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.

There are now over 31,000 maternity beds, more than half of them in public hospitals, and the rest private. Only about 3% of babies are born at home. Maternity care is supervised by the "Society for the Protection of the Mother and the Infant," an organization which itself comes under the auspices of the Ministry of Health, and supervises prenatal and postnatal maternity care, neonatal and infant care, and family planning. The State provides 83% of its budget. French working mothers are entitled to six weeks off before the confinement and eight weeks after delivery, and can claim several kinds of maternity allowances. Almost all of the French population belong to the social security system, which covers all maternity expenses. This includes four antenatal visits, a 12-day stay in hospital, a post-natal examination, and three compulsory examinations of the baby at 8 days, 9 months, and 2 years.

Some Inadequacies

Until 1968 there were several inadequacies in our maternity care—for example, insufficient equipment in the public hospitals, too many small private institutions, lack of interest by most paediatricians and anaesthetists, a shortage of obstetricians, and lack of financial support for perinatal research. These inadequacies began to be commented on in the medical and lay press and eventually the government appointed a secretariat of state whose primary interest was the prevention of perinatal mortality and morbidity. The sheer economic cost to the community of children and adults with disabilities thought to be due to perinatal causes was enormous (2.5% of the gross national product) and a national survey of the problem was obviously needed.

The report recommended aiming at a perinatal mortality rate of 18 per 1,000 by 1980. The measures taken included increasing the number of teachers in perinatal specialties, using private institutions for clinical teaching, reorganizing specialist training in obstetrics and gynaecology, and instituting postgraduate teaching. Despite the difficulties a large programme of postgraduate training has been started throughout France, and films (on prenatal and neonatal care) are to be distributed free of charge to all doctors and midwives.

A programme of vaccination against rubella of all girls aged 13 years and over and women at risk was started in 1971 with 50,000 vaccinations a year. The following year a law introduced minimal requirements for private institutions so far as the number of beds, surgical and resuscitation equipment, and availability of medical care were concerned. Since then 84 institutions have closed and 476 are expected to close soon.

In 1971 9.4 m. francs were spent on this improvement programme and the budget for the next five years is 258 m. francs, 74 m. coming from the State. At the same time a big effort has been made by the doctors themselves: private institutions have been reorganized on a larger basis; a Society of Perinatal Medicine was established in 1971; and perinatal research teams have been organized.

One of the results of these measures has been that the reduction in the perinatal mortality rate which should have been reached in 1980 has already been achieved, owing partly to the fact that even before the government's action the medical profession had begun to improve the quality of care and there had been technical improvements. Of course, in some fields improvements still have to be made—particularly in the organization of obstetric and paediatric departments and of putting research on a permanent basis.

Université René Descartes, Paris

CLAUDE SUREAU, M.D., Professor of Obstetrics and Gynaecology

The General Practitioner in Europe

Chairman's Introduction

R. de SMET

Today our programme centres on the general practitioner. The patient hopes to find a man in whom he can confide, someone who will help him find his way in the increasingly complicated labyrinth of specialist medicine; administrators expect him to carry out the task of primary physician; and the sociologist hopes the general practitioner will give medical care a more human face and make our society healthier.

Though the general practitioner is confident that he can fulfil this task, everywhere he is trying to define his functions more accurately. Inevitably this ends up by confirming that general practice rests on three pillars: frontline care, integral approach, and continuous medical assistance. By these three essential characteristics, general practice clearly stands apart from specialist medicine, and the necessity for specific vocational training is obvious.

If we wish to steer western Europe's medicine in the right tracks then we should start trying to understand each other. We must focus our attention on our common interests rather than on the differences that may seem to separate us.

Heverlee, Belgium

R. DE SMET, M.D., President of the Scientific Society of Flemish General Practitioners

Great Britain

JOHN FRY

There is no single "best-buy" system of medical care that can be applied to all countries. The National Health Service is certainly not exportable across the English Channel because of the nature of its evolution—from the friendly societies and sick clubs of the last century, Lloyd George's National Health Insurance Act of 1911, and the Emergency Medical Service of World War II. Even in 1948 it was not a radically new system that was introduced into my practice: the only difference was the form of payment, and this was merely an extension of the previous capitation system of the National Health Insurance to cover the whole population.

We must accept as inevitable that even though we have a Common Market there will always be different forms of general practice in the member countries. It is quite wrong to work for, or expect, the development of a common form of medical care system and general practice in the E.E.C. What we should strive to achieve are common approaches to our problems. We should try and learn from one another through regular discussions, and an E.E.C. general practice group should be set up to study common problems. Political clashes with governments over remuneration, conversely, must be left to local professional associations.

More important for improvements in the quality and status of general practice are the education of undergraduates in general practice and the continuing education of established doctors; research into the common clinical conditions seen in practice; studies into the best methods of care in general practice using techniques for early diagnosis, long-term care of chronic conditions, preventive methods, and health education. There are also the respective roles of hospital doctors and general practitioners.

Despite the depression and demoralization in the 1950s and early 1960s (which resulted in the emigration of many British