KING EDWARD'S HOSPITAL FUND
FOR LONDON

EUROPEAN CONFERENCE

to consider

THE HOSPITAL SERVICES,
THEIR ORGANISATION AND SCOPE

with special reference to

HOSPITAL ADMINISTRATION
IN WESTERN EUROPEAN COUNTRIES

NOVEMBER 26th to 30th, 1962

HOSPITAL ADMINISTRATIVE STAFF COLLEGE
2, Palace Court, Bayswater, W.2

No. 2 Palace Court

(Headquarters of the Staff College)

KING EDWARD'S HOSPITAL FUND FOR LONDON

PATRON:
HER MAJESTY THE QUEEN

PRESIDENT:
HIS ROYAL HIGHNESS THE DUKE OF GLOUCESTER

TREASURER:
LORD ASHBURTON, K.C.V.O.

CHAIRMAN OF THE MANAGEMENT COMMITTEE:
LORD McCORQUODALE, P.C.

SECRETARY:
R. E. PEERS

The Fund was established in 1897 *by His Majesty King Edward VII (when Prince of Wales) for the 'support, benefit or extension' of the hospitals of London, and was incorporated by Act of Parliament in* 1907. *It is not directly affected by the provisions of the National Health Service Act of* 1946.

It was from the first intended that it should:

(*a*) *be a permanent Fund as distinct from a mere agency for the distribution of monies received;*

(*b*) *concern itself with efficiency as well as with the need of hospitals for monetary assistance.*

Moreover it was in the minds of those associated with the foundation of the Fund that it should exercise a co-ordinating influence over hospital affairs in London, and enlist the help of all in the search for solutions to the problems of the metropolitan hospitals.

For fifty years the main functions of the Fund were the distribution of grants and the provision of a system of visitation which did much to help and improve the voluntary hospitals in the Greater London area. In recent years, and more particularly since the coming into operation of the National Health Service Act, the Fund's activities, though still directed to easing the burden thrown upon hospitals, have tended to cover a much wider field.

The last half-century has witnessed a growing recognition throughout the community of the value of training for almost all kinds of work and of good principles and practice in the management of staff. As the Fund's resources were released from the demand of annual maintenance it became clear that they could be invested to good effect in the establishment, amongst other activities, of training centres. Thus the King's Fund now conducts, in addition to the Hospital Administrative Staff College, residential Staff Colleges for Ward Sisters and for Hospital Matrons and a School of Hospital Catering.

HOSPITAL ADMINISTRATIVE STAFF COLLEGE
2 Palace Court, W.2 .. .. *Telephone:* BAYswater 9361

HOSPITAL ADMINISTRATIVE STAFF COLLEGE

The King's Fund established the Hospital Administrative Staff College following the termination of a bursary scheme under which some fifty men and women were awarded bursaries to be trained in the practice of hospital administration.

The four main functions of the Staff College remain, as at the start in April 1951:

(1) to provide refresher courses for the most senior administrative officers in the hospital service;

(2) to provide training courses for those who, with further experience after training, might be likely to reach senior administrative posts;

(3) to undertake studies in hospital administration;

(4) to provide a meeting place for those interested in or associated with the National Health Service.

All refresher courses are fully residential and, so far as possible, the membership of each course is twelve.

The refresher courses are from one to four weeks' duration, the shorter ones usually being devoted to special subjects, e.g., management efficiency, the organisation of a hospital building project.

Training courses of three years' duration are provided for trainees under a Ministry of Health selective recruitment and training scheme. The Staff College also provides the theoretical content of a two-and-a-half year course for Regional trainees under a new, additional, Ministry of Health scheme.

In 1960, at the suggestion of the Minister of Health, 16-week courses for the training of work study officers and one-week courses in work study appreciation for those responsible for the use of work study techniques in the hospital service were established.

In all, the Staff College has held over 135 separate refresher and training courses. Other activities have included the provision of a recruitment advisory service and a medical records advisory service.

Guest night dinners and receptions designed to bring together, with the members of the courses, those interested in, or associated with the National Health Service, are a special feature of the life of the Staff College.

CONFERENCE PARTICIPANTS

Belgium	Dr. S. Halter	Directeur-Général, Ministère de la Santé Publique et de la Famille, Administration de l'hygiene Publique.
	Professor G. van der Schueren	Director, University Clinics, Catholic University of Louvain.
	Dr. A. Prims	Director, Federation of Catholic Hospitals.
Denmark	Dr. C. Toftemark	Deputy Director-General, National Health Service of Denmark.
Finland	Professor Dr. N. Pessonen	Director General, State Medical Board.
	Mr. O. Vauhkonen	Chairman of Direktion, Foundation for Education in Hospital Administration.
France	M. L. Peyssard	Inspecteur Général, Au Ministère de la Santé Publique et de la Population.
Ireland	Mr. C. O. Nuallain	Training Officer, Institute of Public Administration.
Italy	Professor F. Benvenuti	The University of Milan and The Institute of Public Administration.
Netherlands	Dr. J. B. Stolte	Medical Director, St. Elisabeth-Ziekenhuis.
Norway	Dr. H. Palmer	President, Norwegian Hospital Association.
Portugal	Dr. C. A. Ferreira	Director General of Hospitals, Ministério de Saúde e Assistência.
Spain	Dr. M. de la Mata	Direccion General de Sanidad, Jefe de la Seccion del Hospital.
Sweden	Dr. A. Engel	Director-General, Royal Medical Board.
	Mr. G. Albinsson	Landstingets kansli.
	Mr. G. Hogberg	Director, Sundsvalls lasarett.

Switzerland	Dr. F. Kohler	Direction, Inselspital.
Western Germany	Dr. S. Eichhorn	Manager, German Hospital Institute.
World Health Organisation	Dr. L. Kaprio	Public Health Administrator, Regional Office for Europe.
International Hospital Federation	Dr. J. C. J. Burkens	Secretary-General.
	Mr. D. G. Harington Hawes	Director-General.
Great Britain	Professor J. H. F. Brotherston	Department of Public Health and Social Medicine, University of Edinburgh.
	Professor T. E. Chester	Department of Social Administration, University of Manchester.
	Mr. N. W. Graham, C.B.	Under-Secretary, Scottish Home and Health Department.
	Mr. J. Kinnaird	Department of Public Health and Social Medicine, University of Edinburgh.
	Dr. D. Macmillan	Director, Nuffield Centre for Hospital and Health Service Studies, University of Leeds.
	Mr. A. S. Marre, C.B.	Under-Secretary, Ministry of Health.
	Mr. G. McLachlan	Secretary, Nuffield Provincial Hospitals Trust.
	Mr. R. A. Mickelwright	Principal, King's Fund Hospital Administrative Staff College.
	Mr. S. R. Speller, O.B.E.	Secretary and Director of Education, The Institute of Hospital Administrators.
	Professor W. S. Walton, G.M.	Professor of Public Health, London School of Hygiene and Tropical Medicine.

GENERAL INFORMATION FOR PARTICIPANTS

The Hospital Administrative Staff College is situated at Nos. 2, 10, 14 and 21, Palace Court, Bayswater, London, W.2.

The Conference will be held at No. 2 Palace Court in which are situated the conference room, library, dining-room, administration, &c.

No. 2 Palace Court is a house on the corner of the Bayswater Road approximately midway between Queensway and Notting Hill Gate stations.

THE NEAREST RAILWAY STATIONS ARE:

Central London Line:	Notting Hill Gate
Metropolitan and Circle Lines:	Notting Hill Gate and Bayswater
British Railways:	Paddington

BUS SERVICES WHICH STOP A FEW YARDS FROM THE STAFF COLLEGE:

No. 12 South Croydon to Harlesden (via Camberwell Green, Elephant and Castle, Westminster Bridge, Whitehall, Trafalgar Square, Charing Cross, Oxford Circus, Shepherds Bush, East Acton).

No. 88 Acton Green to St. Helier (via Shepherds Bush, Notting Hill Gate, Marble Arch, Oxford Circus, Piccadilly Circus, Trafalgar Square, Charing Cross, Whitehall, Westminster, Vauxhall, Stockwell, Clapham Common, Tooting, Mitcham).

In addition, bus services Nos. 27, 27a, 27b, 28, 31, 46 and 52 pass through Notting Hill Gate.

TAXI CABS Are available at all the London Main Line railway stations and at the Air Terminal at Cromwell Road as a convenient means of transport to the Staff College.

RESIDENTIAL ACCOMMODATION is available for registered participants from Sunday, November 25th to Sunday, December 2nd, 1962, inclusive. As guests of the King's Fund Hospital Administrative Staff College there is no charge to conference participants for meals and accommodation.

REGISTRATION

Participants are asked to register at No. 2 Palace Court at any time on Sunday, November 25th, but are asked to notify in advance their approximate time of arrival. Participants are asked to sign the Visitors' Book on arrival.

HOUSEHOLD ARRANGEMENTS

Participants will be awakened at about 7.30 a.m., when they will be offered tea in their bedrooms.

Shoes placed outside bedroom doors overnight will be cleaned and polished by the morning.

Towels and Soap. Towels and soap are provided by the Staff College.

Telephone. The Staff College telephone number is BAYSwater 9361. Public telephone boxes are available for the use of participants.

Meal Times

Breakfast	8.30 a.m.
Luncheon	1.00 p.m.
Afternoon Tea	4.00 p.m.
Dinner	7.00 p.m.
Reception (Tuesday)	6.30-9.30 p.m.

There is also a break for coffee at 11.00 a.m.

Informal dress for all occasions.

LIBRARY

This is on the hall floor of No. 2 Palace Court and is available to participants.

Please do not hesitate to ask the staff if there is anything you require to make your stay more enjoyable and interesting. The information office is next to the conference room (Miss Sharpe).

The King's Fund and the Staff of the College extend a warm welcome to you.

CONFERENCE ARRANGEMENTS

The presentation of papers by participants and the discussions will take place in the Hospital Administrative Staff College each day from Monday to Friday, November, 26th to 30th 1962, in accordance with the programme of sessions.

The Conference will be opened on Monday, November 26th at 10.00 a.m. by:

THE RT. HON. LORD MCCORQUODALE OF NEWTON, P.C.
Chairman of the Management Committee
King Edward's Hospital Fund for London

A GUEST NIGHT DINNER

Will be held at the Staff College on Thursday, November, 29th 6.45 for 7.15 p.m. (informal dress). The guests will include:

THE RT. HON. ENOCH POWELL, M.B.E., M.P.
Minister of Health

SIR BRUCE FRASER, K.C.B.
Permanent Secretary, Ministry of Health

SIR GEORGE GODBER, K.C.B. (D.M., F.R.C.P., D.P.H.).
Chief Medical Officer, Ministry of Health

and representatives of Regional Hospital Boards, Boards of Governors of Teaching Hospitals and Hospital Management Committees. The full list of guests will be published separately.

A BUFFET SUPPER AND RECEPTION

Will be held at the Staff College on Tuesday, November, 27th, 6.30 to 9.30 p.m. (informal dress), to meet representatives of the Ministry of Health, hospital employing authorities, and a number of organisations interested in or associated with the National Health Service. The full list of guests will be published separately.

EUROPEAN CONFERENCE

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HOSPITAL ADMINISTRATION IN WESTERN EUROPEAN COUNTRIES

The King's Fund Hospital Administrative Staff College wishes to express appreciative thanks to the participants who have kindly agreed to present papers to the Conference.

The following pages include the papers received at the time of going to press; others will be circulated as soon as possible before the Conference.

BELGIUM

by

DR. S. HALTER,

Directeur-Général, Ministère de la Santé Publique et de la Famille, Administration de l'hygiene Publique

HEALTH AND HOSPITAL SERVICES IN BELGIUM

I. General Information

Belgium has an area of 30,507 square km. It is divided into nine provinces.

Its population at 31st December 1959 was 9,128,824 inhabitants, or a density of 299 inhabitants per square km.

Population of the Provinces:

Antwerp	1,416,441
Brabant	1,950,779
West Flanders	1,058,746
East Flanders	1,268,034
Hainaut	1,271,888
Liege	1,010,611
Limbourg	563,645
Luxembourg	218,166
Namur	370,514

Belgium has five great centres of population:

Antwerp	546,500
Brussels	1,003,937
Charleroi	211,201
Gand	217,456
Liege	443,094

Belgium has 2,669 communes, of which

54	have more than 20,000 inhabitants
292	have more than 5,000 inhabitants
1,789	have more than 500 inhabitants
534	have fewer than 500 inhabitants

Vital statistics	1960
Percentage of births	17.60%
Percentage of deaths	11.34%
Natural increase	6.26%
Population increase (between 1947 and 1959)	6%
Migratory movement (1959)	0.76%

Health indices	1960	
Expectation of life	70 years (men, 67 years 7 months) (women, 72 years 10 months)	
Average age	36 years 2 months	
(1880)	28 years 6 months	
Infant mortality (under one year)	2.5%	
(1900)	17%	
Neonatal mortality (under one month)	2%	
(1900)	5.15%	
Percentage of people aged over 65 years in the population	1880	6.4%
	1947	10.7%
	1960	12%

Morbidity rates:

No particulars, as no research has been conducted in this field.

Chronic diseases:

Patients in clinics, hospitals, homes	1959	16,150

Chronic patients in or out of hospital represent 4% of the population.

Infectious diseases:

	1945 cases	1950	1959
Typhoid fever ..	715	318	92
Diphtheria	6,106	541	1,011
Polio	852	86	142
Syphilis	3,498	1,188	328
Tuberculosis:			
Number of new cases	15,989	6,132	4,440
Total diagnosed and under supervision 1949	86,422	77,506	72,664

Mortality

Infections	28% in 1900	2.5% in 1960
Cancer	9% in 1930	21% in 1960
Lung cancer ..	680 cases 1955	880 cases 1958
Leukaemia	840 cases 1954	1562 cases 1958
Accidents	4.5% in 1900	7% in 1958

Road accidents 175,000 in 1960:
64,000 slight injuries
13,800 severe injuries
1,500 fatalities

Accidents at work over 400,000 in 1958 with over 500 deaths.

Occupational diseases 1% of exposed persons in 1953
1.5% in 1958

Mental diseases 23,000 committed in 1953
25,500 committed in 1959

Belgium is a constitutional monarchy founded in 1830. The Belgian Constitution dated 7th February 1831 recognises three national powers:

i. The LEGISLATIVE POWER exercised by the *Chamber of Deputies*, with 212 members elected direct; the *Senate*, composed of three sections, one elected direct, one elected by the provincial councils, and a third co-opted by the

other two sections; and the King, who sanctions the laws passed by the two Chambers.

ii. The EXECUTIVE POWER constituted by the King and his Ministers (at present numbering 20) assisted by government departments.

iii. The JUDICIARY POWER exercised in the name of the King by the courts and tribunals which are independent of the other two Powers, but are under the administrative charge of the Minister of Justice.

The Constitution further recognises a subdivision of the country into nine Provinces (Brabant, Antwerp, West Flanders, East Flanders, Limbourg, Liege, Luxembourg, Namur and Hainaut).

The Provinces are administered by a Provincial Council elected direct for four years, and a permanent Deputation appointed by the Provincial Council. The Governor, who is appointed by the King, presides over the permanent Deputation and attends the meetings of the Provincial Council. He has authority over the Communes, which represent the basic administrative unit of the country.

Finally, the Constitution recognises the autonomy of the *Communes* which in fact hold all powers on the local plane. The boundaries of the Communes are fixed by law.

Belgium has more than 2,600 communes, of which the smallest has only 26 inhabitants.

Each commune is administered by a *Communal Council* elected for six years, which appoints from among its own members a *college of deputy-mayors* to attend current administration under the chairmanship of the Burgomaster, who is appointed by the King either from among the communal counsellors or even from outside.

The Burgomaster actually holds all the administrative and police powers and carries all responsibility on the communal plane.

Thus the power of initiative in matters of sanitation, and public hygiene and health is mainly in the hands of the local authority.

It is only because of the inability of these authorities to deal with their problems without technical or financial assistance that the intervention of the Central Executive has developed, and that the authority of the Minister of Health has asserted itself in certain spheres. This historic evolution manifested itself very clearly through the events of the past century.

The communal powers in the matter of assistance to the poor and to the indigent sick are exercised through the Public Assistance Commission which was created in each commune by the Law dated 10th March 1925. This Commission is composed of persons appointed by the Communal Council. The Burgomaster is its chairman, *ex officio*, though a chairman may, in addition, be chosen from among the members.

iv. GENERAL CONSIDERATIONS

From the historical point of view it must be remembered that Belgium proclaimed its independence in 1830 and that until then it had been buffeted in different directions and formed part of different political constellations.

It had successively belonged to Bourgogne, Spain, France, Austria and Holland.

However, from the 11th century, its cities had claimed and secured important privileges and had perpetuated themselves as entities despite changing dominations.

From the point of view of hospitals and social medicine, we have to consider four periods:

The period preceding the Revolution of 1789, evolving from the preceding eras;

The Middle Ages;

The Renaissance;

The French 18th century.

A characteristic of the pre-Revolution period was the existence of many institutions, hostels, hospitals, orphanages, leprosy homes, maintained by religious orders and the towns. However, all of them were staffed by a majority of nuns and, sometimes, by lay persons, chiefly ladies of good family. This work was essentially charitable and voluntary.

The second period runs from 1789 to about 1850.

The hospitals had been nationalised by the Revolution, but from 1800 the religious orders resumed serving them, though without regaining possession of them.

The charitable nature of the organisations was recognised by law and constituted a communal charge. However, hospitals retained their charitable character and depended on the goodwill of the local officials.

The third period extends from 1850 to 1945.

It is characterised by the erection of many public hospitals between 1850 and 1900, then by the creation of many private institutions and clinics, at first on the initiative of physicians and surgeons, then, particularly from 1900, by religious orders. Finally, from 1920, a number of hospitals have been established by mutual benefit movements.

The year 1925 saw the reform of Public Assistance. In each of the 2,600 communes the welfare offices and hospital commissions, formerly independent of each other, were combined.

The fourth period began in 1945 by the inauguration of compulsory social insurance. (Law dated 28th December 1944.) Since then, the social medicine movement has accelerated. Poverty, which had constituted the criterion for the operation of Public Assistance, has considerably diminished, decreasing from 80% to 10% among the patients of the public hospitals. Since 1945 a very large number of new hospitals have been built, particularly in the private sector.

However, it should be noted that the last two periods since 1850 were characterised by a distinct difference as regards the hospital movement between the Northern part of the country, the Flemish region which has a Catholic majority and an agricultural character, where there are many hospitals and clinics; and the Southern, French speaking Walloon region which is more accessible to social movements, has a Socialist majority, has been highly industrialised during the past century, and has less hospital provision.

This difference persists today and has, if anything, increased.

The Flemish Provinces have 22,116 beds for acute cases in a population of 4,306,866, or 5.1%.

The Walloon Provinces have 10,647 beds for a population of 2,871,179, or 3%.

The Province of Brabant, which includes the Capital and has a mixed structure, has 8,362 beds for a population of 1,950,779, or 4.29%.

The Belgian Constitution and laws give sole responsibility for medical care to the communal authorities. In the case of the individual indigent this responsibility is fulfilled through the agency of Public Assistance.

Social Security, which covers only 5,200,000 persons out of the 9,129,000 inhabitants, is alone in having delegated to the Ministry of Health the responsibility for the provision of sufficient medical care.

So far, then, Belgium has no authority whose task would be to regulate or co-ordinate initiatives in this sphere. The State has only auxiliary powers and confines itself to the granting of subsidies for new building. These powers have not been sufficient to even out the distribution of institutions.

II. Responsibility for and Organisation of Medical Services

The authority for health organisation in Belgium lies, in fact, and in law, with the communes.

However, it is necessary to distinguish the various aspects of this provision and to consider general health problems and medical practice.

The general health problems, which in fact include responsibility for public health and protection of the population against the drawbacks of the environment and neighbourhood, are at present in effect shared between the local authorities, which were originally solely responsible, and the Provincial and Central authorities.

Public sanitation, street cleaning, the removal of solid and fluid garbage, the guardianship of the peace, the water supply, domestic sanitation and town planning, are still very definitely in the hands of the local authorities.

The battle against transmissible diseases is already being conducted with more intervention from the central authorities, particularly the Ministry of Health, to which the provincial health inspectors are directly subordinate. The task of these inspectors in each Province is to assist the communal authorities in all matters that lie within their competence. They therefore appear as the natural advisers of the Burgomasters, with whom they collaborate in the struggle against infectious diseases. In this specific sphere they can even act instead of a defaulting or negligent burgomaster by taking the necessary prophylactic measures.

The powers of the communal authorities also extend to the supervision of foodstuffs, which some towns and large communes exercise themselves, while others leave it to the government food inspectors.

On the other hand, in the sphere of the *medical services* the intervention of the public authorities is of recent origin, apart from the responsibility of the communal authorities and the public assistance commission on the financial plane in connection with poor people.

In Belgium the *art of healing*, which includes medical practice, pharmaceutics, dentistry, midwifery and certain paramedical activities, is governed by an old law. (12th March 1818.)

This Law regulates the medical and paramedical professions through local medical commissions and particularly Provincial medical commissions, which were completely reorganised in 1949.

The exercise of the healing art is further subject to registration on the panels of the Order of Physicians and the Order of Pharmacists, and to the discipline imposed by these Orders, which are of recent creation (Physicians, 1938, Pharmacists, 1949).

Belgian law on medical practice, and that relating to the conferment of academic degrees, does not recognise medical specialisation. In principle, each physician is therefore universally competent in all aspects of medicine. Until now, medical specialisation has developed on an empirical basis, without legal sanction. But since the introduction of Social Security the need

for official recognition has made itself felt. Since 1957 the Ministry of Health has created special commissions with the task of recognising medical specialisation. These commissions have established criteria of qualification and have compiled lists of recognised specialists.

A tendency is now evolving in official quarters towards the introduction into the law on university education provision for medical specialisation.

Medical science is headed by the two Academies of Medicine (French and Flemish), which are the supreme consultative medical authorities.

While the practice of medicine is wholly and exclusively the preserve of the doctors, there are on the social and financial plane a great many arrangements and institutions designed to facilitate medical practice in the various curative and preventive spheres.

It should be noted, first of all, that theoretical separation between curative and preventive medicine is particularly sharp in Belgium. This separation was rendered necessary by the pressure of the medical profession. However, we must distinguish between preventive medicine proper, public sanitation and medical prophylaxy through the early detection of certain diseases.

Further, certain diseases whose social or economic repercussions are important are grouped in a context of social medicine whose artificial character is apparent.

These facts are important for an understanding of the structure of the institutions and their hierarchisation.

We shall distinguish between the structure of the institutions of curative medicine, preventive medicine, social medicine and certain activities involving segregation of a purely social nature (the aged, orphans).

CURATIVE MEDICINE

This begins in the surgery of the *general practitioner* who receives the patients there or calls on them.

It continues with the *medical specialist* who attends to patients at his surgery or calls at their homes.

During the past few years *polyclinics* have developed (combined general or specialist medical surgeries under joint administration). Originally, these polyclinics were almost exclusively created on the initiative of the friendly societies or annexed to private or public clinics. At present, a large number (more than 100) exist separately from hospital premises and practise a form of group medicine. In the eyes of the promoters these innovations are justified by the quality of the medical service as well as advantages on the administrative and financial plane.

Medicine is further practised in public or private hospitals which greatly differ as regards capacity, specialisation of services, equipment and staffing.

The hospitals and clinics are of a general character, and are equipped for surgery, general medicine, paediatrics (less frequently) or obstetrics. Some of them provide other medical services.

Finally, there are special *hospitals or clinics* (ear, nose and throat, ophthalmology, rheumatology, orthopaedics, traumatology, dermatology, etc.).

In addition to these curative institutions, which deal with acute complaints, there are specialised *therapeutic sectors* which in Belgium are ranked in the category of *social medicine*. They include establishments to combat tuberculosis, cancer, establishments for mental patients, for abnormal children and some specialised centres for the treatment of cerebral paralysis, disseminated sclerosis, etc.

A tendency to create geriatric hospitals and hospitals for chronic patients in general has become apparent, but has not yet developed further. Some hospitals have installed rehabilitation sections, notably some of the traumatological hospitals.

In the sphere of *early diagnosis of disease*, a chain of *health centres* has developed, public and private, where various kinds of research is conducted on special groups. Antenatal consultation centres are frequently separate or are attached to maternity hospitals. Consultations for infants are assisted or sponsored by

the National Institute for Childhood. School medical inspection is obligatory in the primary schools. Adolescents at work are protected by legal provision under the General Regulations for the Protection of Labour. Arrangements exist for the care of workers and for the control of occupational diseases; medical inspection for those engaging in sports; vocational guidance; consultation on mental hygiene; and many other activities, which are exercised in divers ways according to the centres and the concepts underlying their management.

The work of the Health Centres, although essentially concentrated on early diagnosis of disease, particularly tuberculosis and diabetes, frequently develops in the direction of prophylaxis proper, notably by means of vaccination, health education and health propaganda.

In the past, the diagnosis of and the campaign against tuberculosis were conducted by the *Anti-tuberculosis Dispensaries;* these still exist, but have lost much of their *raison d'être.* The prevention of tuberculosis is promoted by the existence of *Preventive Centres* and by a large chain of *institutions for debilitated children* established or sponsored by the National Institute for Childhood.

This succinct and incomplete picture will now enable us to consider the character of the various public and private organs and their responsibilities.

II. 1. A. NATIONAL CENTRAL ADMINISTRATION

The responsibility for welfare and health is essentially in the hands of:

(*a*) The Ministry of Health and Family (Public health, institutes of social medicine, mental diseases, tuberculosis, and public assistance).

(*b*) The Ministry of Social Welfare as regards the combating of disease within the framework of social insurance (National Insurance Fund against Sickness and Disablement (F.N.A.M.I.))

(*c*) The Ministry of Labour as regards the medical protection of the workers.

The MINISTRY OF HEALTH AND FAMILY is responsible for:

Public health at the central and provincial levels (prophylaxy of communicable diseases—protection of the population).

Supervision of the quality of foodstuffs and meat.

Supervision of pharmacies and medicaments.

Supervision and installation of the water supply.

Combating air and water pollution.

It is further responsible for approving medical specialists and hospitals and clinics.

It is responsible for combating tuberculosis, which is the task of the Belgian National Institute for Combating Tuberculosis, a semi-private organisation supervised and financed by the Ministry.

There are 120 anti-tuberculosis dispensaries, 16 preventive centres with 2,200 beds, 27 sanatoria with 4,600 beds, three reception centres with 135 beds, and six preservation centres with 114 beds.

Prevention of infantile diseases is the task of a semi-government institute which is administratively and, in particular, financially, under the Ministry of Health.

The National Institute of Childhood, created in 1919, whose work chiefly covers the antenatal period and the first months of life (373 antenatal consultations and 1,172 consultations in infancy), combats infantile debility in nine homes with 1,600 beds, 90 approved homes with 10,000 beds and 166 sections for debilitated children with 18,700 beds.

The war against mental disease is carried on by the Ministry of Health in four government establishments and 46 private establishments, altogether with a total of 25,000 beds.

Apart from the four establishments for mental disease, the Ministry of Health and Family has no medical establishments.

The Ministry of Social Welfare owns and runs two centres for treating miners suffering from silicosis.

The Ministry of Labour's only function in this context is through its regulations and its medical inspection service.

II. 1. B. ON THE PROVINCIAL LEVEL

There are only a few establishments, although the law relating to the Provinces imposes on them a residual responsibility.

It should be noted that three Provinces (Namur, Limbourg, Hainaut) have created and are running a Provincial maternity clinic with an obstetric centre. Further, one Province (Hainaut) runs a centre for the re-education of crippled people. One Province (Namur), has created a network of health centres. Two Provinces (Liege and East Flanders), run anti-tuberculosis sanatoria.

While the Provinces have taken the initiative in social medicine only in exceptional cases, they have in general favoured, administratively and even financially, the creation of medical establishments.

II. 1. C. It is essentially on the LOCAL LEVEL (communes and Public Assistance Commission) that the activities of the public authorities have developed.

Thus 24 communes or towns have established health centres.

All the communes have to provide for school inspection. Finally, 100 hospitals are owned by the Public Assistance Commissions. Mental health consultation centres are often due to communal initiative.

II. 2. PART PLAYED BY PRIVATE BODIES

Historically, since the remotest times, the religious orders have undertaken the task of providing medical care to the sick and under-privileged.

After a gap of a century, caused by the Revolution of 1789, these orders resumed the initiative at the end of the 19th century.

At present they constitute the largest section engaged in providing medical care, for they own 144 clinics for acute cases, with 15,204 beds, or 38% of all the hospitals for acute cases.

