

Health Services in Western Europe



Published by
Office of Health Economics
195 Knightsbridge London SW7

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Benefits provided	5
Notes on Comparisons	7
Hospital beds	7
General Practitioners	7
Currency	7
Austria	8
Belgium	8
Denmark	9
Eire	10
Finland	10
France	10
Germany	11
Italy	11
Luxembourg	12
Netherlands	12
Norway	13
Portugal	13
Spain	14
Sweden	15
Switzerland	15
United Kingdom	15

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Health Services in Western Europe

This preliminary survey of the Health Services in Western Europe is being published because of the current interest in continental affairs. It appears to be the first publication of its kind, describing the pattern of the health services in each of these countries. By dealing with outlines rather than with details, it aims to present a broad picture of the ways in which health services can be organised. It concentrates mainly on the organisation of personal medical care, rather than describing ways in which the public health services are provided in the countries.

Britain is not unique in having a health service. Practically every European country has accepted the provision of medical care as a community responsibility. Amongst the sixteen countries in Western Europe, only the Finns have not yet introduced an extensive compulsory pre-payment scheme of some sort and they are to do so in 1964. The schemes are, however, remarkably varied. At one extreme there are the comprehensive schemes predominantly financed out of general taxation and characterised by the National Health Service in Britain. This covers the entire population, including in emergency even visitors from abroad. It provides a full range of personal medical care at nominal cost to the patient. A scheme very nearly as comprehensive exists in Sweden, although patients are left to pay a higher proportion of the cost of some parts of the service. In many countries, however, the health services are not operated directly by the central government. Such schemes provide fewer benefits, and these may be available to only a proportion of the population, so that the upper income groups pay their own medical and hospital bills, or cover them by private insurance. In these cases, there is still a distinction between the public health services, such as the treatment of mental illness and infectious diseases, and the provision of other types of medical care. The former are available to the whole population, but the latter are only provided for those persons

and their dependants who compulsorily or voluntarily have contributed towards their cost.

Many of the present health services have grown out of voluntary insurance schemes started in the nineteenth century. Since then the principle of compulsory insurance has gradually become accepted in order to provide medical care for the old and the chronic sick. Both these groups require a greater amount of attention than the rest of the population and therefore often cannot be protected by private and voluntary health insurance.

For centuries before compulsory or national insurance was introduced it was usual for the State, the churches or other charities to provide medical services for the needy; and free medical care is still available for poor people in countries where health service contributions are not compulsory for the whole population. In some countries public assistance of this sort plays a substantial part in the provision of medical care. For example the lowest paid Portuguese workers are specifically excluded from having to pay health insurance contributions on the understanding that medical care will be made available to them free of charge. In many countries, as in Britain, private insurance of the type provided by the Provident Associations exists in addition to the National Health Service.

The health schemes in the European countries usually form part of a general scheme of social security. They are, however, organised in many different ways. Some, for example the Swedish scheme, are organised and controlled directly by the central government. Others are provided by the local municipal or provincial governments, as in the case of Germany where the Länder administer the health service under the general direction of the Federal Government. In some countries, for example Austria, the health service is provided by a number of public boards comparable in status to corporations such as the B.B.C. or B.O.A.C. Occasionally, as in Holland, private insurance companies or friendly societies organise a State scheme. This is similar to the situation which existed for general practitioner services in Britain

before 1948. Because of these variations, and because some types of medical care are provided independently by the public health authorities, the term 'health service' has very different meanings in different countries¹.

Under the public boards and private insurance companies, each board or company is frequently responsible for the health service provided for one particular section of the population, such as agricultural workers, or railway employees, and their dependants. The schemes for the different groups of workers may vary considerably. There are also variations between different schemes in one country when these are provided by the provincial or municipal governments. The contributions paid and the benefits provided may vary and different categories of people may be legally required to join the scheme. Generally, however, these variations within a country must fall between broad limits laid down by the central government.

Except in Denmark, Eire and the United Kingdom, health insurance contributions are graduated depending on salary or income. In the other Western European countries the employee usually pays a fixed percentage of his salary, so that his contribution increases proportionately to his earnings. There is, however, an upper limit to the contributions, which therefore do not increase indefinitely. Almost invariably, the employer also makes a graduated contribution calculated as a percentage of salary. In addition to the money raised by these contributions some part of the benefits provided under the health service are usually financed from central or local government funds. Sometimes a capitation payment is made by the government to the 'sick funds' and sometimes the government have agreed to provide a proportion of the revenue in order to balance the funds. In other cases, notably Belgium, the funds were originally intended to be self-supporting, but in practice the government has to make a contribution to cover their deficit.

There are three main distinctions between the financial methods on the continent and those in Britain. First of all Britain relies on a basic flat rate contribution independent

of earnings or income, whereas on the continent contributions increase with salary. Secondly in Britain most of the cost of the Health Service is met from general taxation, whereas in the continental countries a greater part of the cost of the medical care is usually met from contributions and a comparatively small part of the cost has to be met by general taxation. Thirdly a higher proportion of the cost of the continental schemes is financed by direct payments by the patients.

In Britain the part of the employees' and their employers' National Insurance contribution allocated to the Health Service averages less than two per cent. of earnings, and these contributions meet about 16 per cent. of the total cost of the National Health Service. Under the continental and Scandinavian schemes their combined contributions to the health service usually amount to between five per cent. and ten per cent. of earnings, and they provide a much greater proportion of the finance.

In all countries participation in the health service is compulsory at least for employees who are being paid less than the average earnings in the country and their dependants. In many of the countries it is also compulsory for the more highly paid employees and for some professional and self-employed people. In addition the scheme may be open to members of the population for whom it is not compulsory. The proportions of the population included appears to have been rising in most of the countries and now the majority – often more than nine-tenths – of the people are covered.

