better ways of making sure that the money is spent to the best advantage.

Finally, Mr. Chairman, I would like to thank you for giving me the opportunity to speak on these matters.

TABLE 1

Beds	Voluntary hospitals	Health board hospitals	Total	Beds per 1,000 population
Medical (including minor surgery beds in district hospitals)	1,389	3,120	4,509	1·57
Surgical	1,328	1,992	3,320	1·15
Gynaecological ..	291	35	326	0·11
Maternity	603	995	1,598	0·55
Ophthalmology ..	201	57	258	0·09
Ear, nose and throat ..	277	64	341	0·12
Paediatric	1,007	646	1,653	0·57
Skin and cancer ..	304	43	347	0·12
Orthopaedic	808	712	1,520	0·53
Cardiac	85	64	149	0·05
Fever	—	621	621	0·22
Others..	303	67	370	0·12
TOTALS	6,596	8,416	15,012	5·20



Present distribution of hospitals

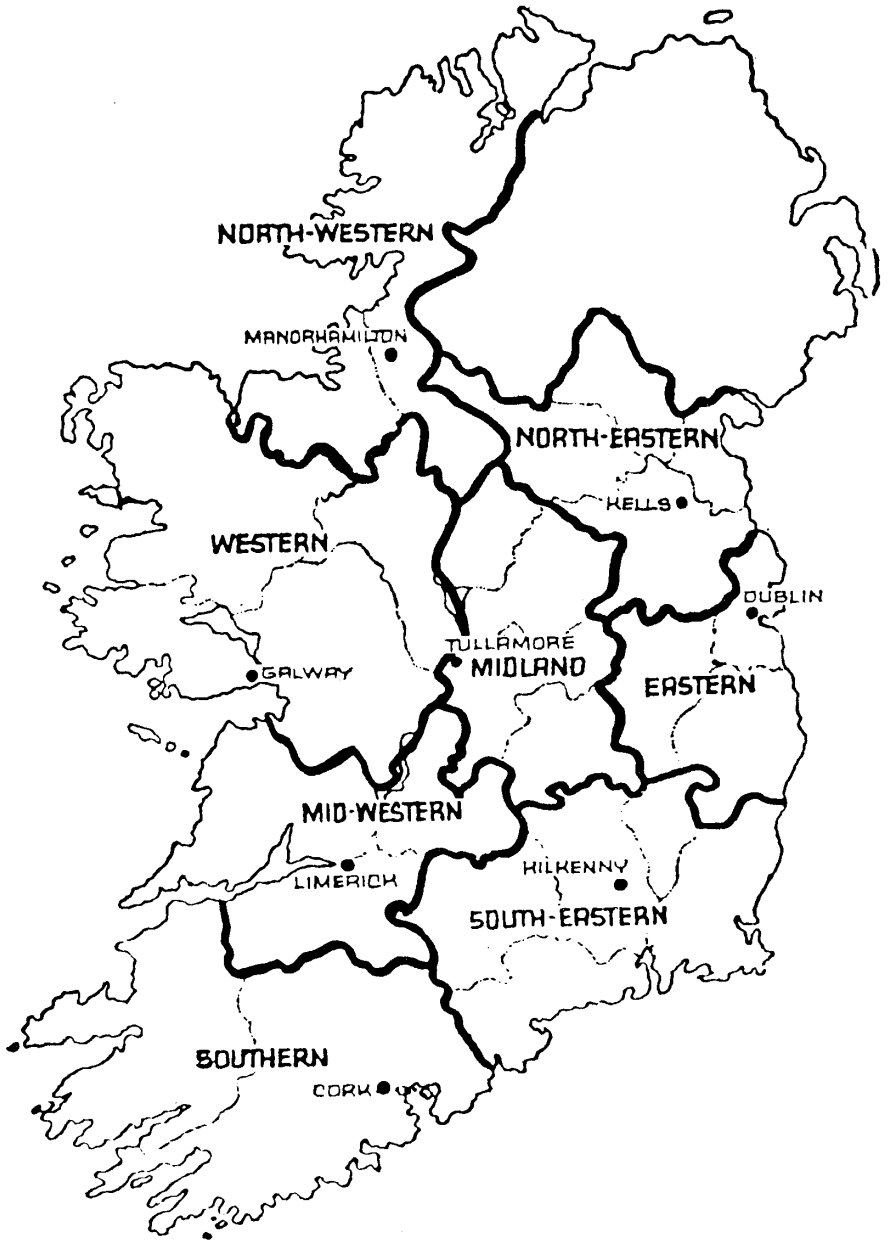
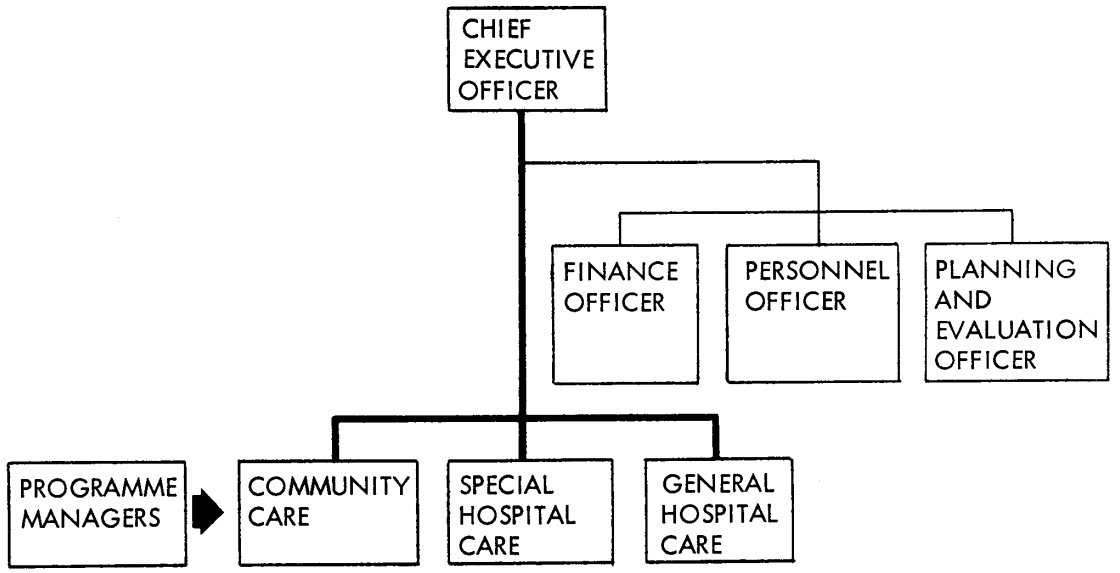