They own and manage 75% of the beds available for mental patients, and their activities extend to all sectors.

In addition to this organisation, which is at present largely centralised in the Federation de Caritas Catholica, there are also other private groups:

The Mutual Aid Associations, which are the executive organs of Social Security, own and run 19 clinics with 1,695 beds, or 5% of the provision for acute disease.

Groups of doctors, non-profit making associations, limited companies, factories or groups of factories, private physicians, etc., are various private bodies which, with 110 hospitals and 7,425 beds, cover 29% of the establishments.

On the whole, as regards hospitals for acute cases, 72% of the establishments and 59% of the number of beds are owned by private bodies. The majority of anti-tuberculosis establishments are owned by private institutions, while 80% of the beds for mental patients are owned by private bodies, mostly religious orders.

Finally, as we have seen, the polyclinics are generally private institutions.

The very type and the different forms of private organisation render inquiries as regards staffing particularly difficult.

On the whole, it can be said that there is a constant shortage of paramedical staff, particularly nurses.

Most of the institutions owned by religious orders employ a mixed staff, both lay and religious.

A fair number of hospitals owned either by public authorities or by some form of private organisation have at their disposal both religious and lay staff.

II. 3. DEVELOPMENT OF HEALTH INSURANCE

Until 1944 there were in Belgium three forms of payment for medical care:

Poor patients were wholly or partly paid for by the Public Assistance Commissions.

Friendly society members (then voluntary) were treated free of charge at the polyclinics and clinics owned by their assurance society. Elsewhere, only part of the cost was paid by the society.

Other citizens had to pay for their own medical treatment.

At present the situation has considerably improved, because the number of indigent patients has greatly decreased owing to compulsory health insurance and a large number of people get free insurance and also refund of the cost of medical treatment.

Compulsory Social Security derives its revenue from contributions by the workers and employers, as well as from the State, for the purpose of forming its general reserves. The State further covers any deficit arising from its operations.

A part of the cost is charged to F.N.A.M.I. (health insurance) which, however, does not cover all the charges of the illness, but pays a lump sum for both general practitioner and specialist treatment as well as hospital treatment. In the case of hospital treatment there are two systems of payment, one involving a lump sum; the other, more advantageous, by contract.

The F.N.A.M.I. also covers pharmaceutical expenses, which are governed by a special tariff which varies according to the products concerned. It similarly pays the greater part of the cost of tuberculosis treatment, dental treatment, prosthesis, etc.

A considerable allocation is made for re-education.

Of the 9,200,000 inhabitants, approximately 5,200,000, or 55%, enjoy the benefits of health insurance. Of the 45% or four million inhabitants who are not covered, 8% are officials, 2% paupers, 10% landworkers, 20% business men and artisans and 5% members of the liberal professions or executives.

It is estimated that in Belgium the 55% having social insurance contribute 62% to health expenditure, against only 38% contributed by the 45% who are uninsured.

Despite the lump-sum and partial character of the refund for medical and other treatment, health insurance shows a large deficit each year. This is partly ascribed by some people to the plural system of this organisation, which consists of six central bodies differing as regards political (Socialist, Christian, Liberal, neutral) or professional affiliations.

Each of these bodies, on its part, has a highly decentralized structure, which in practice comes down to communal units

(2,600 communes) with necessarily cumbersome administrative machinery.

In 1960, the receipts of the F.N.A.M.I. amounted to 10,680,000,000 frs. and the expenditure to 11,656,000,000 frs., or a deficit of 976 millions. In this total, the health services account for 6,345,000,000 frs., the balance representing disability allowances and administrative expenses.

In addition to health insurance, there is insurance against accidents at work, against the risk of occupational diseases and, finally, compulsory insurance against road accidents.

The Belgian State pays the cost of hospitalization and treatment of the great majority of mental patients. The budget of the Ministry of Health and Family in fact includes a Special Fund for assistance to confined, sequestrated patients, impecunious tuberculosis patients, cancer patients and patients suffering from certain other diseases, as cardiopathies, poliomyelitis, cerebral paralysis, etc.

This provision is of the order of 700,000,000 frs. per annum.

The National Institute for Childhood, which provides both preventive and curative treatment for children, has an annual budget of the order of 450 million francs, entirely covered by the Ministry of Health and Family.

II. 4. MEDICAL AND PARAMEDICAL STAFFING

(*a*) *Physicians*

As at 1 January 1960 there were in Belgium 11,380 doctors, or 12.5 per 10,000 inhabitants.

It should be noted that in 1952 the figure was 8,685 or 10 per 10,000 inhabitants.

Of the 11,380 we must deduct 2,000 doctors who are not in practice, while the number of specialists may be estimated at 3,082.

(*b*) *Pharmacists*

As at 1 January 1960 there were 5,266 pharmacists, or 5.6 per 10,000 inhabitants, but the number of dispensaries is about 4,350. In 1952, the figures were 4,234 and 3,500 respectively.

(*c*) *Dentists*

There are 226 stomatologists, 269 doctors qualified in dental science, 1,041 licentiates, 570 qualified dentists ('capacitaires'), or a total of 2,106.

(*d*) *Midwives*

The profession of midwife has long been made comparable by law with that of physician or pharmacist.

Since 1952, the training of midwives has been modified and since then midwives have also been nurses. However, their status has remained in force.

As at 1 January 1960 there were 3,815 midwives as against 3,674 in 1952.

(*e*) *Other paramedical personnel*

It is difficult to determine the exact number of these personnel, because there is no compulsory registration of them. However, it is estimated that there must be 13,000 female nurses, only half of whom work at hospitals, 6,757 male nurses, 1,065 male nurses for mental patients, 2,263 'capacitaires', 437 'kinesistes' and 3,818 children's nurses.

II. 5. HEALTH EXPENDITURE

It is difficult to give precise figures concerning the cost of the health services in Belgium; but by approximation and extrapolation on the basis of social security expenditure, the total expenditure may be estimated at 18,000 million frs.

The F.N.A.M.I. pays 3,055 millions for medical and dental treatment. Private individuals, whether insured or not, pay about 5,782 millions; which makes a total of 8,837 millions without medicaments and hospitalization.

The pharmaceutic expenditure of F.N.A.M.I amounts to 1,719 millions. It may thus be estimated that the total expenditure, together with that of private individuals, amounts to 3,000 million frs.

Hospital treatment of patients in the different sectors may be estimated to account for about 6,000 million francs. (There

are 10 million working days at the hospitals and clinics, to which must be added the mental patients, etc.).

Thus the total of these charges approximates 18,000 millions, which represents 12% of the national budget, and probably 5% of the national income (this income is very variously estimated in Belgium and there is no official figure).

III. Hospital Services

III. 1. A. The 382 hospitals and clinics had on 1st July 1960 a total of 40,925 beds, or 4.48 beds per 1,000 inhabitants.

They are divided into 109 public hospitals with 16,601 beds and 273 private hospitals and clinics with 24,324 beds.

Capacity

Of the 109 public hospitals
- 27 have fewer than 50 beds
- 32 fewer than 100 and more than 50
- 20 fewer than 200 and more than 100
- 17 fewer than 300 and more than 200
- 7 fewer than 500 and more than 300
- 6 have more than 500 beds.

The average capacity is 150 beds.

Of the 273 private hospitals
- 100 have fewer than 50 beds
- 88 fewer than 100
- 61 fewer than 200
- 17 fewer than 300
- 5 fewer than 500
- 2 have more than 500 beds.

The average capacity of these establishments is 90 beds.

OWNERSHIP

Of the 109 public hospitals 98 belong to the C.A.P., the others belong either to the communes or to intercommunal bodies or the Provinces. One Academic hospital is owned by the State.

Of the 273 private hospitals 19 are owned by friendly societies, 144 by religious orders and 110 by other owners.

The hospitals are very unequally distributed throughout the country (see map).

While the proportion for the country is 4.48 beds per 1,000 inhabitants, the Province of

Antwerp	has	5.30 beds per 1,000 inhabitants
Brabant		4.29
West Flanders		5.62
East Flanders		4.75
Hainaut		4.10
Liege		4.02
Limbourg		4.67
Luxembourg		1.92
Namur		2.03

The hospitals for acute cases are further divided into:

University hospitals:

One at Gand (State), two at Brussels (C.A.P.), two at Louvain (one C.A.P., the other the University), one at Liege (C.A.P.).

General hospitals:

with all services, generally publicly owned, in the large towns.

Regional hospitals.

Local hospitals.

Specialist hospitals.

ESTABLISHMENTS FOR MENTAL PATIENTS

(*a*) Closed, for committed patients

Four State establishments at Geel, Rekem, Tournai, Mons. 46 others. Total beds 25,000.

(*b*) Open, for voluntary patients

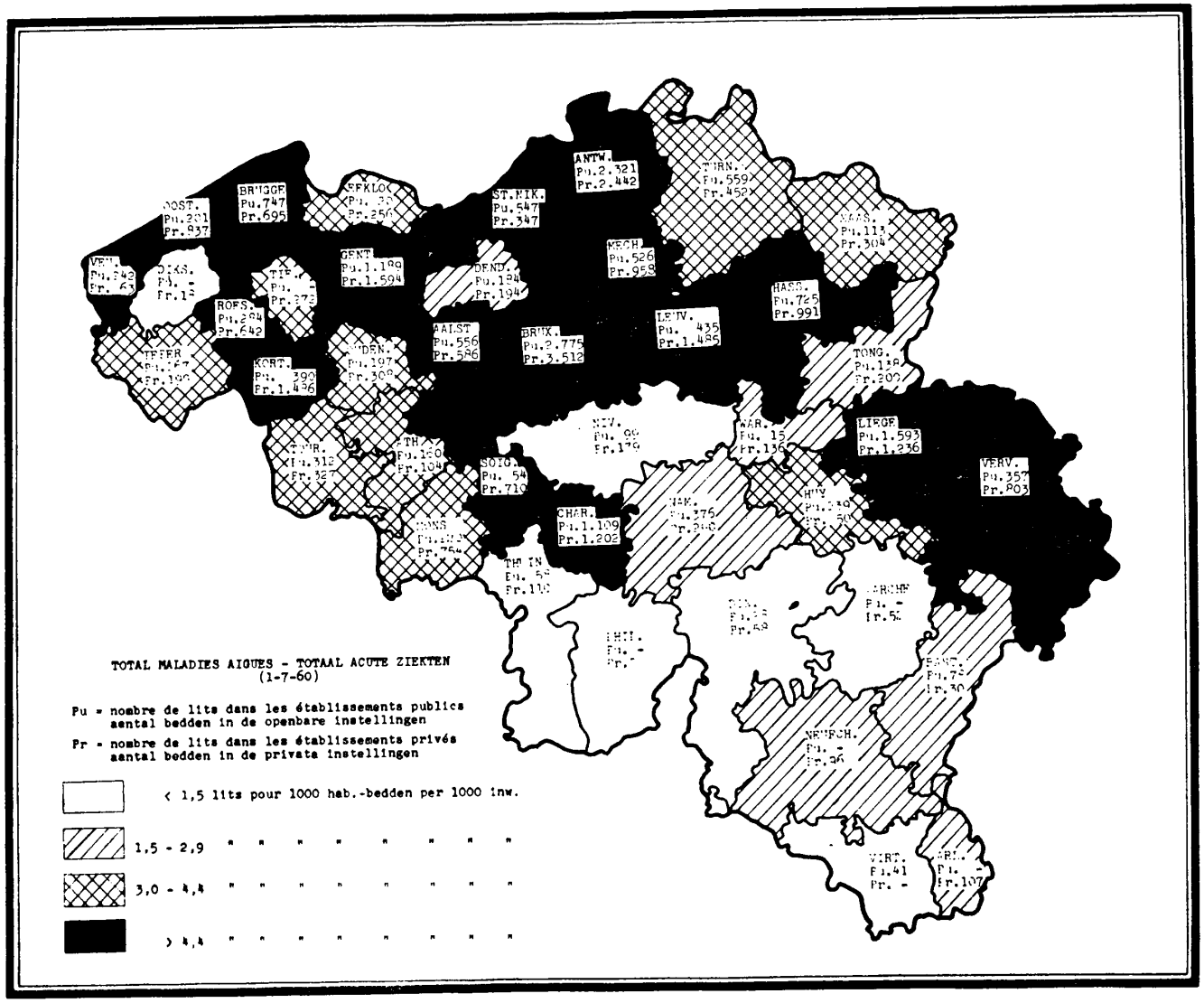
15 establishments or wards with 950 beds.

(*c*) Abnormal or backward children

80 establishments with 11,200 beds.

(*d*) Mental health clinics without hospitalization: 17.

(*e*) Psychiatric wards in general hospitals: In course of creation.


ANTW.
Pu.2.321
Pr.2.442
TURN.
Pu.559
Pr.452
BRUGGE
Pu.747
Pr.695
ST.NIK.
Pu.647
Pr.347
MECH.
Pu.526
Pr.958
GENT
Pu.1.199
Pr.1.594
HASS.
Pu.725
Pr.991
ROES.
Pu.284
Pr.642
AALST
Pu.556
Pr.586
BRUX.
Pu.2.775
Pr.3.513
LEUV.
Pu. 435
Pr.1.485
KORT.
Pu. 390
Pr.1.496
TONG.
Pr.200
LIEGE
Pu.1.593
Pr.1.236
VERV.
Pu.357
Pr.803
CHAR.
Pu.1.109
Pr.1.202
TOTAL MALADIES AIGUES - TOTAAL ACUTE ZIEKTEN
(1-7-60)
Pu = nombre de lits dans les établissements publics
aantal bedden in de openbare instellingen
Pr = nombre de lits dans les établissements privés
aantal bedden in de private instellingen
< 1,5 lits pour 1000 hab.-bedden per 1000 inw.
1,5 - 2,9
3,0 - 4,4
> 4,4

ESTABLISHMENTS FOR COMBATING TUBERCULOSIS

(*a*) Clinics (grouped, owned generally by the Belgian Anti-Tuberculosis League): 120.

(*b*) Sanatoria (grouped and owned by the Belgian Anti-Tuberculosis Association): 27, with 4,405 beds.

(*c*) Preventive centres (owned by the Association or the League for the Protection of Children): 16, with 2,200 beds.

(*d*) Clearing centres (pre- and post-sanatorium) owned by the C.A.P.: three with 135 beds.

(*e*) Child protection centres: six with 114 beds.

GERIATRIC OR CHRONIC HOSPITALS

A number of hospitals or clinics have wards for chronic patients, while others have a proportion of chronic patients as well as ordinary cases. Finally, geriatric wards are annexed to homes for healthy aged people.

A number of hospitals for chronic or geriatric patients are in the course of construction.

At present there are 34 sections for chronic patients with 2,026 beds; five of these establishments accept only chronic patients.

The above figure is made up of 1,715 beds in public and 311 in private hospitals.

HOSPITALS FOR CONVALESCENCE AND RE-EDUCATION

Eight hospitals each have a convalescent section totalling 303 beds. Two of them specialise in convalescence and receive the patients of the general hospitals.

In addition, seven sections for re-education total 192 beds.

III 1. B. Each of the UNIVERSITY HOSPITALS has a statute of its own. There are six of these.

GAND

The University Hospital is owned by the Ministry of Works and is run by the State University on behalf of the Ministry

of Education on which it is administratively and financially dependent.

It comprises important polyclinics and has nearly 500 beds, 130 for paediatrics and 370 for other specialties.

Formerly, the University used a C.A.P. hospital as its teaching hospital. Now the situation has changed and the University runs its own hospital, the building of which is nearing completion. Operational deficits are covered by the Ministry of Education.

BRUSSELS

The Free University and the C.A.P. have an agreement which makes available to the Faculty of Medicine the two large St. Peter's and Brugmann's Hospitals, as well as the cancer centre of the Bordet Institute.

These establishments are run by the C.A.P. which meets the costs and the deficits. The University is in sole charge of the medical work. The overall problems of management are dealt with by a mixed committee of the C.A.P. and the University. The premises comprise approximately 1,300 beds.

LOUVAIN

The Catholic University has a similar contract to that of Brussels for the C.A.P.s St. Peter's Hospital. In addition, it owns the St. Raphael Clinics, which the University runs on its own account and whose financial soundness it ensures. St. Peter's Hospital at present has 400 beds and the University Hospital 749.

LIEGE

The State University has an agreement with the C.A.P. with regard to the Favière Hospital which has 721 beds. The management is in the hands of a mixed commission, but deficits are paid by the C.A.P.

Since 1951, a Royal Decree relating to the grant of subsidies to C.A.P.s (Public Assistance Commissions), which run university hospitals prescribes the formation in each case of a

management and consultative committee composed of representatives of both parties. The efficiency of these committees has varied in the individual case.

III. 1. C. UTILISATION OF HOSPITALS

The percentage of beds is 4.48% per 1,000 inhabitants for acute cases.

In 1959 there were 4,059,585 in-patient days at the public hospitals and 5,908,946 in the private hospitals, or a total of 10,004,531 days.

The *average hospitalization per patient* for the country amounts to 15 days in the public hospitals and to 12 days in the private hospitals, with an overall average of 13 days.

The *occupation of a bed* extends to 249 days in both public and private hospitals, representing an extent of occupation of 68% for all the establishments, with fluctuations per Province between 53% and 72%.

Confinements take place in 80% of cases in maternity hospitals, this rate being exceeded in some Provinces.

The situation as regards maternity beds is paradoxical, because considering that a woman's stay lasts an average of 10 days and that a maternity hospital bed provides from 25 to 30 confinements per annum, one would conclude that in Belgium the number of beds per 1,000 inhabitants ought to fluctuate around 0.6 if all confinements took place at maternity hospitals, which is not the case. Actually, some Provinces whose birthrate is not definitely above the average have up to 0.82 bed per 1,000 and, on the regional level, 0.97 and even 1.02 beds.

III. 2. A. INTERNAL ORGANISATION OF HOSPITALS

There are hardly any laws governing the charters of hospitals and their administrative organisation.

The public hospitals are in general run by the Public Assistance Commissions which include a number of members without previous qualification.

C.A.P. very often decides on its own initiative on all measures

to be taken, so that in fact the Secretary of the Commission exercises executive rights.

However, in a number of hospitals—and this tendency is rapidly developing—one director, mostly an administrative one and very rarely a doctor, is charged with daily management. He is assisted by a variable number of executive officials.

The medical techniques are exclusively in the hands of the doctors, who jealously guard their prerogatives.

The nursing staff is in most cases subordinate to the Director himself and sometimes to a head nurse (Matron).

The recruitment of staff is competitive, but the appointing C.A.P. has relatively wide powers within the staff cadre which it is able to determine for itself, subject to the approval of the appropriate Provincial authorities and the Ministry of Health.

For some years past, the Universities of Brussels and Louvain have had special courses in hospital management and organisation, with a view to training competent staff for the top-level direction of hospitals.

In the past, only a few schools of management have provided a basis—often inadequate—for these functions.

The qualifying conditions fixed by the Ministry of Health and Family provide that a doctor, preferably chosen by his peers, should be appointed to assist and advise the management, and should be responsible for the technical procedures, safety measures for staff and patients, the application of the rules of professional conduct and the legal and by-law provisions.

This provision also applies to private hospitals and clinics.

Further, the rules also provide that each specialty should be headed by a competent doctor, who should be responsible for the satisfactory conduct of his department.

Finally, as regards public hospitals, a Royal Decree dated 27th February 1961 relating to the organisation of hospital accountancy, provides for the creation of a committee to supervise daily management, comprising a representative of the C.A.P., the Administrative Director and a representative of the medical staff.

This committee attends to daily management, but its

powers are limited, and all its decisions must be approved by the C.A.P.

III. 2. B. CATEGORIES OF STAFF

As regards staff, the situation in Belgian hospitals varies a great deal.

In general, the University Hospitals have an ample staff, both medical and paramedical. The other establishments, and particularly the private ones, barely manage to satisfy the qualifying norms, which provide that there must be in permanent employment at least one certificated nurse per 30 patients (one per 20 in maternity hospitals) and that she must be assisted by a sufficient number of auxiliary staff to ensure all necessary attention.

The greatest difficulty is experienced in recruiting nurses, though the schools were officially reorganised in 1957 and 1960.

At present the schools train a certain number of people. In 1959 the figures were: 1,011 nurses, 197 social medicine nurses, 41 nurses for mental patients, 83 midwives, 604 male nurses and 105 male nurses for mental patients.

III. 2. C. MEDICAL TRAINING

A medical degree is granted after seven years of University study (three as undergraduate, four for the doctorate, with obligatory hospital practice).

Specialist diplomas can be obtained, in accordance with certain criteria, by additional study or probation. At present the Universities train anaesthetists in two years and paediatrists in two years. Specialisation in other spheres requires more time: surgery five years of probation, gynaecology five years, etc.

The status of doctors at the hospitals is generally governed by internal regulations which in the case of public hospitals require the approval of the superior authority.

At present the private hospitals affiliated to Caritas Catholica make a contract with their doctors the standard of which has been uniformly fixed for all the institutions.

As a condition of accreditation by the Ministry of Health, each specialist department must be headed by a responsible medical specialist.

Though this provision is not yet entirely general, it is actively gaining ground.

Some private clinics and some small public hospitals are accessible to a large number of doctors. Though entry appears to be unrestricted, in all cases the doctors must be previously approved at least by the owner of the establishment or by the management.

The Public Assistance Law further provides that each C.A.P. must appoint in its hospital a certain number of doctors whose task is to treat indigent patients.

At present, this section of patients has become very small and the doctors mostly treat social insurance and paying patients.

III. 2. D. The remuneration of hospital doctors is effected in very different ways.

Some hospitals—whose numbers are increasing—have full-time doctors. The doctors devote all their time to their hospital practice. They are either paid an annual salary, and the fees from the patients are collected by the hospital, or a smaller salary with a percentage of receipts, or, finally, by a system under which fees are collected by a medical secretariat and the doctor is paid a percentage of the fees or even a sort of lump sum hire.

However, it is the mixed system that is favoured at hospitals and doctors prefer the last method.

In these cases, the fractions given up by the doctor often amount to 10% in the case of an interne, 20% for the surgeon, from 50% to 60% for the laboratory or radiography. These last sometimes give up 75% of their fees, for of course the hospital has to invest capital in the equipment and pay the cost of operation.

There are no statistics to show how many doctors and specialists work at the hospitals and clinics. But it may be estimated that a fair proportion of the 3,082 specialists work there.

Each year approximately 500 new graduates leave the four Universities. In 1960 the figure was 494.

Up to 1960, a number of these doctors went to the Congo. Since then, as a result of events, several hundreds of them have returned to Belgium.

There are only a very few foreign probationer doctors at the Belgian hospitals.

III. 2. E. The Belgian hospitals, both public and private, admit the patients sent to them by the medical attendant.

Most of the hospital doctors communicate in writing with their general practitioner colleagues concerning the cases.

Some hospitals, notably the University hospitals, have created a home treatment service so that beds can be vacated more quickly, which is a valuable aid to the doctors.

These services provide after-care for many cases and have proved highly interesting financially.

III. 3. COST OF FINANCING THE MEDICAL SERVICES

A. HOSPITAL EXPENDITURE

Since Social Security has introduced the system of contracts with hospitals and clinics, it has become possible to make certain comparisons and to consider the elements of the cost of a hospital day.

In general, the largest fraction concerns the cost of staff, which represents 50% or more of the cost of the day.

Next come:

Food
Overheads
Pharmaceutical costs
Administrative costs
Amortisations.

Some time hence, as a result of the application of the accounting plan for public hospitals provided in the Royal Decree dated 27th February 1961, it will further be possible to know exactly the constituent parts of the cost of maintenance at these establishments. However, it would be premature to

enter into this now, and we must wait two years, that is, until 1964, before we can draw any valid conclusions.

At present, the prices paid by F.N.A.M.I. to the hospitals with which it has contracts vary according to the existing services, but are nevertheless fixed in lump sums between 145 and 190 frs. which represent the two extremes of cost, one for simple hospitalization and one for maternity cases. Surgery being computed at 175 frs., the insured patients must provide the difference between this and the actual cost. On the other hand, the daily cost fixed officially for indigent patients is considerably higher, amounting to 350 frs. and more in some hospitals.

It should be noted that this is an outright price, although the hospital can invoice to the F.N.A.M.I. in addition thereto for a number of medical and pharmaceutical services.

Many attempts have been made to control real hospital expenditure and stem the constant rise of costs.

While it is indisputable that the progress of medicine and nursing impose an increasing financial effort, it is nevertheless most important to ensure that no superfluous or avoidable expense has been incurred.

In this connection, the official accounting plan that has been introduced must necessarily be allied with an efficient auditing service with real powers of intervention. For in the past the accounting tests that have been made in Belgium have had a platonic character and have in fact constituted an additional expense without return.

III. 3. B. RESOURCES

As stated above, hospital resources are fed in various ways according to the patient's capacity, who may be:

Indigent and treated at the expense of the C.A.P.

He is admitted on a requisition from the C.A.P. which undertakes to pay.

Indigent, but with social insurance, and treated at the expense of the F.N.A.M.I. and the C.A.P. As regards the

uncovered portion, admission is effected with the agreement of the friendly society and possibly the C.A.P.

A patient with social insurance, treated at the expense of the F.N.A.M.I.

If this patient is treated in a Mutual Aid hospital or in certain public hospitals, he will not have to pay any charges. On the other hand, if he is treated at a private clinic or at certain other public hospitals, an additional payment may be claimed from him which must be paid by himself. Admission is effected with the agreement of the friendly society.

A paying patient.

This category, which is becoming smaller, is composed of patients who have to pay personally. Admission, except in case of urgency, is accompanied by the deposit of a security covering a stay in hospital of from 15 days to one month.

Victims of an accident.

Victims of accidents at work enjoy the benefits of compulsory insurance paid by the employer, and all expenses are repaid in accordance with very wide rules.

On the other hand, the victims of road accidents are in general in the same position as paying patients, because responsibility has yet to be ascertained.

Many tourist organisations (touring club, automobile club, etc.) guarantee their members in relation to clinics where they have to be admitted. This enables these persons to avoid tiresome discussions or indeed difficulties concerning admission to hospital.

Moreover, the Law dated 8th April 1958 makes the C.A.P. of the locality of the accident responsible financially for first aid and urgent hospitalization, as well as for ambulance transport. It is the responsibility of the C.A.P. to make contracts with the neighbouring hospitals to provide for such cases. Then it has to endeavour to recover the sums advanced by it in this manner either from the patient or from his guarantors.

The foregoing essentially concerns acute illnesses.

As regards mental patients, if they are committed, the

expense is assumed by the Ministry of Health and Family in the majority of cases. This is covered by the Special Assistance Fund.

In the case of certain special diseases, such as poliomyelitis, there exist certain private bodies who are concerned, and certain forms of insurance.

All hospitals enjoy the benefits of civil personality and can therefore receive donations and legacies. However, patronage and generosity on the part of testators are becoming less and less frequent.

In summary, it can be said that the funds are provided either by the patient himself or by the C.A.P. or by the F.N.A.M.I. or by some other form of insurance, or yet by the Special Fund or, finally, by certain charitable institutions.

III. 3. C. FINANCING OF MEDICAL RESEARCH

Until 1958, medical research was conducted almost exclusively at the Universities whose budget more or less covered requirements.

Many clinicians set apart from the resources of their service the sums required for research.

At the C.A.P.s university hospitals the Commissions showed a certain benevolence as regards research and agreed to have the cost included in the hospital's charges.

Finally, some philanthropists have contributed, sometimes generously, to the development of this work.

The National Fund for Scientific Research, which has been in existence since before 1930, contributed only to a modest extent, because it kept its means largely for fundamental research.

Since 1958 a Scientific Medical Research Fund has been created which has credits for promoting all forms of research and in particular clinical research. These credits might be larger, but they have incontestably given an impetus to research, which can now be conducted even outside the University centres.

FINANCING OF THE PUBLIC HOSPITALS

This financing is governed by a Royal Decree dated 2nd July 1949.

The C.A.P.s can receive 60% of their total expenditure and in some cases this rate may be increased (up to 90% or even 100%). At present this financing is effected by means of a loan, the redemption and interest on which are covered by the Ministry.

A complex and protracted approval procedure has to be followed and this is reflected in delays in the building of public hospitals.

FINANCING OF PRIVATE HOSPITALS

This is governed by the Royal Decree dated 25th July 1953.

The private body must be non-profit making; they can obtain a 20% subsidy on the sums borrowed by them. These loans must not exceed 75% of the total expenditure. At best it is 15% of the total expenditure.

The procedure is fairly simple and payment is made in two portions: one after the completion of the main structure, and one after the conclusion of the work.

