By an Act of Parliament, which came into force in Denmark on 1 April 1973, all citizens have to belong to the public health insurance scheme. Under the scheme the population falls into two groups. People in the first group, with an annual income of less than £3,000, are entitled to free medical attention from a general practitioner to whom they are allocated and to free medical attention from specialists in the health insurance system, provided that they are referred by their general practitioner. The fees are defrayed by the health insurance authorities in the form of "capitation fees." The second group, Danes who earn over £3,000 a year, have the option of choosing their general practitioner, to whom they pay fees; they are reimbursed in accordance with a specific price schedule on application to the health insurance authorities.

Hospital Treatment

Members of both groups are entitled to free hospital treatment and maternity care and, under some conditions, to such things as dental care, travelling expenses, bandages, glasses, x-ray examinations, laboratory tests, and convalescence. A travellers' health insurance is also available, covering medical care and, if required, repatriation from countries in Europe. This is valid for two months. Recently subsidies on the cost of prescriptions have been granted, irrespective of the patient's economic status. All medical preparations have been classified into three sections, based on medical evaluation of their therapeutic value; due regard is paid to the nature of the disease to be treated and to the patients' ability to pay. Thus specific and valuable drugs such as levodopa or antibiotics are subsidized by 75% of their cost, less valuable agents such as tranquillizers by 50%.

All citizens are entitled to free prophylactic examinations, and to inoculation and vaccination against varicella, diphtheria, tetanus, polio, and pertussis. These costs are defrayed by the local health authorities and the local social services system and are reimbursed by State subsidies.

Temporary residents from the United Kingdom and other Scandinavian countries are entitled to all of the services under the health insurance system on production of the appropriate identification papers certifying that they are members of their own national health insurance scheme. Persons from other countries in the Common Market have to present further documentary evidence before they can take advantage of Danish health services.

Under Bills passed this year free abortion, sterilization, and gonadectomy are available to Danish nationals and, after fulfilment of E.E.C. regulations, to nationals of other member states who have taken up permanent residence in Denmark. Abortion is not undertaken unless the woman personally wants to have her pregnancy terminated before the 12th week of pregnancy, and provided that a gynaecologist can be persuaded to perform the operation. It goes without saying that women who come to Denmark for only a brief stay are not entitled to a free abortion.

Other Benefits

Among the numerous other benefits available to Danish nationals are the old age pension and the disablement annuity. From 1 January 1973 it has been a requirement that nationals of other member states have to stay and work in Denmark for at least a year before they are entitled to apply for these insurances or to have had permanent residence in Denmark for five consecutive years. A "daily benefit scheme" is also in operation; it starts on the first day of disablement, and the patient receives 90% of his average daily income, the only requirement being that he must produce a certificate signed by his employer, testifying that he has been working not less than 40 hours over the month before the illness or accident. Hence the scheme does not apply to tourists.

Hellerup, Denmark

AAGE PEDERSEN, M.D., General Practitioner

Great Britain

JOHN L. KILGOUR

I would first like to note the significant step forward which I believe was made in Brussels last month (see *B.M.J. Supplement*, 10 November, p. 39) by the establishment of some broadly consensus views at the public hearing convened by Commissioner Dahrendorf. Probably these agreements will facilitate the acceptability of some propositions with which the U.K. government has been associated. If I am right we are all brought measurably nearer the achievement of one of the aims of the Treaty of Rome, enshrined particularly in Article 57—the freedom of circulation and the establishment of one at least of the liberal professions. This is not to say that I expect immediate agreement, but that progress over cardinal points of interest should now be possible with eventual agreement now a probability rather than a possibility.