NORTH-WESTERN
MANORHAMILTON
NORTH-EASTERN
KELLS
WESTERN
DUBLIN
TULLAMORE
GALWAY
MIDLAND
EASTERN
MID-WESTERN
LIMERICK
KILKENNY
SOUTH-EASTERN
SOUTHERN
CORK

TABLE 4

HEALTH BOARDS

Title of Board	Functional Area	Population 1971	Membership							
			Local Authority Members	Medical Practitioners	Dentists	Pharmacists	General Nurses	Psychiatric Nurses	Ministerial Nominees	Total
Eastern Health Board	Dublin City and County, Counties Kildare and Wicklow (1,800 sq. Miles)	987,000	19	9	1	1	1	1	3	35
Midland Health Board		179,000	16	7	1	1	1	1	3	30

ORGANISATION OF A LARGER HEALTH BOARD



ORGANISATION OF A SMALLER HEALTH BOARD

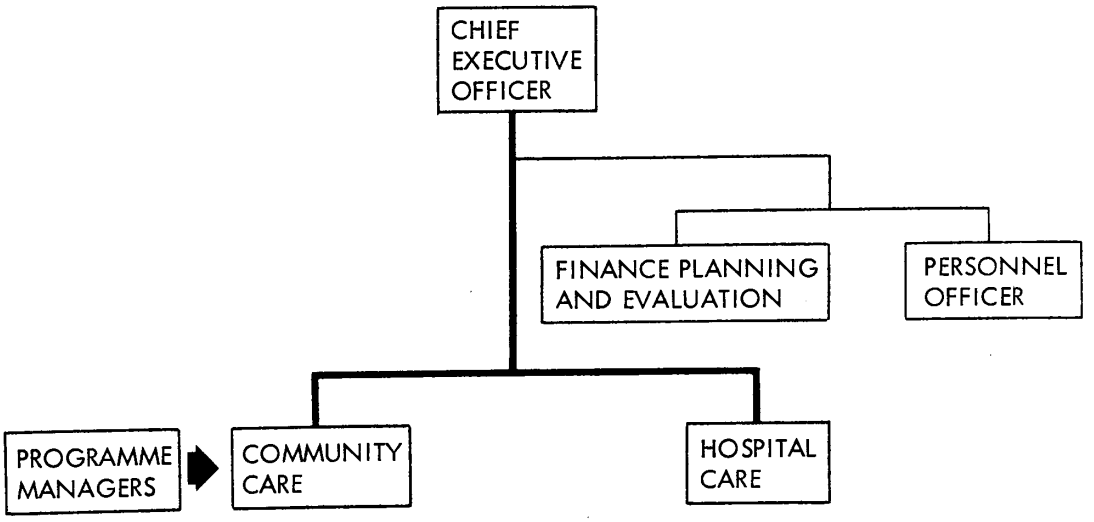
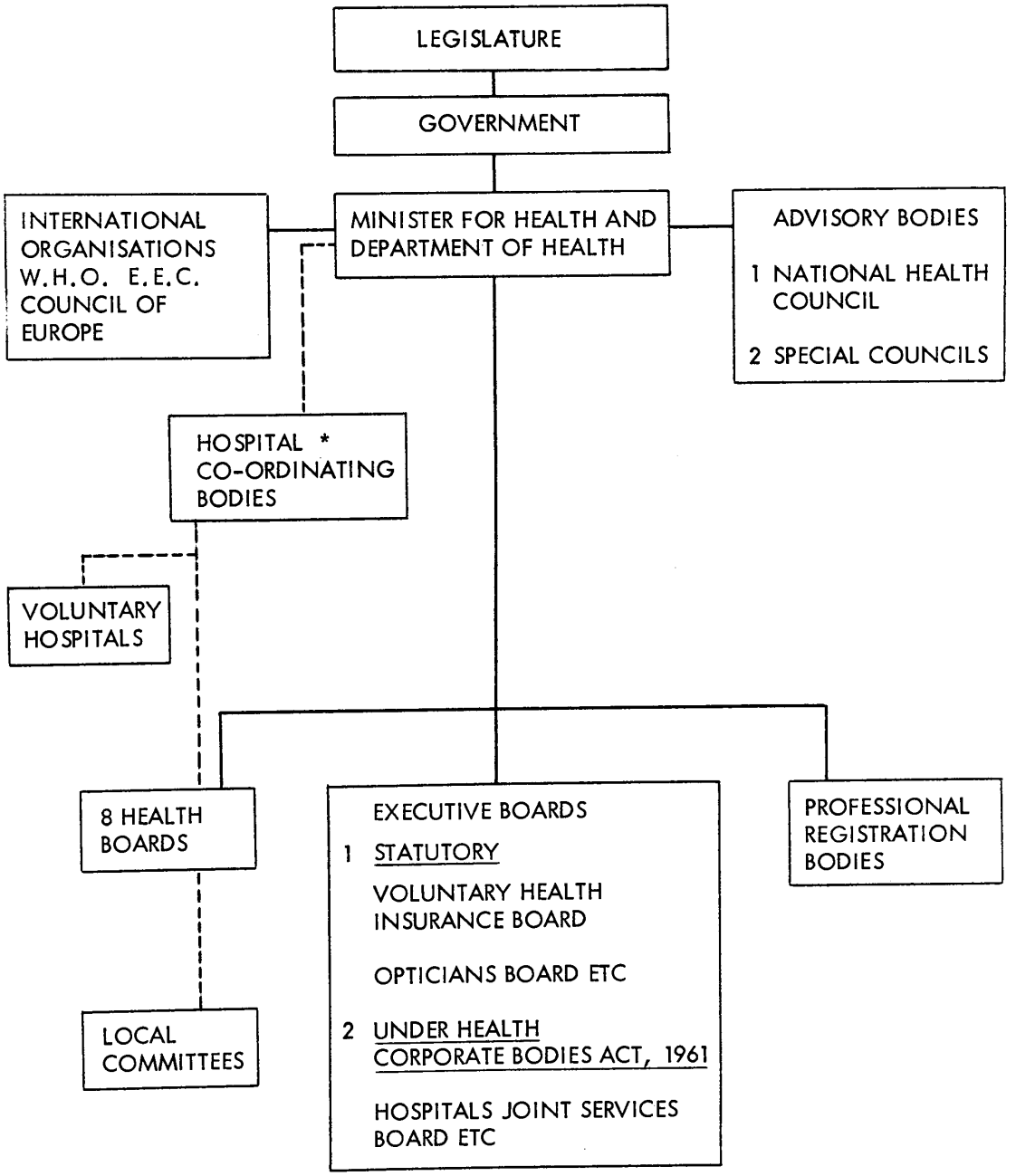