In both cases the plans must be submitted to the Medical Establishments Section of the Ministry of Health and Family for approval.

This examination is only superficial in the case of private establishments, the object being to ensure that the work and plans conform with the approved standards and also with modern technical knowledge.

In the case of public hospitals the examination is more thorough and comprises the preparation of a draft plan, its approval by the Minister, then the preparation of final plans with details of the proposed means, of the sectional plans, and of the materials to be used.

III. 4. PLANNING AND CONSTRUCTION OF NEW BUILDINGS

This refers to hospitals and clinics for acute and chronic complaints.

Construction of anti-tuberculosis establishments has been stopped and only modernisation is proposed. The building of psychiatric hospitals is under consideration but the problem has not been resolved.

(*a*) The responsibility for hospital building is essentially in the hands of the local authorities, the C.A.P.s and the private institutions. The Provinces can do this, but so far they have done so in only three cases (Provincial maternity hospitals).

The State (Ministry of Health and Family), has the role of giving encouragement, but ought to have the responsibility of even distribution, which it could have steered by granting or refusing subsidies. But it has to be stated that this has not been the case. So far, there is no co-ordination and cases of overlapping are numerous. (Examples of simultaneous building of a public hospital and private hospitals in the same locality, while large regions of the country are under-equipped. Also examples of a multiplicity of maternity clinics in certain regions.)

(*b*) The public or private authorities who take the initiative in building a hospital have to collect the necessary funds and prove their capacity to finance their share when they apply for subsidies.

The C.A.P.s may contract loans or use their own assets, which are generally derived from donations or legacies.

Private establishments may borrow money, but may also collect it in various forms. They must possess at least 25% of the expenditure in order to obtain the subsidies. These are granted by the Ministry of Health which enters them in its supplementary budget (investments).

Finally, public tenders are compulsory for public hospitals, and the credits are granted when the Ministry has approved the documents of the tender.

The execution of the work is supervised by the engineers attached to the Ministry of Health and Family (Building Section). The Ministry demands of the contractors a planned building programme which it is unfortunately often difficult to observe.

In either case (public or private) the intervention of the departments of the Ministry of Health and Family constitutes a highly centralized technical intervention whose consultative character is in general highly appreciated because the competence of the officials has considerably developed through the vast experience acquired by them. (During the past 15 years more than 150 public and private hospitals have been built or modernised.)

(*c*) In general, the building of private hospitals is less expensive than that of public hospitals. This is due, in particular, to the flexibility and ease of transacting business in the private sector by contrast with the rigid and cumbersome procedure in the case of public hospitals. Further, the public hospitals tend to equip themselves better and to use more expensive apparatus or material.

The cost per bed in private hospitals varies from 300,000 to 500,000 frs. A traumatological centre with re-education has cost 900,000 frs. per bed.

The price per bed in public hospitals varies between 400,000 and 900,000 frs. and in some large hospitals now in course of construction the price will exceed 1,000,000 per bed. There is a tendency on the part of the Ministry of Health and Family to fix a ceiling price which must not be exceeded. This is already in existence for private hospitals which can receive no subsidy if the price per bed exceeds 450,000 frs.

(*d*) Hitherto hospitals have been built on the basis of modern conceptions of the functional unit. That is why all the hospitals comprise blocks of wards on several floors. Each floor represents one or more units of from 22 to 30 beds. The technical departments, consulting rooms, radiology and operating theatres are in another part of the building.

The standards of approval lay down the need for rooms with one bed, two beds, and four beds, with larger numbers only in exceptional cases.

The hospital units comprise a variable number of technical premises for the staff and for the patient's comfort. There is a definite tendency to build units with several dressing

rooms and, in particular, single bedrooms each with an adjoining dressing room.

Experience confirms that 30 beds per unit should not be exceeded and that the optimal size of a hospital is between 150 and 450 beds.

Similarly, experience shows that it is desirable to create units with eight to 16 beds for the active treatment of very acute cases (accident, surgical, etc.) requiring intensive care. All hospital units are served by intercom. systems. The lighting and heating of the rooms has been very thoroughly studied, as well as the problems of acoustics and the utilisation of materials.

Great efforts have been made in the realisation of technical installations, operating theatres, radio-diagnostic services, and various therapeutic services.

Cuisine and laundry have been inquired into with attempts at standardisation.

Similarly, research and experiments are in progress with a view to building hospitals with an unencumbered area or surface so that the rooms can be easily reorganised.

Extremely flexible hospitals have been erected at Renaix, Verviers and Antwerp with special materials and unusual, original apparatus for the many drainage systems required in a hospital.

(*e*) One of the greatest difficulties of the Ministry of Health and Family in the performance of its mission is due to the absence of information concerning actual morbidity rates and population developments.

Hitherto, planning has been based on the objective of 4.5 beds per 1,000 inhabitants. This aim has now been exceeded in many localities.

For this reason, a private study group in social medicine has been instructed by the Ministry of Health and Family to carry out an extensive inquiry with a view to arriving at a basis of rational planning of current and future needs; this research includes an inquiry into the normal morbidity rate

of the population and the demographic and economic development of the country.

It is not yet possible to supply information on these points.

IV. General Conclusions

It can be asserted that the Belgian population currently enjoys medical services of good quality, but it has to be stated that the doctors are generally overworked and lack the time effectively to keep abreast of medical progress.

The hospitals are generally able to receive the patients who are sent to them, and in Belgium the kind of waiting lists that exist in other countries are unknown. It is in fact probable that some regions are over-supplied, with the result that the patients' stay in hospital is prolonged.

Social Security has greatly favoured reliance on the medical services and has entailed considerable additional expense in the sphere of health care.

The spheres where there is a need for progress are those relating to chronic disease, geriatry and paediatry.

The last named branch of medicine has undergone considerable development in the last 10 years (hospital admissions have doubled) but the number of paediatrists has not followed the same rhythm and it is highly desirable that this specialty should develop. It is further desirable that the number of doctors should increase, so that the individual doctors should have the time to improve their knowledge.

At present negotiations are proceeding between the medical corps and Social Security with a view to better collaboration.
The current problems include:

1. Reconstruction of the anti-tuberculosis defences.
2. Development of new conceptions in psychiatric therapies.
3. Creation of a structure for the rational treatment of chronic patients and for geriatrics.
4. Medical research in spheres where specialisation is still only empirical.

5. Better knowledge of morbidity conditions in the population, so as to be able to make better provision for the future.
6. Improvement of knowledge concerning the financial, administrative and medical management of hospitals, so as to avoid an adverse reaction on the part of the quarters responsible for financing *vis-à-vis* the rapid and continuous increase of costs.
7. Co-ordination of the various private and public initiatives to avoid the overlapping which exists at present and might multiply in the future.

BELGIUM

by

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The Belgian hospitals are, according to their administration, either public or private. They were spread over the country up to now without real planning. They all complain of being in financial troubles. Their administration is entrusted to self-trained men or women but recently real efforts have been made to prepare hospital administrators at different levels. The nursing staff is devoted and on the average of high quality but often below the needed number. Individual medicine in the hospitals is of good quality but in some of them there is a lack of real team-work.

THE HOSPITAL SERVICE: ITS ORGANISATION AND SCOPE

The acute public hospitals are organised by the local communities, only one is owned by the government. By law they are intended to be the hospitals of the poor, but they get round this law, as a horse of Troy, to become hospitals for everybody with gradual increasing social standards, though they are still called 'hospital' which unfortunately sounds a little pejorative in the ears of the Belgian public.

The acute private hospitals have a few more than 24,000 beds against 16,600 for the public sector. The overall number of approximately 41,000 beds gives 4.38 beds for 1,000 inhabitants. A majority of the private beds belong to the catholic religious orders. A smaller number is dependent on social insurance organisations and another small group belongs to several other societies. They are called 'clinics', which suggests more privacy for the patient, which is not always true. These private hospitals are of the 'open' type allowing every doctor to treat his patients, or of the 'closed' type with an appointed staff. There is also a third, 'mixed' type where the appointed staff is supplemented by free doctors. In the open type there may be a definite lack of team work. The nucleus of these private clinics lies often in buildings at first intended for other

purposes. Reconstruction and adding new wings might be badly affected because of the original design. Since World War II however a fair number of private clinics have been built in accordance with modern standards.

Private clinics suffer often from lack of capacity and were at first rather oriented towards a branch of specialised medicine: surgery, obstetrics, paediatrics. There has been a change in this orientation for the last years and many of these smaller hospitals have increased their accommodation making the activity possible of a diverse team of specialists.

The patient is free in the choice of his institution but usually follows the suggestions of his private physician in the matter. The poor patient, who relies on welfare aid, is definitely guided to the public hospital in his locality. Some social insurance organisations may also limit the choice of institution for their members.

Location of the public and private hospitals over the country is the result rather of chance. Every community usually has its public hospital and one or more private institutions. There is no real rivalry between public and private hospitals but sometimes it exists between private hospitals themselves. Anyway there is a lack of collaboration, although it is felt that some sort of hierarchy in equipment and specialisation should be accepted.

One can only encourage the existing goodwill of some promoters of the public and private hospitals to set up, in common understanding, a general planning of hospital beds for the future. A planning-bureau has also been decided on by representatives of both parties, "CEDERSAN".

Financial difficulties exist both in the public and in the private sector though of a different kind. Nearly 75% of the Belgian population is compulsorily insured. The day-cost however for hospitalization, fixed by the Ministry of Social Welfare, remained on the same too low level for years. The supplement which can be charged to the patient by the hospital administration is limited by the Ministry of Public Health. No co-ordination exists between this overall day-cost and the

accreditation standards, which result in a regular increase in daily expenditure on personnel, buildings and equipment.

The public hospitals directed by the local committee of Public Welfare—called Commission of Public Assistance—turn for their deficit towards the budget of the town or city hall. The town administration, in case of the bigger communities, pass a greater part of this deficit to the Ministry of Interior Affairs. These steps loosen the ties of local financial responsibility.

The private hospitals partly make up their shortage by a higher charge for single bedrooms, which are usually in a smaller proportion, by investing all the salaries of their religious nurses and sometimes by arrangements about doctors' fees.

Notwithstanding this financial stress the public seems to be convinced that a hospital remains a profit-making concern. An appeal to the public by a private hospital either to aid the annual budget or for a new building, as is commonly done in the U.S.A., would have neither welcome nor response. The fault lies with the administration of both the public and private hospitals who do not make any effort to stimulate the community's interest or pride in their achievements.

ADMINISTRATIVE STAFFING

The administration of the public hospitals depends on the Board of Public Assistance Commission whose members are recruited on a political basis and may change after every election. These changes may influence fundamental decisions. The meetings of this Board are held usually outside the hospital while the local representative administrator is not allowed to take real decisions. The decisions of the Board are very slow and impaired by control on different higher levels: city, province and government. So the university hospital of the Louvain University decided to be rebuilt by the local board in 1946 is only finished for one-third of its capacity in 1962. A new law passed in 1960 was a first effort to bring an improvement in the situation.

In the religious private hospitals, administration is concentrated in a single person who is appointed rather for her

general capabilities which do not necessarily coincide with a serious training in hospital management. As a representative of the owner she appoints the medical staff, which in itself may constitute a difficulty. Suggestions have been made that religious congregations should limit their activity to nursing and pass their rights as owners, or at least for the daily management, to a committee of lay-men.

Among the hospital administrators of both public and private hospitals, practically none is up to present university graduate standard and practically no medical doctors interest themselves in the field on a scientific basis but exert the influence which they get through their professional accomplishments.

TRAINING OF HOSPITAL ADMINISTRATORS

The appointment of the administrators, as it has been pointed out, cannot really be called an example. A first effort was started with a post-graduate school for trained nurses in 1939 in connection with the University of Louvain and in 1946 with the University of Brussels. They turned out respectively 275 and 173 graduates.

Another initiative was the in service post-graduate training for head nurses (graduates) and last the regular cycles of in service training for hospital matrons assumed by the Catholic Hospital Federation.

At university level a section for hospital administration was started in the University of Louvain in 1961 and in the University of Brussels in 1962. In Louvain this section is open to University graduates and provides a cycle of two years' teaching, leading to a masters degree in hospital sciences on a post-graduate level.

More details will be given on the conception of these schools.

October 1962

DENMARK

by

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1. The Hospital Service, its Organisation and Scope

A Royal Decree of 1806 imposed upon the counties the duty of establishing the necessary number of hospitals, which were to serve both rural areas and towns. The hospitals were intended for such patients as could not be given the necessary nursing in their homes. They had to pay for the treatment if they were able to, otherwise the cost was defrayed by the poor relief fund and by the county. The cost of building and running the hospitals was in all other respects to be shared equally by counties and towns.

Prior to this there had, of course, existed some small and scattered institutions—mostly on a charity basis.

In 1740 the King had founded a teaching hospital in connection with the Copenhagen university.

The Hospital Act of 1806 forms the basis of the development and position of our present-day hospital system. The Danish hospital system is still as it was when it was founded, i.e., public and mainly municipal, so that the local authorities own and manage practically all medical-surgical hospitals.

Up to the beginning of this century, the development of the hospitals could be handled by the local authorities with the aid of local medical officers because the problems, apart from that of limiting the spread of infectious diseases, consisted mainly in meeting the requirements of surgery. There was one exception to this: the Copenhagen hospitals were early in opening specialty departments, including the Copenhagen university hospital.

Around 1925 the number of hospital beds had been increased to 3.4 per 1,000 inhabitants, exclusive of beds for epidemic, insane, and tuberculosis patients.

With one exception (Copenhagen), mental hospitals have for

many years been run by the State and directed by the central administration. Recent years have seen a trend to establish a closer collaboration between the general and mental hospital systems.

Around 1930 our hospital system was ripe for reorganisation and expansion, not in order to increase the number of hospitals but to extend some of those already existing with a view to providing space for specialty departments. It was suggested that each of our 23 counties (populations between 100,000 and 150,000) should develop an existing hospital into a central hospital, which would start with at least three departments—surgical, medical, and radiological—which subsequently would be supplemented by specialty departments to such extent as would be found desirable and financially warrantable.

This programme had been practically accomplished before 1950, having been somewhat delayed by the war.

In 1946 a Hospital Act, which is still in force, was passed. Section 1 of this Act lays down the old rule that it is a duty of the counties and the towns (where convenient, in collaboration) to build and run hospitals according to needs.

All plans for new hospitals, expansions as well as discontinuation of departments, have to be approved by the Ministry of the Interior, which is advised by the National Health Service.

The Act holds out the possibility that certain highly specialised departments that do not fit in with a restricted local administration may be built and run by the State.

The Act, moreover, provides for such State subsidies as are to be paid to the local authorities.

Finally, the Act lays down rules for the establishment of a Supreme Hospital Board made up of (political and administrative) representatives of central and local authorities. 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.

It may be appropriate to mention that the special Danish institution, the National Health Service, which only to a certain

extent functions as a ministry or department of health, was founded in an Act of 1932, from which we quote:

'1. The central administration of the country's public health system shall be called The National Health Service.

2. (1) The National Health Service shall be the chief superviser of public health and nursing, including dental surgery, midwifery and pharmacies, and chief adviser to the public in all matters requiring a knowledge of medicine or drugs. In this capacity the National Health Service shall be consulted by the various departments of the central administration on all matters whose decision is considered by the ministry concerned to require such knowledge—including budgetary questions of this kind. The National Health Service shall likewise on request by the said authorities give opinions on matters of such nature.

(2) The National Health Service shall have . . . overall supervision of all public curative institutions and nursing institutions. The opinion of the National Health Service shall be required as to plans for the building or for extensive alterations to the said institutions.

The National Health Service must be consulted as to qualifications before any appointments are made to posts as physicians at hospitals and elsewhere.

The head of the National Health Service, the Director General, must be a physician, but must not have a professional practice.'

During the last decade many of the existing hospitals have been modernised and expanded, especially with new treatment facilities, such as operating theatres, X-ray departments, laboratories, etc.

Five complete major new hospitals have been built.

The present position may be seen in the map (appendix).

The official statistics for 1959 show that in 144 hospitals with 25,649 beds 539,471 patients were treated by 2,283 doctors with the aid of 9,026 nurses and at a cost of approx. 480 million Danish kroner (£25m.).

Today the National Health Service is working on 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 at any other place but within a hospital.

B. TRAINING

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 administrators' association to establish such training by its own means, the association has now and again tried to make the financial authorities and the Copenhagen School of Commercial Science interested in its plans, though no implementation of the latter 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.

Up to two *advanced-training courses* have been held a year, and a committee set up by the association of hospital governors (the hospital administrators' association) is at present trying to intensify this education, which is designed for officers having the status of managing clerk or some higher rating. In future this education will be given mainly in the form of group work, and the aim is to arrange special courses dealing with subjects pertaining to the management of institutions. Such subjects will comprise: organisation, rationalisation, automation of office work, conduct of meetings, staff policy, agreement conditions, budgets, accounts, statistics, building activities, purchasing, etc.

The *continuation courses* have been held in the form of lectures, and, in contradistinction to the advanced-training courses, are also intended to be continued in this manner. Whilst the object of the advanced-training courses has been to impart to the participants an all-round knowledge of the different branches

of hospital administration, the principal aim of the continuation courses has been to keep already functioning hospital administrators posted on developments in general.

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

1. Principles relating to present-day hospital building.
2. Computation of fees for hospital architects and engineers.
3. Hospital-technical installations.
4. Instruments and apparatus.
5. Arrangement of anaesthetic and recovery departments.
6. Psychiatric departments in county hospitals.
7. Hospital hygiene.
8. Odontological services in our hospitals.
9. Labour-saving experience gained at U.S. hospitals.
10. Future care of the mentally deficient.
11. The Rehabilitation Act.
12. The Ombudsman (the Comptroller of Public Affairs appointed by the Folketing) and the municipal administration.
13. Emergency measures and civil defence duties encumbent upon hospitals in peacetime.
14. Automation of the administration and electronic calculating machines.
15. Safety measures in connection with the use of inflammable and explosive organic solutions in hospitals.

In addition, frequent visits to institutions.

The committee on courses set up by the association of hospital governors 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.

However, a hospital will have every reason to be satisfied with an administrator who, concurrently with his practical training, has been energetic enough to attend the courses arranged by the association of hospital governors and, in addition to this, to graduate as an M.Sc. (econ.). Such a person will possess a detailed knowledge of hospital administration and also

outlining of a general plan aiming at ensuring that the future hospital building and development programme as a whole will proceed in accordance with well considered and consistent principles, so that it will be possible to establish priorities and ensure that each separate development is undertaken in the light of the overall pattern to be produced. Improvements in the hospital service have already done a great deal to enable more patients to be treated in a given number of beds. With the acceleration of physical improvements, greater concentration of treatment in district general hospitals, and greater efficiency generally, the average number of patients treated per bed may be expected to increase still further.

The intention is to achieve an even distribution of effective hospital beds throughout the country at a rate of five per 1,000 inhabitants—approx. 25 per cent. of these beds in specialised departments—including the teaching hospitals.

Most hospital beds will in future, we hope, be concentrated in hospitals of about 400 beds, though naturally some of the regional hospitals, where more specialties are provided, will be larger, while some of the existing smaller ones will prove adequate within the general system for many years to come.

It must be remembered that the hospital system is very old, is locally owned and run and, therefore, not very susceptible to major alterations—which can only be achieved by very intensive propaganda on the part of the National Health Service.

II. Administrative Staffing Structure in the Hospital Service

Modern legislation on the hospital service in Denmark makes 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. Apart from mental hospitals, the State runs hospitals to only a very limited extent, and the hospital service in Denmark, therefore, rests mainly on the local authorities.

Such local authorities as own hospitals will generally appoint a hospital board, which will be responsible to the local council for the management of the hospital. For this purpose the board will be assisted by an administrator (inspector, director, or

executive), who will be responsible for the day-to-day administrative leadership.

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 to the board for its decision, through the administrator, who as a rule acts also as secretary to the hospital board. The records of the admission and discharge of patients as well as all accounts relating to their period of hospitalization are handled by the administrator.

In addition to the above-mentioned duties, the administrator supervises the technical departments: the kitchen, the day-to-day management of which is in charge of a kitchen matron; the laundry, the head of which is a laundry matron or laundry manager; and the boiler and machine department under the management of a chief engineer, who is responsible for the supply of heat and steam to the hospital, and also, in collaboration with various mechanics and artisans, for the inspection and upkeep of the technical installations.

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 and nursing 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 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.

ADMINISTRATIVE SET-UP OF THE NURSING SERVICE

Grades: Matron
Assistant Matron
Departmental Sisters (large hospitals only)
Ward Sisters

Staff Nurses
Student Nurses
Assistant Nurses

RESPONSIBILITY OF THE MATRON

The administration and supervision of the nursing care and the 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 the training of the staff, and will organise the practical work of the student nurses if the hospital is co-ordinated with a nursing school.

RESPONSIBILITY OF DEPARTMENTAL SISTERS AND WARD SISTERS

Departmental and ward management, planning and supervision of the work of the nursing personnel. They are responsible for the care of the patients and for carrying out the prescribed treatment.

Training of student nurses.

III. Appointment and Training of Hospital Administrators

A. APPOINTMENT

The above-mentioned Hospital Act provides that schemes for the erection, extension, major rebuilding and major repairs, as well as the closing of municipal or county hospitals, shall be approved by the Minister of the Interior. The Medical Officers and Practitioners Act provides that no post as medical chief at a municipal hospital can be filled until a statement has been obtained from the National Health Service regarding the qualifications of the candidates for the post in question.

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 the Interior—a condition applying to all comparable official posts.

In former times the post of responsible administrator was held by a senior medical chief in addition to his medical duties. However, since the position as senior medical chief is nowadays a whole-time job, and since the administrative duties in consequence of the increasingly intensive operation of the hospitals demand insight in a wide-ranging field of knowledge, the management has by virtue of the evolution been transferred to an independent administrative leadership co-ordinate with the medical leadership. It should be said that this development has taken place by agreement with the senior medical chiefs who, thanks to this relief, can devote their efforts entirely to their specialties.

An advertised vacant post of administrator at a major hospital will as a rule be applied for both by university graduates and laymen. The university graduate, however, is unlikely to be preferred unless his graduation as 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 many-sided 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.

A growing number of hospital administrators are graduates of universities or schools of commercial science, but as mentioned before, they are typical in that they have practical training in hospital management, often acquired concurrently with their studies.

That so much importance is attached to practical training when hospital administrators are appointed is due to the fact that a hospital is an institution with many different and special functions, with departments whose fields of work are overlapping or touching each other, and with highly differentiated groups of staff, each with its special characteristics. Consequently, the co-ordinating tasks, for instance, to be carried out by an administrator will be so much easier for him if he has grown up in the atmosphere typical of hospitals. Finally, the

the all-round knowledge of the general principles of administration provided by the specialist study. If at the same time he possesses the proper human qualities, he will have extremely good prospects of becoming an efficient hospital administrator.

C. TRAINING OF OTHER GROUPS OF STAFF CONCERNED WITH HOSPITAL ADMINISTRATION

Appointment and training of administrative nursing personnel. 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.

The curriculum comprises: Nursing subjects, social sciences, psychology, ward management, administration of nursing service and nursing education, teaching methods, etc.

This course is also attended by an increasing number of ward sisters and departmental sisters.

A one-month refresher course has been introduced for senior matrons, comprising subjects such as: special administrative problems, personnel management, etc.

Kitchen Matrons. As previously mentioned, a kitchen matron is in charge of the day-to-day management of a hospital kitchen. The kitchen matron receives a special hospital training, partly practical, partly theoretical. The practical training, which takes place in the various sections of the kitchen, at present lasts for a term of three years, to which is added a six-month stay at a matron school, common for the whole country, at which the theoretical lessons in dietetics, etc., take place. On completion of her practical and theoretical training, the student will be appointed assistant kitchen matron, and may later apply for a position as kitchen matron. It should be mentioned that education for kitchen management is in the mould at the moment, and there is every indication that the education of students will in future comprise:

(1) a five-month stay at a preparatory school (domestic science school);

(2) a two-year practical training in a hospital kitchen; and

(3) a six-month stay at the matron school.

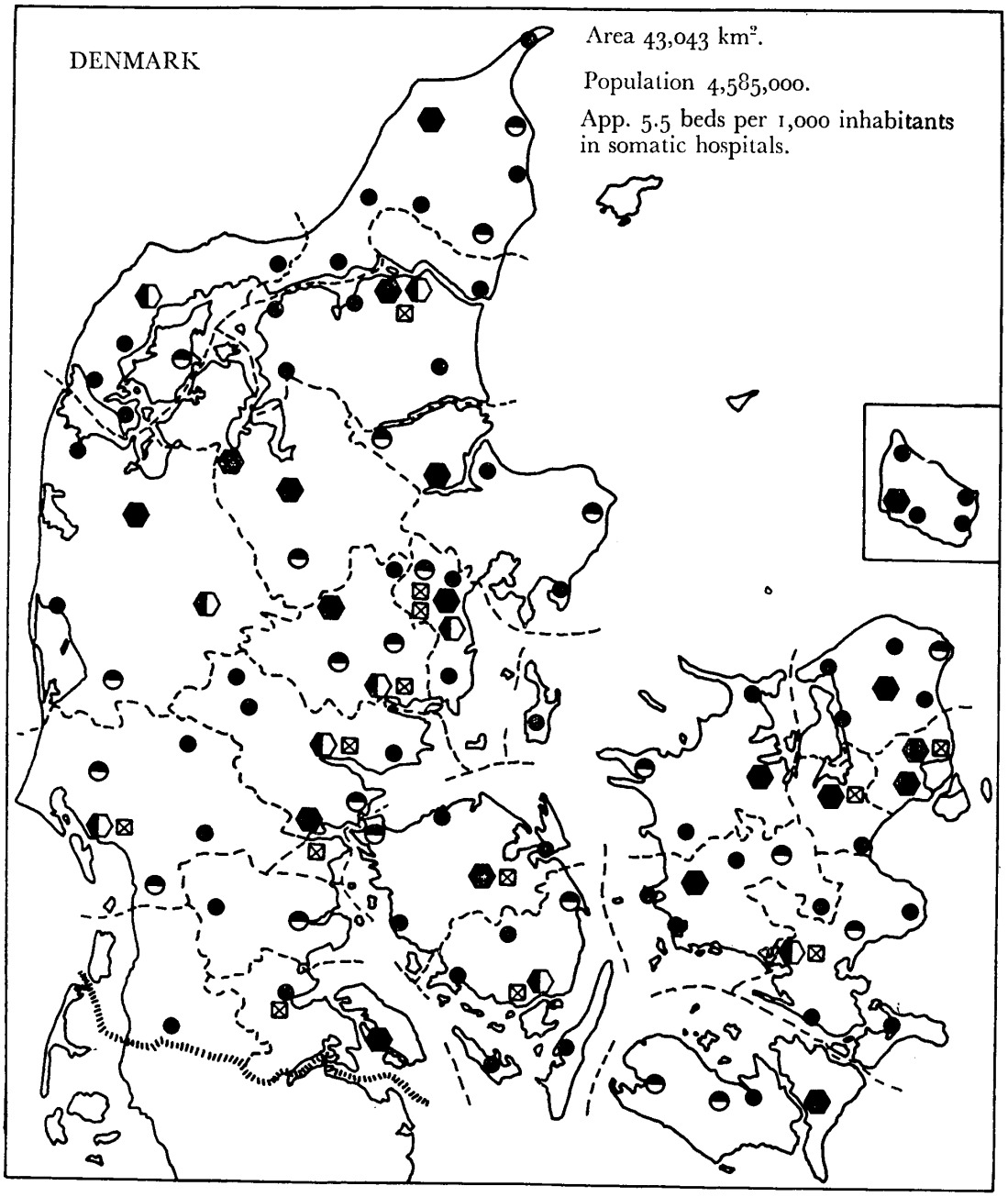
Laundry Matrons or Laundry Managers. As previously mentioned, a laundry matron or laundry manager is in charge of the day-to-day management of a hospital laundry. This person will also see to it that the linen is mended and kept in good repair. The laundry matron (the laundry manager) has generally received a special hospital training. This training lasts for a term of three years, and consists partly of a practical training given in a laundry, a linen depot, and a dressmaker's workroom, partly of a theoretical training, comprising, among other things, commodity study and laundry knowledge. The theoretical training takes place at a day-school, common for the whole country, and lasts for one month. On completion of this training, the student may apply for appointment as an assistant laundry matron and subsequently for appointment as a laundry matron.

Formerly laundry matrons used to be responsible also for the cleaning of the hospital,but this task has gradually been undertaken by a special supervisor in charge of the cleaning staff.

