scale. Though there is some domestic assistance for expectant and nursing mothers, it is insufficient.

There are several defects in our maternity services at present. Firstly, though the official regulations imply that an obstetrician and gynaecologist should head a maternity department, we still have some units where the chief is a surgeon. Secondly, paediatricians are not automatically called when a premature or difficult delivery is likely to occur, and (except in university departments) there is no staff conference where both obstetricians and paediatricians can discuss complicated cases. Thirdly, there is an appreciable shortage of qualified nursing staff. Fourthly, medical records are generally inadequate, and finally, there are still too many small maternity homes isolated from a general hospital. There is a lack of co-operation between the maternity homes without neonatal units and the centres with such units.

Though the National Child Welfare Organization proposed a set of regulations for private or public maternity homes in 1958 this project has still not been implemented for budgetary and political reasons. Ten years ago the same organization launched a very detailed study on 100 maternal deaths which had occurred in institutions all over the country. The main findings and conclusions of it were similar to those of your *Confidential Inquiries into Maternal Deaths in England and Wales*—namely, that there should be early, continuous, and skilled antenatal supervision with special attention to the mother "at risk."

Brussels, Belgium

HUGUETTE MERCHERS, Midwife

Denmark

MOGENS INGERSLEV

The Danish maternity service is one part of a high-quality health care system available to all Danish citizens regardless of cost. The quality is high, as illustrated by the figure for maternal mortality of 0.15/1,000 deliveries and for perinatal mortality of 19/1,000 deliveries. The system is being changed, but I will describe the maternity service as it operates today.

Every pregnant woman is entitled to three antenatal examinations by a general practitioner, free of charge. Any complicated cases are referred to an obstetric outpatient clinic. Normal confinements take place at home, or in a maternity home, with a district midwife and a general practitioner attending. Nevertheless, domiciliary deliveries have decreased considerably in the last ten years and are now only about 5% of the total. Probably no babies will be born at home very soon. About 15% of deliveries take place in municipal maternity homes or in a few privately-owned maternity homes, which are supported by the local authorities. Another 30% of deliveries take place in general hospitals, and complicated cases have priority in the obstetric hospitals—where about 5% of deliveries occur. The obstetric teaching units of the universities are primarily centres for diagnosis and the treatment of cases requiring highly-specialized care. Thus almost all cases complicated, for example, by diabetes, blood group incompatibility, or congenital heart disease, are treated in a few obstetric hospitals.

Midwives

The 600 registered midwives in Denmark attend all deliveries and are responsible for the registration of births. Apart from about 150 midwives who are on the staff of obstetric hospitals, the rest are employed as district midwives by the counties and receive a fixed salary. Several antenatal outpatient clinics have been established in each county—and the midwives work in groups of at least six to seven and preferably alongside general practitioners in group practices. This system will become fully

operative in 1974, and will lead to demands for shorter and more regular working hours—thus highlighting the considerable shortage of midwives.

Any person who has taken up residence in Denmark is entitled to free medical and hospital care.

Taxation also covers costs for antenatal care, confinement, and the lying-in period and even transport to and from midwives, doctors, outpatient departments, and hospitals. Nevertheless, the automatic maternity grant of £60 to all mothers has been suspended because of the national financial situation. The welfare of women before and after delivery and the social security of their families are ensured in several ways. All who are employed receive their usual wages or salaries for a period of four to 14 weeks. This is paid partly by the employer and partly by the social security scheme. All mothers can seek advice on legal, social, and personal matters from the mothers aid institution; unmarried mothers may receive aid and financial support towards caring for the baby and its education; domestic help is available to all expectant and postpartum women whenever necessary; and children can be placed in foster homes during the mother's absence from home. Mothers delivered at home, or discharged early from maternity homes or obstetric departments, are visited by home nurses twice a day for the first week and twice by the midwife during the first fortnight. After this the public health nurse takes over the supervision of infant care in the home. Family planning clinics are available for those women who do not wish to consult their own doctor about contraception.

Since April this year each county council has been made responsible for the social and medical welfare programme of the region. Detailed plans for the maternity service of the region have been drawn up and presented to the Ministry of Health for approval. These include measures for identifying pregnant women, mothers, and newborn babies needing social support.

The growth of the social services has weakened the system in various ways. Patients' demands and the costs—and hence taxes—have all increased, while personal incentive and dedication to work have declined. Fewer people are prepared to work overtime or at night and weekends. The increasing shortage of nurses and hospital staff in the maternity service may mean, for instance, that we shall be forced to apply induction of labour in the morning as a routine, to make sure that as many babies as possible are delivered at a time of day when we can offer optimal care and medical services.

The number of obstetric anaesthetists is increasing but a round-the-clock service is not yet available in many obstetric units. On the whole, Danish women are healthy and well-prepared for delivery. The number of intensive care units for diseased new-born and premature babies is also growing. Everybody realizes that all obstetric departments ought to have an adequate anaesthetic and paediatric service but both money and staff are short.

Before there can be reciprocity in the maternity services within the E.E.C. there must be agreement on several well-defined standards. No doubt the language barrier is one of the main problems to overcome and the differences in education and training are also aspects to be considered. A committee should be set up, and perhaps the reports presented to this section of the conference could form the starting point for the first meeting of such a committee.

Aarhus, Denmark

MOGENS INGERSLEV, M.D., F.R.C.O.G., Professor of Obstetrics

France

CLAUDE SUREAU

The changes in antenatal and maternity care in France in the last five years have been quite startling. In 1968 the perinatal mortality rate was 27 per 1,000 (of 800,000 births). But in 1971 this had dropped to 22.8 per 1,000, owing largely to the measures taken in the intervening years.