TABLE 6

ADMINISTRATIVE STRUCTURE OF THE HEALTH SERVICES



* 3 Regional Hospital Boards

B) Mr D Condon

Introduction

1 The re-structuring of the health services described by Dr Hensey has seen the emergence of new and re-vitalised roles for the finance and personnel functions at national and regional levels. This is not surprising when one takes account of the cost of the services and the labour-intensive nature of them.

Finance

2 By way of back-ground information, there have been four significant landmarks in health services financing since the war.

3 The first was in 1947 when plans were prepared for substantial developments in the services and it was accepted that more generous financial assistance from the State would be needed. At the time, State grants met only 16% of the cost of the services. A White Paper issued in 1947 indicated that State help towards the cost of the services would be substantially increased over the following years and effect was given to this promise in the Health Services (Financial Provisions) Act 1947. In this Act the State undertook to meet, for each health authority, the full amount of any increase in the cost of its services until the total cost was twice the amount met by each authority from local taxation in the year ended 31 March 1948. When the cost of the services rose above that level, it was to be divided equally between local taxation and the national exchequer. This 50/50 situation was reached in 1952.

4 The second development took place in 1966 when a review of the existing system of financing the services was included in a White Paper published in that year. Having referred to the continuing trends towards increasing costs and having given estimates of the cost of the improvements and modifications being proposed, the White Paper went on to state :

> "The Government, having studied this issue, are satisfied that the local rates are not a form of taxation suitable for collecting additional money on this scale. They propose, therefore, that the cost of the further extensions of the services should not be met in any proportion by the local rates. Following this decision other possible sources of revenue to meet the additional costs are being considered but it seems likely that the general body of central taxation must bear the major part of the burden. Pending further consideration of the methods by which extensions of the health services will be financed in future years, the Government have decided to make arrangements which will ensure that the total cost of the services falling on local rates in respect of the year 1966/67 will not exceed the cost in respect of the year 1965/66."

5 This 'freeze' on the rates contribution was not continued for succeeding years. However, the third development which took place was that grants supplementary to the statutory 50% began to be paid from the exchequer so as to reduce the impact on the local rates of the continuing rise in health expenditure. By 1973 the State grants specifically towards the health services were meeting almost 60% of the total cost.

6 In March 1973 the fourth development took place in the form of a decision by the new Government when they took up office. The Government decided that, over a period of four years, the local rates would be relieved entirely of their contribution towards the cost of the health services. We are now half-way towards that goal. By 1977 it is anticipated that the State will be bearing 95% of the cost of the health services; the balance coming from the Hospitals Trust Fund and the contributions coming from the operation of the Health Contributions Act 1971.