For the *supervisors in charge of cleaning*, who at first were chosen mainly from among interested assistant laundry matrons, a special theoretical course has now been introduced at the College of Technology.

It generally applies to all the groups mentioned above that their professional organisations will regularly arrange advanced-training courses for their members.

October 1962



MEDICO-SURGICAL HOSPITALS OUTSIDE COPENHAGEN, 1961

- Central hospitals comprising several departments.
- Other major hospitals.
- Minor hospitals comprising at least two specialities.
- Minor hospitals comprising a mixed surgical-medical department.
- Private hospitals, mainly minor specialities.

FINLAND

by

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Chairman of Direktion, Foundation for Education in Hospital Administration

1. *The hospital service, its organisation and scope*

GENERAL HOSPITALS

For the purpose of general medical care, Finland has been divided into 21 central hospital districts. Each central hospital district is to have its own central hospital. The hospital will be owned and administered by communal federations formed by the municipalities and communes of each central hospital district. Nine central hospitals are already in operation. The rest of the central hospitals will be built during the next ten to 20 years. The central hospitals offer their services in the most general fields of medicine, i.e., surgery, internal medicine, obstetrics and gynaecology, paediatrics, ophthalmology and otorhinolaryngology. In addition, each central hospital has an out-patient department and adequate special service departments.

The central hospitals attached to the University Medical Faculties hold a special position; at present there are two such hospitals, in Helskinki and Turku, and in the next few years one more will be completed in Oulu. These central hospitals are jointly owned by the University and the communes of the central hospital district concerned, and they are therefore called university central hospitals. In those parts of the country where there are no central hospitals, the inhabitants are still being served by State hospitals.

REGIONAL HOSPITALS

In addition to the central hospitals, there are regional hospitals with departments for at least two special branches of medicine, and adequate special service departments; they may also have out-patient departments. These hospitals are likewise

owned by communal federations. There are now over ten regional hospitals in operation.

LOCAL HOSPITALS

The third group of Finnish hospitals consists of the local hospitals, now numbering about 160, which are owned either by a single commune or by several communes jointly. Most of them are smaller and less well equipped than the regional hospitals.

Thus there are three different categories of general hospitals: central hospitals, including university central hospitals as a special group, regional hospitals and local hospitals. Until this network of hospitals is completed, State hospitals, now numbering over ten, will also be in operation. In addition, there are about 35 private hospitals and some 40 communal hospitals operating outside the hospital law and receiving no government aid.

MENTAL HOSPITALS

For the care of mental patients, the country is divided into 18 mental health districts, each having a central mental hospital. The central mental hospital (A-hospital) in each mental health district is owned by the communal federations. In addition to the central mental hospitals, there are also B-hospitals, now numbering about 40, administered by the local authorities or communal federations. The B-hospitals, designed for mental patients who are easy to manage and are dangerous neither to themselves nor to others, have been built as far as possible in the immediate vicinity of the central mental hospitals, which treat acute cases, or at least in places where special treatment can be given.

TUBERCULOSIS SANATORIA

For treatment of tuberculosis, the country is divided into 19 tuberculosis districts, each of which has its own tuberculosis sanatorium. All these hospitals have X-ray facilities and laboratories of their own.

After the Central Hospital Law of 1943 amended in 1948 and

the Hospital Law of 1957 took effect, the construction of hospitals was accelerated. During the last ten years there have been built 30-40 new local hospitals, seven regional hospitals, seven central hospitals, three university central hospital clinics and about 30 hospitals for mental patients. In addition, over 50 hospitals have been rebuilt or expanded with new buildings. Dozens of new local, regional and mental hospitals are being constructed. (See tables overleaf).

2. *The way in which the hospitals are staffed administratively*

The administrative organisation of a hospital depends greatly on its ownership. As pointed out in the foregoing, Finnish hospitals are mostly public institutions. The majority are maintained by the communes and municipalities, but the State still has a number of general hospitals.

THE ADMINISTRATIVE ORGANISATION OF STATE HOSPITALS

Primarily responsible for the overall functioning of any hospital under the administrative control of the State is the *executive director* of the institution, who is invariably a *chief physician.* It is the duty of the executive chief physician to see to it that the laws and decrees currently in effect are adhered to in managing the hospital. He must also see to it that the members of the hospital staff carry out their responsibilities. Furthermore, he is in charge of hiring and dismissing staff members with the exception of leading functionaries. He has an especially important financial responsibility in that he has to control the funds handled by the business manager as well as to approve the hospital budget drawn up and proposed by the latter and to submit it to the Central Medical Board for consideration.

The task of the matron is to supervise the nursing activities in the hospital. It primarily involves organising and directing the work of the nursing staff and other personnel attending to the needs of patients.

The *business manager* is mainly concerned with economic matters, such as book-keeping, drawing up the hospital budget, ordering supplies and paying bills. His functions include those of superintendent for he has primary responsibility for the operation and maintenance of the hospital buildings and tech-

Hospitals	*Ownership*								
	State	*Urban communes, 1st class*	*Urban communes, 2nd class*	*Rural communes*	*University central hospital federations*	*Federations of communes*	*Private*	*Ahvenanmaa province (Aland Islands)*	*Total*
					BEDS				
GENERAL HOSPITALS	2,108	3,683	246	2,627	2,475	4,755	2,570	105	18,569
State hospitals	2,108	—	—	—	—	—	—	—	2,108
University central hospitals	—	—	—	—	2,475	—	—	—	2,475
Central hospitals	—	—	—	—	—	2,124	—	100	2,224
Regional hospitals	—	—	—	—	—	1,140	—	—	1,140
Local hospitals	—	3,316	207	2,171	—	1,328	—	—	7,022
Communal hospitals outside hospital law	—	367	39	456	—	163	—	5	1,030
Private	—	—	—	—	—	—	2,570	—	2,570
MENTAL HOSPITALS	496	3,119	—	190	123	12,015	—	73	16,016
State hospitals	496	—	—	—	—	—	—	—	496
Mental hospitals, type A (acute)	—	2,318	—	—	123	8,372	—	73	10,886
Mental hospitals, type B (chronic)	—	755	—	190	—	3,627	—	—	4,572
Observation stations (acute)	—	46	—	—	—	16	—	—	62
TUBERCULOSIS SANATORIA	—	803	—	97	—	5,492	—	50	6,442
Central sanatoria	—	773	—	—	—	5,379	—	50	6,202
Other sanatoria	—	30	—	97	—	113	—	—	240
Total	2,604	7,605	246	2,914	2,598	22,262	2,570	228	41,027

Beds at special institutions (institutional hospitals)		
Nursing homes		7,486
Military		1,817
Prisons		556
Other		70
Total		9,929
All beds		50,956

Hospitals and Beds by type and ownership at the end of the year 1960

Hospitals	*Ownership*								
	State	*Urban communes, 1st class*	*Urban communes, 2nd class*	*Rural communes*	*University central hospital federations*	*Federations of communes*	*Private*	*Ahvenanmaa province (Aland Islands)*	*Total*
	HOSPITALS								
GENERAL HOSPITALS	12	44	8	113	2	49	35	2	265
State hospitals	12	—	—	—	—	—	—	—	12
University central hospitals	—	—	—	—	2	—	—	—	2
Central hospitals	—	—	—	—	—	6	—	1	7
Regional hospitals	—	—	—	—	—	9	—	—	9
Local hospitals	—	36	6	87	—	31	—	—	160
Communal hospitals outside hospital law	—	8	2	26	—	3	—	1	40
Private	—	—	—	—	—	—	35	—	35
MENTAL HOSPITALS	3	13	—	3	—	37	—	1	57
State hospitals	3	—	—	—	—	—	—	—	3
Mental hospitals, type A	—	3	—	—	—	15	—	1	19
Mental hospitals, type B	—	8	—	3	—	21	—	—	32
Observation stations	—	2	—	—	—	1	—	—	3
TUBERCULOSIS SANATORIA	—	4	—	4	—	17	—	1	26
Central sanatoria	—	3	—	—	—	15	—	1	19
Other sanatoria	—	1	—	4	—	2	—	—	7
Total	15	61	8	120	2	103	35	4	348

nical facilities. Besides money expenditures and keeping the accounts, the business manager is further in charge of the hospital stores.

One of the chief physicians on the staff is appointed executive director of each State hospital for a term of four years. Inasmuch as the State hospitals are divided into special departments, each department (internal medicine, surgery, children's diseases, etc.) has its own chief physician, who is responsible for the medical services offered in his special field. Under his orders are ward physicians and assistant physicians. If the hospital is big enough, there is a doctor in charge of X-ray department and laboratory, holding the title of chief physician, too.

COMMUNAL CENTRAL HOSPITALS (GENERAL HOSPITALS, TUBERCULOSIS SANATORIA AND MENTAL HOSPITALS)

The communal central hospitals are owned by federations of communes and their organisation is based on the same principles as apply to State hospitals. Each special department of medicine has its own chief physician. One of the chief physicians on the staff is appointed in the same way as in State hospitals to take executive charge. The physician in charge is entrusted with administrative duties, but he is not concerned with matters of business management to the same extent as his counterpart in a State hospital. Consequently, the business manager of a communal central hospital has considerably broader authority than that of a State hospital. He also serves as a secretary of the federal board of the federation of communes operating his hospital and generally brings a large part of the economic affairs of the hospital to the attention of the board. The position and duties of the matron are pretty much the same in the communal central hospitals as in State hospitals.

OTHER COMMUNAL HOSPITALS

Besides the hospitals operated by the federations of communes, there are hospitals in Finland owned by individual communes, and, especially, large population centres and cities. In the larger cities municipal hospitals are under the charge of

special boards of directors, while in the smaller rural communes the local board of health or some subordinate agency is in charge. The administrative organisation of the municipal hospitals in the major cities is by and large similar to that of the hospitals belonging to the State and the communal federations. In the very smallest communal general hospitals, the physician in charge is the local health officer, which means that the only responsible member of the staff regularly on duty is the matron. Matters relating to the business management of such hospitals are often combined with the economic administration of the communes or, then, the position of manager is held on a part-time basis.

At present, the principal responsibility in the administration of the hospitals of Finland still rests with the executive chief physicians. In the communal hospitals, the business managers bear a relatively heavy responsibility and exercise considerable authority in economic matters. On the other hand, there is not a single hospital in Finland with an executive director serving on a full-time basis. In the university central hospitals, which are owned by the communal federations, the executive chief physician works together with a hospital board consisting of professors from the medical faculty of the university. The university central hospitals of Helsinki and Turku have an administrative director. Two of the large communal general hospitals have a business executive.

Even in cases where hospitals have an administrative director, the administrative organisation remains dualistic. Responsibility is shared by two executive officers.

The post of executive chief physician requires no special administrative competency. The chief physician of every department of a hospital is regarded as fully qualified in this capacity. Often the position of executive chief physician takes on the character of a 'revolving prize'—being awarded to each chief physician on the staff in turn. This prize is not, however, much sought after for the hospital director is granted no relief from his medicinal duties and the extra salary is only nominal. The system of organisation on the executive level has thus been left at quite a rudimentary stage.

3. *How the hospital administrators are selected and trained*

The qualifications of business manager vary greatly. The administrative director is required to have an academic degree, the business manager generally at least a diploma from a commercial college.

The position of matron is the only one that requires a post-graduate course in administration in addition to the professional examination. Such courses are regularly held in State nurses' training schools for aspirants to the position of head nurse or a matron.

Candidates for positions requiring an academic degree (also administrative director and business managers) are obliged to take the regular course of studies at one of the universities or other institutions of higher learning. Ordinarily, preference is given to graduates of a college of commerce and business administration or a law school. Of late, holders of a degree in political science have also been appointed to administrative posts in hospitals.

Since no specialised administrative training is generally required of appointees to executive positions in the hospital administrative system with exception of matrons acquiring full competency calls for further study. Arranging such opportunities along systematic lines is quite new in Finland. The organisation of advanced training has so far been as follows:

1. Every year the Union of Rural Communes arranges in co-operation with the State medical authorities a three-day course of lectures and conferences on questions of current interest concerning hospital administration and business management. The course is taken separately by the executive and managing officers of (*a*) general hospitals and (*b*) mental hospitals and tuberculosis sanatoria.

2. At the end of 1961, the *Sairaalatalousyhdistys r.y.* (the Hospital Business Managers Association) arranged a one-week course of basic education in hospital administration for junior office personnel responsible for the business management of their respective hospitals. It is planned to continue with this training programme on an annual basis.

3. In the autumn of 1961, the Medical Association in

Finland, the Finnish Federations of Nurses—the Finnish Nurses' Association and the Hospital Business Managers Association jointly established, with the assistance of the government authorities, a Foundation for Education in Hospital Administration. The aim of this foundation is to promote education in administration among hospital administrative personnel in Finland as well as hospital trustees. The programme includes courses and other educational sessions in administration and leadership, special instruction in hospital management and the performance of executive functions, making recommendations for the elimination of defects in the system and the improvement of prevailing conditions.

The Board of Governors of the foundation consist of representatives of the sponsoring organisations, the government and hospital trustees.

The foundation held its first conference in September, 1962, with Prof. T. E. Chester from Manchester as guest lecturer. The main theme of the conference is 'The Application of Modern Ideas and Methods of Leadership to Hospital Administration'.

In the spring of 1962, the Medical Association in Finland arranged on its own initiative a course of basic administrative training for hospital doctors. The course places special emphasis on the administrative functions of hospital physicians in executive positions. It is planned to hold a corresponding course in the autumn of 1962. Preliminary plans have been laid for the organisation of a basic course in hospital administrations for physicians undertaking to serve a period (as medical assistants) on a hospital staff in order to qualify as specialists. It has become the task of the Foundation for Education in Hospital Administration to synchronise the programmes of basic training in administration for physicians, business managers and nurses entrusted with administrative duties. It should further be mentioned that the Society of Bachelors of Medicine will arrange its first seminar in hospital policy for members this autumn. This may also be considered the opening signal for the organic linking of training in hospital administration to the programme of medical education in the future.

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IRELAND

by

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I. Organisation and Scope of the Hospital Service

NUMBER AND TYPES OF HOSPITAL

1. Ireland has a total of 426 hospitals and health institutions providing care and treatment which vary widely in both type and degree. These institutions include general medical and surgical, maternity and mental hospitals, hospitals for infectious diseases, including TB, orthopaedic and other specialised hospitals, institutions for mentally handicapped, homes for old people, maternity, nursing and convalescent homes and homes for mothers and children.

2. There is accommodation in these institutions for over 60,000 in-patients. For acute treatment (i.e., medical and surgical, infectious diseases, orthopaedic and other specialised treatment) there are over 19,000 beds or 6.86 beds per 1,000 population. There are over 2,700 beds for maternity patients in hospitals and homes and these represent 0.97 beds per 1,000 population. Mental hospitals contain over 20,500 patients on average representing 7.29 per 1,000 population. County Homes and other homes for the care and treatment of the aged and chronic sick have a total of 12,400 beds or 4.41 beds per 1,000 population.

3. The great majority of hospitals are controlled and administered by local authorities, and these dispose of almost 42,000 beds. The remaining 18,000 beds are in voluntary institutions. With two exceptions, all types of hospital accommodation and treatment are provided both in local authority and voluntary institutions. The exceptions are:

(*a*) infectious diseases hospitals (other than tuberculosis), which are entirely under local authority control, and

(*b*) homes for mentally handicapped people, which are entirely voluntary.

4. The local authority institutions include many general hospitals which provide a high standard of care for medical, surgical and maternity patients. These hospitals cater for individual counties or for some specialised forms of treatment for groups of counties. There are also hospitals which specialise in such fields as tuberculosis, other infectious diseases, orthopaedic treatment and maternity. These specialised hospitals cater mainly for regions comprising a number of counties. There is, in addition, a large number of smaller district hospitals which provide, at general practitioner level, general medical, and a limited amount of surgical treatment. Most of the mental hospital beds are in institutions of local authorities, which also control the county homes where the majority of beds for the care and treatment of the aged and chronic sick are located.

5. The public voluntary hospitals, of which there are over 50 in the country as a whole, include a large proportion of teaching hospitals and of hospitals which specialise in dealing with children, maternity, orthopaedic, tuberculosis and cancer patients and in the treatment of defects of the eye and ear.

6. The public hospitals, both local authority and voluntary, have semi-private and private accommodation which is small in relation to total numbers of beds. There is also a number of private hospitals and nursing homes with an aggregate of about 2,000 beds, while convalescent homes and maternity homes provide a further 700 beds.

ADMINISTRATIVE ORGANISATION

7. The administrative authorities are:

(*a*) The Minister for Health and his Department whose functions in relation to local authority hospitals include supervision of the development of hospital service; the control of expenditure and staffing; and the fixing of rates (or limits to rates) of charge for services. In relation to voluntary hospitals the functions comprise the allocation of grants towards revenue deficits, and for capital purposes, and regulation of the financial arrangements under which voluntary hospitals provide services on behalf of health authorities.

(*b*) Health Authorities. These are the County Councils, except in areas of the four principal cities—Dublin, Cork, Limerick and Waterford—for each of which there is a unified Health Authority administering services for the joint areas of the city and county in each case. In some cases joint boards have been established, e.g., to operate mental hospitals for two or more counties. Each health authority is responsible for the provision of health services relating to both physical and mental health. Hospital services are provided in institutions administered by the health authorities, and also in voluntary institutions, on a basis of payment by the health authorities to the latter for services rendered.

(*c*) Voluntary hospital authorities. These vary considerably in their Constitution. Many authorities are religious communities while others are Corporate bodies. The latter are in some cases fully autonomous, while in others their boards are appointed by the Minister. Seven of the voluntary hospitals in Dublin have recently federated in order to optimise the resources and facilities for specialisation, and to realise the greater financial and administrative advantages to be derived from unification.

(*d*) The Hospitals Commission, which was established under the Public Hospitals Act, 1933, and ordinarily consists of a chairman and two other members appointed by the Minister. The Commission has the function of advising the Minister on matters relating to hospital facilities, and on the administration of the Hospitals Trust Fund, which was established by the same Act. The Commission collects from the voluntary hospitals estimates and accounts of income and expenditure by reference to which grants from the Hospitals Trust Fund towards revenue deficits are made on the direction of the Minister.

The income of the Hospitals Trust Fund comes from sweepstakes on horse-racing and is used both to provide grants to meet capital expenditure and to pay deficits on the running expenses of voluntary hospitals. The administration of the fund is entrusted to the Hospitals Trust Board, a statutory body appointed by the Minister.

8. The percentage of the gross national product spent from taxation, both central and local, on health services amounts to almost 3%. This excludes private expenditure such as private payment for general practitioner, specialist and hospital services and the purchase of drugs. The total revenue cost of the hospital services to public funds currently amounts to almost £16¼ millions a year.

9. One-half of the total net current expenditure of the health authorities on health services—including institutional services—is paid for from the local rates levied by local authorities, and one-half is met from national taxation and is paid by the State to health authorities. Expenditure on capital works is usually met by way of a grant from the Hospitals Trust Fund and/or loans raised by the promoters. Of the total of £16¼ millions expenditure from public funds on hospital services, the State and health authorities share equally an expenditure of about £14½ millions while the deficits of voluntary hospitals to be covered by grants from the Hospitals Trust Fund are estimated at £1.8 to £2 million per annum.

10. The sum of £14½ millions includes the net cost of running local authority hospitals of all types, estimated at just over £11 millions, together with the amount payable to voluntary institutions for the maintenance and treatment of patients receiving services under the Health Act, which is estimated at almost £3½ millions. This latter sum comprises daily or weekly capitation payments for patients chargeable to the health authorities.

11. The Hospitals Trust Fund has been an important source of revenue for the hospital services. Up to 31st March, 1962, the total receipts into the Fund, mainly from Sweepstakes, was about £50.6 million. Grants from the Fund to meet deficits in the running costs of voluntary hospitals amounted, over the same period, to £15 million.

12. After the last war a programme of hospital construction was carried out, involving heavy capital expenditure. In the period from 1st April, 1948 to 31st March, 1962 capital grants amounting to £26.3 million were provided from the Hospitals

Trust Fund which during this period was assisted by a subvention from the Exchequer to the extent of £6.8 million. The capital expenditure from local authority funds during this period is estimated at about £5 million. This resulted in the provision of about 10,500 beds gross, the net gain in beds being in the region of 7,500. In all, grants totalling £29.8 million have been made from the Hospitals Trust Fund in the period from its inception up to 31st March, 1962, to meet capital expenditure on hospital services.

13. The accounts of the health authorities, including their hospital accounts, are subject to audit by local government auditors, whose reports are made available to the Minister. The accounting system of health authority hospitals—which is much the same as that in voluntary hospitals—provides for a subjective analysis of expenditure, and the production of an average daily (or yearly) cost per patient. There is virtually no departmental costing.

BASIS OF ELIGIBILITY FOR INSTITUTIONAL AND SPECIALIST SERVICES

14. Eligibility for these Services is determined in accordance with the provisions of the Health Act, 1953, as amended, by reference to membership of one or other of four broadly-defined classes:

(i) the lower income group, or persons who are unable to provide health services for themselves and their dependants from their own resources;

(ii) the middle-income group, which includes
  (*a*) persons insured under the Social Welfare Acts;
  (*b*) persons whose family income is less that £800 a year;
  (*c*) persons whose livelihood is derived mainly from agriculture and the valuations of whose holding does not exceed £50;
  (*d*) the dependants of all such persons;

(iii) pupils of National Schools who receive hospital treatment for ailments discovered at School health examinations; and

(iv) those outside these groups who in the opinion of the health authority concerned, could not, without undue hardship, provide the services from their own resources.

15. It is calculated that 85% of the population come within classes (i) and (ii). For those who do not come within the ambit of the Health Act Services—and indeed also for those who do, if they so wish—a scheme of voluntary health insurance is available for hospital (excluding normal maternity) services. This scheme was introduced under an Act of 1957, and is administered by a Board appointed by the Minister.

SCOPE OF SERVICES AND BASIS OF CHARGE

16. Services are available to the eligible classes of people in general and specialist hospitals, mental hospitals, and in nursing homes, convalescent homes and homes for handicapped persons. These services include out-patient specialist services. The services which a health authority must provide are made available in public accommodation. The patient may be provided with accommodation in an institution run by the health authority, or he may be referred by the health authority to a voluntary hospital, or to a hospital belonging to another local authority. A health authority may operate an arrangement whereby patients who enter approved hospitals of their own choice are deemed to have been sent to them by the health authority and the health authority in such cases pay the voluntary hospitals the full capitation rate. Where the patient chooses his or her own hospital, nursing home or maternity home a subvention is paid towards his or her expenses by the health authority. The amount of the subvention depends on the particular hospital chosen, and on the type of accommodation, i.e., whether public or private.

17. Hospital treatment for infectious diseases is available free of charge without reference to the means of the patient. Members of the lower income group, and National School pupils receiving treatment for defects or ailments discovered at School health examinations are entitled to hospital and specialist services without charge. There is provision for charges not exceeding 10/- a day for persons in the middle-income

group, and higher charges can be made for cases dealt with under the 'undue hardship' clause.

18. The payment made by a health authority to a voluntary hospital for persons treated on its behalf are at rates approved or directed by the Minister. A capitation payment is made to cover maintenance and treatment in the hospital, and special supplementary payments are made for some of the more expensive drugs and appliances. An additional payment is made into a special fund or 'pool' from which the visiting medical staffs of the hospital are remunerated for their services for Health Act patients.

19. The manner of distribution of this pool, which does not form part of the funds of the hospitals, is determined by the staffs participating in it. There are three types of visiting specialists—Anaesthetists, Radiologists, and Pathologists—who do not participate in the 'pool' distribution. These are remunerated from the funds of the hospitals and, in the case of the Radiologists and Pathologists, partly by local authorities.

II. Administrative Staffing of Hospitals

20. Local authority hospitals, forming part of the health services of the functional areas of the health authorities, are to a large extent managed from the central administrative offices of the health authorities. The lay administrative or office staff of the hospital may be, and indeed often is, quite small. Medical and nursing control as such is, however, retained by the appropriate medical and nursing officers in each hospital.

21. Voluntary hospitals are managed from within, each hospital having its own controlling authority and its lay, medical, and nursing departments wholly within the institution.

22. If we regard the administrative staff of the hospitals as comprising medical, nursing and lay administrators, we can say that while basically there is, in every hospital, somebody responsible for the functioning of each of the three spheres of authority, there are variations in the scope and span of control of each sphere, and, in some cases, in the designations of those in charge. This is true of both health authority and voluntary hospitals.

23. Taking medical administration for example, we find that the Medical Director is usually a consultant in medical charge of a specialised unit or institution, for example, a cancer hospital. In such a case, the Medical Director has personal responsibility for the medical care of the patients in the unit or hospital.

24. The Medical Superintendent, on the other hand, tends to have a wider field of authority or supervision, and he is usually found in a sanatorium or mental or regional hospital. He enters to a much greater extent into the detailed administration of the hospital, and exercises control and authority over aspects of the hospital life which might otherwise be left to the nursing or lay administrator.

25. The medical staff committee, or board, with selection agreed upon by the staff, and with the chairmanship rotating, is generally accepted as the most effective method for internal medical administration in a general hospital, and is in fact, the one generally adopted in practice. In such cases this Committee is subordinate to the Board of Governors or Committee of Management which, however, includes representatives from the medical staff committee.

26. On the nursing side, the Matron, who is the senior nursing administrator, may have varying areas of responsibility. Thus, in many cases, in addition to nursing responsibilities the Matron may have overall responsibility for domestic staff, laundry, and in some cases, for catering. The tendency now, however, is to relieve the Matron of some or all of these non-nursing responsibilities.

27. So far as the lay administration is concerned we can say that it is in this sphere that there is the greatest difference between the health authority and voluntary hospitals.

28. It may be well, first, to explain briefly a feature of the Irish system of local administration which is not akin to that obtaining in Britain and many other countries. Over the past 30 years or so a system of local administration has been introduced whereby County and City Managers discharge most executive functions of the local authority with considerable freedom from intervention by their Council or Corporation.

These Managers, in general, exercise the same functions in respect of the health authorities. In fact it is interesting to note that their decisions in relation to what are referred to as 'individual health functions' or functions relating, *inter alia*, to decisions as to the eligibility or otherwise of individuals for health services, and the making or recovery, or amount if any charge for a service made available in respect of an individual, and decisions relating to the recruitment, discipline, promotion, superannuation, etc., of members of the staff are not subject to any control by the elected representatives of the health authorities.

29. The overall administration and control of the hospital services of a health authority is therefore one of the responsibilities of the County or City Manager. The discharge of their responsibility in detail is, however, normally delegated. The pattern which emerges is that the hospitals are controlled as follows:

Regional Hospitals:
The Resident Medical Superintendent (in one case a Lay Superintendent is also appointed).

Regional Sanatoria:
The Resident Medical Superintendent assisted by a Secretary/Clerk.

County Hospital:
The County Surgeon and the County Physician.

Mental Hospital:
The R.M.S. and the Chief Clerk/Secretary (jointly).

In each case, the Matron or Head Nurse assists the medical supervision, and, except with smaller institutions, separate clerical assistance is made available in the institution itself. Members of the administrative staffs of the County Council as health authority, assist the County Manager in the exercise of the controlling functions over the health services administered by him. The status and authority of the lay administrator in the health authority hospital is generally lower than that of the lay administrator in the voluntary hospital.

30. In the voluntary hospitals, while there is not any uniformity in the status, designation and functions of the lay

administrators, there has been a noticeable tendency in recent years for them to be given wider responsibility than heretofore, and to have this increased responsibility recognised in their status and salary.

31. As in the case of the health authority hospitals, there is some variation in the titles given to the senior lay administrator in different voluntary hospitals. For example, he or she may variously be referred to as the Secretary, Registrar, or Secretary/Manager of the hospital.

SELECTION AND TRAINING OF HOSPITAL ADMINISTRATORS

SELECTION

(i) *Health Authorities*

32. It is desirable, at the outset, to say a few words of explanation about a body which is prominently involved in the selection of administrators for the health authorities. Under the Local Authorities (Officers and Employees) Act, 1926, a body known as the Local Appointments Commission was set up—the members of which are appointed by the Government. This body has the function of recommending candidates for appointment to fill certain offices in the local government (including the health authorities) service. In general, for all the appointments to major or important posts—including all permanent professional posts—local authorities are required to follow a statutory procedure whereby they request the Commission for a recommendation for the filling of these posts. Local authorities are also required to appoint the candidate recommended by the Commission.

33. In determining the candidate or candidates to be recommended in a particular instance the Commission invites applications by public advertisement from persons who possess the qualifications prescribed for the post, and subsequently arranges to have such persons interviewed by a Selection Board appointed by them.

