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.

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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