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OHE briefing

ILL IN EUROPE

Introduction

People pay for some health care themselves out of income and savings. In Britain, out of a total expenditure on health care of all kinds of £13,700 million in 1981 it is estimated that some 3.0 per cent was paid for in this way, partly for non-prescription medicines. They also claim health care insurance. In 1981, BUPA and other health insurance agencies paid out almost £205 million, or 1.5 per cent of the total expenditure. A small part of health care is paid for by the national insurance fund, to cover some of the costs of road accidents. In other European countries, the compulsory national insurance or social security funds provide the bulk of the costs of medical care, as was the case in Britain before 1948. Since then, however, the bulk of health care costs have been carried by the National Health Service – some £13,100 million in 1981, or 95.5 per cent of the total.

The United Kingdom and now Italy are very much the odd men out in Europe, because so much of this health care falls directly on the taxpayer, and because the health care – the hospitals, the doctors, the ambulances – is predominantly provided by the state in the same way that the police and the army are. Moreover, the service is for the most part free of direct charge to the patient.

Elsewhere there is much more of an insurance element in the payment for services, and the services are themselves provided by churches, charities, companies, trade unions, as well as by the state. The fact that for over a third of a century the British have gone down a different path, and have not been followed, except by Italy, is explicable in several ways. In Roman Catholic countries, like the Republic of Ireland, the church has been wary of direct state involvement in medical care, as it has been of direct state involvement in education. In many countries, the medical profession has been deeply sceptical of 'socialist' control of their work. And, historically, from Bismark's time on, the provision of health care has been linked to the social security system, and the idea of social insurance, with benefits on what seems to the British a lavish scale, has been a powerful tradition in Germany and the countries associated with it.

In general, a distinction may be drawn between centralised *payment* for health care and its centralised *provision*. The result of these differences of payment and provision seems to have surprisingly little effect on the outcomes, mortality and morbidity rates, or the take-up of medical care. But it has deeply affected the style of provision, the attitudes of the public, and the remuneration of the doctors. Of course some differences arise because some countries are richer than others. Germany's wealth is reflected in its gleaming hospitals. But the differences go beyond that.

In what follows there is a brief description of the finance and the provision of health care in the countries of the European Community, including Spain but excluding Greece and Portugal, which are too poor for valid comparisons. The paper also tries to attach some numbers to the indications of cost and provision. Finally, it raises some questions for the organisation of health care in Britain.

Expenditure and benefits

There are several ways of expressing the amount that is spent on health care. It can be in absolute terms – so many billions of dollars or pounds; or a percentage of the GNP (Gross National Product); or as expenditure per capita. Table 1 shows the percentage of gross national product for 10 European countries, including the United Kingdom.

Obviously, the richest countries spend the most, as a proportion of GNP and per capita. That is no mystery. But several qualifications have to be made before simple comparisons are made. The population at risk differs from country to country. Ireland, for example, has disproportionately more children, 31.4 per cent under 14 compared with 22.2 per cent in England and Wales. And that influences expenditure. Other countries have a disproportionate number of elderly people – Germany has 15.3 per cent of its

Table 1 *Expenditure in Health Care in 10 countries as a percentage of GNP; about 1980*

	% of GNP[3]
Belgium	6.1
Denmark	6.7
France	8.1
F.R. Germany	8.0
Holland	8.7
Ireland	8.4
Italy	6.4
Luxembourg	9.5
Spain	5.4
United Kingdom	5.7

Source: OECD estimates

Table 2 (1976)

	Doctors per 10,000 people	*Nursing Personnel per 10,000 people*
France	16.3	57.4
Germany F.R.	19.9	37.1
United Kingdom	15.2	37.4

Source: Health Services in Europe, Vol.2, World Health Organisation, Copenhagen, 1981

Table 3 *Health Indicators, Europe (1978)*

	Infant mortality per 1,000 live births	*Expectation of life, males aged 45*
Belgium	13.9	27.6 (1976)
Denmark	8.9	29.5
France	10.6	28.6 (1976)
Germany F.R.	14.7	28.1
Ireland	15.6 (1977)	27.7 (1975)
Italy	17.7 (1977)	28.6 (1975)
Luxembourg	9.6	27.0
Netherlands	8.1	29.7
Spain	15.1	29.5 (1976)
England and Wales	13.1	28.2 (1977)
Scotland	13.0	26.5

Source: WHO, 1981

population over 65 compared with 10.8 per cent in Ireland for example. A sophisticated statistical exercise would be necessary to ensure that like was really being compared with like.