In Britain since the introduction of the health service covering the whole population in 1948 there has been a steady growth in private health insurance. By 1963 about two per cent. of the population had made private arrangements either to cover the cost of certain medical services outside the National Health Service, or to supplement the benefits provided by it. In other countries the health services usually started on a limited scale and have gradually been made available to larger sectors of the public. They also appear to be approaching a situation where only a small proportion of

¹ On subsequent pages the organisations providing the national health services are for convenience generally referred to either as 'the service' or 'the scheme'; or by the continental phrase of 'sick funds'. No attempt is made to define exactly the scope of the organisation in each country. The term 'parastatal' which appears in literature discussing social security on the continent, is also used. It describes the status of the public boards referred to above.

² When doctors are remunerated by capitation fees there is also a financial advantage in having a large 'panel' of comparatively healthy people instead of accepting the elderly or chronic sick.

people choose to be independent of the service.

Benefits Provided

Hospital care is invariably covered by the schemes and only in France and Ireland must the patient pay a proportion of the hospital costs personally. In some countries, however, the patient may have to contribute towards their living costs in hospital, as in Switzerland, or may lose part of their cash sickness benefit during the period they are in hospital, as in Portugal. Under some of the schemes there is a limit to the period of hospital treatment which is paid for by the sick funds. In these cases patients requiring more prolonged hospital treatment must either pay the cost themselves or else accept public assistance. The hospitals may be owned and administered by the sick funds; by the state or local government; or privately. In the two latter cases the hospitals can of course accept patients whether they are covered by the health service or not. In some countries, for example Norway, if the patients would prefer to be treated in a hospital outside the scheme, they receive a contribution towards their private hospital fees from the health service.

A great degree of freedom is left to the medical profession under each of the health services. It is unusual for doctors to be full-time salaried employees. This does happen however, when doctors are on the staff of a hospital administered by the health service and especially in the case of mental hospitals. It may also occur, as for example in Italy, where some doctors are full-time employees working in a health centre. Under the British National Health Service general practitioners are paid on a capitation fee system, whereby they receive a fixed sum for each person on their 'list' regardless of whether the person requires constant treatment or none at all. The same method is used in Holland; and under a similar system in Austria the doctors receive a capitation fee based on the number of patients they have seen, independent of the amount of treatment required.

However, by far the most common method of remuneration for general practitioners is the payment of a fee either for each consultation, or as in the case of Germany, for each item of service which the doctor gives. These fees are usually negotiated between the doctors and the sick fund. In some cases the patient pays the fee to the doctor and is reimbursed by the service, and in others the service pays the doctor directly. Usually the patient either has to pay a proportion of the fee, or else makes a small fixed payment to the doctor for each consultation. In many countries doctors combine hospital and general practice responsibilities, which accounts for the comparatively high proportion of 'general practitioners' in these countries. In some countries, for example Norway, doctors can combine the duties of local medical officer of health with those of a general practitioner. As in Britain, under Part III of the N.H.S. Act, local medical officers of health are usually also responsible for certain aspects of the health service.

Several factors may influence the type of medicine practised by 'family doctors' on the continent compared to that practised in Britain. First, as continental patients usually have to make a small payment for attending their doctor they may be discouraged from consulting him when they are suffering from what they consider, rightly or wrongly, to be minor complaints. Secondly, the capitation fee basis of payment in Britain and Holland means that a doctor who deliberately restricts his list of patients because he believes this will enable him to practise medicine more effectively earns less than another doctor with a larger number of patients². The fee per consultation or item of service in other countries might encourage doctors to give more extensive treatment to a smaller number of patients, although this may not necessarily be desirable if there is a shortage of doctors. Thirdly, it is considerably easier for a patient to change or even to consult several different doctors in some continental countries. Fourthly, many European doctors still have a larger proportion of private patients. Finally, the 'general practitioner' is a particularly British concept, applying

only in some other European countries. Elsewhere most doctors divide their time between general medicine and some speciality.

It is a feature of the health service in Britain that most patients requiring diagnostic tests or minor surgery are referred to hospital. This trend is possibly less pronounced on the continent and certainly in some countries doctors have better equipped surgeries or have more diagnostic facilities available to them than the average British general practitioner. For example in Copenhagen a laboratory which can carry out all types of pathological tests is organised by the general practitioners, and financed by the sick funds.

The environment in which treatment is provided is also important. Although general practitioners appear to face the same problems in other countries as they do in Britain, their appointment systems, waiting rooms and consulting rooms sometimes appear better and hospitals on the continent may sometimes be more up-to-date. How far would the British taxpayer wish, in present day society, to have these additional comforts and standards and to pay for them out of his taxes or privately?

At least part of the cost of prescriptions is borne by the service in each of the continental countries. Once again, however, there is a considerable variation between the different schemes. In Germany, as in Britain, doctors are free to prescribe any drug, and the patient pays only a fixed prescription charge of approximately a shilling. There is pressure on the doctors to prescribe economically, and indeed doctors who over-prescribe may be charged with the excess costs. In France and Sweden, where doctors are also free to prescribe any drugs, the patient pays a proportion of the costs of the prescription. In France, for example, the patient pays ten per cent. of the cost of 'essential life-saving' drugs, and 30 per cent. of the cost of other proprietary drugs.

In certain countries only a restricted list of drugs are reimbursed by the sick funds. Sometimes there is one list of drugs which may be freely prescribed and a second list of less essential or more expensive drugs for

which prescriptions have to be approved by a local medical officer of the insurance fund before they are reimbursed. Drugs not included on either list must be paid for by the patient. Where this method is applied, the number of drugs freely available may be affected by the financial position of the fund. For example, the financial deficit in Belgium has resulted in extensive restrictions on the range of drugs provided. In some countries, for example France, the patient pays the full price of his prescription, and is then reimbursed by the health service. In others for example the Netherlands the health service pays the pharmacist direct.

In the majority of continental countries, the health service either charges the patient a substantial part of the cost of his drugs or restricts the list of drugs available within the service. It is difficult to assess the effect of these measures on the drug bill. The only available comparative study suggested that in the mid-1950's they did not explain variations between the expenditures on drugs in different countries³. Certainly evidence submitted to the Kefauver committee in the United States showed that branded drugs in Britain tended to be lower priced than on the continent.