7 The Hospitals Trust Fund originated in the nineteen-thirties and was for a long while an important new source of moneys for the health services. The income of the Fund comes from sweepstakes on horse racing and it has been used for capital expenditure on health services generally and also to pay the deficits on the running expenses of the voluntary hospitals. A body called the Hospitals Commission was established to advise on issues from the Fund. In recent years the income of the Fund has remained more or less static and the Fund has, therefore, considerably decreased in relative importance.

8 The Health Contributions Act, 1971, introduced a new course of finance to meet part of the cost of the hospital services. This is a scheme of contributions by persons entitled to hospital services, i.e. those with "limited eligibility", to meet a fraction of the cost of the services available to them. The present rate of contribution is 15 pence per week for insured workers and £7 a year for farmers, other self-employed persons and those with private means. The contributions are collected from insured workers through the social insurance scheme, from the farmers direct by the health boards and from others by the Revenue Commissioners. The gross income from these contributions is about £5 million a year.

It is important to note that these contributions do not provide an insurance base for the hospital or health services. They meet but a small proportion of the cost of the services and entitlement to the services is not essentially related to having had a particular pattern of these contributions paid. The Health Contributions Act specifically requires that these contributions, in whatever way they are collected, are paid over to the Minister for Health. The proceeds of the contributions thus go to relieve his demands on central taxation to meet the expenditure on the health services: the contributions do not go into a separate fund from which payments are made to hospitals.

It should be mentioned, too, that payments under EEC Regulation 1408/71 for health services provided for migrant workers will normally be channelled into the central funds administered by the Minister for Health for distribution

by him in the general grants to the health boards and voluntary hospitals. It can be stated that the trend is to arrange that all sources of finance for public expenditure on the health services will come together under the Minister for Health who, in the future, will have responsibility for allocating the expenditure between the different services and the different hospitals within the hospital system.

9 When one discounts the effects of inflation, there has been about a 50% increase over the last four years in real terms in expenditure on the health services. In the same period the G.N.P. increased by 17% at constant prices.

The increasing proportion of our G.N.P. devoted to public expenditure on health services is shown in the following table:

	%
1968/69	3.6
1969/70	3.7
1970/71	4.2
1971/72	4.5
1972/73	4.7
1973/74	4.9

10 Public expenditure on the health services amounts to £162 million in the present year (this excludes capital expenditure). The distribution of this revenue expenditure between the major health care programmes follows the following pattern:

	%
General Hospital Care (including obstetrics)	43
Special Hospital Care (psychiatry, mental handicap, physical handicap, infectious disease, long stay hospitals etc.)	28
Community Care (General practitioner, home nursing, public health and preventive services etc.)	24
Support Services	5
	100

The spending agencies can be summarised as follows:

	%
Health Boards	72.7
Voluntary Hospitals	25.3
Other corporate bodies	0.7
Department of Health	1.3
	100

11 In the financial area in the past there was a tendency to concentrate almost exclusively on 'inputs' (money) and to pay little attention to 'output' (value received). At best, analyses concentrated on efficiency rather than effectiveness. Now, however, in common with other Government Departments, the Department of Health is developing a system of programme budgeting which will supercede the traditional system. The main components of this more sophisticated arrangement will be:

objectives, directed at realising deparmental policy and expressed in terms of end results;

programme structures, linking objectives and activities in the form of programmes;

programme budgets, containing estimates of costs and outputs for each programme, sub-programme and activity;

in-depth analytical studies, involving a detailed and comprehensive examination of the various programmes, schemes and expenditures;

procedures for systematic review and analysis of programmes;

management information systems to provide the necessary information for planning, budgeting, control and review and,

identification and assignment of managerial responsibility for programmes.