34. All medical posts in the service of health authorities—

with the exception of short-term temporary posts—are filled as a result of this procedure.

35. Similarly, posts of Matron and Assistant Matron, and the corresponding male nursing posts in mental hospitals, are filled on the recommendations of the Local Appointments Commission.

36. If we take lay administrative posts involved in hospital administration as including all those from County and City Manager down, referred to in paragraph 29, then we may say that County and City Managers invariably and Secretaries and Accountants of health authorities in general, are selected through Local Appointments Commission procedure; and that those at executive level, mainly staff officers, are normally selected locally by competitive interview by a Board (appointed by the City or County Manager) from members of a basic clerical grade recruited initially by open competitive written examination at University entrance level.

37. In practice, there is a very general tendency for those aspiring to promotion to the executive and higher grades to acquire post-entry educational qualifications, e.g., in Arts, Commerce or Economics at a University, in Accountancy or Secretaryship, or in the form of a Diploma in Local Administration awarded by the Institute of Public Administration.

(ii) *Voluntary Hospitals*

38. Senior medical staff in voluntary hospitals are, in practice, nominated by the medical staff Committee, subject to approval by the Board of Governors or Committee of Management.

39. Senior nursing posts are advertised, and filled by selection from the applicants by a joint committee of members of the medical and nursing staff and Board members.

40. Senior members of the lay administrative staff are generally recruited by advertisement and interview by a selection sub-committee of the Board of Governors or Committee of Management. Minor clerical appointments are generally made by the Secretary in consultation with the Chairman of the Board.

TRAINING

41. Until recently there has not been any formal scheme for the training as administrators of senior medical, nursing, and lay personnel engaged in hospital administration in either health authority or voluntary hospitals.

42. Senior medical staff have, from time to time, attended conferences, lectures and discussions arranged by their own professional bodies in which administrative problems have come under review. Some senior medical staff have also been granted fellowships by the World Health Organisation and other international bodies, and have been enabled to study administrative problems and their methods of solution in other countries.

43. Senior nursing staff have, in some cases, had similar opportunities to study nursing administration abroad. In addition, An Bord Altranais, the Irish Nursing Registration Board, which has responsibility, *inter alia*, for nursing registration, and for education and training of nurses, has recently organised and conducted courses for Matrons, and Sister Tutors in which various aspects of Nursing Administration have been dealt with. By arrangement with the National University, a special University Course of two academic years' duration has been provided for Sister Tutors.

44. The Institute of Hospital Administrators, in co-operation with the Vocational Education authorities, recently introduced a course extending over a period of two years leading to the award of a diploma in Hospital Administration. Many engaged in hospital administration, particularly on the lay side, have undertaken this course.

45. Within the past year, the Institute of Public Administration introduced a number of short courses in hospital administration for senior people in this field. These courses have met with a considerable and countrywide response, and have been attended by medical, nursing and lay administrators.

In addition, a number of people employed in health authorities have also attended courses in Organisation and Methods Work Study Appreciation, Machine Accounting and A.D.P.,

Stores Management and Purchasing, and Supervision, conducted by the Institute.

In view of the extent of the response to these courses, and the evident need for a formal scheme of training for those engaged in the hospital services, the Institute has decided to undertake as a regular feature of its training activities, the provision of a number of courses on hospital administration, and in management and other techniques likely to be of use to hospital administrators.

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ITALY

by

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THE STRUCTURE OF ITALIAN HOSPITAL ORGANISATION; DEVELOPMENT AND CONTEMPORARY PROBLEMS.

1. In Italy the present organisation of hospitals is not uniform: in spite of some reforms the present structure results from a group of institutions which were founded one after the other at different times and with different purposes, and which, for the most part, have maintained unaltered their fundamental characteristics.

Hospital organisation is based on local public bodies called 'Charitable and Public Assistance Institutions'; in modern terms this might be called 'nationalisation' of hospital services, hospitals previously having been either private or religious institutions.

In the beginning[1] hospital assistance had been undertaken by the Church or by private associations which had collected all legacies bequeathed by wealthy citizens for the care of the sick and needy in their areas.

The technical idea of the hospital as it is today, did not exist and hospital activity was concentrated largely on medical treatment and assistance for the sick and needy.

Thus hospitals, as general medical care institutions, were subordinate to 'Charitable Institutions' and there the part played by the Church was paramount.

The law of 17th July, 1890, no. 6972[2] (the bill was presented to Parliament by the then president of the Council of Ministers, Francesco Crispi) converted the previous Charitable Institutions into public bodies. The administration of these bodies was entrusted either to the 'Charity Congregations' then existing (which were a kind of committee of citizens concerned with public charity in general) or else to boards already provided for under the 'statutes'.

Therefore, each hospital came under the control of local public bodies. Nevertheless the fundamental distinction was maintained between the 'Charity Institutions' as the administrative bodies and 'Hospitals' as the administered institutions providing medical services. Because of this distinction the Government has been empowered by the law of 1890 to amalgamate the various charity institutions, which were often too small to be economically or technically efficient. In practice, State intervention was extremely limited because of the difficulty of amalgamating not only the charity institutions, but even the hospitals. In addition to these technical and economic reasons, there were political and administrative obstacles which were difficult to overcome.

The above mentioned law of 1890, with a few modifications introduced in 1923, is still the fundamental law governing the administration of the funds of charitable institutions. This allows the development of hospital activities, the functioning of the administrative agencies and the State supervision of these authorities.

The organisation of hospitals[3] however (as a complex of technical and medical services) for the admittance and medical assistance of sick persons (whether poor or not) is governed by the Royal Decree, 30th September, 1938, no. 1631, which lays down the general rules for the medical services and the staff of the hospitals, excepting those engaged in the administration.

This law, which led to the classification of hospitals under the control of all kinds of public bodies, including those under the control of local assistance and charitable institutions, detailed the standards to which every hospital had to conform in order to meet the hygienic and technical requirements. The same law made a distinction between general and specialised hospitals, the former divided into three categories according to the number of patients, and made subject to certain compulsory regulations; each hospital unit was then divided into departments for which a maximum and a minimum number of beds was fixed.

The same law regulated the selection standards for hospital physicians, and also their tasks, rights and duties. A medical director[4] was appointed as the technical co-ordinator for each

hospital. In each hospital department a chain of command was set up. At the top is a chief physician (responsible for all his department services) followed by his assistants and nursing staff (see table no. 1).

Thus, although the various types of hospitals, many of them of long standing, were kept and continued to be governed by their statutes as regard the administration of their funds and the appointment of their boards, their administration is now regulated by certain fundamental rules, one of which provides for unified State control (these rules are contained in the law of 1890). The standards of medical and technical services, however, were made uniform by the decree of 1938.

In this way satisfactory results were achieved: a pluralist structure was efficiently allied to administrative uniformity and equality of services; local communities were given the assurance that their hospitals were democratically organised, while over-centralization, that would have made hospitals top-heavy and deprived them of initiative, was avoided.

On the other hand, the uniform regulation of hospital services which applies to any public body managing hospitals was extended to new hospitals of the great social insurance bodies. Indeed, sanatoria, set up by INPS (the National Institute for old-age pensions and TB insurance) (see table no. 2), the traumatological hospitals run by INAIL (the National Institute for Industrial Accidents Insurance) (see table no. 3), the medical services organised by INAM (the National Institute for Health Insurance) (see table no. 4)[5], were adapted to the same principles as the hospitals managed by the local Charitable Institutions.

Only two fields of activity have been omitted from the system: first, psychiatric hospitals[6] which exist in all provinces and which are subordinate to the provincial administration on the basis of general principles laid down by the law of 14th February, 1904, no. 36 and homes for abandoned children, which also come under the authority of the provinces; secondly, university clinics which, when they do not rely on agreements with local hospitals, are governed by the principles laid down in the laws concerning the universities.

To sum up, hospital organisation[7] in Italy is dependent either on local *ad hoc* bodies (Charitable Institutions) or on the provinces and social insurance institutions. Uniformity is guaranteed—for the first group both by the law of 1890 as regards the administration and by the decree of 1938 as to medical practice, and for the second group either by special laws (lunatic asylums, homes for abandoned children, universities) or by the same decree of 1938 (see table no. 5).

2. Here it is important to explain the purpose of these hospital organisations.

It has already been said that formerly charitable institutions aimed at helping the sick and needy and, indeed, even today the law defines as a charitable institution any body whose partial or total aim is to give assistance to the poor.

Following from this, even charitable institutions that offer hospital care are bound to admit poor patients free of charge; but this is no longer one of the most important purposes of hospitals and not even they are obliged today—except in special cases—to give free assistance to the poor.

As regards the latter, the same law of 1890 established what was called the 'assistance by place of residence'[8]; that is, the 'commune', or official district of residence of the poor persons concerned, had to be identified and was made responsible for the cost of medical treatment and other expenses sustained by a charitable institution.

In fact, the duty of hospitals to give free assistance and treatment to needy persons concerns only cases of serious illness, when the patient has no right to 'assistance by place of residence' or to insurance sickness benefit.

Thus we have come to a subject which, at this moment, is much talked about in Italy: that of the relations between hospitals, 'communes' and the insurance organisations with regard to hospital expenses[9].

In theory, the situation is simple, hospitals are entitled to exact payment of charges either from the patient (if he has to pay for himself) or from the 'commune' (if he is a poor person who has a right to the 'assistance by place of residence' rule) or from the insurance organisations (if he is insured).

Obviously, it is not necessary to dwell upon uncommon cases, such as those in which the commune disclaims responsibility or passes it on to another commune; or when a commune alleges the existence of an insurance liability or vice versa.

In such cases of disagreement between hospitals on one side and subjects expected to pay on the other, Italian law provides for special procedures designed to guarantee a rapid solution of the problem, so as not to leave hospitals too much at the mercy of undischarged debts.

The most serious case is that in which the insurance organisations refuse to pay the hospital charges of one of its clients.

There are, of course, a lot of pretexts but the one which has given rise to the greatest number of disputes was the refusal, on the part of INAM, to recognise the decisions taken each year by the hospitals, to increase their charges.

The law now lays down that charges should be fixed in accordance with total expenditure during the preceding year, thus arriving at an estimate which is likely to cover future commitments.

At present, the greatest number of patients consists of insurance beneficiaries. While, therefore, it is bad enough when there is a refusal to recognise the charges approved by the hospitals, it is even worse when the insurance organisation refuses to pay the compensation allowed by its own terms.

This has indeed brought about an extremely difficult situation both because of the many legal controversies and because hospitals have been deprived of a part of their regular income and have therefore run into a heavy debt.

It may now be asked why there has been and is no intervention by the State; that is by the Ministries, whose business it is to supervise both hospitals and insurance organisations.

It is possible to give a formal reply to this question by pointing out that administrative authorities cannot intervene on problems concerning rights, the solution of which belongs only to judges, and that the autonomy of the various organisations had to be fully respected when such a right is claimed against a third party.

In fact the Government did not intervene because they have no clear idea of a solution to the problem of relations between hospitals and insurance organisations.

Disagreement between the two sides is due to the attempt by insurance organisations—and particularly by INAM—to take upon themselves the control of the charitable institutions. They attempted to do this by infiltrating their own representatives into the board of management of the institutions in order to engineer changes in their statutes and thereby gain control of them[10].

Thus, we have a repetition of the struggle between the State and private or religious bodies, which, as already recounted, ended with the law of 1890, in the victory of the State and marked the end of private assistance in favour of public assistance.

The problem now consists in seeing whether participation by insurance organisations in hospital management can be limited to purely insurance matters, or if they can interfere with day-to-day management in order to cut down costs. If the former principle can be established, the insurance organisations will leave technical considerations and the treatment of the sick to the hospitals themselves.

It is obvious that there is one major reason for the struggle between the two bodies: that is, the attempt by insurance organisations to cut the costs for which they have to pay.

3. We are, then, in Italy, faced with a crisis in hospital services[11] and it is necessary, at this point, to give some further explanation: this means that we must take into consideration how general hospitals fulfil their functions (we can ignore special hospital establishments, like for instance, lunatic asylums, homes for abandoned children, sanatoria, etc.).

It is well-known that these general hospitals are now feeling the effects of new medical discoveries and techniques.

For large hospitals of the first category (see table no. 6) (as for instance large town hospitals) it has not been difficult to adapt services to the new techniques of treatment and, apart from the classical departments of medicine and surgery, to establish specialised sections, and it can be said that the average

standard of performance is fairly high. But hospitals of the second and third category (such as small town or rural district hospitals) are today in serious straits.

Finances (for the most part corresponding to the number of beds already available) do not permit the establishment of new departments, and in general in second category hospitals, obstetrics, radiology and a traditional specialisation like ear, nose and throat diseases or ophthalmology are the only departments in existence (see table no. 7). Third category hospitals—having a daily average of 30 to 200 patients—are limited to general medicine and surgery, relying on the nearest and better equipped hospitals for specialised treatment and consultation.

Under such circumstances, it is obvious that it is necessary to reorganise the hospital service; third category hospitals are, in reality, little better than sick-bays, that is places where medical treatment is limited to what is easiest and centres for diagnosis or transfer of patients to better equipped hospitals.

Next, the problem arises as to the changes to be introduced in second category hospitals (from 200 to 600 beds daily) which have either to be developed, in all their departments, or to be highly specialised, in order to link them with higher units at the provincial level. Thus the problem of costs could partially be solved.

But all this encounters one great difficulty, the autonomy of hospital institutions does not allow outside interferences with their functions as laid down in their statutes. There is also the important sociological factor of local prestige; this would not permit either closing the hospital or any specialisation which might mean its ceasing to be the hospital of the local commune and regarded by everyone as such.

4. Taking into account these requirements, the Italian Government has worked out a bill for the reform of hospital organisation, which was introduced in the Chamber of Deputies on 10th November, 1961[12].

By this reform all medical institutions are divided into hospitals, hospitals for the chronic sick and convalescent homes.

As to the first of these, the Government report on the bill stresses the fact that a rational hospital organisation must be in

a position to assure not the same treatment at all levels, but the same quality of treatment at each level.

This means that the distinction drawn between the various types of hospitals must take into account the range of treatment available rather than the method of treatment, since this—in both small and large hospitals—is supposed to be the same.

From this point of view the bill provides for the following categories:

1st Central hospitals
2nd Principal hospitals
3rd Hospitals

The first category must be self-sufficient in all respects and must include the departments of medicine, surgery, obstetrics and gynaecology, paediatrics, infectious diseases, ophthalmology, ear, nose and throat diseases, traumatology and orthopaedics, dermosyphilopathy, urology, neurology, dentistry and stomatology, unless some of these specialised treatments are provided for by local institutions.

Moreover, they must also have separated services for radiology, physiotherapy, pathological anatomy, chemical, clinical, microbiological and virus researches, anaesthesia, reanimation and transfusion.

In their turn, principal hospitals are expected to have the same departments as the central ones, except for neurology, dermosyphilopathy, dentistry and stomatology, for which some services will be enough.

Both central and principal hospitals must also have medical auxiliary services and, in any case, a residential school for professional nurses and a school for male nurses.

In third category hospitals, apart from the services of radiology and analysis, of anaesthesia and reanimation, and of transfusion, separate sections of general medicine, surgery, obstetrics and gynaecology and paediatrics are expected to exist.

In order to permit a more rapid adaptation to the requirements of the hospitals in existence, the Governmental bill for the reform of hospital organisation lays down that the provincial

medical officer, who is the representative of the Health Ministry in the province, draws up a 'provincial hospital plan', in which he defines the range of activity of every institution in order to co-ordinate it with the others operating in the province. Furthermore every financial engagement of the institutions themselves is subject to the approval of the provincial plan.

This bill has given rise to many discussions and controversies, since some believed it too revolutionary, and some too moderate. In reality, it does not tackle the fundamental problems of the Italian hospital organisation.

To solve these problems, it would be necessary not only to institute a classification of hospitals, but also to completely transform them. Such a transformation, however, cannot be brought about by a plan worked out in the office of the provincial medical officer without the co-operation of all those interested in hospital organisation.

This bill, however, is bound to come to nothing if regions are established in Italy. Indeed by Art. 117 of the Constitution, regions would be entrusted with legislative authority regarding 'charity, medical and hospital assistance'. It is obvious that every region, being a democratic institution aware of local needs, will be able to draw the lines for future development of hospital organisation within the limits of the general principles established by the national Parliament (see table no. 8).

5. Up to now, we have considered the principal lines of hospital organisation, and contemporary problems. It is now necessary to point out both its elective and administrative structure.

As we saw before, each hospital is in general governed by a charitable institution and therefore, in practice, the hospital is administered by the board of management[13] of the institution itself. The only exception is the case in which the hospital is dependent on a commune rather than on a charitable institution. This means that it is administered by the commune representatives; all measures are taken by resolutions of the Town Council, which acts as a Board of Management.

In the charitable institutions, however, the boards of management are appointed in several different ways. As it was

mentioned before, the institutions are autonomous bodies having their own special statutes. Except in a few cases (i.e., the exclusion of governmental and communal employees from membership) the law is fairly liberal, so that it is not possible to find a uniform scheme for the membership of charitable institutions. It must be added that members of these boards are always appointed by some public authority and are not directly elected by the people; thus, for instance, a board of management consists of two representatives appointed by the Town Council, two others appointed by the provincial council and one appointed by the Prefect; in other cases this power of appointment belongs to other authorities such as the Provincial Assistance and Charity Committee and sometimes even to local church authorities. However, physicians employed in the hospital never take part in the board of management; only infrequently are freelance physicians admitted. So there is no direct link between board management and technical services.

However, a liaison between the two is made possible by permitting the administrative secretary (who, in some statutes, is also called the secretary director, the managing director or the general secretary) and the medical director (a physician) to attend meetings of the board of management. This privilege is limited to formal attendance and the right of an advisory vote (in some cases the latter is compulsory).

Thus, the managing director must subscribe to all proceedings of the board, thus taking upon himself their responsibility, but he may be relieved of his responsibility if he directs that his dissent is recorded in the minute.

The medical director, in his turn, submits the measures concerning the medical and nursing staff to the board and expresses his opinion on the subject of appointments, job allocations and disciplinary measures; together with his own observations he gives the reports of the health officers. Finally, he gives advice regarding the selection and purchase of apparatus as well as anything else which might be required in the hospital.

With the advice of the two directors—the most important being the managing director, who co-operates with the President, who is the executive of the hospital administration—the board of management takes all measures concerning the hospital

activity. When, however, these measures concern balance sheets, investment of funds, the size and character of the establishment of internal regulations[14] they must be submitted for approval to a State agency, namely the Provincial Charity and Assistance Committee, which is composed of the Prefect, who acts as a chairman, of other State officers and also of members elected by the Provincial Council or appointed by the trade unions.

The scope of administrative supervision is rather limited, although, in practice, hospital administration tends to increase the number of measures to be submitted for approval to the boards, in order to be relieved of some of their responsibilities.

Here it is necessary to point out that the Prefect can always demand that a resolution of a charitable institution be submitted to him and he can cancel it if he thinks that it is unlawful. The Prefect can also send commissioners to defend the institution's interests, if a hospital administration, even after a warning from the Prefect, continues to disregard the regulations of law or to prejudice its own interests. In the most serious cases, the board of management may even be dissolved and then the commissioner assumes temporarily (no longer than three months) all the powers of the dissolved body. These powers are then transferred to the new administration.

This system of hospital administration, dating back to the law of 1890, is based on the liberal *laissez-faire* principles of that time. In the different social, economic and political climate of today, there is much greater need for the State to lay down broad general principles to bring about better co-ordination and stimulate development by those bodies responsible for national medical services.

It is just for that reason that today—as we mentioned before—the idea of giving planning authority[15] to governmental bodies has become popular. This would remove some of the major disadvantages to be found in the autonomous system of Italian hospital organisation of today.

It is not possible to say much about the internal organisation of Italian hospitals, since this depends, to a large extent, on the size of each hospital and individual requirements.

As a general rule, there are many departments[16] subordinate to the secretary director: namely, the accountant's department, the steward's office (purchase and distribution office), the reception and admittance office, with financial office (which is concerned with patients' fees), the personnel office, etc. This matter, however, is regulated by each hospital. They also regulate the procedure to fill vacant posts by a system of public and internal competition (the latter being reserved for employees of the hospital concerned).

The same procedure is followed when appointing a general secretary director, while there are legal regulations governing public competition for the appointment of the medical director.

It would, however, be desirable that, at least with regard to the appointment of the secretary directors, the State laid down the general rules of procedure and the qualifications required.

6. This lack of uniformity in hospital organisation, resulting from the autonomy of the various charitable institutions controlling them, also explains why schools or training and finishing courses for administrative employees do not exist. Only recently have the two organisations concerned with these matters—on one side the hospitals and on the other the secretary directors—taken the initiative by holding courses and study meetings every year[17].

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NOTES

[1] For the history of Italian Hospitals see NASALLI ROCCA E., *Il diritto ospedaliero nei suoi lineamenti storici* (Milan 1956), p. 244, Biblioteca della rivista di storia del diritto italiano, 20. Moreover, at Reggio Emilia, two national congresses on hospital history were held in 1956 and in 1960, the proceedings of which were published (Bologna 1962, Reggio Emilia 1962). In this town, under the auspices of the first congress, a *Centro di studi di storia ospedaliera* (Research centre for hospital history) was established. See also BUGLIONE DI MONALE A. *Beneficenza ed assistenza* in 'Cento anni di amministrazione pubblica', special issue of 'Amministrazione civile', 1961, XLVII-LI, 371-394.

[2] For the law of 1890 concerning public assistance and charitable institutions see LUCHINI, *Le istituzioni pubbliche di beneficenza nella legislazione italiana* (Florence 1894); LONGO, *Le istituzioni pubbliche di beneficenza* in 'Trattato Orlando', VIII, p. 387 on; GILARDONI, *Delle istituzioni di beneficenza* (Turin 1907); D'AMELIO S., *La beneficenza nel diritto italiano* (Rome—Padua 1930); LENTINI, *Commento alla legislazione sulle istituzioni pubbliche di assistenza e beneficenza* (Naples 1934).

[3] For the Royal Decree, 30th September, 1938, no. 1631, see PAPPALARDO, *Il nuovo stato giuridico dei sanitari ospedalieri* in 'Rivista del pubblico impiego', 1939, I, 29.

[4] See PULCHER, *Funzioni e compiti del direttore sanitario di ospedale*, in 'Nuova rassegna', 1956, 621; DE GAETANO, *Lo annoso dibattito sulla direzione degli ospedali*, ib., 1957, 754.

[5] A description (dated 1957) of the medical equipment of the Social Insurance Institutions is given in CAMERA DEI DEPUTATI, SENATO DELLA REPUBBLICA, *Relazioni della commissione parlamentare di inchiesta sulle condizioni dei lavoratori in Italia*, vol. XII, Previdenza sociale (Rome 1962), 21-268.

[6] SIRACUSA, *I manicomi* (Rome 1931); SOLMI, *La provincia* (Padua 1961); *Atti del convegno di studi per la riforma degli ospedali psichiatrici* (Milan 1956).

[7] In general, for the present hospital organisation, see CORTESE G., *L'organizzazione ospedaliera*, in 'Annali Ravasini', 20th November, 1960; A.A.I., *Organi ed enti di assistenza pubblici e privati in Italia* (Rome 1953); BERNABI A., *La situazione ospedaliere in Italia* (Rome 1952); TIZZANO A., *Gli istituti di cura in Italia*, in 'Notiziario dell'amministrazione sanitaria', 1956, January; FURINO P., *L'organizzazione ospedaliera*, I (Turin 1960).

[8] For the 'assistance by place of residence' and hospital charges regulations, see ROHERSSEN G., L'*ordinamento del soccorso ospedaliero legale e le spese di spedalità*, in 'Rivista Amm.', 1941, 3, 73, 145; ROMANO A., *La legge* 26 *aprile* 1954 *sulle spedalità e il domicilio di soccorso*, in 'Amm. it.', 1955, 1055. Among preceding texts see: *Domicilio di soccorso, spedalità, azione popolare sulla legge sulle istituzioni pubbliche di beneficenza* (Rome 1914), report of the Director General (PIRONTI) of the 'Amministrazione civile' (local government); CATALDI G., *Le legislazioni speciali* (Bologna 1956), p. 215 on.

[9] On the subject see *La retta ospedaliera ed i rapporti congli enti mutualistici ed assicurativi* (reports by GENNAI TONIETTI, GIULIANI, BARTOLINI) in 'Atti del primo convegno di studi sull'azienda ospedaliera' (Milan sd) 149-179; LIXIA A., *La regolamentazione delle rette ospedaliere*, in 'Annali Ravasini', 1960; GIARDINA C., *Il problema ospedaliero*, in 'Rassegna sanitaria', 1960, 156. Also examine the following circulars: Ministry of the Interior, 3rd May,

1950, no. 48; Board of Health, 3rd May, 1950; Min. of Int., 25th April, 1958, nos. 15, 100, 119; Ministry of Health, 20th June, 1959, no. 71 in 'Corr. Amm.', 1959, 1950-1951.

[10] These attempts met with the opposition of the judiciary, see: Cons. Stato, *Ad. Plen.*, 9th December, 1959, no. 16, in 'Riv. Amm.', 1960, 97-100; on this subject see also MARAFIOTI D., *Sulle rappresentanza degli enti previdenziali nei consigli di amministrazione dei pubblici ospedali*, in 'Riv. It. Prev. Soc.', 1960, 373-382.

[11] On the general deficiencies of the present public health and hospital structure see SPALTRO E., *Esiste una politica sanitaria*, in (CUR); POZZANI S., *Il paese come se* (Milan 1961) 329; BALBI R., *L'ospedale in Italia*, in 'Nord e Sud', 1961, LXXVI, 14-28; COPPO D., *Per una riforma ospedaliera*, in 'Problema della sicurezza sociale', 1960, 775-780; PERRINO A., *Il problema ospedaliero meridionale*, in 'Atti del convegno nazionale' (see note 14).

[12] Cf. *Atti parlamentari*, III legislature, Camera dei Deputati, Documenti n. 3356. On the recent trends for reform see MACCOLINI STERNINI, *Nuovi orientamenti in tema di amministrazione sanitaria ospedaliera*, in 'Annali della sanità pubblica', 1953, n. 2; SORGE G., *Nuove prospettive dell'assistenza ospedaliera*, in 'Atti del convegno' (quoted).

[13] For hospital administrators see POTOTSCHNIG U., *Osservazioni in margine alle responsabilità patrimoniali degli amministratori ospedalieri*, in 'Atti del I convegno di studi' (quoted) 65.

[14] On this subject see *Autonomie, controlli e decentramento ospedaliero* (reports by SANTI, SABBADINI, BERTORELLI) in 'Atti del I convegno' (quoted), p. 33-61; POTOTSCHNIG U., *Autonomie e controlli nel governo degli ospedali*, in 'Associazione regionale PUGLIESE-LUCANA ospedaliera, Atti del convegno nazionale di studi ospedalieri', Selva di Fasano, 24th-28th September, 1960 (Brindisi 1961) 64-75.

[15] See GENNAI TONIETTI E., *L'amministrazione centrale e gli ospedali pubblici*, in 'Atti del convegno nazionale' (quoted) 83 on; BONOMO V., *Il coordinamento degli ospedali* (quoted) 140 on.

[16] See, in general, the description in BEARZI G., *Amministrazione e contabilità nell'ospedale moderno* (Milan 1952) and also the reports, *La contabilità ospedaliera*, in 'Atti del I convegno' (quoted) 127-148; ARDEMANI E., *L'azienda ospedaliera e le sue esigenze contabili*, in 'Atti del convegno nazionale' (quoted), 56.

[17] Apart from the congresses quoted in the preceding notes see also *Il simposio sui problemi ospedalieri*, Rome, 14th-18th May, 1960 and the *Convegno di studi ospedalieri*, La Mendola 1958, the proceedings of which have been published (*L'ospedale, pubblico servizio*, Milan 1959).

(Eight tables of statistical information will be distributed at the Conference).

PORTUGAL

by

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1. THE PORTUGUESE CONCEPT OF HOSPITAL

1. Throughout the centuries the Portuguese hospital, as a social institution, was influenced by the fundamental traits of each epoch; it was dispersed, theocentric and technically rudimentary in the Middles Ages; it was concentrated, humanised and administrated by representatives of the Crown in the Modern Age, the epoch of the concentration of political power and trade bourgeoisie; it was secular and scientific in the centuries of liberalism and positivism; it is national and social in the present epoch.