In addition, however, what is paid for a unit of service varies greatly. In the United Kingdom with a virtual monopoly supplier of health services, the price of inputs, especially the fees and salaries of doctors, nurses and paramedicals, and the costs of pharmaceuticals have been strictly controlled. In Germany, by contrast, the relatively more free market has enabled fees to be bid up to a higher level. If, as in Table 2, facilities are compared it can be seen that there is less disparity than might be expected from expenditure figures. Other indicators suggest different traditions in patterns of health care, resulting in a different pattern of outlays. It is not possible to say *a priori* which pattern is the 'best': the 'best' depends upon what you want.

One way of pointing out what is the 'best' is to compare outcomes – deaths, morbidity rates – though it is of course a debatable point as to how far these outcomes are due to medical care. A rich country tends to have people who eat more, drink more and smoke more, and who travel in cars more, than a poor one. The health services spend a great deal clearing up the consequences of affluence. Much illness also, of course, arises from poverty.

For what it is worth, in Table 3 there are some comparisons of infant mortality rates and expectation of life for men at the age of 45. It will be seen that Denmark, France and Holland have low rates of infant mortality, while Spain and Germany have high rates (though in all cases the rates are low by world standards – about 1 per cent). The expectation of life for men at 45 is again roughly the same – ranging from 26.5 years in Scotland to 29.7 in Holland. The extra 3 years may represent better health care, but as the Spanish figure is almost the same as the Dutch, and the Luxembourg figure is only a little better than the Scottish, it is hard to believe that the pattern or even the quality of health care makes much difference in itself.

But of course such gross differences are not the only or indeed the main indicators of health care quality. The data in this section of the paper illustrate the fact that the mode of payment is not of itself a direct determinant either of how much is spent, or what is the consequent healthiness of the population.

Who pays and how?

How then do people pay for health care? In each country two extremes may be briefly stated. There is a small proportion of wealthy people, often internationally oriented, who pay for virtually all their own medical care – wealthy Arabs for example, who patronise the fashionable practitioners in London, Monte Carlo, Paris or Zurich, and who use private hospitals and clinics. There is, too, a population of grossly disabled people, mentally handicapped, seriously schizophrenic, or senile, who spend their lives in publicly provided or charitable hospitals for long-stay patients. The way such patients are cared for is a sign of the quality of a society, but it is not necessarily an indication of the quality of medical care in general. This *Briefing* is not about the grossly handicapped or the extremely rich, nor is it about the health care of those who serve in the armed forces, nor in other specialised groups. It is about the payment for health care and its provision for the great majority of the population.

It is easiest to begin at home. In the **UNITED KINGDOM** (and usually this will be shorthand for England and Wales, since there are marginal differences in Scotland and Northern Ireland and it would be tedious continually to refer to them), the National Health Service has provided medical care for most people since 1948. Access to primary medical care is free. The general practitioner may be visited at his practice, or at a health centre provided by the NHS, where simple procedures may be carried out; or the doctor may make domiciliary visits. Nursing and other auxiliary services are free, as are ambulances.

The general practice doctor is paid partly on a salary, partly by a capitation fee and partly on a fee for item of service basis. There are restrictions on the number of doctors who may offer their services in any area.

Pharmaceuticals are available on prescription, for which a standard charge is made of £1.30 per item. However 75 per cent of prescriptions are exempt from this charge because of patients' age, medical condition or poverty.

Dental care and opticians' services are similarly available for more substantial charges.

Hospital care, both in-patient and out-patient, is free, though out-patients pay the standard charge for prescriptions. The hospital staff is paid a salary, and not by a payment per item of service.

The National Health Service is centrally organised but locally administered. It is financed from general taxation, with a contribution of 9 per cent from the National Insurance fund, itself financed by a compulsory pay-roll levy, and 3 per cent by patient payments.