In all countries some dental and ophthalmic treatments are available under the health scheme. Generally, however, the service provided appears less comprehensive than in Britain; for example the provision of dental treatment may be restricted to a school dental service. Prior approval is invariably required for certain types of treatment, such as the supply of dentures. The ophthalmic services illustrate the difficulty in making objective international comparisons. In Portugal spectacles are provided under the health service, but these are so inferior that many people apparently prefer to forego this benefit and purchase their spectacles privately. In Britain the most modern designs, for example, of bifocal spectacles, may not be available under the National Health Service, but the majority of people have spectacles prescribed and at least the lenses supplied under the scheme⁴. Although from this evidence there would appear to be a marked

difference between the standard of ophthalmic treatment provided in Britain and Portugal, the situation in both countries could be broadly defined as being the same: a restricted range of spectacles are provided by the scheme in each case. Any attempt to *measure* the difference in the quality of the service between the two countries would involve a professional comparison of the accuracy of diagnosis and appropriateness of the spectacles supplied.

In countries where only a restricted range of benefits is available under a health scheme, it is likely that many people will feel they can get superior medical care outside the scheme, as happens in Portugal. In these cases it is however equally difficult to *measure* the difference between the treatment provided by the scheme and that provided privately. The situation should theoretically be avoided, however, if unrestricted benefits are available within the health service, as is the case with the general medical and pharmaceutical services of the N.H.S.

The following pages contain brief details of the health services in each of the countries in Western Europe comprising the European Common Market, the European Free Trade Area, Ireland and Spain. The descriptions are based on information collected from experience in the countries, and sources include Embassies in London, Organisation for European Economic Co-operation, World Health Organisation and International Labour Organisation reports. The object has been to provide a broad picture of the organisation in each country, rather than details of each scheme. Indeed in many countries there are such substantial variations between the scheme in different parts of the country or for different groups of workers, that the national position can only be described in the most general terms.

Many medical advances have taken place since the N.H.S. was conceived in the 1930's and designed in the 1940's; already suggestions have been made for changes in its organisation. Experience abroad can provide a useful background against which such proposals can be discussed.

More information is needed about the

³ An International Labour Office study 'The Cost of Medical Care' published in 1959 compared expenditures under various health services. As a percentage of income per head, they reported (page 43) the following total expenditures on pharmaceutical benefits outside hospital wards in 1953. Despite the undoubted limitations of the study, the figures did not suggest that unrestricted availability of free drugs in Britain had caused excessive drug expenditure.

Switzerland	0.34
England & Wales	0.36
Denmark	0.36
Netherlands	0.52
Belgium	0.57
Germany (Federal Republic)	0.67
Norway	*0.77
Italy	0.95
France	1.06
	*1955

⁴For new spectacles prescribed for adults under N.H.S. in 1961, 84 per cent. of the lenses but only 37 per cent. of the frames were dispensed within the service. (Ministry of Health Report Part 1, 1961, p.68).

relationship between general practice and hospital treatment, and the part played by health centres and out-patient clinics in different countries. It would also be valuable to know how much other health services have concentrated on programmes of preventive medicine, attempting for example to diagnose tuberculosis, diabetes or cancer before obvious clinical symptoms developed. How far are such programmes, and other public health schemes under the medical officers of health, integrated with the services providing personal medical care? The effect of the continuing existence of private practice alongside other health services can also be studied. Finally, perhaps most important of all, there is a need to study the way in which the practice of medicine is affected both by the charges levied on patients, and the methods of remunerating doctors within the service.

Study missions abroad have already proved informative. Great value would be derived from the government, and other bodies, sending appropriately qualified groups to further investigate those and other questions in Europe and elsewhere. International studies can throw light on many controversial issues, about which only hypothetical conclusions can be reached within Britain itself. They can also provide a framework within which to assess both existing features and proposed changes in the N.H.S. More understanding of the health services and organisation of medical care abroad could help to make Britain's own comprehensive National Health Service even better.

Notes on Comparisons

Hospital Beds

International comparisons are beset with difficulties because even the simplest concepts may be differently defined in neighbouring countries. The number of hospital beds in a country may be substantially affected because different types of institutions are classed as hospitals in different countries. Britain is unusual in regarding institutes for the treatment of mental subnormality as hospitals; and there is no uniform definition of the distinction between a hospital for chronic geriatric patients and an old people's home.

With this reservation, it is interesting that in practically all the Western European countries there is approximately one hospital bed for every 100 of the population. Britain has a slightly larger proportion of hospital beds, probably due to a wider definition of the term 'hospital'. Sweden and Ireland however, are exceptional and provide almost 50 per cent. more hospital beds in proportion to their population than the other European countries, (or the United States of America). The fact that some sources quote an even higher number of hospital beds in Sweden, giving a ratio of one for every 50 of the population, illustrates the difficulty in obtaining reliable figures.

General Practitioners

No meaningful comparison can be made between the numbers of general practitioners in each country. First, the extent of their responsibilities outside general practice vary enormously. Some general practitioners spend a substantial proportion of their time either in hospital or on specialist consultations and they may also have responsibilities for public health. Secondly the scope of general practice varies; minor surgery may or may not be included and immunisation programmes may be the responsibility of either general practitioners or the public health authorities. Finally the average figure for the number of the popu-

lation attended by each practitioner can be rendered meaningless by uneven distribution within the country. In less advanced countries, a small proportion of the population may command the attention of the majority of the doctors.

Similar difficulties arise even in attempting to compare the total numbers of doctors in each country. Crude figures have to be refined, for example, to allow for doctors who have retired, or changed to other careers, and to take account of doctors practising at sea or abroad.

Currency

For convenience foreign currencies have been exchanged into their sterling equivalents. It should however be borne in mind that the real value of the same salary varies considerably between different countries.

Austria

The health services in Austria which are provided under the compulsory schemes cover all workers and employed persons. In certain States within the Federal Republic membership may also be compulsory for other groups such as self-employed business men and farmers. They are run by Government controlled corporations, each of which covers a particular group of the population. Although they are all subject to direction from the Ministry of Social Administration, they operate independently. There is some legal control over the contributions and benefits provided, but these can vary considerably between the different insurance corporations. Certain people not compulsorily covered by the health service may also be covered voluntarily by the Scheme. In all about nine-tenths of the population participate in the health services.