2. The present concept of hospital is summed up in the following extract from an Act now being debated in the National Assembly (the Statute of Health and Public Assistance) which reads in Section XII as follows:

'The aim of hospital activities is to provide, in hospitals or in connection with them, medical care and medical rehabilitation and to collaborate in preventive medicine and social and professional rehabilitation. The nature of the activity of general hospitals, as well as of hospitals specialising in any branch of medicine, must be simultaneously medical and social and, when practicable, hospitals shall co-operate in teaching and medical research. Therefore the following must also be considered as aims of hospital activity:

(*a*) To co-operate with social services in all aspects of problems relating to illness;

(*b*) To provide a field of demonstration and practice for training schools in any way connected with the medical profession and health.'

3. On analysing the above legal extract, which has been integrated and developed in the plan for the new Hospital Act, also in preparation, the Portuguese concept of hospital can be drawn up as follows:

(*a*) The hospital is an institution having not only a medical but also a social character;

(*b*) It has its own duties and an obligation to participate in other activities;

(*c*) Its own duties are to provide medical care and medical rehabilitation;

(*d*) Its participation in other activities cover the aid the hospital must give to:

preventive medicine;
professional rehabilitation;
teaching and scientific research.

4. Hereinafter I will try to set down the most essential details of each of the aforementioned functions, explaining how they are conceived and carried out in Portugal.

2. THE PORTUGUESE HOSPITAL AND MEDICAL CARE

1. The bulk of medical care in Portugal is carried out by the hospital through its in-patients department, out-patients department and domiciliary services.

2. There are general hospitals and hospitals specialising in maternity care, tuberculosis, psychiatry, etc., the latter being dependent on special 'Institutes' which co-ordinate the respective services.

3. The Social Insurance System, through the Ministry of Labour, has a wide network of Centres in which about 2,000,000 people have the right to first aid or to consult a doctor. These Centres have no in-patients department.

There is an agreement between the Social Insurance Service and the hospitals whereby the latter admit and treat patients covered by Social Insurance, the cost being settled by the said insurance. For the time being, however, this agreement applies only to general surgical operations.

4. The doctors on the hospital staff can have their private patients admitted to special rooms in the hospital reserved for private patients.

5. The salary of the doctors on the hospital staff is composed of two parts: a fixed salary according to the doctor's category on

the staff and a floating salary resulting from the division of fees paid by his patients. (It should be pointed out that it is not only the doctor who benefits from this division of fees but also his technical auxiliaries and the nursing staff.)

6. The main lines on which our hospitals are run are summarised in Section VII of the new Hospital Act which reads as follows:

'Section VII—1. Hospital care shall adhere to the following guiding rules:

(1) The main aim is the medical care and the medical rehabilitation of the patient. All other aims are to be considered as accessories to this main aim.

(2) Patients shall only be admitted to hospital when they cannot be treated as out-patients or at home.

(3) The specialisation either of hospitals or of services shall be restricted to the cases in which this is technically indispensable but the need for close collaboration between the general hospitals and the specialist hospitals must always be borne in mind.

(4) Continuity of treatment shall always be carefully assured when the patient has to be transferred to another hospital or to a different department of the same hospital.

(5) The criterion for priority for admission to hospital shall be based on the medical and social needs of the patient. Under no circumstance whatsoever shall the amount payable by the patient, either directly or indirectly, be used as a reason for granting priority.

(6) Treatment will not necessarily end just because the patient is allowed to go home. It is up to the hospital to keep in touch with the patient until he is fit to return to work, or even afterwards, in order to establish an efficient follow-up of the case.'

3. THE PORTUGUESE HOSPITAL AND MEDICAL REHABILITATION

1. As Portugal did not enter the last war, the problems arising from mutilation, lesions and other forms of physical disabilities are not so great as in other countries. The attention

of the Government has been drawn to this sector of medical and social activity, however, by the increasing number of accidents on the road and at work and by the possibilities that modern science can afford for the elimination or reduction of sensorial, physical, motor or visceral incapacities.

2. The hospital has taken upon itself not only the phase pertaining to medical care and medical rehabilitation but has also committed itself to collaborate in social and professional rehabilitation.

3. The plan, already partially in operation, comprises the following:

(*a*) *In the hospital:* medical care and medical rehabilitation services;

(*b*) *Outside the hospital but in liaison with it:* special centres for physical medicine and rehabilitation.

4. All hospital services are being encouraged to take part in the new orientation being given to medical rehabilitation, particularly in connection with orthopaedics, traumatology, neurology and neurosurgery and physiotherapy.

5. Apart from the usual funds allocated to the hospitals by the Government, 50% of the net proceeds of the Football Coupons have been set aside for the treatment of the physically handicapped. (It should be pointed out that the Football Coupons are run under the auspices of the State.) This grant will finance not only the medical phase of rehabilitation but also the non-medical phase which comes under the Public Assistance Board.

Three Physical Medicine and Rehabilitation Centres are being built at the moment, one in each of the hospital zones into which the country is divided.

4. THE PORTUGUESE HOSPITAL AND PREVENTIVE MEDICINE

1. Health is, in itself, a unitary concept. It is essential that services dealing with health problems should bear this concept in mind.

2. Bearing this principle in mind, Portuguese health legislation allows Public Health Officers to work, in their capacity,

in hospitals. In the more outlying districts, these Officers have more responsibilities: Therefore:

3. Section XXXIII of the new Hospital Act predicts that there shall be a representative of the Public Health Service on the Board of Directors of the hospitals.

4. On the equivalent of the British Regional Hospital Board ('Comissão Inter-Hospitalar'), as is explained hereinafter, there is always a representative of the Public Health Service from the area in question.

5. Health Centres, dependent on the Public Health Service, will operate in the country hospitals, known as sub-regional hospitals, in installations granted them specially for this purpose.

5. THE PORTUGUESE HOSPITAL AND TEACHING

1. As has been seen from the guiding rules quoted above from Section VII of the Hospital Act, the main aim of all hospitals is the medical care and medical rehabilitation of the patient. All other aims, including teaching and research, are considered as being secondary.

2. There are, however, special teaching hospitals where medicine, nursing and other subjects connected with health services, are taught. These hospitals are called 'teaching hospitals'. There are three in all, one in Lisbon, one in Oporto, and one in Coimbra, functioning in liaison with the respective Faculties of Medicine.

3. Teaching hospitals, like any other hospital, are integrated in the general organisation for medical attention in this country and also come under the Ministry of Health and Public Assistance which administrates them through a staff appointed by the Minister.

4. There is always a representative of the Faculty of Medicine on the Board of Directors of these teaching hospitals. Under Portuguese law, the Administrator of a teaching hospital may be a Professor of Medicine, but not necessarily, and is appointed in agreement with the Ministry of Education. On the other hand, the Faculties of Medicine have representatives with

the right to vote both on the Board of Directors and on the Medical Committee. Lastly, the direction of each of the hospital departments goes by right to the professors of the corresponding Chair in the Faculty of Medicine. If there is no Chair corresponding to the hospital department in question, the Ministry of Health, when appointing a Director for the department, gives the post in preference to Professors or Doctors in Medicine.

6. HOSPITAL REGIONALISATION IN PORTUGAL

1. The first Act establishing the basis for hospital regionalisation in Portugal was Act 2011 dated 15th April 1947. Under this Act, the country was divided into three zones (North, Centre and South), the capitals being the university cities of Oporto, Coimbra and Lisbon. Each zone is divided up into regions which normally correspond to the districts of the administrative division of the country. Each region is further divided up into sub-regions which also normally correspond to an area coming under local municipal authorities. In the head of each hospital zone, there are central hospitals which are the most advanced in the organisation and must therefore aid and guide the regional hospitals. Some of these central hospitals are also teaching hospitals.

In the head of each region, there is a regional hospital and in the head of each sub-region, a sub-regional hospital.

2. We feel justified in calling the Portuguese regionalisation system an advanced one seeing that the hospitals are, so-to-speak, on a scale and are classified according to the standard of medical treatment they must provide. The medical duties of each hospital are concerned not only with its own functions but also with those of the hospitals under it. The hospitals at the top of the scale give every aid and backing to the hospitals lower down the scale.

3. The sub-regional hospitals are at the bottom of the scale. Their function is to provide their area with general medical and surgical care, obstetrics and, when necessary, accommodation for isolation cases.

These sub-regional hospitals are situated in the municipal areas.

4. The regional hospitals are in the middle of the scale and provide, for their area, general medical and surgical services, obstetrics and isolation, as is the case with sub-regional hospitals, and also all current specialist treatment. These hospitals treat the patients from the sub-regional hospitals when the state of health of the patient is very serious and exceeds the technical capacity of the sub-regional hospitals.

These hospitals must also guide the sub-regional hospitals existing in the regional area, and establish a liaison with the hospital at the top of the scale (the central hospital).

5. The central hospitals are the apex of the organisation and deal not only with current specialist services, as is the case with regional hospitals, but also with rare specialist cases. Our aim is to make each zone technically autonomous and to supply each zone with all the working elements required for a fully comprehensive unit with the capacity to resolve all medical problems in their area.

6. The Portuguese system of hospital regionalisation can only be efficient so long as each zone has committees capable of co-ordinating the hospital services under their jurisdiction, drawing up the plans for regional activity and controlling and supervising the execution of these plans. Hospital regionalisation entails transferring responsibilities from a central office to the zone or regional hospital authorities and, needless to say, the setting up of an efficient service to supervise and control the actions of the latter.

7. In each head of a zone, there is a Zone Director who is the permanent delegate of the 'General Direction of Hospitals' to the hospitals in the area. In each of these regions there is also the equivalent of a British Regional Hospital Board ('Comissão Inter-Hospitalar') formed by representatives of each type of hospital in the area in question, whether general or specialist, central, regional or sub-regional.

8. Each 'Comissão Inter-Hospitalar' has a Plenary Coun-

cil which sets the policy for the hospital activity and approves the major plans and an Executive Council which is entrusted with the execution of the decisions taken by the Plenary Council or of instructions from the General Direction of Hospitals.

9. The main characteristic of the Portuguese regionalisation system lies precisely in the fact that the members of the 'Comissão Inter-Hospitalar' are elected by the actual hospitals and that their duties are limited to orientation and co-ordination and not to hospital management.

10. In actual fact the 'Comissão Inter-Hospitalar' in Portugal is formed not by civil servants but rather by representatives elected by the actual hospitals. On the other hand, it has no administrative duties, the latter being entirely in the hands of each individual hospital. The functions of the 'Comissão Inter-Hospitalar' are limited to co-ordination, orientation, encouragement and supervision There can however be collective services for the transportation of patients, for purchases, statistics, etc.

11. At each of the regional hospitals there is a Bed Bureau to which the patients who cannot be treated by the sub-regional hospitals may apply to find out which hospital is more suited to their particular case. This Bureau reserves the beds for these patients and notes why the sub-regional hospital was unable to treat them.

12. These Bed Bureaus are essential in the Portuguese regionalisation system because patients are only transferred to other hospitals when it is proved that there are medical reasons for doing so. The Bed Bureau must be informed why the hospital was unable to treat the patient.

The Bed Bureaus work not only in liaison with the regional hospitals but also with the 'Comissões Inter-Hospitalares', the latter being the apex of the organisation.

13. The regionalisation movement is already in operation. More than half of the country has been brought under this system and it is hoped that it will be in operation all over the country by the end of the first trimester of 1963.

7. OWNERSHIP AND ADMINISTRATION OF THE HOSPITALS IN PORTUGAL

1. As regards ownership, upkeep and administration, there are two types of hospitals in Portugal: public hospitals and private hospitals.

Public hospitals are founded, supported and administered exclusively by the State. The private hospitals are founded, supported and administered by the 'Santas Casas da Misericordia', or by other private institutions, although the State grants them considerable financial aid.

2. The 'Santas Casas da Misericordia' are private institutions which came into being in the XVth century as brotherhoods.

There are a total of 14,000 beds in the 'Misericordia's' hospitals, i.e., 60% of the general hospital beds.

3. Hospital activity is nowadays a public function to which no State can remain indifferent. It is one of the most pressing collective necessities and nationalisation is therefore accordingly fully justified.

4. The problem, however, is to know whether special conditions existing in some countries might not make it advisable to permit the ownership and administration of hospitals to remain private but to subject them to State orientation and supervision.

In my country we are trying to maintain this alliance between the private character of the hospitals and State supervision.

5. As regards the general hospitals, the State owns and administers directly only the central hospitals and the teaching hospitals. The other general hospitals belong to the 'Santas Casas da Misericordia'. In Oporto, however, there is a central hospital belonging to the 'Santa Casa da Misericordia'.

6. But, no matter whether public or private, all hospitals are integrated in the same regionalisation system on a national level, all come under the technical orientation of the Ministry of Health and all are subject to the administrative tutelage of the State which approves their budgets and audits their reports.

7. The administration of the private hospitals belongs to a 'Board' formed by citizens elected by the General Assembly of the 'Misericordia'. In the more progressive hospitals, however, there are qualified Administrators responsible to the Board for the management of the hospital.

8. THE FINANCING OF THE HOSPITALS

1. Funds for the financing of the hospitals are obtained from the following sources:

(*a*) The fees paid by the patients who can afford to do so;

(*b*) The Municipal Authorities who pay the fees for needy patients domiciled in their area;

(*c*) The Social Insurance Service which is responsible for its insured in the terms of the agreement already mentioned;

(*d*) The hospitals themselves from income from private property or from the exploitation of services operated through the hospitals;

(*e*) The State which makes up for any deficiency in the aforementioned sources.

2. The portion payable by the patients depends on their financial status and is assessed by a means test; there are accordingly patients who pay the full fees, whereas others pay only a part or nothing at all.

3. The Municipal Authorities pay a portion of the cost of the daily upkeep of the patient. This portion is variable depending on the category of the hospital.

4. The Social Insurance Service pays in the terms of the aforementioned agreement but, for the time being, this applies only to general surgical operations. Their responsibility is limited to 20 days stay in hospital.

5. The hospitals own property, sometimes exceedingly valuable, the income from which goes towards its running costs.

6. Lastly, the State, through the Ministry of Health and Public Assistance, grants subsidies to the hospitals, the rate being that which will assure their proper functioning and in accordance with the needs of the hospital.

9. THE CONSTRUCTION AND EQUIPPING OF THE HOSPITALS

1. The Committee for Hospital Constructions, under the Ministry for Public Works, is presided over by the Director General of the Hospitals. This Committee is responsible for the construction and remodelling of the public hospitals and, in the case of private hospitals, gives technical guidance.

2. A Committee was also formed for the re-equipment of the hospitals and is annually granted funds from the State Budget. These funds are used to carry out the plans drawn up by the 'Comissões Inter-Hospitalares' and passed by the Minister of Finance and the Minister of Health.

10. THE ADMINISTRATIVE STAFF OF THE HOSPITALS

1. A distinction must be made between the regimen applicable to public hospitals and the regimen for private or 'Misericordia' hospitals. A further distinction must be made between the managing staff and the purely executive staff.

2. In public hospitals the managing staff (administrators and heads of departments) are chosen from candidates holding a university degree and with administrative experience. A Course for hospital administrators has not yet been started but will start under the National School for Public Health, the foundation of which depends on a new law pending for debate in the National Assembly.

3. The executive staff of the public hospitals all follow a common career in the services of the Ministry of Health. The members of the staff are admitted or promoted by means of an examination.

4. Both the managing staff and the executive staff of the public hospitals are civil servants.

5. The administrative staff of the 'Misericordia' hospitals have, up to now, been appointed freely by the Board of Directors without any special qualifications being required.

6. However, under a new regulation being gradually applied to regional hospitals, this freedom of appointment has been limited by the following conditions:

(*a*) The administrators and head clerks can only be chosen from candidates who have passed an examination set by the General Direction of Hospitals;

(*b*) The executive staff can only be chosen from candidates who have passed a similar type of examination and who hold academic qualifications on a high school level.

7. A Course in Hospital Administration has already been held for Head Clerks and it is hoped to hold a similar course for Administrators soon.

11. THE GENERAL DIRECTION OF HOSPITALS

1. The General Direction of Hospitals, formed under Decree 43,853 of 10th August 1961, comes under the Ministry of Health and Public Assistance and must guide, co-ordinate, supervise and control the activity of public and private hospitals.

2. The General Direction of Hospitals is being organised on an essentially technical basis and responsibility is being gradually delegated to the zone and regional hospital authorities.

3. Its central offices comprise the following departments: medicine, pharmacy, nursing, social services, management and regional organisation, which are backed by a central department of Archives, Library, Statistics and General Information.

4. In the head city of each zone, there is a Director who presides at the 'Comissão Inter-Hospitalar'. This Director is the representative of the General Direction of Hospitals for the area and must see that the instructions from headquarters are carried out. He is also responsible for drawing up, and execution of, the hospital plan for the zone. In each region there is a regional delegate.

October 1962

PORTUGUESE HOSPITAL SERVICES ON 31/12/60

Map I—Total Number of Hospitals and Beds

Classification	*Units*	*Beds*
General Hospitals	267	21,086
Mental Hospitals	11	6,441
Tuberculosis Hospitals	96	10,093
Maternities	15	1,082
Cancer	1	300
Cottage Hospitals	39	1,823
Nursing Homes	118	8,751
Total	447	49,576

Map II—Public and Private Hospitals

Classification	*Public Hospitals*		*Private Hospitals*	
	Unities	*Beds*	*Units*	*Beds*
General Hospitals	8	5,809	259	15,277
Mental Hospitals	4	2,996	7	3,445
Tuberculosis Hospitals	23	5,154	73	4,939
Maternities	6	967	9	115
Cottage Hospitals	—	—	39	1,823
Nursing Homes	—	—	118	8,751
Total	41	14,926	505	34,350

Map III—General Hospitals

Classification	*Units*	*Beds*
Central Hospitals	14	7,544
Regional Hospitals	24	4,622
Sub-Regional Hospitals	229	8,920
Total	267	21,086

PORTUGAL

Area	91,618.81 Km2
Population	9,130,410 inhabitants
Doctors	7,797

SWEDEN

by

GILLIS ALBINSSON

1. *The hospital service, its organisation and scope*

For a right understanding of the Swedish hospital service and its organisation it is necessary to give a general survey of the major factors in the administrative organisation of the Swedish democracy.

A. THE ROYAL GOVERNMENT

The Swedish Ministries have the ultimate political responsibility and are responsible for the general policy in all departments of the State. Their duties are mainly in the field of legislation and the compiling of annual Estimates and the distribution of the grants to State institutions. The supervision and management of the State work and services is in the hands of administrative boards, which are responsible not to the Minister but to the King in Council (the Crown) and have a largely independent status.

The ministerial responsibility for the health services rests in the way mentioned above with the Ministry of the Interior (there are at present proposals that it will be taken over by the Ministry of Social Affairs). The Ministry is concerned with such matters as the preparation of legislation and the annual Estimates for the State hospitals and laboratories. The King in Council (that means in practice the Minister of the Interior) also appoints senior physicians and other higher officers in the public health field.

The management of the governmental services and the supervision of the municipal and private services rest with the Royal Medical Board, which as said has a real independent status in relation to the Minister but is subordinated the King in Council. The board's functions can be classified as advisory, supervisory and administrative. They advise government departments and other national boards and local authorities on all matters requiring medical knowledge, watch over the

state of the national health, supervise the medical management of the hospitals and other health services run by local authorities, and are themselves directly responsible for mental hospitals and certain other institutions. They authorise doctors, dentists, midwives and other medical workers to practise and make proposals to the Crown for new legislation.

B. THE COUNTY COMMUNITIES

The planning, organisation and financing of the Swedish hospitals have, during most of the two hundred years we have had hospitals in a modern sense, been the duty of regional authorities in territories corresponding to the British counties. The primary communities—rural communities and smaller towns—corresponding to the British parishes have no tasks in the hospital field.

Up to 1864 the hospitals in the territories (provinces) were administrated by special committees with the Province Governor as chairman. From 1864 the management and responsibility for the planning and organisation of the hospital services, their running and financing have been the duty of the County Councils which were instituted in 1862.

At first, a few words on the *County Council* and the *County Community*. These represent local self-government in the county. There are 25 counties. They have between 150,000 and 450,000 inhabitants. Only two are smaller than 100,000 inhabitants. There are great differences between their areas and populations. The county of Norrbotten in the upper north embraces 25% of the total area of Sweden but only 2½% of its population, but the county of Stockholm (the surroundings of the capital) has about 450,000 inhabitants on a relatively small area.

The four greatest towns do not belong to counties and they are themselves responsible for the same tasks as the county. They can be called county boroughs.

By law the counties are entitled to deal with matters concerning, *inter alia*, public health and sick care. In reality the major responsibility of public health and sick care rests on the counties and these tasks take about 80-85% of their gross expenditures.

The power of decision in the county lies with the County Council. The administrative and executive power belongs to the Board of Administration, the Sick-care Board and other committees. The members of the County Councils are elected by general and direct elections every fourth year. The members of the Boards are appointed by the Council, mostly for four years. The County Council meets once or twice a year, the Board of Administration once a month or more frequently. The County Council has an office and secretariat managed by a county director and with a varying number of staff.

The County Council has an unlimited power of taxation. The tax to the county is fixed on the same principles as the local income tax. On average for the country the tax to the counties takes about 5% of a person's income.

The County Councils are to a high degree independent in relation to local as well as central state administration.

C. THE HOSPITAL SYSTEM

According to the Hospital Act, the counties and the county boroughs are responsible for the somatic hospitals. Each county forms legally a sick-care district and the county has to provide facilities of hospital care for everyone living in the county, both hospital beds and out-patient services.

The Act defines different types of hospitals. For somatic care there are generally *lasarett* (general hospitals) and *sjukstugor* (cottage hospitals). Furthermore there are some special hospitals for TB (sanatorias) but nowadays many of them are used for other purposes such as care of chronic sick. The reason is the diminishing incidence of TB in Sweden, which has made it possible to move the TB-care into special pulmonary clinics in the general hospitals. There also are special hospitals and nursing homes for chronic sick, for epidemics and for maternity care. In most general hospitals, however, there are maternity wards, special clinics for chronic sick and sometimes (in the central hospitals) also infectious clinics, which replace the special epidemic hospitals.

The State owns and runs the mental hospitals but according to a committee report some years ago it is expected that the

counties will have to take them over in the next ten years. Owing to the deficiency of beds in the State mental hospitals and counties since about 1927 they have had nursing homes for mentally diseased and in the last ten years they have built psychiatric clinics in their general hospitals.

The State has three general hospitals, all of them university hospitals in Stockholm and Uppsala. The most well-known is perhaps the Karolinska Hospital. All other university hospitals are owned by counties or county boroughs.

The care and education of the mentally deficient patients rest with the counties with the exception of certain categories, such as the social and crippled, etc., who are treated in State hospitals.

The following table shows the distribution of beds by owner at the end of 1959.

Table 1. *Hospital beds by owner* 31.12.1959. (926 hospitals, nursing homes, etc.)

	The State	*Counties*	*County Boroughs*	*Local Auth.*	*Funds, etc.*	*Private*	*Total*
General hospitals and similar	4,033	28,199	9,072	7	1,162	1,354	43,827
Epidemic hospitals	—	1,865	1,151	—	—	—	3,016
Hospitals for TB of the lungs	—	4,673	1,076	—	254	—	6,003
Independent maternity hospitals	—	151	129	6	144	5	435
Nursing homes for the chronic sick	—	6,852	4,738	1,120	317	481	13,508
Mental hospitals	20,703	—	5,666	339	—	30	26,738
Nursing homes for ment. diseased	—	4,635	516	—	54	1,083	6,288
Total	24,736	46,375	22,348	1,472	1,931	2,953	99,815

This table does not include the establishments and schools for the mentally deficient.

The most striking feature which emerges from the table seems to be the low ratio of private beds and beds in hospitals run by funds. The beds run by primary communities are mostly linked together with homes for aged. Their number has diminished during the last ten years.

On the county level we have at least one *central hospital*, in which there is a range of general and specialist clinics such as

surgery, medicine, obstetrics and gynaecology, ear-nose-throat, eye, paediatric, X-ray, psychiatric and generally also chronic/geriatric and infectious clinics. The central hospital is 'neighbour hospital' for a certain part of the county and specialised hospital for a greater part or all the county. Besides this there are what we in Sweden call *'normal hospitals'* with surgery, medicine and X-ray, sometimes also one or two other clinics such as ear-nose-throat, paediatric or gynaecology. Generally there is also a ward for the chronic sick. As 'neighbour hospital' we also have so-called *mixed hospitals* with mainly surgery and in the sparsely populated areas *cottage hospitals* where often the district medical officer is also the hospital doctor. Besides the clinics or wards for chronic sick in the general hospitals there are *nursing homes* for these patients in different places in the county and also nursing homes for the mentally diseased. There may also be a separate *TB-sanatorium* and an *epidemic hospital.*

As an illustration I will give a survey of the hospitals in the county of Halland on the west-coast, where I have my daily work.

The county is about 90 miles from north to south and from nine to 30 miles from west to east. It has 172,000 inhabitants.

We have a central hospital with 500 beds in the biggest town (40,000 inhabitants) which serve about 87,000 inhabitants as 'neighbour hospital' and all the county as specialised hospital. In the second town (15,000 inhabitants) we have a 'normal hospital' with 160 beds serving about 54,000 inhabitants and in the third town (11,000 inhabitants) a mixed hospital with 93 beds serving about 29,000 inhabitants. Furthermore we have two cottage hospitals, one with 30 beds in a small town and partly serving 20,000 inhabitants together with the normal hospital mentioned above. Two doctors are fully employed in this cottage hospital and its out-patient service. The second cottage hospital is in another little town and has a district medical officer as part-time doctor. It is a secondary hospital to the central hospital and serves a part of its district.

For TB we have a TB-sanatorium with 145 beds of which only about 50 are occupied by TB-patients and two wards are used for chronic sick. This sanatorium will be closed in the next

three years and the patients transferred to a new pulmonary clinic at the central hospital.

On the central hospital we have a clinic for chronic sick and linked together with the normal hospital, the mixed hospital and the cottage hospitals we have nursing homes for such patients. Besides these we also have one independent nursing home. In all, the county has from next year 405 beds for this category.

Our epidemic hospital closed in 1961 and since then we have had an infectious clinic built at our central hospital.

For mentally diseased we have two nursing homes with a total of 150 beds and for mentally deficient two schools and two nursing homes.

Besides these institutions we have also a number of institutions and health workers outside the hospitals but as our theme is the hospital service I will not enter deeply into this subject.

The above gives the hospital and institutional provision of the hospital service in a county of 172,000 inhabitants. Such a county is not large enough to provide the highly specialised hospital care such as neuro-surgery, thorax-surgery, neurology, special cardiology, plastic-surgery, etc. For these specialities the counties and county boroughs have now introduced a system (based on a governmental survey and report in 1958) whereby the university hospitals and two other hospitals have been enlarged in order to serve larger regions with about 1 million inhabitants, in these specialities. The system is based on free negotiations between the counties.

Table 2 shows the number of beds in hospitals for somatic diseases and the distribution on special departments or special hospitals for the most frequent specialities.

It is necessary to lay stress upon the fact that in Sweden about 99% of the births take place in hospitals. Formerly there were a large number of small independent maternity homes but as communications have improved especially by the motorising of the rural districts many of these homes have been closed and the general hospitals and the cottage hospitals have taken nearly all births in their maternity departments.

Table 2. Hospital beds for somatic diseases 1959.

	Beds	*Beds per* 10,000 *inhabitants*
Non-specialised departments	3,778	5.1
Medicine	8,817	11.8
Paediatrics	2,318	3.1
Dermato-venereology	637	0.8
Neurology	300	0.4
TB	6,366	8.5
Surgery	9,848	13.2
Obstetrics	2,207	3.0
Gynaecology	1,765	2.4
Ophthalmology	873	1.2
Oto-rhino-laryngology	1,429	1.9
Maternity wards without specialist	1,367	1.8
For chronic sick	16,023	21.4
Beds at epidemic hospitals	3,601	4.8
Non-specified specialities	7,473	10.0
Total	66,799	89.4

In Sweden much stress is laid upon the out-patient work of the hospitals, especially in the general hospitals and the cottage hospitals. Every clinic or special department has its own out-patient department. In 1959 the number of visits at out-patients departments in general hospitals was about 4.7 million and the number of visits per out-patient was 2.4. In the State mental hospitals there is very little out-patient work and in some types of special hospitals, such as nursing homes for chronic sick and epidemic hospitals, there is no out-patient work at all.

D. THE HOSPITAL PERSONNEL

The personnel in hospitals for somatic diseases is shown in table 3:

From the table one can see that the number of personnel per 100 beds is 110.5 in general hospitals. In cottage hospitals it is 71.2 and in epidemic hospitals 61. Attention may be drawn to the relatively low ratio of nurses and midwives. In Swedish hospitals there are many special groups of nurses' aids and semi-trained nursing personnel (auxiliary nursing personnel). The training of nurses in Sweden is given in schools run by the County Councils and county boroughs and a few private schools. The training lasts three years. We seek to give all nurses' aids a special training, now including seven weeks of theoretical educa-

Table 3. Personnel in hospitals for somatic diseases 1959.