That, then, in brief, is the British system. It is supplemented for some 7 per cent of the population by health insurance schemes, which provide privacy in hospitals, and speedy access to medical consultation, and medical and surgical treatment. Only a small minority of the 7 per cent who are so insured rely on the insurance for all their medical care.

The nearest approach to the British system – other than Italy – is that found in **DENMARK.** The whole population since 1973 has been covered by a compulsory health insurance scheme. There are 2 categories, group 1 and group 2. In *group 1*, covering 93 per cent of the population, there is a free choice of general practitioner, who may refer to a specialist. All medical care, inclusive of hospital care, is free. Medicines in hospital are free and outside hospital medicines are reimbursed to the extent of 75 per cent, 50 per cent or nil. Medicines with 'valuable therapeutic effect' are reimbursed at a 50 per cent rate and medicines used for treatment of well defined, often mortal diseases are reimbursed at 75 per cent of cost. All other medicines, including those sold over the counter are not reimbursed. For patients belonging to *group 2* of the insurance scheme the general practitioner is entitled to charge the patient a sum in excess of the standard reimbursable fee. The patient can go directly to a specialist and normally he has to pay him a sum in excess of the standard reimbursable fee. Pharmaceutical reimbursement is the same as in group 1. All hospital care is free.

The health service is financed by the counties, under the supervision of the National Board of Health with part of the cost financed by the state and the rest by local (county) income tax. The reimbursement by the state is in the form of a lump sum subsidy the amount of which is based on objective criteria (population, age distribution, road length etc.). This lump sum covers all medical activities in the county which can allocate the money as it so wishes.

An alternative system to a centralised tax and insurance scheme, like that in Denmark, is a series of insurance schemes as in the **GERMAN FEDERAL REPUBLIC.** Over 90 per cent of the German people belong to a statutory health insurance scheme and a further 8 per cent to private non-statutory insurance schemes. The statutory scheme provides virtually free health care for its members with nominal charges for medicines, dentistry and – on a more limited scale – spectacles (every three years, except for medical reasons).

All treatment is therefore free at point of service and the doctor or hospital is paid directly by the scheme. In the private schemes, expenditure is reimbursed within set limits. The compulsory insurance schemes are autonomous – over 1,400 of them – and are divided into eight categories whose resources are derived from compulsory levies of 7 to 14 per cent of earnings (the average is 12 per cent), divided equally between employer and employed.

BELGIUM has a compulsory insurance system covering virtually the whole population. There are about 1,745 sick funds providing health care insurance, organised into six major groupings. Health care contributions levied on employers and employees are paid, via the National Social Security Office (ONSS), to the National Institute for Sickness and Invalidity Insurance (INAMI), which divides them amongst the sick fund groupings.

The patient pays the GP a standard fee direct, and subsequently receives partial or full reimbursement from his sick fund. For a normal patient, the rate of reimbursement is at present at least 75 per cent, although the government has very recently proposed that this rate of reimbursement should be reduced. Special category patients (eg the disabled, pensioners, widows and orphans with low incomes) receive 100 per cent reimbursement.

The doctor is free to prescribe any medicine, but there is a four-category system providing for different levels of patient contribution to the cost of the medicines prescribed. Category A (life saving medicines) are fully reimbursed. For category B (therapeutically useful medicines such as antibiotics), normal patients pay 25 per cent of the price up to BF 300, while special category patients pay 15 per cent of the price up to BF 200. For category C (less useful medicines), patients pay 50 per cent of the price, with a ceiling of BF 500 for normal patients and one of BF 300 for special category patients. Category D medicines (such as oral contraceptives) are non-reimburseable. With the first three categories, the pharmacist is paid the balance of the price by the sick funds.

The patient pays the hospital a daily fee (the amount of which is regulated by law) covering nursing services, hotel costs, administration, depreciation, etc., and, in addition, he pays for the services of doctors and for medicines supplied. He is fully reimbursed by his sick fund in respect of the daily fee for the first 40 days spent in hospital. Thereafter, if he can afford it, he has to bear part of the hotel cost element out of his own pocket. Reimbursement of the patient's payment for doctors' services and for medicines supplied is made on the same basis as for non-hospital patients.

The state pays 95 per cent of the cost of treating the social diseases (cancer, tuberculosis, poliomyelitis, mental illness and handicap).