My subject today is to outline the position of the E.E.C. citizen in the United Kingdom as a patient. The U.K. follows a good samaritan policy which extends this right of access to all its residents, including its temporary residents—that is, those who may be visiting its shores for whatever reasons (except specifically to obtain medical care). This includes, of course, our friends from our partner countries in the European Community. There are no formalities beyond the briefest essentials. The N.H.S. has been careful to preserve the freedom of choice both for the patient in selecting his doctor of primary contact and for the doctor accepting his patient, such freedom being only qualified by the unavoidable constraints imposed by geographical accessibility.

In the United Kingdom we have noted with interest the developments in the delivery of health care in the countries of the six founder members of the Community, and whether these services have been funded centrally or are based on the insurance principle. Despite differences due to the varying historical experience in each country, the changes have all seemed to be on a converging path towards the goal of universal access to necessary care for all, without administrative or financial obstacle at the time of need. This is, of course, because the social and political pressures in each country tend the same way, and this co-ordination and achievement of aim possibly by separate methods would surely have pleased the drafters of the Treaty of Rome. It is in the spirit of the directives—agreeing an aim and leaving the method of attainment to each country rather than by regulatory prescription—that I believe we shall come closer together in the field of health and what we offer to the patient in Europe.

Department of Health and Social Security, London

JOHN L. KILGOUR, M.B., CH.B., Principal Medical Officer

Maternity Services

Chairman's Address: Great Britain

JOSEPHINE BARNES

The number of births annually in Great Britain is now about 700,000, having fallen progressively in recent years. Perhaps the most important change has been the tendency for women in Britain to have their babies in hospital rather than at home. In 1927 15% of live births in England and Wales took place in hospital. By 1970 the percentage of hospital deliveries had risen to over 80%. This has been achieved by the provision of more hospital beds, by the practice of sending women home early after delivery, and, to a large degree, by the mothers themselves, who have come to prefer hospital delivery.

All district general hospitals are staffed by obstetricians and midwives and by anaesthetists and paediatricians. In theory anaesthesia is available to every woman in labour and the services of a paediatrician to every newborn baby. In practice, arrangements are not always as satisfactory as they might be. Some maternity units are in old-fashioned buildings, others are isolated from general hospitals—and this makes for difficulty particularly in emergency staffing. In some areas there is a shortage of personnel, particularly nursing staff and anaesthetists.

The chief improvements to be looked for in British maternity services are the improvement of our maternity hospitals and their incorporation into the district general hospitals. Our health service is about to be reorganized and it is hoped that this will be taken into account when new buildings are planned.

Charing Cross Hospital, London

JOSEPHINE BARNES, F.R.C.S., F.R.C.O.G., Consultant Obstetrician and Gynaecologist

Netherlands

TJ. L. A. DE BRUÏNE

The Netherlands has a special position in Europe in that 55% of babies are still born at home—though this proportion drops to 35% in Amsterdam, Rotterdam, and The Hague. There are no private clinics and 80% of hospital deliveries take place in a general hospital, and the rest in recognized maternity clinics. Virtually all home confinements are attended by general practitioners and midwives. The smaller the town the larger the percentage of home deliveries undertaken by the family doctor. Both general practitioners and midwives receive a fee per delivery. Some of the smaller towns where there are too few births to guarantee the midwife a reasonable salary provide an annual grant of 5,000 guilders. The current fee for a midwife under the Health Insurance Act is 243 guilders per birth (including prenatal care and the lying-in period). Under the Health Insurance Act, general practitioners are paid only for obstetric work in places without a resident midwife, their fee being 310 guilders. Thus patients who want to have their family doctor in attendance when their babies are born have to pay for this as private ones (about 300-350 guilders). The social security foots the bill for attendance by an obstetrician only if the woman needs a hospital confinement, or when a specialist is consulted by a general practitioner or midwife attending a home delivery. Hospital deliveries have tended to increase with our increasing knowledge of obstetrics.