Personnel	*Number*	*Per 100 beds in general hospitals*
Physicians	3,603	7.52
Nurses	10,440	22.54
Midwives	656	
Physiotherapists	507	
Occupational therapists	188	
Social workers	203	58.73
Doctors' secretaries	1,462	
Auxiliary nursing personnel	28,884	
Administrative staff	1,295	2.98
Domestic staff	10,951	18.73
Total	58,469	110.50
The number in general hospitals	41,653	

tion and 16 weeks of practical training. After this training and two years of work in hospital the girl can attend a further course of eight weeks of theory and 24 weeks of practical training in order to get a higher position as semi-trained nursing personnel.

The following table shows the personnel at establishments for mental diseases:

Table 4. Personnel at establishments for mental diseases 1959.

Personnel	*Number*	*Per 100 beds in State mental hospitals*	*Mental hosp. of the three largest cities*
Physicans	474	0.9	1.6
Nursing personnel	11,154	36.1	42.2
Administrative staff	395		
Domestic staff	2,642		
Total	14,665		

E. FINANCES, CHARGES AND COSTS

The charges a hospital may make for treatment are stated by the owner; for somatic hospitals usually the County Council (or county borough council). By tradition they have become fixed considerably below the real cost of maintaining and treating a patient. Before 1955 about 60% of the population were members of the State controlled sickness insurance which paid for them during hospital stay, and from 1955 the National Sickness Insurance pays for all hospitals patients by the local sickness fund. According to recommendations from the Federation of

Swedish County Councils and the Federation of Swedish Towns all counties and county boroughs have fixed the same charge for their hospitals, about 7s. a day (5 sw.cr.). In the State hospitals the same charge is made. That low charge throws the major part of the expenses on the hospital owner. The counties and county boroughs have only small subsidies from the central government and have to cover their costs mainly by taxation. They also have to subsidise the State somatic hospitals by paying practically all costs for patients from their counties and boroughs who are treated in these hospitals.

The running cost per bed-day was in 1959 in general hospitals about 65 swedish crowns (£4 10s.), in cottage hospitals 41 sw. crowns (£3) and in homes for the chronic sick 27 sw. crowns (£2). In the State mental hospitals the average running cost per bed-day was 22 sw. crowns (£1 11s.) and in the mental hospitals of the three largest county boroughs 30 sw. crowns (£2 3s.).

The total net expenses (operation and capital development) of all types of hospitals in 1959 amounted to about 1,470 million swedish crowns (approximately £100 million) of which the share for mental hospitals was approximately 367 million crowns and 1,105 million crowns was the costs of all other hospitals. The expenses of the State for mental hospitals were about 281 million crowns and for other hospitals (including subsidies to hospitals run by local authorities) 88 million crowns. The expenses of the counties were 805 million crowns and the county boroughs paid approximately 298 million crowns. The capital costs for hospitals were approximately 290 million crowns or £20 million.

The average length of stay in general hospitals was in 1959 13.6 days and the costs per admission were 890 sw. crowns (£61 8s.).

The increases of the hospital costs in Sweden are attributed mainly to a rising level of salaries and wages. More than 70% of all costs of general hospitals are wage and salary expenditures.

2. *The way in which the hospitals are staffed administratively*

So far I have made no mention of the hospital administration. I will therefore first give some information about the Sick-care Board and the Hospital Boards.

It has been said before that every County Council has to elect a Sick-care Board with special duties in the administration of the county's hospitals. The Board co-ordinates the activities of different hospitals, plans the continuous development of the hospitals and other forms of public health; and it has also to appoint all assistant doctors and hospital secretaries. The head-physicians are appointed by the King in Council after recommendation by the Sick-care Board of the respective counties, which has to choose among four applicants put on a ranking list by the National Health Board. Many County Councils have entrusted the duties of the Sick-care Board to the Board of Administration, which has the central administrative, executive and economic power of the county between the council's meetings.

The direct administrative power of the hospitals is given to the Hospital Boards, one for each hospital or for a group of hospitals. The Hospital Board controls the grants from the County Council, it prepares the estimates which later are scrutinised in the Board of Administration; the Hospital Board also appoints all hospital staff besides the doctors and the hospital secretary.

The daily administrative job rests upon the medical director. He is normally a clinician responsible for patients. There are no fully employed directors without clinical responsibility. The economic responsibility rests upon the hospital secretary. In the Hospital Act the medical director and the hospital secretary together are called the Hospital Guidance. According to the latest Hospital Act (of 1959) the County Council can decide to lay the full guidance of the hospital in the hands of a hospital manager. Hitherto ten Swedish hospitals have adopted this form of administration (eight county hospitals and two State mental hospitals). The eight hospital managers at county hospitals are two lawyers with administrative training, one is M.A., two are graduates from the Stockholm School of Social Work and Public Administration, two are graduates from commercial colleges and one has long practical experience in hospital work. There are no obstacles to a doctor becoming hospital manager, but there has been very little interest among doctors for these jobs.

The hospital manager administers the executive power on behalf of the Hospital Board. So does the medical director in co-operation with the hospital secretary. But the Hospital Boards have given more power and more independence to the hospital managers.

The ratio of administrative and secretarial staff in Swedish hospitals is rather low in comparison with many other countries. I have had information from Professor Chester showing them to be only half the ratio of England or about 4% of the total hospital staff while the ratio in England is said to be about 8%. Professor Chester has said that the only explanation attempted at this stage is that in Sweden administrative functions may well be performed in the offices of the County Councils; and I think he is right.

3. *How the administrators are selected and trained*

Hitherto the administrators in Swedish hospitals have been recruited from persons with commercial training and to some extent also from persons with general administrative training, especially graduates from schools of Social Work and Public Administration (three such schools are now working in Sweden giving training for social work and in providing special courses also for public administration with special regard to municipal administration). The administrator has entered the hospital work in a lower position as clerk, cashier or assistant secretary and then worked up to a position as hospital secretary. He will have been given special training in a three or four month course at a school of Social Work and Public Administration with special regard to hospital administration for people working in that field. The hospitals have had some difficulty in competing with the general municipal administration for the trained and graduate personnel. The medical directors have had no special training apart from some weekly courses arranged by the Federation of Swedish County Councils, which has arranged similar courses for administrators as well.

A governmental committee has a few weeks ago presented a report on this subject. Their proposals are, shortly, as follows:

A special training shall be given to students who intend to enter hospital administration. That training shall be given in a

special institution at the University of Uppsala during four years of theoretical and practical studies. It is meant to embrace law, statistics, sociology, economics and hospital administration.

Besides this training there are proposed special ten-weeks courses for doctors intending to seek positions as medical directors, and refresher courses for administrators. Special courses of 15 weeks will, according to the report, be arranged for administrators who have not taken the university training.

I think the proposals will be met with some doubts from many people and institutions involved in hospital administration and perhaps the training of hospital administrators will be given, in some respects, a form and a programme which differ from the proposals.

September 1962

SWITZERLAND

by

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I. THE GENERAL SITUATION

Swiss hospitals and their organisation can only be understood in the light of the political and also the geographical structure of the country. I shall therefore begin with a few remarks of a general nature:

1. The Swiss Confederation is a federative state consisting of 25 independent cantons and half-cantons. Each of these cantons has its government, its parliament (in three small cantons it is called 'Landsgemeinde') elected by the people and also its own laws. More than in other states the commune is the cradle of political life, in which the work is carried out by a communal council also elected by the people. Furthermore, in larger communes there is a communal parliament while in smaller communes the electors gather together at a communal assembly.

It should be emphasised here that Switzerland is the *land of direct democracy* in which the electors not only vote in the parliament (and in the communes and cantons the executive body) but are also often called to vote on amendments to the constitution and on the approval of laws and even on decisions concerning large expenditure. For hospitals this means that—for example in the canton of Berne—a law governing cantonal subsidies to district hospitals has to be accepted by the people and the same happens with the decision to rebuild the university hospital for S.Fr. 70 millions.

2. The autonomy of the cantons mentioned above is particularly pronounced in the domain of health and hospital services, as the Confederation has no legislative power over hospitals and does not participate in any financial aid for construction and running of hospitals. There are two exceptions, one based on a federal law of 1928, for tuberculosis-sanatoria, the other—since the new law of 1960 governing the federal

invalid-insurance—for the construction and completion of public and private but non-lucrative establishments, dealing especially with rehabilitation. In both cases the federal state gives subventions for building and running costs without actually either building or running these establishments itself. It only runs establishments on a modest scale for military purposes, while the Swiss Accidents Insurance, which assumes the compulsory accident-insurance for employers and workers in all factories, transport and buildings concerns, runs a spa and a school of rehabilitation for the limbless.

But the autonomy of the communes is also of great importance in the domain of hospital service as the majority of the district and municipal hospitals is planned, built and run by the commune or—as is more often the case—by several communes which associate for this purpose in the legal form of an association or a co-operative.

II. HOSPITAL PLANNING

I feel that—without deviating from the subject—it is necessary to say something about hospital planning on a regional scale as this influences the number, size and situation of hospitals.

It should be mentioned that—because the federal state has little to do with hospitals—there is no regional planning for the whole area of the Confederation which covers 41,000 km2 and counts 5,429,000 inhabitants.

Each canton therefore establishes its own planning principles, whereby even some of the larger cantons do little or nothing in this respect. Again it must be emphasised that the conditions differ entirely from canton to canton. For example, one is a typical urban canton (Basel-Stadt) with 6,081 inhabitants to the square kilometer, while the other is a typical mountain area with only 21 inhabitants to the km2. Yet another canton has to base its planning on an area of 1,729 km2 with nearly 1 million inhabitants, a further one plans for 274 km2 with 22,188 inhabitants.

Thus each canton has its own planning principles and hospital problems. But it can be said that at present there are some generally used basic figures establishing the coefficient bed/

population, which vary noticeably according to the way of life and the 'hospital habits'.

The figures which I am going to give you can be considered more or less representative for Switzerland:

General hospitals	*per* 10,000 *inhabitants*
Beds for general medicine and related fields	16
Beds for general surgery and related fields	20
Beds for children (medicine and surgery)	7
Beds for infectious diseases	3
Beds for maternity (without babies'-beds)	7
Total regional beds	53
Report	53
Super-regional beds for highly specialised treatments	10
Total beds in general hospitals and maternity (without babies)	63
Mental hospitals of which 4 for acute cases	34
Hospitals for the chronic sick of all ages (urban districts)	30–33

To conclude this chapter it should be noted that the lack of general planning in hospital service has not yet proved disadvantageous. On the contrary the autonomy of the communes and cantons has a stimulating effect. There is no red tape and bureaucracy. We have at our disposal a close network of generally speaking well-equipped hospitals, a situation which we owe above all—and this we should always remember—to the peaceful development of the country throughout generations.

III. THE DIFFERENT TYPES OF HOSPITALS

1. As a rule each canton has a *central hospital* built and run as a specialised or super-specialised establishment. The mental hospitals are also generally cantonal establishments. *Five* cantonal hospitals are at the same time *university-hospitals.*

Besides, depending on the size and density of the population, there are one or many district hospitals with a capacity of under 50 beds (but this is rather an exception) to 380 beds. In the large canton of Berne (about 900,000 inhabitants) there are, for instance, 33 district hospitals, 24 of which have less than 150 beds.

The geographical distribution, even there where no planning exists, is not unsatisfactory, as the hospitals are generally built in the normal centre of attraction of a region, the cantonal hospitals usually in the cantonal capital with good communications.

2. Contrary to Germany, for instance, public hospitals run by private bodies only play a secondary role. The vast majority of beds for general and mental cases belong to the cantons and communes. On the other hand, the hospitalization of the chronic sick and the mental defectives is still often the work of benevolent institutions which can reckon with the substantial aid of the population and the public authorities.

In the big cities (as for instance in Lausanne, Zürich and Berne) the private nursing homes play a part of a considerable importance. They either belong to religious communities of all denominations or are purely business concerns in which the doctors are often financially involved.

3. For us in Switzerland the question of the *optimum size of the hospitals* is of less importance than in certain other countries for the simple reason that because of the intense decentralization of hospital services and of the communal autonomy, Switzerland is the land of small and medium-sized hospitals. Only in the university-hospitals does the number of beds exceed a thousand, which is due to the teaching requirements. It can be rightly said that we have too many small hospitals. This might be true from the viewpoint of economics and of concentration of means. People cling to their district hospitals and wish if possible to be cared for in the vicinity of their homes. Furthermore, the highly important contact between the hospital and the general practitioner, which is apt to be underestimated, is thus guaranteed.

The newest trend in the *hospitalization of the chronic sick of all*

age-groups is to abandon the idea of the hospital for chronic sick. The chronic department is incorporated in the general hospital, a procedure which has been practised with success in various hospitals for several decades. We are thus approaching the famous idea of the 'balanced hospital community' conceived by Prof. McKeown of Birmingham, all the more as in the large hospitals—although still on a limited scale—beds are being made available for psychiatric cases.

The tendency to decentralize also affects the *old peoples homes* so that the inmates don't lose contact with their former surroundings. Fortunately, the old idea of building these homes in far away places is being gradually abandoned.

4. Many of our district hospitals are so called *two-man hospitals*, i.e., with a physician and a surgeon, the latter dealing also with gynaecology and obstetrics. There is a noticeable trend to the three-man hospital which means that there is more and more tendency to appoint an independent surgeon for gynaecology and obstetrics.

According to Dr. Büchel, cantonal physician of Zürich, the number of beds for these types of hospitals are as follows:

Two-man hospital	
Medicine	70
Surgery, obstetrics and gynaecology	100
Three-man hospital	
Medicine	90
Surgery	100
Gynaecology and obstetrics (not including beds for babies)	50

The next step before the real 'health centre' is what is known as a 'Vollkrankenhaus' (complete unity) with the following departments:

International medicine	100
Surgery	120
Gynaecology and obstetrics	60
Paediatrics	30
ENT and ophthalmology together	30

I would like however to stress the highly theoretical nature of these figures.

IV. THE ORGANISATION OF HOSPITALS

1. In order to understand the organisation of the hospital services in the cantons, it is necessary to say a word or two about the *financing of construction and running costs*. As we have seen, the Confederation contributes nothing apart from very few exceptions. The canton pays the total building costs and assumes the entire running deficit in the case of a cantonal establishment. Communal and intercommunal hospitals are principally financed by the commune or communes for construction and exploitation. As, however, this financial burden is constantly increasing and exceeding the possibilities of the communes, it has become a rule that the cantons help with *subsidies* for both construction and running costs. The amount varies from canton to canton. In the canton of Zürich it varies between 10% and 50% for construction and goes up to 90% for the exploitation deficit.

In a word, the public hospitals cannot cover their expenses with their receipts as the fees—except for amenity wards—do not cover the real costs. The difference is paid by the cantons and communes by means of subsidies.

2. In all the cantons, hospitals are subordinated to the cantonal ministry of health. For cantonal hospitals it is a direct subordination, for the others it is more a sort of supervision and control. Here, too, the solutions differ according to the cantons. Still, it is possible to establish the following principles:

(*a*) *Cantonal Hospitals*

They are subordinated directly to the ministry of health, usually by intercalating a hospital-board which sometimes has only supervisory and advisory powers and sometimes also is competent to make important decisions. Should this not be the case, the hospital administration is directly responsible to the ministry of health or to the whole government (e.g., the cantonal university hospital of Lausanne). The election of these boards is done by the cantonal government, the minister of health being *ex officio* member or even chairman of the board. The remaining members come from all professions and all classes and exercise their activity in an honorary capacity. This system

is also valid for hospitals belonging to an urban commune (for instance, Zürich).

(*b*) *District Hospitals* (*intercommunal*)

The communes delegate their representatives to a hospital board in which there are also members designated by the cantonal government. These usually large boards, whose members are also honorary, often nominate a management committee which carries out the administrative work and to whom the medical superintendent and administrator are responsible.

3. We come now to the problem of the actual *administrative structure* of the hospital. Neither here is there a generalised Swiss solution, but here, too, one can discern some basic principles to which I add my personal views:

(*a*) In the case of an establishment with a single type of patients (mental hospital, TB-sanatorium, children's hospital) the following type of administration is justified:

Hospital board
(or management committee)
|
medical superintendent—director
|
administrator

In this case, the administration is subordinated to the medical superintendent. There are also hospitals of this type in which the medical superintendent and the administrator are on the same footing. If you were to ask me my opinion, I would cite as many examples in both cases where difficulties have arisen between these two gentlemen. We must bear in mind that especially in the hospital field all organisation and ruling is useless if people do not get on together.

(*b*) It still happens today in Switzerland that smaller hospitals (the limit being about 30,000 days of sickness) *do not have a full-time administrator.* I consider this solution as absolutely feasible, so long as two conditions are fulfilled: The chairman of the board must really look after his hospital. The medical superintendent and the matrons should be capable organisers and should have experience in hospital exploitation. In this case the school-teacher or the communal clerk will act as a

secretary-treasurer of the hospital and the board can rely on an active women's committee which deals with the purchase of linen and household goods. I consider this a very happy and truly democratic form of organisation.

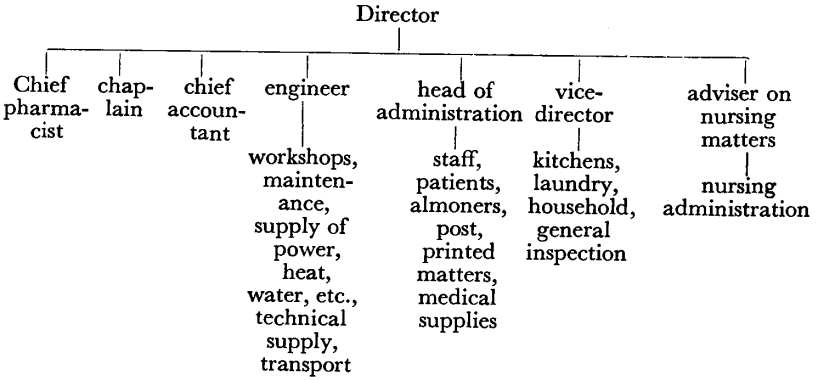
(*c*) In smaller hospitals with several departments, one of the hospital physicians is nominated as responsible medical officer to the board. The administrator is then generally directly subordinated to the hospital authorities. In medium-sized hospitals (which means for Switzerland about 200 beds), the chief medical officers usually form a college and elect one of their number as chairman and spokesman to the board. In this case the administrator is *always* subordinated directly to the hospital authorities.

(*d*) In *big hospitals* the tendency in Switzerland is to follow the French system, in which the management is entrusted to a lay-man alone. For my hospital we thus have the following organisation:

Board of governors
|
management committee
|
director

The medical superintendents form a college, the chairman of which is present at all the sessions of the board and the committee with an advisory vote. He is not—as in Germany—the medical director of the hospital but spokesman for his colleagues and adviser to the director on medical matters concerning the entire hospital. It corresponds however to the individualism of the Swiss medical corps—this may also be true for other countries—that the director should first discuss with each senior medical officer problems concerning his own particular department.

(*e*) Let us now look at the administrative structure of our particular hospital, always remembering that each hospital is at liberty to choose its own type of organisation. The following example of the Inselspital, a university hospital of a thousand beds, is thus by no means generally applicable. Our present schema is roughly as follows:



To this I should like to make a fundamental remark: Except in smaller hospitals and establishments we in Switzerland have been aware for a long time that the matron is responsible for the nursing administration and not for the kitchens, laundry and household even if she would like to be. We are not warmly disposed towards those all-powerful ladies who rule the whole hospital including the doctors and the administrator. The above mentioned vice-director of the Inselspital has under him seven particularly well trained and qualified *house governesses* who have full responsibility for household, kitchens and laundry and are given wide catering competences.

V. SELECTION AND TRAINING OF ADMINISTRATORS

If the organisers and participants of this meeting hoped to learn something new and even revolutionary concerning the training of a hospital administrator, they will be disappointed by Switzerland's contribution to this problem. I must confess here that this question has not yet been solved in Switzerland and there seems to be no solution in sight. I will content myself with a description of the present situation and with my personal opinion:

1. Some years ago the university hospital of Basel founded a school of administrators with the help of the Swiss Hospital Association. The training of a *mainly* practical nature lasted—if I am not mistaken—two years. The number of candidates was modest and the quality rather poor. *One* candidate managed

to finish the course and then the school ceased to exist; the experiment had failed. The reasons for this failure are manifold. Owing to the language problem in our country (we have three national languages) and due also to the exiguity of Switzerland, the number of candidates will always be small. Moreover, the financial questions were not solved, as the candidates were paid little or nothing even though they had had previous professional training. Furthermore, the overworked collaborators of a big hospital do not form the ideal teaching staff for such a school.

Be this as it may, no one today mentions this school and in Switzerland an administrator does not acquire his professional knowledge either in a specialised school or at a university. It is the same old story, namely that one is nominated administrator or director of a hospital by destiny, chance, promotion, vocation or sometimes by favourable political circumstances. It should be recognised that progress has been made in the timely training of a successor within the hospital and that generally the administrator receives an adequate salary. I know that the salaries of directors of big hospitals are noticeably higher here in Switzerland than for instance in France, Germany and Holland.

2. When a small or medium-sized hospital with a board, a senior medical officer and a matron dealing directly with the problems of daily administration looks for a full-time administrator, it will choose primarily a man with commercial or administrative experience. The candidate with previous hospital experience will be at an advantage. It should be noted with gratitude and satisfaction that our hospital authorities are being swayed by the point of view that administrators who have gleaned their knowledge in small hospitals should be nominated to more responsible jobs. This shows the greatly desired possibility of a hospital career, one which goes even further than the still rather sealed frontiers of our cantons.

In larger hospitals (I am referring here to the not very numerous general hospitals of 400 beds and over) the commercial training is not always a decisive factor as generally there is a qualified staff of collaborators to hand. When I consider the six big hospitals of my country (five university

hospitals and a cantonal hospital) I note that three of the directors are lawyers, one an economist, one a mathematician and the other a man of commercial experience. In this connection it should be mentioned that the conception of the doctor as director in the sense of administrator has died out in Switzerland, the last example having been up to 1954 in my hospital.

3. From the foregoing it appears that the hospital administrator in Switzerland either learns his profession by gathering his experience in a subordinate position in the hospital and is then promoted or nominated to a leading post in another establishment. Or he will be elected without any hospital experience (which is still possible in the case of certain political elections) and has to learn his profession while already holding down a responsible job. I shall come back to this aspect of the problem.

The hospital administrator is not without any training possibilities: The Swiss Hospital Association holds annual training courses and there are also in Zürich and St. Gallen institutes of economics which organise regular sessions for hospital and home administrators. In some cantons and larger towns the administrators organise regular meetings and visits. Many hospital authorities encourage participation in foreign congresses and specialised exhibitions. The Swiss and German or French hospital press is read and studied nearly everywhere. The five directors of the university hospitals meet several times a year to deal with professional problems and our most important collaborators gather annually for a two-day working session. All this is facilitated by the small distances and the excellent communications of our country.

4. In conclusion I should like to answer briefly the question whether it is unfortunate, that we in Switzerland have no actual course for training administrators, no clearly defined administrator's career.

The longer I work in a big hospital which is in the throes of a tremendous scheme of extension, and the more often I have the opportunity to study the structure of other hospitals in our country, the more I am convinced that the question of whether the administrator or director is fitted for his job is not really

dependent on his specialised knowledge or on his skill in 'technique hospitalière'. In Switzerland, as in your countries, the hospital is what we call in German a real 'wasps-nest' with many very intricate problems concerning human relations. Moreover, a large hospital has also become big business and an especially complicated enterprise. Whoever has to direct it or to assist in its direction must first be a *leader* and secondly an *organiser*. If these conditions are not fulfilled, all the technical knowledge is of no avail. This knowledge is acquired very rapidly—I could mention many examples—if the profession is exercised with enthusiasm, even with fervour. Two years ago during a conference I gave in Holland I made a list of what I feel to be the principle qualities of a hospital administrator. In conclusion may I repeat them:

a good education;
great tact and no exaggerated personal ambitions;
a sense of team-work;
a talent for organisation;
good understanding for problems of public health and welfare;
a good sense of humour, broad shoulders and an ability to remain even-tempered.

Under these conditions I feel it is possible to get on well with a large number of professors of medicine and a regiment of nurses.

September 1962.

WESTERN GERMANY

by

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THE HOSPITAL SERVICE IN THE GERMAN FEDERAL REPUBLIC

A. Population Statistics

The area of the Federal Republic without West Berlin numbered at December 31st, 1960, 53.8 m. inhabitants. The ratio of males to females was 100:112. In an area of about 248,000 km^2 the population amounted to 217 inhabitants per km^2. Since 1950 (194 inhabitants per km^2) population density has increased considerably. West Berlin at the same time had 2.2 m. inhabitants. The total population increase between 1950 (48.2 m.) and 1960 amounted to 5.6 m. or 11.6%. It consists of 51% increase in births and about 49% immigration increase. In 1960 there were 9.3 marriages, 17.7 births and 11.3 deaths for every 1,000 inhabitants. The infant mortality per 1,000 inhabitants amounted to 34 (i.e., died during the first year of life). Taking into account the births and deaths there is a total increase in births of 6.4 per 1,000 inhabitants. 9.4% of the population are children below the age of six, 12.1% are children from six to 14 years, 68% are persons of employable age from 15 to 65 years and 10.5% of the population are persons of 65 years and above. The number of old people beyond the age of 65 has constantly increased during the last decades. While it amounted in 1910 only to 5% of the total population, it reached 7.8% in 1939, 9.3% in 1950 and finally 10.5% in 1960 (men 9.2%, women 11.7%). According to the estimates of the probable population development it is reckoned that the number of old people will amount to 15% by 1980. Employed persons account for up to about 50% (men 64.1% and women 33.8%).

B. Organisation and Administration of the Health and Hospital Service

The German Federal Republic is a federative government. In the field of the health service all executive power is assigned

to the 'Länder'. 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 other healing professions,

control of medicines, drugs, anaesthetics and poisons,

protection in handling food, semi-luxuries and necessaries,

public welfare, including the public health service.

It is the Health Ministry which is responsible for the health service for the Federal Government. Furthermore at the Federal level there is the Federal Board of Health which particularly carries out research work in the field of public health service and provides additional statistical data. The Federal Health Council, which is composed of 50 non-professional members of scientific and professional associations, local institutions for public welfare, etc., assists the Federal Government in drafting Health Acts.

In the 'Lands' (Länder) the interests of the health service are in each case taken care of by a central authority of the health administration. The health departments of the 'Lands' are directed by a Medical Health Officer, who is in the case of the City States (West Berlin, Bremen and Hamburg) directly subordinated to the Senator for the Health Service and in the other 'Lands' to the responsible Minister. The central Land authorities prepare the Land Acts, give instructions as to their execution and ensure that they are carried out in accordance with the law.

The Boards of Health are affiliated to the city and rural districts, and are the lowest administration authorities. The Boards of Health are under a Medical Health Officer. He is in charge of the following medical tasks: health of the police, public health instruction, school health service, mother and child consultation, care of tuberculous, venereal, physically handicapped, chronic sick and addicted persons. To these duties may be added further voluntary tasks in the field of public health service. As part of their compulsory duties, the Boards of Health also supervise all hospitals. In most of the 'Lands' the supervision of the Boards of Health is not the direct

responsibility of the Medical Health Officer of the 'Land', but of the Department of Health Service of the President of the administrative district.

The character, organisation and structure of the ambulatory and stationary health service are determined by the so-called 'social insurance'. The 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 the social insurance is its compulsory character. It arises from the social insurance acts of 1881 and includes health insurance, accident insurance, pension insurance, unemployment insurance and unemployment relief, children's allowance and pension insurance of farmers.

The body responsible for the health insurance—which is our prime concern here—is the health insurance fund and also the 'Land' Insurance Institutions in respect of those tasks which are executed jointly for the district of a 'Land' (insanity, tuberculosis). The German health insurance is based upon compulsory insurance. Subject to obligatory insurance are all labourers and employees and certain independent persons engaged in gainful activity, if their regular annual salaries or wages do not exceed DM. 7,920—also widows entitled to pension, widowers and orphans. Under certain preconditions a voluntary insurance with the legal health insurance or a voluntary continuation of insurance of persons who are no longer liable is possible. Including the family-members who participate in the insurance the social health insurance includes approximately 80% of the population of the Federal Republic.