Both employer and employee pay contributions of about two per cent. of the employee's salary. These contributions are, however, calculated only on salary up to the equivalent of approximately £600 a year. Manual workers pay rather higher contributions which cover cash sickness benefits as well as the cost of medical treatment. Such cash benefits are unnecessary in the case of clerical staff, whose employers have in any case to continue paying their salaries during sickness.

There are about 5,300 doctors fully or partially in general practice in Austria, one for every 1,400 of the population. All these may accept patients under the scheme. They receive a fixed capitation fee (which is independent of the amount of treatment required) for each of the patients whom they attend. Under some of the corporations the patient has to make some payment to the doctor, and although most of the sick funds pay the general practitioners directly, in some cases the patient makes the full payment to the doctor and is then reimbursed. The Austrian funds have a restricted list of drugs which they reimburse. This is divided into two parts; the first includes cheap or essential medicines which are automatically paid for;

the second part of the list consists of less essential or more expensive medicines for which patients are not normally reimbursed unless the prescriptions for them are approved by the sick funds. Drugs not included in either part of the list must be paid for by the patient, but it is estimated that about 85 per cent. of all prescribed medicines are partly reimbursed under the scheme.

Hospital care is provided by the sick funds for a limited period, varying between the different corporations, but usually under one year. If patients wish for special amenities in hospitals they must pay the whole cost of the treatment themselves. Under these circumstances the patient receives a cash reimbursement from the sick fund, but this usually covers only a small proportion of the total payments which they have to make. Austria has 280 hospitals with 73,000 beds, approximately one for every 100 of the population. These include both state and municipal hospitals, and some private hospitals.

The health service also provides some dental and ophthalmic treatment although it is understood that many people prefer to be treated privately.

The corporations are heavily subsidised from government funds. As in most other countries free medical treatment is provided by the state for impoverished members of the population not covered by the health service. The state also provides essential hospital treatment beyond the period for which it is provided by the service. Such medical care is nominally financed by the government on the basis of a loan to the patient, although in the case of the genuinely indigent this 'loan' is not expected to be repaid. The present health scheme came into force at the beginning of 1956, although less comprehensive health insurance had been available for many years previously.

Belgium

The health services in Belgium which are provided under the compulsory schemes cover all wage earners and their families. They are provided by the Fonds National d'Assurance Maladie-Invalidité (F.N.A.M.I.), a national sick fund which is under the direction of the Ministry of National Insurance. In addition certain sections of the population are insured through parastatal mutual funds (e.g. the 'Mutuelle' of the Belgium Railways) and by private insurance. The health service is part of the comprehensive social security system providing old age pensions, sickness and unemployment benefits, family allowances and holidays with pay. About three-quarters of the population participate in the health services mainly through the F.N.A.M.I.

Both employer and employee pay contributions to the sick funds, which are calculated as a percentage of earnings. Each pay about three per cent. of salary to the F.N.A.M.I., these contributions are, however, calculated only for salaries up to the equivalent of about £600 a year. These payments cover insurance for sickness and disablement.

There are about 5,200 doctors wholly or partly in general practice in Belgium, one for every 1,750 of the population. All of these may accept patients under the health scheme, and they are paid by the patient according to a set scale of fees. The patient then recovers about three-quarters of these fees from the F.N.A.M.I. However the doctors sometimes charge higher fees than those agreed by the service, and under these circumstances the patient must also pay the difference. Under the health service, doctors may only prescribe from a restricted list of drugs. The patient pays one-half of the cost to the pharmacist, who claims the balance from the F.N.A.M.I. Because the sick fund has been short of money, it has tended to delay making these payments to pharmacists, who in turn have become heavily indebted to pharmaceutical wholesalers and manufacturers.

There are about 380 hospitals in Belgium with a total of 83,000 beds, equivalent to

one for 110 of the population. 113 of the hospitals are managed by the F.N.A.M.I., and in these all treatment including medicines is provided free. In hospitals not managed by the sick funds medicines are provided on the same basis as in general practice, and only a part of the hospital costs are reimbursed. 80 per cent. of the cost of dental treatment is reimbursed, although dentures are provided only in special cases.

The F.N.A.M.I. was created in 1945, health insurance having been on a private basis until that date. The rising cost of medical care has severely embarrassed the sick fund, which has attempted to restrict expenditure by curtailing the range of services available. The substantial deficit which the fund incurs is met by the state.

Denmark

All persons domiciled in Denmark are eligible from their sixteenth birthday for membership of the National Health Service. Those under sixteen are covered by their parents' membership. There are two sections of the service, one for lower paid workers earning less than about £700 a year and an additional scheme for those earning more than this. Both parts of the service are organised by numerous sick funds controlled by a directorate responsible to the Minister of Social Affairs. In all about nine-tenths of the population are members of one of the health services. Anyone who has not made use of his right to membership of the service is automatically and compulsorily a 'passive' member. Such people have no right to any benefit, but can join the service at any time, although there is a waiting period of six months before they receive benefits. There is a reciprocal arrangement between Denmark and Britain, whereby Britons can obtain health service benefits in Denmark.

People earning below the £700 income limit pay a fixed contribution to their sick fund. For these people the state also contributes to the fund an amount equivalent to about 25 per cent. of the benefits paid

out. Members of the scheme in the more highly paid group pay the same contributions, but also pay an amount equivalent to the state grant paid on behalf of the other members.

There are approximately 2,000 general practitioners in Denmark, one for every 2,200 of the population. All doctors may treat health service patients, who pay no part of the cost of the treatment if they are in the lower income group. For these people the Medical Association and the sick funds usually negotiate the terms of the doctors' remuneration, which may either be a capitation fee or a fee for items of service. In such cases the sick funds pay the doctors direct. The other people pay their doctors direct and have their fees reimbursed.