The health boards and other agencies will also operate on a programme budgeting basis and their arrangements will be in conformity with those for the Department. A good management information system is essential for the

purpose of programme budgeting. While information on the systems of health care is available, this is not always complete and comparable. Steps are at present being taken to establish a co-ordinated management information system whereby the financial and other statistics for the different programmes will be fully comparable. Insofar as the eight health boards are concerned, this will involve a computerised system linked with a central computer in Dublin from which consistent comparable statistics will be obtained. The bigger voluntary hospitals are also being linked in with this system. Significant progress has been made in installing the new system. A major step towards this goal was the development in co-operation with the health boards and the voluntary hospitals of a standard expenditure/income code. The code consists of 9 digits and check digit. The first digit identifies the agency (e.g. health board or voluntary hospital etc.); the second and third digits identify the main cost centre (e.g. health board service or hospital unit); the fourth and fifth digits identify the sub-cost centre (e.g. a hospital department), the sixth digit classifies the expenditure/income as between pay and non-pay while the seventh, eight and ninth digits identify the elements of expenditure/income (e.g. staff grades, medicines, fuel etc.). The code has been put into operation.

12 Voluntary hospital finance

The voluntary hospitals were founded through being financed by donations by public-spirited persons. Some forty or fifty years ago, when these donations were clearly inadequate to maintain the voluntary hospital system, the hospitals relied on income from the Hospitals Sweepstakes to meet a considerable part of their expenditure. However, with the very substantial increase in hospital costs in recent years, these hospitals have become increasingly dependent on public funds. Much of the aid from public funds to the voluntary hospitals comes from payments by the health boards for the maintenance and treatment of patients for whom they have responsibility, but the rates of these payments have not been adequate to meet the full cost of the average voluntary hospital. The difference has been met to some extent by private income but to a much greater extent by special "deficit" payments made by the Minister for Health from the Hospitals Trust Fund (this fund was initially financed entirely from Sweepstakes money, as referred to already, but in recent years has been mainly financed from central taxation). Hence the voluntary hospitals had to deal with two sources for obtaining their finance from public funds.

From 1 April 1974 the system of financing the hospitals has been changed so that each voluntary hospital now has its budget financed to the extent that it is not met from private fees and other sources entirely by way of payments from the Department of Health and that that Department will allocate to the budget of each health board the part of the contribution to the voluntary hospital applicable to patients from that health board's area. In this way, the financial arrangements for the voluntary hospitals will be simplified, but the expenditure will be properly associated with the accounts of the health boards responsible for arranging services for the patients.

13 Capital Expenditure

In the past, the main source of capital expenditure on hospitals in Ireland was the Hospitals Trust Fund. This Fund was established in 1933. As already indicated above, the Fund derived its income from sweepstakes on horse races and these were for many years very successful in raising money for the building of hospitals. In all, the yield for this purpose from the sweepstakes has been about £32 million. The funds derived from the sweepstakes are administered by a body separate from that which operates the sweepstakes. This is the Hospitals Trust Board, a statutory body appointed by the Minister for Health. The Fund was designed to meet both capital and current requirements of the hospitals. Payments from the Fund are directed by the Minister for Health. In recent years, the income from the sweepstakes has become a much less significant part of the resources for capital expenditure (as well as for current expenditure - see paragraph 7). At present about 85% of the money for capital expenditure is met by taxation.

The allocation of moneys for capital purposes is in the hands of the Minister of for Health and the total amount of capital expenditure on hospital services in any year is agreed with the Minister for Finance as part of a general public capital programme. In the year ending 31 March 1974, the allocation of public capital for hospital purposes was £9 million out of a total public capital programme for all purposes of £305 million. Specific allocations of capital resources are decided on by the Minister for Health. In making his decisions, he takes into account national priorities for different categories of services and the needs of particular areas and particular institutions. In particular, where health board hospitals are concerned in capital development, the views of the health board in relation to priorities are given proper weight. The Department of Health supervises expenditure of allocated moneys. Depending on the scale of expenditure and the type of project, this can vary from involvement in detailed specifications and plans to a general overall specification for accommodation and limits of costs.

14 Personnel

The health services are probably the biggest employers of staff in Ireland. There are over 40,000 people involved in nearly 300 different grades and, perhaps most importantly from a personnel viewpoint, the various professions within the services are scattered through almost all the bodies and areas of the services. Annual expenditure on staff is approaching £110 million.