The right of the insured to ambulatory medical treatment is guaranteed by the health insurance through qualified medical practitioners and dentists. Apart from the treatment in urgent cases not all qualified medical practitioners are admitted to ambulatory treatment of the insured, but only those who are granted a licence by so-called 'licensing committees'. In total, there are in the Federal Republic about 74,600 employed physicians, (as well as 30,600 employed dentists) 44,500 of whom are general practitioners and about 30,100 are specialists. About 46,700 physicians are self-employed persons and about 21,450 are full-time employees of hospitals. About 7,150

of the self-employed physicians have a part-time employment in hospitals. Some 44,263 of the self-employed physicians (approx. 60%) are permitted to give ambulatory medical treatment to panel patients. Although the provision of hospital treatment is according to legal provisions a permissive performance, in practice the insured claim it as a right. The health insurances grant their insured persons hospital treatment in hospitals of their own choice. As a rule the health insurances conclude general contracts with the hospitals. The nursing costs of the hospitals, agreed upon in these contracts, are paid by the health insurances directly to the hospitals instead of being reimbursed to the insured persons.

There is no legal obligation in the Federal Republic for the provision of hospitals. Such obligations are only in part incorporated in some of the 'Land' Acts. However, there are special regulations for the provision of epidemic beds. Thus there is only a limited amount of compulsory construction of hospitals. The local authorities are only on account of regulations regarding the control of contagious diseases obliged to provide hospital beds. The social insurance institutions have to provide for hospital beds for the medical treatment of casualties. For the treatment and nursing of indigent and psychopathic persons and cripples the 'Land' Welfare Organisations have to provide the appropriate accommodation.

The establishment of general hospital beds is preponderately left to the local authorities, the local authority organisations and to non-profit organisations. To a larger extent than in most other countries the hospital beds of the Federal Republic are supported by free social bodies (non-profit organisations). The public hospitals are mainly in the hands of local authorities and local authority organisations.

The 'Lands' confine themselves to the provision of beds for psychopathic persons, while the Federal Republic only provides hospitals for disabled ex-servicemen. The interest of the social insurance institutions in public hospitals is only important in case of tuberculosis-hospitals. The burden of free general hospitals is borne by various bodies. For example, hospitals are run among others by religious communities, parishes, ecclesi-

astical and secular communities. Those carrying responsibility for private hospitals are mostly members of the medical profession.

The public and free hospitals of general benefit do not require any Government licence, since they are not business enterprises. Private hospitals need a licence, which is granted to the owner personally. All hospitals, regardless of their kind, are subject to governmental supervision. The latter is executed by the Boards of Health. Psychiatric hospitals are subject to special supervision. However, the Medical Health Officers have no material influence upon the working of the hospitals, except for general police interests in case of danger.

C. The Existing Hospital Resources

1. HOSPITALS, HOSPITAL BEDS, HOSPITAL INSTITUTIONS

The number of hospitals in the Federal Republic without West Berlin amounts to 3,451 with a total of 553,424 hospital beds. Thus the rate of hospital beds per 1,000 inhabitants amounts to 10.4. This ratio of hospital beds varies between 8.6 in Bremen and 11.2 in Bavaria. Still greater are the regional differences of the number of hospital beds within the various 'Lands'. These regional differences in the number of hospital beds available, however, do not permit the drawing of any definite conclusion as to a regional variation of requirement for hospitals, since it has to be taken into account that some of the hospitals are of more than local importance (university hospitals, larger municipal hospitals, above all special hospitals, such as tuberculosis sanatoria and nursing homes). Through the superimposition of the various catchment areas, the regional differences in the total amount of beds are partly balanced, mainly within the various 'Lands'.

56% of all hospital beds are in public hospitals, 37% in free hospitals of general benefit and 7% in private hospitals. The number of hospital beds in public hospitals reduced somewhat during the past few years, whereas the number of hospital beds in free hospitals of general benefit and in private hospitals increased. Statements as to the breakdown of hospital beds available among the larger groups of hospital institutions in the

Federal Republic do not exist. Table 1 shows the breakdown of hospitals and hospital beds per hospital institution in North-Rhine-Westfalia as per December 31st, 1955. Table 2 gives a survey of the classification of hospitals as to working capacity. According to table 2 the point of main emphasis is on hospitals of 100 to 200 beds (19.9%). They are followed by hospitals of 200 to 300 beds (14.1%) and by hospitals with 300 to 400 beds (10.4%). 18.1% 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 46.6% of all hospital beds are in hospitals with 500 and more beds. With free hospitals for general benefit the concentration lies with hospitals of the largest class, of 400 beds (72.1% of all hospital beds). 66.1% of all private beds are in hospitals up to 100 beds. The interesting point is that against previous years the number of beds in smaller hospitals decreased and in larger ones increased. The most outstanding thing of all is the increase in the number of beds in hospitals of 200 to 500 beds.

2. REQUIREMENTS AND OBJECTIVES OF HOSPITALS

52.5% of all hospitals in the Federal Republic are General Hospitals. They unite in each case several special departments (surgery, medical department, gynaecology/maternity, and departments for throat, nose, ear and eye diseases, etc.). The special hospitals (also designated nursing-home, asylum and sanatorium) account for 47.5%. 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 ways of treatment (observation hospitals, sanatoria). In terms of beds the proportion is as follows: general hospitals 58.5%, special hospitals 41.5%. Table 3 shows the breakdown of hospitals according to their classification (medical-nursing objects).

As to questions of hospital bed requirements, the regional distribution of beds available, the bodies or institutions responsible for hospitals and payment it is usual to distinguish between hospital beds for the so-called 'general hospital service' and the so-called 'special hospital service'. Hereby the hospital

beds for tuberculous persons, cripples, psychiatric persons, and addicts, as well as those for chronic diseases rank amongst special hospital service. They are characterised by the fact that they have a predominantly long average stay period and are as a rule of great supra-regional importance. The number of beds for the special hospital service amounts to 3.2%. Any other hospital beds in general and special hospitals class as general hospital service. These hospitals are characterised by a predominantly short average stay period and are mostly of limited regional importance. The number of beds for the general hospital service comes to 7.2%. Statements as to the number of beds for the various medical specialties for the total area of the Federal Republic do not exist, but only for individual 'Lands'. For the 'Land' North-Rhine-Westfalia the number of beds per medical specialty is given in table 4.

3. PERFORMANCES OF HOSPITALS

Approximately 7.0 m. patients were given stationary treatment in 1960 and the nursing days amounted to about 188.6 m. To each 1,000 inhabitants there are some 131 hospital bed-cases and some 3,500 hospital days. Every hospital bed on average has been occupied for 339 nursing days, the average use thus came up to 92.9%, the average stay period being 28.3 days. The high average value for the stay period is due to the very long stay period in some special departments (particularly tuberculosis, psychiatry and orthopaedics). The general hospital service shows an average stay period of about 21 days. Studies as to the stay period revealed that the duration of the patient's stay in hospital is not only determined by medical reasons. The age of the patient, the sex and question of accommodation (single persons stay normally longer) are in this context of considerable importance. Of further significance is the question, whether the patients themselves have to pay for their stay in hospitals or whether the social health insurance takes over the costs (self-paying people on an average stay a shorter time). The number of hospital cases treated under the general hospital service on a Federal average amounts to 110 per 1,000 inhabitants. This number has constantly increased during the past years (1949: approx. 103).

4. HOSPITAL STAFF

The hospitals of the Federal Republic employ about 21,450 full-time physicians and about 7,150 part-time physicians. Furthermore there are about 350 auditing and unpaid physicians as well as about 3,050 medical assistants. The number of nursing employees totals 100,665 plus 23,253 nurses in training. According to the object and size of the hospital the number of employees in the individual hospital varies considerably. For the most important groups of personnel the situation is as follows: The number of patients attended by one physician fluctuates between 12 and 30. The number of patients to be cared for by one nursing employee fluctuates between three and five. The number of hospital beds per one maid varies between nine and 12. The number of beds as per administrative employee varies between 20 and 35. The number of patients per one employee of the kitchen personnel varies between 25 and 40. The output of labour of the laundry personnel fluctuates between 40 and 60 kg. dry-wash per each employee per day. The relation of the total employees to the patients to be cared for fluctuates approximately between 0.8 and 2.0. Table 5 shows a survey of the average monthly salaries for the most important groups of personnel.

5. ORGANISATION AND MANAGEMENT OF HOSPITALS

The management of the hospital is the responsibility of the hospital board which is composed of the medical director, the hospital matron and the director of administration. The full-time employed physicians are in charge of the medical service. Only 848 hospitals within the Federal Republic are so-called 'Beleg' Hospitals, in which self-employed physicians attend their patients without being responsible for the technical and economic organisation of the hospital. Every special department is directed by a leading physician. One of the leading departmental physicians acts at the same time as a medical director of the hospital with the task of general medical supervision in medical-hygienic matters. The subordinated medical service is performed by full-time senior physicians and medical residents. Furthermore there are so-called medical assistants, who after finishing their studies work in hospitals until they

acquire the qualification of a physician (two years). The conduct of the nursing service is in the hands of the hospital matron. The hospital matron nowadays mostly has a one-year's special training course at a nursing college. The nursing service as a rule is so organised that small groups of patients (14 to 17 persons) are to be looked after by one nursing team (hospital nurses, curators and nurses still in training). Several such nursing teams (if possible all nursing teams of a special medical department) are combined organisationally and are subject to the control of a ward sister. Ward sisters must also be trained at a nursing college. The nurse-training lasts three years, and is executed in nursing schools recognised by the government, which are attached to the hospitals. The training is concluded with a governmental examination. Besides the hospital nurses there are auxiliary nursing personnel, so-called nurses who have a different general background and training. The training of these persons as a rule lasts one year. The administrative management of the hospital lies with the director of administration (see passage D).

6. COSTS AND FINANCING OF HOSPITAL MANAGEMENT

Exact statements as to the financial economy of hospitals in the Federal Republic are not available—neither as to total expenditure nor as to turnover, nor as to fixed assets. Only the expenditure of the social health insurance for hospital services and stay at a spa is known. Expenditure for some 60.4 m. nursing days amounted in 1960 to approximately 1.57 milliards, as against a corresponding cost of about DM 440 m. in 1950, an increase of about 270%. According to the medical-nursing needs of the hospitals the prime costs per patient day vary between DM 20 and DM 40. Taking an average value of DM 25 as a basis, the result is an annual turnover in the hospitals of DM 4.7 milliards.

About 50 to 55% of the operating costs are in respect of personnel. The cost of material goods (medical requirements, food, water, power, laundry requirements, other requirements and administrative requirements) amount to about 30 to 35% of the operating costs. Of these, the cost of food, about 15 to 20%, is of great weight. This is followed by medical require-

ments with 8 to 12%. About 15 to 18% of the total costs are in respect of costs of depreciations and maintenance. The costs of financing amount to 1 to 2%. During the past years the costs of the hospitals increased considerably, some above 100%. Particularly striking is the large increase in salaries and wages and the increase in costs of medical requirements (intensification of treatment and nursing—shortening of the stay period).

The individual costs making the total cost thereby varied to some extent, but the sequence of the individual costs, however, hardly changed. For about 80% of the population associated with social insurance, the health insurances take over the costs for the hospital stay. About 10% of the population has a legal claim of another kind to medical treatment (e.g., public welfare, armed forces, etc.). The remaining 10% are self-paying persons, i.e., they have to bear the costs for hospital treatment themselves. The larger part of these patients belongs to private health insurances. The health insurances take over the costs of hospital stay for 78 weeks. If necessitated through the financial position of the patient, the public welfare bears the hospital costs after termination of this period.

Apart from the self-paying persons of the first and second nursing class (6 to 8% of all patients), the daily costs (cost per day per patient) are price-controlled by means of legal regulations. According to the 'Federal Government Hospital Costs Regulation' of August 31st, 1954, the determining of the daily costs (for all patients except for the self-paying persons of the first and second class) has to be based upon the prime-costs within the meaning of this regulation. But the 'regulation prime costs' differ from the actual prime costs for the purpose of price calculation. Neither the interest on borrowed capital nor the depreciations for acquisition values may fully be taken into account. The difference between the actual prime costs and the returns resulting from daily costs is covered by means of unsystematic contributions of the responsible institutions or public authorities, as well as by means of private contributions or through withdrawals from the hospitals' real assets. This considerable gap in the current financing of hospitals is still further aggravated by two factors. On the one hand the social insurances may argue that they, with regard to their difficult

financial position, are not in a position to reimburse the hospitals the 'regulation prime costs'. On the other hand the valid daily cost rates of the current accounting period are based upon the actual costs of the last accounting period, very often even the preceding one, which are in part as a result of the upward trend of prices considerably below the real costs. The most important difference to the actual prime costs, however, is due to the fact that the usually paid public contributions, i.e., such as those fixed by parliamentary bodies and shown in the regular public budgets, may not be considered in the prime cost calculation of the hospitals. This regulation is in particular a heavy burden for the municipal hospitals. At present there are three proposals for the termination of the financial difficulties of the hospitals under discussion:

1. Full cover of prime costs through the daily cost rates and an increase in the health insurance contribution.

2. Full cover of prime costs through the daily cost rates, constant health insurance contributions, with financial support of the health insurances through subsidies from the Federal Government.

3. Division of the daily cost rate; reimbursement of the current operating costs through the health insurance, and reimbursement of 'Vorhaltungskosten' through the government.

The hospitals claim full reimbursement of the prime costs through the daily cost rate, since they fear that if they accept the 'Vorhaltungskosten' costs from the State, the government will exert its influence on the management.

7. HOSPITAL PLANNING

Adhering to the principle of voluntary self-help there is no governmental planning in the Federal Republic for the operation and construction of hospitals. The planning is up to the individual hospital institutions and to the regional planning communities of several hospital institutions. Any new planning of a hospital is as a rule preceded by an estimate of the future bed requirements. The studies necessary comprise mainly the catchment areas for any planned medical specialty,

the ascertainment of beds available, and otherwise planned additional hospital beds, the number and kind of hospital cases to be expected, the probable duration of the in-patient stay and the minimum, optimum and maximum of the future bed-occupation. A number of further factors influences the result of the estimate, among other things migration and immigration, the age structure, the social and industrial structure, the traffic conditions, the housing conditions and the frequency of accidents. Due to medical nursing and economic reasons it is necessary to graduate the total number of beds available according to the demand. On a lower level hospital beds are available for the kind of treatment which can be spread over a large region. Moreover on a central level those beds that do not allow a wide dispersal must be available. On the upper level special beds and equipment have to be provided which are used relatively seldom and which therefore have, out of medical, nursing and economic reasons, to be centralized. The density of this network of hospitals with different requirements has to be in conformity with the population density and the traffic connections. On account of this graduation the following types of General Hospital developed:

Minimum service: Comprising at least the following main subjects (directed by a full-time hospital physician): Surgery and Medical Department and starting with a minimum of 120 beds.

Basic service: Comprising additionally as subsidiary subjects (looked after by a part-time employed independent physician) gynaecology and obstetrics, throat, nose, ear and eye diseases. The minimum number of beds is around 200.

Regular service: Its minimum requirement is Surgical and Medical departments, Gynaecology, Obstetrics, as well as Paediatrics, as main subjects, and as subsidiary subjects throat, nose, ear and eye diseases, special technical equipment and personnel, aid such as radiologist service, with extra beds and full pharmacy. The minimum number of beds is about 400.

Central service: As against the regular service it is supplemented by the main subjects of Urology and Neurology, with a total

of 600 beds, furthermore by additional technical equipment such as special laboratories and pathology.

Maximum service: Comprises all, or at least a great number of general specialties as main subjects, furthermore all technical equipment and personnel with a minimum number of about 1,000 beds.

Besides, there are the small hospitals with less than 120 beds for an additional service. Specialty hospitals are according to their objects, size and structure as the case may be associated with one of these six types.

The voluntary conformity and classification of the various hospitals into this network of general hospital service is supervised and supported by the government, subsidising the construction of hospitals with public funds (contributions by the 'Lands' amount to 30 to 70% of the total building costs). In case of financial applications, the health authorities as a rule examine the question of requirement and the suitability in relation to the whole network of 'stationary' hospital service.

The individual construction of a hospital is as a rule methodically and intensively planned. Members of the planning team are: hospital management, architect, physicians, hospital nurses, hospital consultants and special technicians. Planning and building of a hospital comprises the following steps:

1. Ascertainment of bed requirements.
2. Determination of the medical nursing objects (number and size of the medical departments and treatment equipment).
3. Drawing up of a working programme (performances, staff problems, division of work, working process, places of work).
4. Setting out the building programme (functional continuity, functional space co-ordination, accommodation, requirement *re* site area, working spaces and room areas).
5. Planning the hospital building.
6. Execution of the hospital building.
7. Opening.

8. BUILDING HOSPITALS

Within the Federal Republic, in order to concentrate treatment facilities and on grounds of economy, hospitals are reverting from the pavilion building method back to the block building method. The block building is at present constructed in T-form, Y-form, H-form or in comb form. The hospital establishments are constructionally divided into a nursing, a treatment and a maintenance sector plus a personnel accommodation sector and if the occasion arises establishments for teaching, research work, and extra services. The basic constructional conception of hospitals now prevailing is that the nursing sector and the corresponding treatment facilities are combined horizontally (for instance beds of the surgical department on the same floor with operating rooms, surgical ambulatory department, central sterilization, etc.). In order to meet the varied requirements of functional continuity and of the dissimilar corridors in the nursing and treatment section, nowadays the two-floor system is largely chosen for the nursing sector as well as treatment sector. Whereas in the treatment sector, lighting and ventilation are mostly artificial, it is preferred to solve the lighting and ventilation problems in the nursing sector by means of large interior courts. Altogether one endeavours in planning a hospital to provide all the prerequisites as regards the building, the equipment and furnishings for an efficient hospital service, i.e., to give the best possible service to the patient, to limit expenditure and to give favourable working conditions for staff. With the development of the modern hospital service, the building costs for hospitals have risen steeply. The space necessary per bed fluctuates at present between 140 and 220 cubic metres interior space per bed, the building costs between DM 140 and 200 per cubic meter interior space. To this according to requirements is added 15 to 25% for cost of equipment and furnishings and about 10 to 15% incidental expenses. Thus the building costs per hospital bed, without the costs for the site and the opening up, vary at present between DM 30,000 and 65,000. About 55% of the total costs fall to the nursing section, 30% to the treatment section and 15% to the supply section (excluding staff accommodation, facilities for teaching and research work). The hospital beds are

mainly financed through contributions '*a fonds perdu*' of the government, to some extent through own funds, through loans at a reduced rate of interest granted by the government or private persons, through other borrowed capital or private contributions. The present relation of building and working costs is that the current working costs reach the initial investment costs after about three to six years. This circumstance justifies the effort to save current working costs by additional capital expenditure, for instance through mechanisation of transport, through the use of labour-saving devices, through the centralization of all supply services, etc. A reduction of the running costs of DM 300, per bed and year (DM 1 per patient day) would in a 50-year period balance a larger capital investment of about DM 4,900 per bed.

When planning and building hospitals the general legal provisions (technical building provisions, DIN-standards, provisions of professional organisations) have to be observed. Furthermore minimum requirements for hospitals are prescribed by police regulations, or regulations as to the design, building and fittings of hospitals, which differ within the various 'Lands'. Above all they relate to the position of the site, the total layout, the nursing units, traffic questions, the lavatories, the supply facilities, the removal of sewage, etc. Additional regulations exist furthermore for surgical departments, lying-in departments, children's departments, infectious diseases departments, tuberculosis departments, chronic patients' departments as well as departments for neurotic and mentally ill persons.

D. Hospital Administration

1. TASKS

Administration and supplies for the hospital are the responsibility of the hospital administrator. As per spheres of operation they are classified as follows:

1. Reception: information, telephone service.
2. Registration: acceptance and transmitting of particulars about patients, ascertaining of the person liable for payment, cost protection.

3. Booking office: acceptance and execution of payments.

4. Accounting office: registration, compiling and payment for patients' treatment.

5. Book-keeping office: financial and operating book-keeping control, audit, statistics.

6. Personnel department: staff records, wages and salaries.

7. Supply department: ordering, purchasing and administration of stocks, stock control.

8. Business management: supervision and control of all business activities of the hospital, planning and organisation.

The management of the hospital administration is the responsibility of the co-called administration manager, who in larger hospitals is also called director of administration. One departmental head is in charge of one or several spheres of operation. He is assisted by case workers. In the past the hospital administration has seen its main task in the administration of the assets of the hospital, in registering receipts and expenditure, in purchasing and keeping records. With the development of the hospital to a complicated operating organisation, the task of hospital administration further developed along managerial lines. Nowadays planning, organisation and control of operating activities are the main task of the hospital administration including co-ordinating the works and spheres of activity of the nursing, treatment and supply sector with the officer in charge of the respective services (medical service, nursing service, supply service). The registration in terms of figures, the description and the control of all activities is the task of the accounting department, which by the recording of receipts and expenditure has developed as a decisive tool of management.

This change of the character of hospital administration is still in an elementary stage. Above all in establishments, where the administration manager mastered the tasks from the point of view of his general background and personality, it was possible to transform the mere hospital administration into a real hospital management.

2. TRAINING OF ADMINISTRATION MANAGERS

The general background of the administration managers was quite different during the past. Partly they came from the public service, partly from industry. In the first case they had an administrative training, in the second a commercial training. During the past few years, however, the hospital institutions were led to believe that the position of an administration manager depends upon special knowledge of the science of business management, upon technical and medical knowledge and thus upon a special general background. Moreover they found that it cannot be a matter of chance, to find the proper personality for this position. Thus for a couple of years endeavours have been made to systemise the training of administration managers. There are two possibilities:

1. Theoretical training of younger experienced members of the hospital staff at a university seminar.

The 'Deutsche Krankenhausinstitut e.V.' and the Seminar for Social Policy at the University of Cologne run a two-year seminar for hospital administration. For this purpose the participants come four times for a period of four to five weeks to the University of Cologne, in order to become acquainted by means of lectures, seminars and exercises with the basic facts of the science of hospital management, of economics, of business financing, of jurisprudence, of medicine, of building and of technology. In the meantime special practical work and written exercises have to be executed. The total number of lectures and seminar lessons within the two years amounts to about 450, 260 of which comprise the science of business management, 60 economics and business finance, 80 jurisprudence and 50 medicine, building and technology.

2. Theoretical training on university lines and practical training of university graduates (experts on business management, jurists, physicians).

The hospital institutions are aware of the fact that in view of the manifold tasks of hospital administration—mainly in larger hospitals—a university training is desirable for the future administration manager. Therefore one envisages that, im-

mediately after having finished their studies, university graduates (experts on business management, jurists, physicians) would be acquainted by means of lectures, seminars and exercises at the Cologne University, with the special problems and questions of hospitals. Moreover these applicants for hospital administration would gather experience in especially chosen and appropriate training hospitals as management assistants. Also these applicants for hospital management would undertake a larger (scientific or practical) work in the hospital field. One intends to determine a total training term of about three years. This second, however, very important way, to regulate the general background and training of hospital administration managers, is up to the present only in a state of planning and testing.

E. Development Tendencies of the Hospital System

Seen from the present situation the following development tendencies for the German hospitals may be recognised:

1. PRESERVATION OF DECENTRALIZED ADMINISTRATION OF GERMAN HOSPITALS

The present structure, according to which the stationary health service is no concern of the government, but a task of voluntary self-help, is to be preserved at all events.

2. SATISFACTORY SETTLEMENT OF THE QUESTION OF FINANCING THE WORKING OF HOSPITALS

Since it is generally accepted that the prime costs of hospitals have to be reimbursed, a reasonable way for the raising of the necessary funds has to be found, which is acceptable both to the hospitals and the health insurances.

3. INTENSIFICATION OF REGIONAL HOSPITAL PLANNING

The individual hospital institutions need to work more closely together than hitherto to form regional planning communities, in order to shape the structure of hospital beds available in an optimum way.

4. INTENSIFICATION OF OPERATIONAL PLANNING OF THE HOSPITAL

The previous endeavours for a strict planning, organisation and control of hospital activities should be intensified.

5. FUNCTIONAL ADJUSTMENT OF HOSPITAL BUILDING

Still more than up to now hospital building should be adjusted to the operational requirements of the hospital.

6. INTENSIFICATION AND SYSTEMATISATION OF THE TRAINING OF HOSPITAL PERSONNEL, ABOVE ALL FOR HOSPITAL MANAGEMENT

The hitherto rather unsystematic endeavours of individual professional associations as to the training of hospital personnel should be systematised and intensified. Above all instructions and uniform arrangements should be provided for the leading hospital professions (medical director, administration manager, hospital matron).

Table 1. *The hospitals in North-Rhine-Westfalia according to hospital institutions* (1955)

Institutions	Hospitals			Hospital beds		
	Number	%	%	Number	%	%
Public Hospitals	163	100	20.4	61,085	100	37.2
Towns	28	17.2		15,867	25.9	
County Municipalities	45	27.6		6,303	10.3	
Rural Districts	18	11.0		3,873	6.3	
Landschaft Associations	27	16.6		20,178	33.0	
Other Municipal Administrative Associations	5	3.0		1,687	2.8	
'Lands'	11	6.8		5,266	8.7	
Land Insurance Institution	14	8.6		2,796	4.6	
Other (e.g., Professional Associations)	15	9.2		5,115	8.4	
Free Hospitals of General Benefit	558	100	70.2	100,716	100	61.6
Caritas (a charitable institution)	439	78.7		72,989	72.9	
Home Mission	92	16.5		23,935	23.9	
German Red Cross	8	1.4		697	0.7	
Other	19	3.4		3,095	30.9	
Private Hospitals	75	—	9.4	2,514	—	1.6
North-Rhine-Westfalia in total	796	—	100	164,315	—	100

Table 2. Hospitals and Hospital Beds According to the Operational Size (1960)

Size of Hospitals as per Number of Hospital Beds	Hospitals Number	Hospital Beds as planned— Number	Hospital Beds as planned— %
— 25	483	6,840	1.2
25— 50	627	22,520	4.1
50— 100	780	54,640	9.9
100— 150	480	57,067	10.3
150— 200	304	52,916	9.6
200— 300	327	78,247	14.1
300— 400	169	57,316	10.4
400— 500	92	40,534	7.3
500— 600	47	25,678	4.6
600— 800	41	27,314	4.9
800—1,000	35	30,448	5.5
1,000—and above	66	99,904	18. 1
Total	3,451	553,424	100

Table 3. Hospitals and Hospital Beds According to Classification (1960)

Purpose Determination	Hospitals	Hospital Beds
General Hospitals	1,823	324,188
Hospitals for General Medicine	122	12,256
Hospitals for Infectious Diseases	4	245
Babies' and Children's Hospitals	77	11,430
Tuberculosis Hospitals	268	38,651
Surgical Hospitals	172	11,324
Orthopaedic Hospitals	39	4,678
Gynaecological Hospitals/Maternity Hospitals ..	170	8,416
Lying-in Hospitals	38	363
Mental Hospitals and Homes	76	68,067
Psychiatric Hospitals	51	23,284
Neurological Hospitals	19	1,676
Hospitals for		
Addicts	6	756
Throat-Nose-Ear-Diseases	40	897
Eye Diseases	45	1,743
Skin and Venereal Diseases	13	1,313
Roentgenology and	8	369
Chronic Diseases	20	4,103
Sanatoria	382	32,059
Other Special Hospitals	40	5,377
Prison Hospitals	38	2,229
Total	3,451	553,424

Table 4. *Bed Rates* (*Hospital beds per* 1,000 *inhabitants*) *according to special Medical Departments in North-Rhine-Westfalia* (1960).

Specialty	Number of Beds per 1,000 Inhabitants
General Beds	0.5
Surgery	2.0
General Medicine	1.9
Infectious Diseases	0.3
Skin and Venereal Diseases	0.1
Gynaecology/Maternity	0.8
Babies and Children	0.5
Psychiatry/Neurology	2.0
Throat/Nose/Ear	0.2
Eyes	0.1
Urology	0.1
Roentgenology	0.04
Other*	0.1
Total	8.64

*Among others beds for silicosis patients, dentistry, orthodontics, sanatoria, prison hospitals.

Table 5. *Summary of Average Monthly Salaries of Hospital Personnel*

Professional group	Salary in DM
Chief Physicians	2,050
Head Physicians	1,750
Medical Residents	1,350
Matrons	900
Probationers	580
Nurses	550
Nursing Helps	480
Midwives	650
Medical-technical Assistants (female)	620
Gymnasts/Masseuses/Bath Attendants	550
Supply Manager/Kitchen Manager	1,000
Cooks	750
Dietitians	650
House-maids	450
Administration Manager	1,400

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