Some of the General Practitioners also have responsibilities for preventive medicine, such as routine child care. Since there are no hospital 'out-patient' departments, general practitioners also carry out specialist examinations, and facilities for them to do so are provided by the sick funds. The Health Service pays three-quarters of the cost of essential and specified 'important' medicines. The patient generally pays his share of the cost at the time of the purchase and the chemist claims the remainder from the sick fund.

Hospital care, including the cost of drugs and treatments, is available under the health service. There are approximately 320 hospitals in Denmark with 47,000 beds, or about one for every 100 of the population. The general hospitals are provided by the local authorities, and are mainly financed from the central and local government funds, rather than through the sick funds. The few private hospitals in Denmark do not play a substantial role in the general hospital system.

The health service provides either free or partly free dental treatment, and a grant towards the cost of spectacles.

The first of the health insurance associations in Denmark ('The Sick Clubs') was formed in 1857. They were private voluntary societies which were first regulated by law in 1892. The present comprehensive health service came into operation on 1st April, 1961.

Eire

The health services in the Irish Republic which are provided by the central government under the compulsory schemes cover all employed people earning less than about £800 a year. Employees whose earnings rise above this level may remain in the scheme voluntarily. In addition the local authorities provide entirely free medical care for the majority of agricultural workers and other poor people. About one-third of the population receive free medical care under the local authorities scheme, and in all more than four-fifths of the population are covered by one or other of these schemes. There is also a Government Voluntary Health Insurance Scheme open to the remainder of the population.

Both employer and employee pay a fixed contribution to the health service, but a substantial proportion of the cost is paid for from Government funds.

The national health scheme makes no contribution towards the cost of general practitioner treatment or drugs. The agricultural workers and poor people entitled to entirely free medical care do, however, receive medical attention and free drugs at 'dispensaries' run by the local authorities.

Hospital treatment is the principal benefit provided under the health schemes. Even in hospital, however, the patient pays some proportion of the total cost. There are approximately 250 hospitals with about 43,000 beds, one for every 65 of the population.

Very limited dental and ophthalmic services are available under the health service and for those people entitled to free medical care.

The health services for the poor in Ireland originated early in the nineteenth-century and the present social security scheme was unified under the Minister of Social Welfare in 1953. The National Voluntary Insurance Scheme covering the remainder of the population was introduced in 1957.

Finland

Finland has no general health service, and there is no compulsory health insurance. There is, however, an extensive public health scheme providing medical care for children and those who are unable to pay for their own medical treatment. The number of hospitals maintained by the state and communes is being increased under a law passed in 1947, and patients are required to pay only 15 per cent. to 20 per cent. of their expenses in these. Apart from this, private voluntary health insurance schemes are available, but it is reported that only about ten per cent. of the working population have taken out such insurance.

Legislation providing comprehensive health service in Finland has, however, been completed, and a national health scheme will come into operation in 1964. Details of the scheme are still being discussed, but it is understood that it will be organised by the central government to cover the whole population, and contributions will be graduated according to salary.

France

The health services which are provided in France under the compulsory schemes cover all salaried and wage earning employees, and participation in these schemes is also optional for the rest of the population. They form part of the comprehensive social security scheme which covers some nine-tenths of the population. These schemes are run by private regional organisations, which re-insure with a national fund. Any deficit on the national fund is met from public funds.

Both the employer and the employee pay a percentage of salary as contributions to the social security funds. The French system is characterised by high contributions, which for less highly paid workers amount to over 20 per cent. of salary, and proportionately high benefits. For example certain people, especially amongst war veterans

and public servants, receive a State pension equal to 100 per cent. of their final salary.

There are about 25,000 doctors wholly or partly in general practice in France, one for every 1,800 of the population. Under the scheme it was intended that patients could go to any doctor and pay them fees which have been agreed by the social security organisations. They would then receive a refund of 80 per cent. (100 per cent. for certain illnesses) of these fees. However, in certain parts of the country, (notably Paris) doctors have not yet signed an agreement with the social security over fees and therefore reimbursement is on a provisional and arbitrary basis.

The patients may sometimes pay as much as 50 per cent. of their doctor's fees. Unless they are in receipt of national assistance, patients pay the full price for their medicine at the pharmacy. They are then reimbursed by the social security for either nine-tenths or seven-tenths of the price, depending on whether the medicine is regarded as an 'essential life saving drug' or not. Although theoretically proprietary medicines are only reimbursed by the social security if they are on an approved list, this has little effect in practice because approval appears to be given automatically provided that permission to market the drug has been given by the Ministry of Health.

In hospital the patient pays 20 per cent. of the cost direct to the hospital, and the other 80 per cent. is recovered by the hospital from the social security. For prolonged treatment or if they are in receipt of public assistance, however, patients need make no payment. About 4,500 hospitals have a total of 450,000 beds, roughly one for every 100 of the population.

The health service pays 80 per cent. of the cost of dental treatment and dentures, which are fixed by a tariff. In the case of certain ophthalmic services, approval from a hospital specialist is required before visiting an optician.

The present social security scheme was introduced in 1945.

Germany

The health services in the German Federal Republic which are provided under the compulsory schemes cover all weekly paid workers and salaried employees earning less than about £700 a year. They are provided by the Krankenkasse (Sick Fund) which is controlled by the Federal Government, but administered by the local administrations of the Länder. Other people may belong to privately organised sick funds, the Ersatzkassen, which provide similar benefits. Between the Krankenkasse and the Ersatzkassen, about nine-tenths of the population participate in the health services.

Both employer and employee pay contributions to the sick funds, which are graduated according to the employee's salary. These contributions cover both sickness and accident insurance; the benefits include cash sick relief for the period the members are unable to work, free medical and hospital treatment for members and their families, and the provision of free medicines against a doctor's prescription.