The Netherlands government favours bringing everybody under the Health Insurance Act but 30.8% of our population is not covered by it because their annual income exceeds the so-called prosperity limit of 23,000 guilders. They can insure themselves for illness and confinement with any insurance company they choose—only very few people have no insurance at all. Private fees for a delivery (including prenatal care and the lying-in period) are about 300 for a midwife, 400 for a general practitioner, and about 700 guilders for an obstetrician. In practice, private sickness insurance companies cover the costs of a hospital delivery if this is necessary.

Obviously so large a percentage of home deliveries can be justified only if home maternity care is well organized—that is, the midwife or general practitioner is present at the birth, and there is adequate nursing care of mother and baby during a lying-in period of ten days together with domestic help. Home maternity care has never been strictly controlled by the government but, it supervises and helps with subsidies when needed. The training of maternity welfare workers takes 15 months after completion of primary school education—three months' theoretical education and 12 months' practical training.

After Sweden and Norway, the Netherlands has the lowest perinatal mortality per 1,000 births in Europe: this is still diminishing, the current level being 17.6 per 1,000 births, in 1966 our maternal

mortality was 20 per 100,000 births, much the same as in other countries. From a birth rate of over 20 per 1,000 population there was a gradual decrease to 17.3 per 1,000 in 1971 and 16.5 per 1,000 in 1972, and our major cities are already moving towards a birth rate of 14 per 1,000.

Since home deliveries are the sole source of income for the midwives the decrease in the birth rate affects them, and as they are independent contractors the increasing social security benefits which employed workers in the Netherlands enjoy pass them by. Not surprisingly, therefore, the younger midwives have little interest in private practice. To the general practitioners, who also undertake deliveries as independent contractors, obstetrics represent only a small part of their income. In addition the unwillingness of general practitioners and midwives to work irregular hours nowadays has led to a shortage of obstetric manpower—which to some extent is offset by the diminishing birth rate.

Social developments will, I think, contribute much more to changes in obstetric practice than the many suggestions for perfecting obstetric care. Some obstetricians—but in particular the existing home maternity care organization and the government—advocate establishing obstetric centres. Prenatal care would have to be concentrated in these centres, while normal deliveries would be attended by midwives under supervision of an obstetrician. Some suggest that general practitioners should also have access to these centres.

So far as hospital obstetrics are concerned we face the difficulty of ensuring that adequately trained auxiliary personnel are available, particularly at nights and weekends. (To ensure round-the-clock availability today means having five people covering one post.) In the Netherlands the vast majority of hospital confinements are completed without any form of anaesthesia, except, of course, for caesarean sections and complicated deliveries. Paediatricians play very little part in antenatal and perinatal care.

As to the possibility of reciprocity of maternity services among the E.E.C. countries, in the old Common Market, without Great Britain, we never had a symposium such as this. Despite the great differences which obviously still exist, we shall have to form larger units because, as smaller communities, we may not survive. If we are to achieve this, however, we shall have to accept wider views and broader visions, and in this respect we have still much to learn from our British friends.

Haarlem, Holland

TJ. L. A. DE BRUÏNE, M.D., Obstetrician

Belgium

HUGUETTE MERCHIEERS

In 1972 the birth rate in Belgium was 13.82 per 1,000 yet our population growth remains at 1.82 per 1,000. Unfortunately we still have a persistently high mortality among our babies: every day in 1969 and 1970 Belgium lost eight infants below 1 year, of which six were less than 7 days old.

Most women have their babies in private institutions, while home confinement is a rarity. Any pregnant mother has the right to free antenatal examinations at one of the 350 clinics of the "National Child Welfare Organization." One-third of mothers take advantage of this. Free postnatal examination is available within two months of confinement.

All nationals from other member states of the E.E.C. have the same privileges as the Belgian workers themselves. The social security payments include maternity grants, which vary according to the birth order of the child—from £125 for the first to £45 for the third—children's allowances, and payment of part of the woman's earnings for up to 14 weeks. Fees for consultations, and of normal and abnormal deliveries are reimbursed by the social security system on a fixed