The **FRENCH** health care system is financed by the social security systems (or *caisses*) which cover the whole population. They are administered by boards representative of the employers and the unions; the Socialist government's projected law will give the trade unions a majority of seats on the boards. The *caisses* impose a levy on employers and employees, and in return finance most health care.

General practitioners are of two grades; simply corresponding to specialists and non-specialists. The 85 per cent who fall into the latter category can charge standard fees, while the rest can charge more. The social security system will refund 80 per cent of the standard charge for a consultation, subject to a maximum contribution by the assured, of 100 Fr. Fr. a month, or 600 Fr. Fr. in six months. This is subject, too, to the over-riding constraint that 24 scheduled major diseases, eg tuberculosis, cerebral-vascular diseases, multiple sclerosis, pernicious anaemia etc., or a '25th' that is assessed by the doctor of the social security scheme to be chronic or severe, is treated without charge. No charge is levied on those receiving 'social aid' i.e. the poor.

Almost all hospital care is thus virtually free. The patient is required to pay 20 per cent of his hospital bill but since hospital care runs into one or other of these barriers of expense or scheduled illness, and psychiatric and maternity beds are also provided free of charge, few charges are actually levied.

Pharmaceutical prescriptions are reimbursed on three scales – 'life saving' medicines, or those prescribed in the 24 listed illnesses – are free, other medicines are 70 per cent free; but a group of 'comfort medicines' – eg laxatives, tonics, slimming preparations – are only 40 per cent reimbursable. (Again all these charges are subject to the 100 Fr. Fr. limit of health expenditure by the patient in any one month.)

Surgical care is free if the operation is rated by a scale of gravity at or above appendicitis, known colloquially as 'K50'.

It will be seen, therefore, that the bulk of French medical care is free of charge. 99.5 per cent of hospital care in public hospitals is free, and 66 per cent of non-hospital health care.

THE NETHERLANDS has a system not unlike that of the French, but with less comprehensive care. About two-thirds of the population is insured by a state system, which meets most of the costs of services of general practitioners, dentists, hospitals and medicines, for a levy on earnings, divided equally between the employer and the employee. The rest of the population is covered by private insurance. Hospital care and specialist service is only reimbursed if referral is made by a general practitioner.

IRELAND is a much poorer country than Holland, but it has a relatively lavish system of health care. The population is divided into three categories. The first, the poorest, or roughly 40 per cent, assessed by a means test, receive all primary and hospital health care free, including pharmaceuticals and other treatment, as well as dentistry. A second category, some 48 per cent of the population, make an earnings-related contribution to the health care system, and in return receive free hospital and maternity care, with some reimbursement for medicines. The third category, covered by private health insurance, is about 17 per cent of the population, thus overlapping the second category. It gets free in-patient treatment in public wards, and contributions towards other fees and charges (for specialists, medicines, dentistry) but general practitioner services must be paid, unless the insurance scheme covers that expenditure.

LUXEMBOURG has 30 hospitals, no health centres, and just over 400 physicians. Over 99 per cent of the population is covered by a sickness insurance similar to that of Denmark.

ITALY is a mixture of an advanced industrial country and a rural one. Since 1979 it has had a National Health Service administered by 20 regions. The bulk of the expenditure comes from contributions paid by employers and employees through the National Provident Institute, supplemented by special taxation levied on citizens non subject to social security scheme. This system replaces the previous 200 or so insurance funds, whose administration ceased in December 1981.

All medical care is free of charge except for prescriptions for which a charge is made for some medicaments. The private sector is flourishing for the better-off. There is great unevenness of provision, and the system is said to be greatly open to abuse.

SPAIN resembles Italy economically and socially. It has a health insurance system covering 90 per cent of the population, which reimburses all or part of the cost of medicines. The scheme is financed by the state, employers and employees on a tripartite basis, through the Instituto Nacional de Prevision. In rural areas general practitioners are paid by the state to provide free care for the insured. In towns children may be treated free by paediatricians. General practitioners in towns are reimbursed by the Instituto Nacional de Prevision. And there are also free clinics for the poor, for emergencies and for persons on social security.