There are 45,000 doctors wholly or partly in general practice in Germany, one for every 1,250 of the population. Most of these may accept patients under the health schemes and very few are dependent on private practice exclusively. For their health service patients doctors receive a set scale of payments per consultation. They receive additional payments for special items of treatment including, for example, injections. This method of payment has been said to influence the types of treatment given by the doctors and injections are given more frequently by German general practitioners than their British colleagues. Even so it is difficult for all the 45,000 German doctors to make an adequate living and some take part-time employment in addition to their medical practice. Except for a prescription charge of about 1s., all drugs are free to health service patients and there are no restrictions on those which doctors may prescribe. The sick funds do, however, attempt to control the total expenditure on drugs by imposing a cash limit for each general practitioner which is related to the number of patients

he has treated. In applying this rule, however, the specific circumstances of each case are taken into account, and it is recognised that the prescription of costly medicines, resulting in prompt cure, may be the most economical method.

Hospital care, including the cost of drugs and treatments given in hospital, is provided by the sick funds. This benefit does not, however, continue indefinitely, and in the case of the employee himself is provided for about 18 months. Approximately 3,500 hospitals have in all about 570,000 beds, roughly one for every 100 of the population.

The health service also provides free dental and ophthalmic services, although the patient must pay some part of the cost of dentures.

The present health service in Germany is based largely on the German Social Health Insurance Act, 1911, although some form of insurance had been provided as far back as 1880. The present schemes are intended to be self-financing, but in practice leave a small deficit to be met from Government funds.

Italy

In Italy the health service is provided by parastatal sick funds which have a status similar to the British government corporations. These are responsible to the appropriate Ministers, e.g. Minister of Labour, Minister of Public Health, etc., according to which group of people are covered by the particular fund. Participation in the health service is compulsory for all employed persons and some categories of independent workers. The majority of the population are covered by the service.

Both employer and employee pay contributions to the sick funds, and these are graduated dependent on the wage or salary. For sickness benefits alone the employer pays between four and seven per cent. and the employee 0.15 per cent. of his salary. This is collected along with other contributions covering pensions and unemployment.

The extent of benefit and the way in which it is applied varies between the funds but generally the patient pays no part of general practitioner fees or hospital costs. The largest sick fund, I.N.A.M. (National Health Institute) has broadly three categories of doctors working for it. Doctors in the first category receive a fee of approximately 4s. for each consultation, paid direct from the sick fund. A second group of doctors receive a monthly salary which varies according to the district. Both these categories of doctor are free to undertake private practice in addition to their health service work, and are even free to treat their own sick fund patients on a private basis. A third category of doctor receives a salary on the understanding that they work full time for the sick fund; doctors paid in this way either work in hospitals or in clinics or dispensaries. There has recently been dissatisfaction amongst Italian doctors because they consider that they have been inadequately paid by the sick funds.

I.N.A.M. provide the majority of medicines free to patients, reimbursing the pharmacist directly. Certain proprietary medicines, however, are not reimbursed by the sick fund, and others are only partially reimbursed. Other sick funds allow more freedom to the doctor, but reimburse the patient for the cost of his medicine rather than paying direct to the pharmacist. Some sick funds, however, leave the patient to pay the whole cost of his medicines.

Hospital care is fully paid for by the health service. The 2,483 hospitals contain approximately 440,000 beds, about one for every 110 of the population.

Luxembourg

The health service is provided under the Code of Social Assurance for workers and their dependants, and in addition all other categories of the population are also covered by the sick funds. Each fund within the framework of the general legislation enjoys considerable autonomy and as a result benefits often vary from one fund to

another.

As in the majority of other European countries contributions are calculated as a percentage of salary up to a certain limit. The employee pays approximately four per cent. and the employer two per cent.

Medical and hospital treatment and pharmaceutical supplies are provided within the health service. Although the benefits vary under the different sick funds, the law provides that the patient must not have to meet more than 25 per cent. of the total cost of any treatment. Generally the patient has to pay between ten per cent. and 20 per cent. of the total cost, except in the case of hospital treatment which is provided entirely free.

Payments are made in the normal way by the patient, who is then reimbursed with at least 75 per cent. by the sick fund. A list of medicines which are not reimbursable is periodically published in the Official Journal of the Grand Duchy of Luxembourg.

There are 20 hospitals in Luxembourg, with approximately 3,500 hospital beds, one for every 100 of the population. The health service bears the whole cost of treatment in approved hospitals, for a period not exceeding six months.

Dental and ophthalmic treatment are provided on the same basis as medical care.

The sick funds must be entirely self-financing and if they incur a deficit in any year they are legally entitled to lower the benefits or increase subscriptions in subsequent years.

The scheme first started in 1901.

Netherlands

The health services in the Netherlands which are provided under the compulsory schemes cover all employees earning less than a fixed maximum salary (about £800 a year). Those earning higher salaries, or who are self-employed are also free to join the scheme. Health insurance was formerly organised by approximately 600 private insurance companies, but since 1941 their number has been restricted and there are

now about 115 private companies organising the health service. About four-fifths of the population participate in the health services.

Both employer and employee pay equal contributions to the insurance companies, calculated at a fixed percentage of salary, each paying approximately 2.5 per cent. This percentage is, however, only calculated on salary up to a maximum of about £800 a year. Benefits include free medical attention, hospital and specialist treatment, and free drugs; in the Netherlands, therefore, the health service contributions cover the cost of medical care only and are not combined with other forms of social security payments.

There are about 6,700 doctors wholly or partly in general practice in the Netherlands, one for every 1,750 of the population. Most of these may accept health service patients and their activities are supervised by 'controlling doctors' employed by the sick funds. They are paid a capitation fee for each patient on their list. The patient makes no payment for treatment by either the general practitioner or specialist. Drugs are also supplied free, provided that they are included on a list prepared by a commission set up by the sick funds; but others may also be supplied at no cost to the patient provided that the prescriptions for them are approved by the local 'controlling doctor'. The pharmacist is paid direct by the sick fund for approved medicines supplied to patients.

Patients are entitled to ten weeks free hospital care and this period can be extended by the payment of extra insurance premiums. Beyond this period only the cost of drugs and medical treatment is provided by the health service.

Dental treatment is provided entirely free on condition that the patient attends for regular dental examination. Some treatment, however, must be approved before being carried out, and part of the cost of dentures must be paid by the patient.