15 As a general statement it is true to say that, apart from some local difficulties and problems in relation to certain paramedical grades, there is no serious general shortage of qualified staff. At recruitment level, there is a large surplus of eligible candidates seeking entry to the nurse training schools. So far as medicine is concerned, the output of the five medical schools is a little over 500 a year. These schools are the Royal College of Physicians and Surgeons, the University of Dublin (Trinity College) and the three Colleges of the National University of Ireland in Dublin, Cork and Galway. The output of 500 doctors is much in excess of national requirements even making a liberal allowance for overseas students and a margin for emigration of Irish graduates. The following table gives the numbers of staff employed in broad general categories:

	No.	% of total
Doctors and dentists	3,200	7.5
Nurses	21,000	49.0
Paramedical	2,200	5.0
Catering and Housekeeping	9,300	21.5
Administrative and Clerical	4,000	8.5
Maintenance	2,400	5.5
Other	1,200	3.0
	43,300	100

16 Most of the personnel in the health services are paid on a salaried basis. The major exceptions to this are, firstly, doctors participating in the general medical services ('choice of doctor') scheme, who are paid by way of fees related to patient contacts, and secondly, most of the consultants attached to the voluntary hospitals who are renumerated in respect of in-patients from a 'pool' derived from payments by the health boards to the hospitals and divided among the consultants by agreement among themselves; payments on a session basis, are made direct to these consultants by the health boards in respect of out-patients.

17 Remuneration, conditions of service and superannuation are compatible for all like grades of staff whether they are employed by the health boards, by the voluntary hospitals or by other health agencies. There is a conciliation and arbitration scheme for staff of the health boards. Some health board staff (mainly psychiatric nurses) and the staffs of the voluntary hospitals and certain other bodies have access to the Labour Court, a statutory body established under the Industrial Relations Acts.

18 Appointments, qualifications and conditions of service for health board staff are reserved to the chief executive officer of each board and he, in turn, when taking decisions on these, must act in accordance with the directions of the Minister. The Minister has given directions and guidelines of a general nature and, provided these are complied with, there is little further 'reference back' to the Department. Posts in health boards requiring professional qualifications and posts of chief executive officer must be filled by way of competition run by a national statutory body called the Local Appointments Commission. The voluntary hospitals and other agencies do their own selection of staff, invariably following public advertisement. At the Minister's request, the Hospitals Council (a national body set up under the Health Act 1970 to regulate the number and types of consultant posts in hospitals providing services under the Health Acts) has produced a scheme putting forward a common selection procedure for consultants, whether employed by the health boards or the voluntary hospitals. This is at present under examination in the Department.

19 Adjustments in rates of remuneration have been determined since 1970 on the basis of the three National Wage Agreements negotiated by Employer-Labour Conferences and which were of general application throughout the economy as a whole. Pay increases agreed by these conferences and subsequently ratified by the parties concerned have been either in the nature of 'flat rate' increases or, more commonly, by way of graduated percentages which, in either way, tended to favour the lower paid by giving higher percentage increases to them. The current agreement provides the vehicle for moving towards the implementation of the recommendations for equal pay made in the Report of the Commission on the Status of Women. The agreements also contain provisions for ironing out anomalies and for recognising changes in conditions of employment. Procedures are also included for resolving disputes relating to matters covered by the agreements.

20 Mention has already been made of the five undergraduate medical schools in the Country.

Irish medical education, both at undergraduate and post-graduate level, has traditionally been closely linked with that in Britain. At post-graduate level, where we as a Department are primarily concerned, this close link has been maintained. In some specialities such as medicine and surgery, there are Joint Postgraduate bodies on which we are represented with England and Wales, Scotland and Northern Ireland. In other specialities there is close link between our bodies with the corresponding bodies in Britain. We established a Council for Post-Graduate Medical and Dental Education and Training at the end of last year. Its terms of reference are similar to those of the Councils in England and Wales, Scotland and Northern Ireland and I understand that it intends to establish liasion with these Councils. Our position differs, however, from that in Britain in that we have a separate body which regulates the numbers of consultants and senior registrars. This is a Council known as Comhairle na nOspidéal or the Hospitals Council. Medical registration and the surveillance of standards in the medical schools is entrusted by law to the Medical Registration Council. There is reciprocity between doctors on the register and those on the British register. The Dental Board partners the Medical Registration Council in the regulation of the dental profession. There are two dental schools in the country, one in Dublin and the other in Cork. Rationalisation of dental teaching, by providing for it in one national centre in Dublin, was recommended in 1972 in the Report of the Higher Education Authority. This matter has not yet been resolved.