Health care in Europe thus presents a complex picture. Perhaps Table 4 may make it more clear. What is perhaps most surprising is that once you know your way around the system in each country, most health care is either free or heavily subsidised. The differences arise in the way you pay – through taxes or by insurance (which usually comes to the same thing) – and whether you have to fill in forms to get your money back.

There is also a difference in the availability of adequate health care geographically – paradoxically some of the poorer areas of Europe, like rural Ireland and Scotland do best – and of its speed and 'luxury' of provision. In Britain the patient is accustomed to wait to see a hospital specialist, but not in France and Germany. And in Germany (to a lesser extent in France) the hospitals are modern and have single or small rooms.

Who provides the services and how?

In the United Kingdom the great majority of hospitals are owned by the National Health Service (or in Northern Ireland a parallel body), and operated on its behalf by Health Districts, with whom primary medical care teams have contracts of service. Above the Districts are the Regions, which employ the hospital consultants. It follows that the planning of provision is a central responsibility (though it is subject for most purposes to subordinate bodies) as are the negotiations on salaries, fees and other costs. In the United States, in direct contrast, hospitals may be operated by states and counties, by universities, by lay and religious charities, by co-operatives, or by private firms. Primary care teams are private enterprises, sometimes working as a partnership in a firm, as lawyers do. Their expenses are met by the patients, who may be reimbursed by public or private insurance.

The dichotomy between a central monopoly scheme and a spontaneous and heterogeneous health care market is not a clear cut one, however. The bulk of European systems fall between the two models, with Denmark and Italy being nearest the British system, and Germany nearest the American circumstances. Even so, however, all countries have some sort of attempt at controlling costs, and some efforts to plan the provision of medical care.

The extremes meet in mental health. All countries provide publicly-supported hospitals for long-stay psychiatric and mental handicapped patients. No country provides intensive psycho-analysis for all patients who seek it, whether on a free-at-point-of-service or an insurance scheme.

In medicine and surgery, most countries reimburse a high proportion of the cost of most prescribed medications. Most countries reimburse much or all of the cost of short-term hospital care. But the way that hospitals are owned and managed varies greatly.

Historically the doctor was self employed, working alone or in partnership, and the British National Health Service recognises that by paying fees and expenses generally on a per capita basis. The general practitioner is not a salaried employee.[1] This is broadly true of all European systems, except that the doctor is usually reimbursed on a fee per item of service basis, either directly by the insurance scheme, or directly by the patient who is then reimbursed wholly or in part by the insurance scheme. In hospitals, however, the doctors are usually paid salaries. Dentists, pharmacists and opticians are almost universally paid on a fee per item of service basis.

The exceptions to this rule are to be found in the rural areas of Ireland and Spain, where the state (or the social security system) provides a dispensary, staffed by a salaried medical care team, or an individual doctor (for example there is a salaried doctor on Clare Island, a remote community in Clew Bay off the coast of County Mayo, in Ireland). This has its origins in nineteenth century attempts to provide basic services to remote communities, and such services, often with religious and charitable origins, are to be found in the poorer parts of many European towns, sometimes transmuted into a modern neighbourhood health centre.

In Britain the medical profession has been more or less divided into two, the general practitioners, and the hospital doctors who provide specialist treatment. Sometimes the general practitioner runs a clinic in a hospital, and the specialists occasionally make domiciliary visits, but in general the roles are in practice distinct. In continental Europe this division is less apparent. Patients will turn directly to different doctors for different problems. Some health insurance systems require a referral by a general practitioner (as a means of limiting expenditure, since specialist consultations are more expensive). Nevertheless quite a small town will have streets with rows of brass plates, modestly advertising specialists in skin diseases, obstetrics, gynaecology, chest and thoracic problems, allergies or psychiatry, to which the local population will turn directly. In Germany, for example, over half the 56,000 specialist physicians practice outside hospitals.