The modern health service in the Netherlands may be said to have begun in 1865 when an Act was passed providing for state supervision of public health. Since then private initiative has played an important

part in the provision of medical care. Up till 1940 the general sickness funds (also dating from the nineteenth century) provided a voluntary sickness insurance which covered about 50 per cent. of the population and when in 1941 a statutory regulation providing for a compulsory health service was introduced the earlier organisation was used as its basis. The sick funds receive no subsidy from state or local taxation.

Norway

The health services in Norway which are provided under the compulsory schemes cover both employees and non-employees. The former receive both medical treatment and cash sickness benefit, whilst the latter are covered for medical treatment only. The health service is organised by local insurance funds attached to each municipality. There are autonomous bodies, but a National Insurance Institution supervises the local boards in the discharge of their duties. Over four-fifths of the population participate in the health services.

Individuals pay contributions to the health scheme which are graduated, in the case of employees according to their earned income and in the case of non-employees according to their total income. The payments by individuals range between about 2s. and 8s. a week. In addition employers, the municipalities and the state each contribute to the funds, providing between them about half the income.

There are about 1,500 general practitioners in Norway, one for every 2,300 of the population. In addition the local medical officers of health in some districts attend individual patients. Doctors receive consulting fees for their health service patients, which are either paid direct by the sick fund, or else paid by the patient who is subsequently reimbursed by the sick fund. Medical fees are not always reimbursed fully, and under most of the sick funds about a quarter of the fee must be paid by the patient himself. The patient is also reimbursed with 75 per cent.

of the cost of certain essential or important drugs. These are mostly confined, however, to drugs required for long term treatments, e.g. insulin, and in other cases the patient pays the whole cost of the medicine himself.

There are 340 hospitals with a total of 33,000 beds, approximately one for every 100 of the population. The health service pays the total cost of hospital treatment in public hospitals. In the case of treatment in private hospitals the patient receives a contribution equal to the amount which the same treatment would have cost in a public hospital.

Some dental treatment is covered by the Norwegian Health Service.

Norway has had a system of Public Health Insurance since 1911, but the present scheme dates from 1956.

Portugal

In Portugal the health services provided under the compulsory schemes cover all employed people earning more than about £15 a month. It is provided by independent agencies, usually associated with particular groups of employees, for example all fishermen, or the staff of a very large company. The activities of these agencies are co-ordinated and supervised by the Under Secretary of State for Social Welfare, and they also rely to some extent on government finance. In addition to these health services, entirely free medical care is available from the public health authorities for everyone earning less than about £15 a month. The majority of the population are provided with medical care either through the scheme or by public assistance.

Employees pay rather over five per cent. of their salary to the scheme, calculated up to a salary limit of about £700 a year. Their employer contributes a considerably larger percentage of their salary. These contributions cover all types of social benefits which vary considerably between the different agencies.

There are about 3,000 physicians working under the health service, and about

800 communal medical officers (who provide the free medical care to the needy). There is a tendency for most medical care to be provided from hospital out-patient departments or from health centres, rather than in private practice. Doctors working in these health centres or hospitals are salaried employees of the service. The patient pays a nominal fee of about 3d. to the doctor for each consultation. Doctors are free to prescribe any drugs, and in some cases these are provided by a dispensary operated by the scheme. In other cases prescriptions are dispensed by private pharmacies who are reimbursed by the scheme. The patient pays some part of the cost of the medicine.

Hospital treatment is provided free, except that a proportion of the cash sickness benefit to the patient may be withheld during the period that he is in hospital. The patient also has to pay all or a large proportion of the cost if he wishes hospital treatment in a private room or hospital. The duration of free hospital treatment also varies between different agencies. The impression is that certain of the wealthier agencies provide generous benefits, including hospital treatment outside Portugal in cases where this is desirable.

Dental and ophthalmic treatment are also provided by the agencies on the payment of the same nominal fee levied for medical treatment. Some provision of medical care, mainly by churches, has existed for many centuries. The present service, however, dates from 1945.

Spain

The health services in Spain provided under the compulsory schemes cover all employees earning up to about £300. Benefits are available to those employees and their dependants and also to all old age pensioners. The health scheme is part of the comprehensive State Welfare Service. It is operated by the National Institute of Social Provisions and by mutualities organised by industry. The National Institute of Social

Provisions is an autonomous body financed by health service contributions and by the Ministry of Labour. Employees are represented on this body by the Trade Unions; Trade Union membership is compulsory in Spain. It is estimated that the health scheme covers four-fifths of the population. Private insurance schemes are available for those persons not covered by the State scheme.

Both employer and employee pay contributions to the sick fund. The employee contributes two per cent. and the employer five per cent. of the basic salary. Deficits incurred by the health service are paid for by the Government. These contributions do not include accident insurance, which is borne entirely by the employer, paying ten per cent. of salary.

Patients may select any doctor. Patients make no payment whatsoever to the doctor, who is paid by the Institute on a capitation basis. Doctors are free to choose between private or health service practice, or a combination of both. There appears to be no clear distinction between general practitioners and specialists.

Doctors are free to prescribe any drugs they think fit, although expensive courses of treatment have to be approved by the Institute. No charge is made to the patients for prescriptions. Chemists are paid directly by the Institute or by the mutuality.

At present Spain is embarking on a new hospital building programme. There appears to be a great emphasis on domiciliary care by the Spaniards, perhaps because of their stronger family ties. Hospitals are concerned only with in-patients and out-patient care is the responsibility of health clinics. No charge is made for health service patients attending hospitals or health clinics. Mental hospitals are under separate administration and are organised and run by local authorities in conjunction with the state. Again no charge is made.

Before the Civil War there was only a nominal social service in Spain. The present system dates from the late 1940's.

Sweden

The health service in Sweden has covered the whole population since 1955, and is provided by a national health scheme. There is a reciprocal arrangement between Sweden and Britain whereby Britons can obtain the health service benefits provided in Sweden.

Individuals pay contributions to the health scheme according to their income tax liability, and employers and the state also contribute. These contributions cover both the cost of medical care and cash sickness benefits paid to patients.