The Nursing Board regulates the teaching and provides for the registration of nurses. The Board keeps a register of nurses with separate divisions for general trained nurses; male general nurses; mental handicap nurses; midwives; psychiatric nurses and sick children's nurses. The period of basic training is three years.

The Council of the Pharmaceutical Society is the governing body for pharmaceutical chemists. It lays down the training programme which is a combination of theoretical and practical instruction with apprenticeship under a member of the Society. A three year course of study at University College, Dublin, and at the Society's College of Pharmacy leads to a Degree of Bachelor of Science (Pharmacy).

The Opticians Board arranges for the registration of opticians and supervises them in the practice of their profession. The Board maintains two registers, one for ophthalmic opticians (who both prescribe and supply spectacles) and one for dispensing opticians (who only supply spectacles on the prescription of others).

These are the professional categories for which there is statutory registration. There are training facilities also for other groups such as physiotherapists, radiographers, laboratory technicians, health inspectors, occupational therapists, leading to recognised qualifications which are required for persons employed in the health services. For clerical and administrative staffs a series of grades is being evolved associated with a system of job evaluation leading to a career structure.

21 Since Ireland's entry to the EEC the most significant development on personnel took place in relation to doctors. The Working Part on Directives for achieving Freedom of Movement and the Mutual Recognition of Degrees and Diplomas has been very active and substantial progress has been made towards resolving outstanding problems.

22 Conclusions

To equip the Department to carry out its role in the finance and personnel areas, Finance and Personnel Staff Units have been created. These Units work in close partnership with the other Staff Units for Planning and Organisation and with line management within the Department and in the health boards and other agencies.

Their functions, respectively, can be summarised as follows: -

(i) discharging the traditional functions of the Departmental Accountant, including the collation of Departmental Estimates, the making of payments, the carrying out of internal audit and the preparation of the Appropriation Account;

(ii) the detailed measurement, in terms of budgetary resources, of alternative programmes identified from the plans produced by the Planning Unit and the co-ordination of the financial aspects of Departmental plans and programmes;

(iii) the provision of assistance and guidance for line management in reviewing expenditure in relation to budgetary allocations and programme output and for this purpose -

- to identify, in consultation with the three other staff units and line management, output and other data for the measurement of efficiency and effectiveness;
- to select, in consultation with the Department's senior staff, issues for the cost/utility and financial analysis and to arrange for the carrying out of such analyses either by the Finance Unit itself or others and to promote the use of the results of such analyses for decision making;

(iv) to participate in determining programmes and budgets for Departmental Agencies;

(v) to pursue such development, further to the above functions, of the Departmental budgeting and accounting systems as may be required to make programme budgeting fully operational in the Department itself and in Departmental Agencies.

Personnel The functions listed here cover those for discharge over the whole area of the health services.

(i) to plan the availability of staff with the necessary qualifications, skills and experience;

(ii) using the best available procedures and techniques to meet line management's staffing needs by selection, recruitment and promotion;

(iii) to devise, implement and review the effectiveness of promotion and policies;

(iv) to assist line management by instituting a set of policies forming a coherent programme of staff development embracing formal and informal training, education, career planning and systems of motivation and of appraisal;

(v) to provide such training as line managers, because of limitations of time or skill, cannot themselves provide for their staff;

(vi) to ensure the operation of effective staff relations policies and systems;

(vii) to maintain and operate equitable and effective systems of determining pay, pensions and conditions of employment.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