These doctors often have beds in the local hospitals, as was once almost universal in Britain, and still is in rural areas with small 'cottage' hospitals. In France, a specialist is allowed two 'private' beds for every forty within the public sector. The hospitals themselves are provided by a variety of means. In Britain they are owned by the state. In Denmark they are owned by the counties. They are publicly owned by 8 regional health boards in Ireland, although there are voluntary hospitals sometimes provided by religious orders whose costs are mainly reimbursed by the insurance scheme. For the most part these voluntary hospitals are university teaching hospitals. In Belgium, the hospitals are

1 British hospital doctors, on the other hand, are salaried employees, either on a full-time or part-time basis.

Table 4

	Basis of payment	*General Practitioner*	*'Comfort' medicines*	*'Serious' medicines*	*Specialist Consultation*	*Hospital Care*	*Long-term Care*	*Dentistry*
Belgium	(Insurance)	S	P	S	F	F	F	P
Denmark	(Insurance)	F	P	S	F	F	F	F
France	(Insurance)	S	P	S	S	F	F	P,F
Germany F.R.	(Insurance)	F	F	F	F	F	F	F
Holland	(Insurance)	F,P	F,P	F,P	F,P	F,P	F	F,P
Ireland	(Tax/Insurance)	F,U	F,U	F,U	F,P	F,P	F,P	F,P
Italy	(Tax/Insurance)	F	U	S,F	F	F	F	P
Luxembourg	(Insurance)	F	F	F	F	F	F	P
Spain	(Insurance/Tax)	F,P,U,	F,P,U	F,P,U	F,P,U	F,P,U	F	F,P,U
United Kingdom	(Tax)	F	S	S	F	F	F	P

F=Free at point of service S=Small charge P=Partial reimbursement U=Unfree

provided by public social aid centres (formerly the poor law authorities), and by mutual aid societies and religious bodies. In France the hospitals are provided by communes, by religious orders, or by private bodies, all supervised by Regional Directorates of Hospitals and the Inspectorate-General of Health, to make sure that the number and type of beds provided is appropriate to the demand. The current costs of the public hospitals are met by reimbursement from the social security system.

In Germany about half the hospital beds are in hospitals owned by the Länder or town councils: a third are run by charities: and the remainder are privately operated. In Italy the hospitals are publicly funded by the National Health Service, but administered by autonomous boards representing the local political parties.

Curiously enough, only in the United Kingdom and Denmark are ambulances regarded as a social service. In Belgium, for example, ambulance services are provided by the Red Cross and by private organisations. In France, there is an agreed scale of charges met by the social security system for ambulances provided by the Red Cross or private firms.

Each country also has a publicly-provided system of community health care, health education, medical research, control of pharmaceuticals, sanitary inspection, public health laboratories and occupational and school health care provision. The same problems affect all health care provision and development, whatever the structure of finance and control.

Are there any general lessons to be derived?

1. The control of costs In state-provided sectors the main means of cost control is by negotiation with the professions over salaries and fees, and the cost of pharmaceuticals and other supplies. This puts a limit on costs and together with a limitation of hospital budgets so that in effect they ration the supply of medical care, chiefly by allowing waiting lists for consultation and treatment to grow or diminish. In the insurance systems such mechanisms are more difficult to operate. The doctor often sets his own fee. The insurance scheme can set the maximum it will reimburse, leaving the patient to negotiate the remainder (the doctor may charge say £50; the set insurance fee may be £40, of which 75 per cent is reimbursed. The patient thus pays the doctor £20). The effect of this escalation of costs is to make insurance schemes less viable.

2. The viability of insurance As costs have escalated, so the contributions have increased. Few public schemes are funded, they are based (like the National Insurance scheme or the French social security system) on a pay-as-you-go principle. Resistance to increased contributions, which are in effect a form of income tax, has driven more and more schemes to seek state assistance from general tax-funds. Thus in Denmark and Ireland the contribution directly from tax has to a great degree superseded the insurance basis.

3. Exclusions In all systems there is special provision for the indigent and for the long-term sick, or mentally handicapped patients. These have sooner or later to be integrated into the rest of the health care system.

4. Planning of provision General practitioners usually 'set up shop' and act as entrepreneurs. Poorer and remote areas need special treatment if adequate provision is to be made. For that reason salaried services are common in rural Ireland. Increasingly, too, the concept of the primary health care team has developed, requiring a fully staffed and equipped health centre. This concept is furthest advanced in Britain and Denmark. It is contrary, however, to the tradition in continental Europe of direct access to the specialist.