There are about 7,200 doctors in Sweden of whom about 4,000 are hospital physicians. There are about 1,400 doctors in practice, but most have some specialty as well as being in general practice. There is no such thing as a doctors' panel of patients, so that patients may consult more than one doctor as well as choosing the hospital specialist they desire. The health service regulations stipulate a standard doctor's fee, which patients pay to the doctor, subsequently reclaiming 70 per cent. from the scheme. Doctors may charge higher fees, but the reimbursement is still only based on the standard fees. Doctors can prescribe any drugs but less than half of the cost is met by the health service. This amount is refunded direct by the health service to the pharmacist who collects the patient's proportion of the cost at the time of dispensing the medicine. Certain specified drugs required in the prolonged treatment of some diseases (e.g. diabetes) are supplied completely free.

Hospital care is provided free of charge in hospitals run by the county and city councils. According to the World Health Organisation there are about 930 hospitals in Sweden, with a total of 111,000 beds which is equivalent to one for every 70 of the population. Although even this is a higher proportion than in other European countries, other sources suggest that in fact the number and proportion of hospital beds in Sweden is greater still, and that there is one bed for every 50 of the population.

A shortage of dentists has delayed plans for extending free dental care to the whole population.

Switzerland

A Federal Swiss law of 1911 entitles all citizens to insure against illness and over 80 per cent. of the population are members of a social health scheme. The bodies responsible for this are the numerous mutual aid societies and cantonal or communal sick funds. If these societies fulfil the minimum requirements fixed by Federal law for health and accident insurance, they are subsidised by the federal government by means of an annual grant for each member. Although there is a Federal Health and Accident Insurance Law, it is for the cantons to decide whether and for whom membership of the health scheme should be compulsory. This power may be delegated to the communes. As a result in some cantons the scheme covers the whole population, and in others possibly as few as 50 per cent. may be covered. Overall the health service covers more than four-fifths of the population.

The amount of contributions paid varies considerably from fund to fund, owing to differences in the degree of risk and in the rules of the individual fund. Employers are not required to pay any part of these contributions, although they may do so voluntarily by arrangement with their employees.

There are over 5,000 physicians in Switzerland, one for every 1,000 of the population. All of these may treat health service patients, and are paid for each consultation either directly or indirectly by the sick funds. The patient usually has to contribute between 10 per cent. and 25 per cent. of the fee. Sick funds subsidised by the Government are required by law to pay at least 75 per cent. of the cost of non-proprietary preparations. They usually also pay at least 75 per cent. of the cost of proprietary preparations which are included in a list established by the federal board on the advice of an expert committee.

The subsidised sick funds are also obliged to make a contribution towards the cost of medical and pharmaceutical treatment in hospital. Maintenance costs are not a statutory benefit, but many funds make contributions to these costs also. Not all

the funds provide these benefits for an indefinite period, but impose time limits. For example medical and pharmaceutical benefits are frequently provided for only 180 days in any period of 360. There are 500 hospitals with a total of 70,000 beds. This is equivalent to one for every 75 of the population.

Sick funds are not legally required to pay for dental treatment, however, many do contribute to such costs.

United Kingdom

The National Health Service covers the whole population of Great Britain and Northern Ireland including temporary residents. It is provided mainly by the central government and the general medical, hospital, dental, pharmaceutical and ophthalmic services are supervised by local voluntary committees under the general direction of the Minister of Health.

The Health Service is financed primarily from general taxation. In addition a flat rate national insurance contribution independent of income is collected from the majority of people of working age. For employed people part of this contribution is paid by their employers. Only a small proportion of these payments, however, are used to finance the health service, and the remainder go towards the cost of other social security benefits, principally pensions.

There are about 23,000 general practitioners in the United Kingdom, approximately one for every 2,300 of the population. They may all accept patients under the National Health Service, and in practice nearly all do. Patients choose their own general practitioner, and then receive from him whatever treatment is necessary without payment. General practitioners receive a capitation fee for each patient on their list independent of the amount of treatment which the patient requires. Doctors are free to prescribe any drugs under the Health Service. The patient pays 2s. for each prescription, and the remaining cost of the drug is paid direct by the Govern-

ment to the pharmacy. Doctors are discouraged from prescribing nationally advertised or unnecessarily expensive medicines. There is a possibility that if their prescribing is excessive they may be charged part of the excess cost, although this sanction is rarely applied.

Hospital treatment, including out-patient consultations and diagnostic tests, is provided without charge and for an unlimited period. The hospitals are owned by the state, and administered on their behalf by local voluntary committees. Junior hospital doctors and some senior staff are full-time salaried employees.

Most of the consultants, however, are part-time staff. They still receive a salary and possibly a 'merit award' but they are also free to accept private patients.

Hospital beds are sometimes available in small wards or single rooms for patients who are prepared to pay a fairly modest charge. Such amenities are, however, often not available within the Health Service hospitals, and usually if patients wish privacy or special amenities they must enter a nursing home or the private wing of a hospital and must bear the whole cost themselves. About 3,200 hospitals have a total of 560,000 beds, roughly one for every 95 of the population. A major hospital building programme has just been initiated.

The National Health Service provides dental and ophthalmic treatment, although fixed charges may be levied on the patient for such services.

The present National Health Service was introduced in 1948. It was based on the previous Health Insurance Scheme which dated from 1911, and only covered a proportion of the population. Under the Health Service doctors are generally free to accept private patients and some private practice still exists. Approximately two per cent. of the population are also members of private insurance schemes, which mainly cover some private hospital and specialist treatment costs.

Office of Health Economics

The Office of Health Economics was founded in 1962 by the Association of the British Pharmaceutical Industry with the following terms of reference:

1. To undertake research to evaluate the economic aspects of medical care.
2. To investigate, from time to time, other health and social problems.
3. To collect data on experience in other countries.
4. To publish results, data and conclusions relevant to the above.

The Office of Health Economics welcomes financial support and discussion of research problems with any persons or bodies interested in its work.

Health Services in Western Europe