The specialists in Britain and Denmark practice for the most part in hospitals. Access to hospitals by the local doctors is more common in other countries. One consequence that was found by the European Collaborative Hospital Study (London School of Hygiene and Tropical Medicine, 1980), is that in Limerick and Londonderry more consultations and investigations take place in hospital, than in Colchester, where only the seriously ill are admitted to hospital. In Britain the 'Resource Allocation Working Party' (RAWP) principles have since 1975 been applied to bring about a better geographical distribution of resources.

The pattern of hospital provision represents the result of history. In countries like Germany adaptation takes place as a result of pressures by patients through the insurance system, as they demand extra care, and as a result of local authorities, mutual funds, charities and private bodies responding to that pressure, or anticipating it. For example, German insurance schemes pay for treatment at spas. In spas all over Germany there has been a substantial growth of therapeutic and hotel provision to meet the demand. In Britain, in contrast, medical opinion is against spa treatment and the hospitals at Droitwich, Bath and elsewhere have either closed or given it up. In Britain hospital provision is altered as a result of 'expert' opinion (modified by public pressure) on what specialities should grow and what should decline. To take one treatment as an example, cardiac surgery is only two-thirds of the internationally recommended quantity, and one-fifth as common as in the United States, where provision is demand-led.

In France the two approaches are reconciled by a planning process under the Commissariat au Plan, which seeks to even up supply to meet demand, by stimulating investment in both the public and the private sectors. This is an attempt at planning by increasing provision. It makes little or no contribution to withdrawing redundant facilities.

5. Geographical imbalance In Alan Maynard's and Anne Ludbrook's 'Thirty Years of Fruitless Endeavour?' (1981), an attempt is made on the basis of the 1977 data to illustrate regional differences in France, Holland and England. In England, the co-efficient of variation for doctors was 0.092, while in France it was 0.257 and in Holland 0.282. For hospital beds in England it was 0.109, in France 0.179 and in Holland 0.153. Thus in France and Holland the highest region had 2½ times more doctors per head than the lowest, and in England less than 2/5 more, while for beds the English had 50 per cent more, while in France it was double and in Holland nearly double. If the objective of health care policy is in some sense to equalise geographical provision, then it is clear that the National Health Service has more formidable means of doing so than the other systems.

6. Social imbalance Maynard and Ludbrook conclude that the lowering of financial barriers to health care consumption has not been particularly successful in achieving greater social equality, a conclusion endorsed by the Black Report (Townsend P and Davidson N, 1982). It seems that on crude measures of outcome (eg mortality) and of input (expenditure, doctors etc.) significant inequality continues to exist and may have increased over the last 20 years! This dictum applies to Britain and France but it is widely accepted that it is more generally applicable. It follows therefore that neither the mode of finance, nor the form of provision of health care have made much difference to social equality of access to health care.

Conclusion

This brief survey of European health care ends with a set of questions. It seems fairly clear that despite the difference between centralised tax-based funding of health care and insurance-based funding, the differences in how one pays as perceived by the patients are small. Most care when you are ill is free, throughout Europe. Is it true to say, therefore, that it does not much matter whether the United Kingdom shifts to an insurance-based scheme or not? Do people on the continent think they are getting what they pay for, because they have insurance? Or do the British think that a 'free' service is a social right which they value greatly? Is there anything to be said for the fact that insurance systems seem to give administrative roles to trades unionists and businessmen (as in the former British Friendly Societies) and that this involvement is desirable on general grounds?

More profoundly, there is a major distinction between modes of *payment* and modes of *provision*. William Beveridge in *Full Employment in a Free Society* (1944) wrote 'removal

of economic barriers between the patient and treatment is only a minor step, even for cure of disease. The real task lies in the organisation of the health service'. It has been assumed in the United Kingdom that because most health care is centrally funded, it has to be centrally provided. This is not axiomatic. It would be possible, for example, for all hospitals to be 'private', in the sense that they invoiced the NHS for each item of service, and cut their coat according to their cloth. Perhaps the most striking effect of a visit to the continent by somebody from the United Kingdom is to become aware of the extent of the diversity of methods of provision of care there, compared with its relative uniformity here. Is there a way of reconciling centralised finance and overall planning with greater diversity of provision? It is upon this question, perhaps, that those who contemplate any long-term restructuring of the National Health Service might dwell.

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